STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING 00 B. WING	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOLY CROSS REHABILITATION AND WELLNESS	17475 DUGDALE DR SOUTH BEND, IN 46635

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 14, 15, 16, 17, 20 and 21, 2024 Facility number: 001201 Provider number: 155506 AIM number: 100380860 Census Bed Type: SNF/NF: 46 SNF: 31 Total: 77 Census Payor Type: Medicare: 16 Medicaid: 34 Other: 27 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 5/29/2024.	F 0000	F000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Roger Garmendia | Administrator | 06/14/2024

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	(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to provide the resident or representative, a notice of transfer/discharge or a copy of the bed hold policy for 1 of 1 resident reviewed for hospitalizations. (Resident 65) Finding includes: During an interview, on 5/14/24 at 10:29 A.M., Resident 65 indicated he was hospitalized a couple of weeks ago but could not recall why. A record review for Resident 65 was conducted on 5/16/24 at 9:31 A.M. Diagnoses included, but were no limited to, partial amputation of right foot and diabetes mellitus. A Five Day Minimum Data Set assessment, dated 4/19/24, indicated Resident 65 had an intact	F 0625	F625 – Bed Hold The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 65 is no longer a resident of the facility. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	07/05/2024

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	cognition Nursing Progress Notes, dated 5/1/24, indicated Resident 65 was sent to the emergency room for a change in condition and was admitted to the acute care center with a diagnosis of pneumonia. The record lacked documentation a notice of transfer/discharge or a bed hold policy was given to the resident when he was sent to the emergency room. During an interview, on 5/17/24 at 2:23 P.M., the DON indicated she was unable to find tdocumentation Resident 65 was provided a notice of transfer/discharge or a copy of the bed hold policy for the 5/1/24 admission to the hospital. On 5/20/24 at 3:24 P.M., the DON provided a checklist form for transfers and indicated there was not a policy that addresses documents that should be sent when a resident goes to the hospital but she did provide a checklist. 3.1-12(a)(25)(26)		A review of residents from the last 30 days was completed on those residents that were transferred/discharged to the hospital. Any identified concerns will be addressed with education to the staff members. Bed hold information was given to residents/responsible parties as necessary. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All active nurses and the SSD will be re-educated on the transfer/discharge process to include providing a notice of Bed hold form at time of transfer by 6/14/2024. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The IDT team will review all transfers and discharges the following business day to verify the notice of Bed hold was provided for 4 weeks. Then, a random audit of transfers will be completed by the DON/designee to verify the notice of Bed hold was provided weekly for 4 weeks, then monthly for 4 months. Results of audits will be	

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			taken to QAPI for review/revision as appropriate. Compliance Date: 7/5/2024	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

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	(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to develop a person-centered care plan addressing depression for 1 of 21 residents whose care plans were reviewed. (Resident 53) Finding includes: A record review was completed on 5/15/2024 at 12:22 P.M. for Resident 53. Diagnoses included, but were not limited to major depressive disorder, chronic obstructive pulmonary disease, and heart failure. A Care Plan, dated 4/29/2024, indicated Resident 53 had mood and behavior concerns related to depression. Interventions included: administer medications as ordered; provide a calm and quiet environment; monitor for triggers of mood changes and provide appropriate interventions as needed. There were no specific interventions to address what specific triggers the resident exhibited or what "appropropriate" interventions were planned for	F 0656	F656 – Comprehensive Care Plan The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 53 is no longer a resident in the facility. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit of depression care plans on all rehab residents was completed on 6/12/2024. Any concerns identified were addressed immediately.	07/05/2024

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	Resident 53. During an interview, on 5/20/2024 at 10:08 A.M., the Assistant Director of Nursing indicated Resident 53 did not have person-centered interventions for her Care Plan. A policy for developing person-center care plans was requested from the Director of Nursing, on 5/20/2025 at 10:30 A.M. During an interview on 5/20/2024 at 1:22 P.M., the Director of Nursing indicated the facility did not have a policy for person-centered care plans. 3.1-35(a)		Inter-disciplinary team will review all LTC residents' and Rehab residents' care plans during care conferences and as needed to assure care plan is comprehensive. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: An in-service with the inter-disciplinary team on Care Plan policies and procedures will be completed by 6/14/2024. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will complete a random audit of care plans that have been reviewed by the Care Conference team weekly for 4 weeks, then monthly for 5 months to assure care plans are comprehensive. Results of audits will be taken to QAPI for review/revision as appropriate. Compliance Date: 7/5/2024	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan			

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	must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review, and interview, the facility failed to ensure care plans were revised and care conferences were held quarterly for 2 of 3 residents reviewed for care planning. (Resident 37 & 58) Finding include: During an observation, on 5/14/2024 at 3:18 P.M., Resident 37's right hand was contracted and there was no splint on the resident's right hand. During an observation, on 5/15/2024 at 9:16 A.M.,	F 0657	F657 – Care plan Timing/Revision The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident 37’s care plan was revised to include the current order for his hand splint.	07/05/2024

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	Resident 37 was wearing a soft splint to her right hand. During an observation, on 5/17/2024 at 9:11 A.M., Resident 37 was not wearing a soft splint to her right hand. A Physicians Order, dated 8/31/2019, indicated to apply a soft resting hand splint to the right hand daily, place on prior to bed and take off upon rising. A Care Plan, dated 5/22/2020, indicated the following: -"I have right side hemiparesis related to cardiovascular accident. Interventions included: I wear a soft splint to my right hand, on in AM, off HS (hour of sleep)." -"I have self care deficits associated with need for assistance with activities of daily living (ADL's). Interventions included: right soft resting hand splint to right hand daily ON PB (prior to bed)." - "I am at risk for skin breakdown. Interventions included: right soft resting hand splint to right hand daily, on prior to bed, off at hour of sleep." During an interview, on 5/17/24 at 1:26 P.M., LPN 14 indicated Resident 37's soft right hand splint got put on in the evening prior to bed time and removed upon waking. She indicated the care plan needed to be revised. On 5/20/24, at 3:31 P.M., a policy for revising care plans was requested and one was not provided prior to the survey exit. During an interview, on 5/15/24 at 9:18 A.M.,		2. Staff reviewed the care plan for Residents 37 and 58 with their responsible parties on 6/13/2024 • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The Care review meeting schedule process was reviewed to ensure all residents are being scheduled for Care plan meetings according to the RAI manual and the resident or responsible party is invited to attend. All care plans will be reviewed by the IDT prior to each care plan meeting to assure the care plan reflects the current treatment plan. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur An in-service with the inter-disciplinary team on Care Plan policies and procedures will be completed by 6/14/2024. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will	

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	Resident 37's family indicated it had been more than a year since they had been invited to a care conference. A record review was completed on 5/16/24 at 9:56 A.M., for Resident 37. Diagnosis included, but were not limited to: Type 2 diabetes, aphasia, major depressive disorder, and dementia. There was no documentation in the record to indicate Resident 37 had a care conference conducted since 3/30/2023. During an interview, on 5/20/24 at 3:25 P.M., the DON indicated Resident 37 had not had a care conference in the last year and should have. 2. A record review was completed, on 5/16/24 at 3:12 P.M., for Resident 58. Diagnoses included, but were not limited to scoliosis, hypertensive heart disease, adjustment disorder with anxiety and depressed mood, and insomnia. During an interview, on 5/14/24 at 10:03 A.M., Resident 58's family indicated it had been 6-9 months since they were invited to a care conference. There was no documentation int he record to indicate Resident 58 had a care conference conducted between 6/27/23 and 3/21/24. During an interview, on 5/20/24 at 3:25 P.M., the DON indicated Resident 37 and Resident 58 did not have a care conference every quarter and should have had one scheduled. On 5/20/24, at 3:28 P.M., a policy for care conferences was requested and one was not provided prior to the survey exit.		complete a random audit of care plans that have been reviewed by the Care Conference team weekly for 4 weeks, then monthly for 5 months to assure care plans are comprehensive. The DON or designee will complete a random audit to assure care plan meetings are being scheduled per RAI manual and the resident/responsible party is invited to attend weekly x4 weeks, then monthly for 5 months. Results of audits will be taken to QAPI for review/revision as appropriate. Compliance Date: 7/5/2024	

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	3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs) related to bed baths, shaving, and turning and positioning per standards of care for 2 of 3 residents reviewed for ADL care. (Resident 37 & 46) Finding includes: 1. During an observation, on 5/14/24 at 3:18 P.M., Resident 37's fingernails were long and dirty. During an observation, on 5/15/2024 at 9:16 A.M., Resident 37's fingernails remained long and dirty. During an observation, on 5/16/2024 at 10:19 A.M., Resident 37's fingernails remained long and dirty. A record review was completed on 5/16/2024 at 9:56 A.M. for Resident 37. Diagnoses included, but were not limited to hemiplegia and hemiparesis, type 2 diabetes, major depressive disorder, dementia, and aphasia. A Quarterly Minimum Data Set (MDS) assessment, dated 3/6/2024, indicated that Resident 37 had severely impaired cognition and was dependent on staff with bed mobility, transfers, dressing, toileting, hygiene and bathing,	F 0677	F677 – ADL Care The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident 37 has been offered and has received bed baths at least 2 times weekly. Nail care has been provided for resident 37. 2. Resident 46 has been offered and has been shaved, turned, and repositioned according to his preferences. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The bath schedule was reviewed to assure all residents are offered a bath according to their preferences. Resident summaries will be reviewed according to the RAI schedule to	07/05/2024

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	and required a mechanical lift (hoyer) with two staff for transfers. A current Care Plan, dated 8/8/2019, was provided and indicated Resident 37 required staff assistance with deficits of activities of daily living (ADLs) with a current intervention of "Assist with personal hygiene." On 5/20/2024 at 10:30 A.M., Resident 37's shower record from 3/8/2024 to 5/16/2024 was provided by the Administrator. Resident 37 received one bed bath between 4/16/2024 and 4/30/2024, and one bed bath between 5/3/2024 and 5/13/2024, with no refusals of care documented for that time period. During an interview, on 5/16/24 at 11:01 A.M., CNA 13 indicated during a sponge bath warm water and soap were used and staff washed the resident's entire body. Nail care was included in sponge baths and whenever staff observed the resident needed it. During an interview, on 5/21/24 at 09:11 A.M., the DON indicated the resident should have had additional bed bath during the timeframe where there were large gaps between dates. 2. During an interview on 5/15/2024 at 9:25 A.M., Resident 46 indicated that he never gets shaved unless CNA 12 worked, she was the only one who shaved him. When he lived at home, he shaved every day, and he preferred to be shaved daily. He was observed to be unshaven at the time of the interview.. During an observation on 5/15/2024 at 2:56 P.M., he was remained unshaved. During an observation and interview on 5/16/2024 at 10:44 A.M., Resident 46 indicated he had not		assure ADL directions to the clinical staff are accurate and inclusive of needed support with ADLs. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All active Nursing staff will be educated on daily cares per the resident care plan to include shaving, completing nail care, repositioning, and the bath schedule to include documentation of completed baths by 6/14/2024. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON/unit managers/designee will complete a random audit of bath documentation to assure baths completed per resident preference 2x/week for 4 weeks, then weekly for 4 weeks, then monthly for 4 months. The DON/unit managers/designee will complete random audits to assure shaving and nail care is being completed and repositioning of residents being completed per resident care plan 2x/week for 4	

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	been washed up yet or shaved today and his call light was on to be changed. During an observation and interview on 5/16/2024 at 3:05 P.M., Resident 46 indicated he was not shaved today, facial hair was present. During an observation on 5/17/2024 at 9:15 A.M., Resident 46 was unshaven. During an observation on 5/17/2024 at 2:08 P.M., Resident 46 was unshaven. During an observation and interview on 5/20/2024 at 9:24 A.M. Resident 46 indicated he had not been shaved all weekend, he had an increased growth of whiskers. During an observation on 5/21/2024 at 9:35 A.M., Resident 46 was unshaven. A record review was completed on 5/17/2024 at 9:05 A.M. for Resident 46. Diagnoses included, but were not limited to cardiovascular accident, hemiplegia, hemiparesis, peripheral vascular disease and depression. A Quarterly Minimum Data Set Assessment, dated 4/24/2024, indicated Resident 46 was dependent for oral hygiene, personal hygiene, shower/bath, upper and lower body dressing, toileting, transfers and bed mobility. He had limited range of motion on one side to the upper and lower body extremity. A Care Plan, dated 2/12/2019, for self care deficit associated with need for assistance with ADL's related to history of cerebrovascular accident resulting in left sided weakness, included a goal the for the resident to be neat, clean and		weeks, then weekly for 4 weeks, then monthly for 4 months. Results of audits will be taken to QAPI for review/revision as appropriate. Compliance Date: 7/5/2024	

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	155506	A. BUILDING 00 B. WING	05/21/2024

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	well-groomed. A Resident Summary on activities of daily living care/bathing, dated 1/3/2022, indicated Resident 46 was extensive assist of 2 with a hoyer lift for transfers and bed mobility, supervision with eating, assist with oral care twice daily, expressed a shower preference of twice a week and had full dentures. On 5/17/2024 at 11:30 A.M., the DON indicated resident preferences could be found on the resident's summary. During an interview on 5/16/2024 at 1:42 P.M., CNA 5 indicated when she completed morning care, she washed the resident's underarms and peri-area, brushed the resident's teeth, applies lotion, combed the resident's hair and made the bed. During an interview on 5/16/2024 at 2:01 P.M., CNA 6 indicated that when she completed morning care, she provided a bed bath, applied lotion, assisted with dressing, brushed the resident's teeth, combed the resident's hair and offered a shave. During an interview on 5/17/2024 at 9:18 A.M., CNA 7 indicated that when she completed morning care, she washed the resident's upper body, then peri-area, put on a brief, assisted with dressing, and brushed the resident's teeth. During an interview on 5/20/2024 at 11:13 A. M., the Director of Nursing indicated she did not have a policy on activities of daily living or shaving. During an interview on 5/15/2024 at 9:25 A.M., Resident 46 indicated that the staff did not turn			

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	him every two hours. He indicated he would like to get the pressure off his buttock, he became sore at times and rarely got out of bed. During an observation and interview on 5/16/2024 at 10:44 A.M., Resident 46 indicated he had not been washed up yet or shaved today and his light was on to be changed. Resident 46 was lying in a supine position in bed. During an observation on 5/16/2024 at 3:05 P.M., Resident 46 was on his back in bed. During an observation on 5/17/2024 at the following times: 9:15 A.M., 10:28 A.M., 11:48 A.M., 1:18 P.M., 2:08 P.M., resident was in bed positioned on his back. During an interview on 5/17/2024 at 11:48 A.M., Resident 46 indicated no one has turned and repositioned him today. During an observation on 5/20/2024 at the following times: 9:24 A.M., 11:50 A.M. and 2:37 P.M. the resident was lying on his back in bed. During an observation on 5/21/2024 at 9:35 A.M., the resident was lying on his back in bed. The CNA documentation on turn and reposition for Resident 46 in the electronic medical record indicated the following:: 5/14/2024 1:51 P.M. 5/14/2024 9:13 P.M. 5/15/2024 3:20 A.M. 5/15/2024 11:29 A.M. 5/15/2024 2:25 P.M. 5/16/2024 12:10 A.M. 5/16/2024 2:08 P.M. 5/16/2024 3:46 P.M.			

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	5/16/2024 11:52 P.M. 5/17/2024 10:35 A.M. 5/17/2024 9:49 P.M. 5/18/2024 12:43 A.M. 5/18/2024 12:59 P.M. 5/18/2024 7:13 P.M. 5/19/2024 5:40 A.M. 5/19/2024 9:23 P.M. 5/20/2024 3:59 A.M. 5/20/2024 10:50 A.M. 5/20/2024 9:25 P.M. 5/21/2024 12:14 A.M. A Care Plan, dated 2/12/2019, for risk for skin breakdown related to left side hemiparesis, weakness, and history of cerebrovascular accident, with an intervention to assist with turning and repositioning as directed on resident summary. A Resident Summary for Resident 46, , on mobility/specialized devices dated 9/16/2021, indicated to ensure resident is lying in the middle of the bed, and position the legs and feet to prevent pressure injuries. Skin care dated 9/16/2021 indicated care of the supra pubic catheter to prevent skin breakdown. During an interview on 5/17/2024 at 11:40 A.M., CNA 7 indicated when she took care of a dependent resident, she would turn and reposition them every two hours, and do range of motion, provided a drink of water, if nothing by mouth (NPO) she would provide oral care every time she changed them. During an interview on 5/17/2024 at 11:43 A.M., CNA 8 indicated when she took care of a dependent resident, she checked and changed them every two hours and assisted with meals if			

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	needed. During an interview on 5/21/2024 at 9:11 A.M., the DON indicated the resident summary did not mention turning and repositioning the resident, she would expect her staff to do rounds every couple of hours to keep residents clean and repositioned. The staff were not charting in the kiosk like she would prefer regarding turning and repositioning of residents. She indicated there needed to be more information be added to the resident summary. On 5/20/2024 at 11:13 A.M., the DON indicated they did not have a policy regarding turning and repositioning or completing the resident summary. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence			

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	unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure a resident with a limited range of motion received appropriate treatments and services to prevent further decrease in range of motion for 1 of 3 residents for range of motion. (Resident 46) Finding includes: During an interview and observation on 5/15/2024 at 9:35 A.M., Resident 46 indicated RN 4 is was the only nurse that put his left hand splint on him. There was no splint observed on the resident's left hand. During an observation and interview on 5/16/2024 at 10:42 A.M., the resident was awake and indicated he had not seen his nurse today. The resident did not have a splint on his left hand. During an observation on 5/17/2024 at 10:59 A.M. at 10:59 A.M., 1:18 A.M., and 2:09 P.M. Resident 46 did not have a left hand splint on. The splint was noted on the nightstand. During observations on 5/20/2024 at 9:25 A.M., 11:49 A.M., and 2:37 P.M., Resident 46's left hand splint was not on the resident's hand. The splint was observed on the top of his nightstand. During an observation on 5/21/2024 at 9:35 A.M., Resident 46 was awake and his hand splint was not on the left hand. A record review was completed on 5/17/2024 at 9:05 A.M., for Resident 46. Diagnoses included, but were not limited to cardiovascular accident, hemiplegia, hemiparesis, peripheral vascular	F 0688	F688 – ROM/Mobility The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The physician's order and care plan for Resident 46 were verified/updated to reflect current treatment plan. Hand splint has been offered and will be worn according to residents' preferences and physicians' orders. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents with orders for splints/orthotics were reviewed to assure physician order and care plan for the splint/orthotic were accurate. These residents were reviewed to assure the orthotic/splint is being applied per treatment plan. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:	07/05/2024

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	disease and depression. A Physician Order, dated 11/3/2022, indicated : "orthosis/splint two times a day, apply to the left hand resting splint, on upon risking and off prior to bed." A Care Plan for self- care deficit, dated 2/12/2019, included an intervention to apply left hand resting splint upon rising and may remove prior to bed and for hygiene and skin inspection. The May 2024 TAR (Treatment Administration Record), indicated that the splint was applied on the following dates: 5/15/2024, 5/16/2024. 5/17/2024 and 5/20/2024. During an interview on 5/20/2024 at 3:30 P.M., the DON indicated the day nurse was finishing her end of shift report and had not completed her scheduled day shift treatments. During an interview on 5/21/2024 at 9:26 A.M., the DON indicated she would expect her staff to follow the physician's orders for splints/braces. During an interview on 5/21/2024 at 9:31 A.M., LPN 9 indicated that Resident 46 wore a left hand splint and she sometimes put it on him after noon, even though the order was upon rising. She completed her treatment last because the med pass was so heavy and sometimes she did not finish until 5:00 P.M. During an interview on 5/21/2024 at 9:26 A.M., the DON indicated there had no policy for splint or braces 2.1-42(a)(2)		All active Nursing staff will be educated on following physicians' orders/care plan for application of splints/orthotics by 6/14/2024 • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON/unit managers/designee will complete a random audit of residents with orders for splints/orthotics to assure they are being applied per order/care plan 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x 4 months. Results of audits will be taken to QAPI for review/revision as appropriate. Compliance Date: 7/5/2024	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications stored in the med cart were labeled according to accepted professional standards for 1 of 3 medication carts observed. (St. John's Way medication cart) Finding includes: During an observation of the medication cart on St. John's Way, on 5/20/24 at 10:16 A.M., with LPN 11, a half full bottle of milk of magnesia was	F 0761	F761 – Medication Storage/Labeling The facility requests paper compliance • What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	07/05/2024

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	found without a pharmacy label or any information to identify the resident to whom it belonged. During an interview, on 5/20/24 at 10:16 A.M., LPN 11 indicated she did not know to whom the milk of magnesia belonged. She did not know why it was there and it should not be kept in the cart. Resident medications were kept in their room in a locked cabinet. On 5/20/24 at 2:07 P.M., the Executive Director provided a policy titled, "Storage and Expiration Dating of Medications, Biological's," dated 8/7/23, and indicated the policy was the one currently used by the facility. The policy included, but was not limited to, "...Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels...." 3.1-25(j)		The bottle of Milk of Magnesia has been removed from the medication cart on St. John's and destroyed. • How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: An audit of the medication carts for all units was completed to assure proper medication labeling and storage on 6/1/2024. Any identified concerns were addressed immediately. • What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All active nurses and medication aides will be educated on appropriate procedures for labeling and storage of medications by 6/14/2024. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON/unit managers/designee will audit medication carts weekly for 4 weeks, then monthly x 5 to ensure proper medication storage and labeling. Results of audits will	

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			be taken to QAPI for review/revision as appropriate. Compliance date: 7/5/2024	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation and record review, the facility failed to maintain appropriate food temperatures of the meal trays on St. Paul's Unit. This had the potential to affect the 21 Residents who eat on St. Paul's Unit. Finding includes: During an interview, on 4/15/2024 at 11:15 A.M., Resident 117 indicated he ate his meals in the dinning area on the unit and most of his meals were cold. Resident 117 was able to request to have his meals heated to a warmer temperature, but stopped asking because every meal was cold. An observation of food temperatures for the meal trays on St. Paul's Unit was completed, on 5/20/2024 at 12:13 P.M. The Dietary Project Manager pulled the first tray off the food cart and used her thermometer to take the temperature of	F 0804	F804 – Palatable/Preferred Food Temperature The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Tray temperatures are being checked prior to service of each meal on St. Paul's and any trays found below the recommended temperatures are addressed immediately. • how other residents having the potential to be affected by the same deficient practice will be	07/05/2024

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	the food. The cabbage had a temperature of 135 degrees Fahrenheit and the pot roast had a temperature of 141 degrees Fahrenheit. The Dietary Project Manger requested a dietary aide begin microwave each plate. There were 21 trays on the food cart. During an interview, on 5/20/2024 at 12:15 P.M., the Dietary Project Manager indicated the cabbage and pot roast were not at the correct temperature to serve and all the meals trays on St. Paul's Unit would have to be heated in the microwave until the food was 145 degrees Fahrenheit. On 5/20/2024 at 2:13 P.M., the Administrator provided a current policy, dated 1/2024, and titled, "Meal Quality and Temperature." The policy indicated, "...Food and drinks are palatable, attractive and served at a safe and appetizing temperature to ensure resident satisfaction and to meet nutrition and hydration needs...." 3.1-21(a)(2)		identified and what corrective action(s) will be taken; Tray temperatures for all units are being checked prior to service of each meal and any trays found below the recommended temperatures are addressed immediately. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Dietary staff will be educated on assuring proper food temperatures prior to meal service 6/14/2024. Plate warmer and SmartTherm unit have been inspected to ensure they are functioning appropriately. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Dietary Services Manager/designee will complete a random audit of food tray temperatures prior to meal service 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x 4. Results of audits will be taken to QAPI for review/revision as appropriate.	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared and served in a sanitary manner in 1 of 1 kitchens observed. The facility also failed to ensure food brought in by outside sources and placed in resident nourishment refrigerators was stored in accordance with professional standards for food safety and used for food and beverages only for 4 of 4 panty rooms observed. This deficient practice had the potential to affect 76 of 77 residents who resided in the facility and consumed from from the kitchen	F 0812	F812 – Kitchen The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. The ice scoops in the kitchen were cleaned, sanitized, and properly stored immediately. 2. The stuffing, wheat pasta, ziti	07/05/2024

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	or pantries.. Findings include: 1. Upon entering the kitchen on 5/14/2024 at 9:05 A.M., on top of the ice machine was 2 scoops lying uncovered, and the storage container was open but empty. During an interview on 5/14/2024 at 9:06 A.M., the Dietary Supervisor indicated that the scoop storage container was broken, and they had just been laying the scoops on top of the machine, another container had been ordered. On 5/15/2024 at 3:33 P.M., the Administrator provided a policy titled, "Sanitation and Infection Prevention/Control," dated 1/24 and indicated the policy was the one currently used by the facility. The policy indicated "...Use a scoop to remove ice from the storage bin into the receptacle used for service. Store the scoop in a self-draining container, in an area protected from contamination. The scoop cannot be stored in the ice bin, unless the container for the scoop is placed in a way that does not allow the ice scoop handle to come in contact with the ice....." 2. On 5/14/2024 at 9:07 A.M. to 9:44 A.M., an initial tour of the kitchen was completed with the Dietary Supervisor and the following was observed: a. Dry storage there was a bag of stuffing with an open date of 4/7/2024 with a best used by date of 4/10/2024, a bag of wheat pasta opened 12/12/2023 with best used by date of 5/9/2024, a bag of ziti noodles opened 3/23/2023 with best used by date of 3/21/2024, a box of Orzo opened 4/20/2024 with best used by date of 4/23/2024 and a container of coriander spice expired 2/27/2024.		noodles, Orzo and coriander spice in the dry storage area were disposed of. 3. The opened/undated items in the freezer were disposed of. 4. The Sous chef was re-educated on wearing a facial hair cover when working with food in the kitchen. 5. CAN 3 was re-educated on not touching food with bare hands. 6. The undated/unlabeled food was disposed of from the St. John's nourishment refrigerator. 7. The ice packs were removed from the St. Mark's refrigerator. 8. The ice packs were removed from the St. Luke's refrigerator. 9. The pizza in the St. Joseph's Way refrigerator was disposed of. 10. The undated food in the St. Paul's refrigerator was disposed of. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit of the kitchen stock completed on 6/8/2024 revealed no other expired items/items without opening date. An audit of all nourishment refrigerators completed on 6/8/2024 revealed no other issues. An audit of all ice machines in the facility revealed no other issues. Meals with ready-to-eat items are being monitored for appropriate food	

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	b. In the freezer the following items were opened, unsealed and undated: a box of cooked sausage crumble, chicken Kiev portions, pate scones, cookies and green beans. There was also an opened unsealed bag of carrots open dated 5/11/2024 and pollack fish dated 5/11/2024. During an interview on 5/14/2024 at 9:17 A.M., the Dietary Supervisor indicated the food should be dated when open and sealed. On 3/15/2024 at 3:24 P.M., the Administrator provided a policy titled, " PRODUCTION, PURCHASING, STORAGE, FOOD AND SUPPLY STORAGE," dated 1/24, and indicated the policy was the one currently used by the facility. The policy indicated, "...Most but not all products contain an expiration date. The words "sell-by", "best-by", "enjoy by" or "use-by" should precede the date. The "sell-by" date is the last date that food can be sold or consumed; do not sell products in retail areas or place on patient trays/resident plates past the date on the product. Foods past the "used-by", "sell-by", "best-by", or "enjoy-by" date should be discarded. Cover, label and date unused portions and open packages. Complete all sections on a Morrison orange label or use the Medvantage/Freshdate labeling system. Products are good through the close of business on the date noted on the label. 3. During a follow up observation in the kitchen, on 5/16/2024 at 11:10 A.M.,the Sous Chef 2 was pureeing zucchini and pasta. The Sous Chef had a mustache and a goatee, approximately 1/4 inch long, neatly trimmed, without a hair restraint. During an interview on 5/16/2024 at 11:26 A.M., the Sous Chef indicated he did not have to wear a hair restraint because he kept it short. The State		handling. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All kitchen staff will be educated on food storage procedures, and beard cover policy by 6/14/2024. All staff will be educated on ice scoop storage, ready-to-eat food handling procedures, and food storage procedures as well as not storing staff food on the units and not storing ice packs in the nourishment refrigerators by 6/14/2024. Nursing staff will be educated on properly assisting residents with eating without touching food with bare hands. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Dietary Services Manager/designee will complete a random audit of food storage areas, refrigerators, and ice machines to ensure all policies followed 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate.	

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	allowed it. The Project Manager handed him a hair restraint. On 5/16/2024 at 12:10 P.M., the Project Manager provided a policy titled, "Safety and Sanitation, Hair Restraints/Beard Guards," revised 2/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...Beards* are not recommended for any team member who handles food however if a team member had a beard/Facial Hair 1/4' growth or more than a beard guard must be worn at all times while in the kitchen and/or handing food. *Please refer to the local state requirements....." 4. During a dining room observation on 5/14/2024 at 12:05 P.M., Resident 4 was given his tray with the food covered. At 12:15 P.M., the resident's food was uncovered and CNA 3 sat down to assist the resident with his meal of sandwich and chips. CNA 3 was observed feeding the resident his sandwich and potato chips with her bare hands. During an interview on 5/14/2024 at 12:24 P.M., CNA 3 indicated she should be wearing gloves when assisting with finger-foods, however, the DON had informed her they were not to wear gloves outside the resident's rooms. CNA 3 indicated she was confused regarding when she should be wearing gloves. On 5/15/2024 at 3:29 P.M., the DON indicated they did not have a policy on assisting with meal service with dependent residents or the passing of trays. 5. During an observation on 5/20/2024 at 10:07 A.M., St. John's nourishment refrigerator		The Dietary Services Manager/designee will complete an audit to assure staff has proper hair/beard covering on per policy 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate. The DON or designee will complete a random audit to assure staff assisting residents with eating properly without touching food with bare hands weekly x4, then monthly x5. Results of audits will be taken to QAPI for review/revision as appropriate. Compliance Date: 7/5/2024	

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	contained a covered dinner plate with a note stating "SAVE" containing a chef's salad, a store bag with 4 containers of Okio brand yogurt without a label or date. 6. During an observation on 5/20/2024 at 10:08 A.M., the St. Mark's refrigerator/freezer contained three resident's treatment ice packs in the freezer with ice cream cups. The Project Manager did not know why the treatment ice packs were in the freezer with food items. 7. During an observation on 5/20/2024 at 10:11 A.M., the St. Luke's unit freezer contained had 4 resident's treatment ice packs, along with an unlabeled frozen dinner and ice cream cups. 8. During an observation on 5/20/2024 at 10:18 A.M., the St. Joseph Way refrigerator contained a cardboard pizza box, dated 5/18/2024 and labeled [first name]. The Project Manager indicated it was a staff member's pizza. 9. During an observation on 5/20/2024 at 10:21 A.M., the St. Paul's refrigerator contained take out containers from the store of chicken Alfredo and 2 salads with Resident 16's name on it, all undated. During an interview on 5/20/2024 at 10:23 A.M., the Project Manager indicated food brought in by the residents needed to be labeled with their name and the date. Employee foods should not have been in the resident refrigerator and residents' treatment ice packs caused cross contamination. On 5/20/2024 at 11:28 A.M., the Project Manager provided a policy titled, "Use and STORAGE OF FOOD BROUGHT TO RESIDENTS FROM THE OUTSIDE." revised 1/24, and indicated the policy was the one currently used by the facility. The			

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	policy indicated "...The outside food must be stored in a container with a tight-fitting lid, clearly labeled with the residents name and room number, the date the food was brought to the resident, and the use-by date....." On 5/20/2024 at 12:55 P.M., the Project Manger provided a policy titled, "Cleaning of Refrigerators," revised 11/1/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Food for colleagues shall not be stored in the resident refrigerator....." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

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	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to follow standards of practice for infection control to help prevent the development and transmission of communicable diseased and infections for 1 of 3 residents who received pressure ulcer care requiring enhanced barrier precautions (EBP) and 1 of 4 residents observed during medication administration. (Residents 181 and 16) Findings include: 1. During an observation, on 5/17/24 at 11:41 A.M., RN 10 was documenting on the computer immediately before donning gloves to perform a blood glucose check for Resident 181. He did not wash his hands prior to donning the gloves. He cleansed the resident's finger with an alcohol swab and fanned the area with his gloved hand. During an interview, on 5/17/24 at 11:45 A.M., RN 10 indicated he should have washed his hands before applying the gloves and did not know fanning the swabbed area was an infection control issue.2. During an observation of wound dressing change for Resident 16 on 5/17/2024 at 1:53 P.M., LPN 9 applied alcohol based hand rub (ABHR), donned gloves and soaped up washcloths, placed them on a towel on the bed, removed the resident's ace wrap and the soiled dressing from his heel. Next, she picked up the washcloths, cleaned the wound, then applied the	F 0880	F880 – Infection Control The facility requests paper compliance • What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1. RN 10 has been educated on the handwashing prior to donning gloves and proper technique to obtain a blood glucose level. 2. LPN 9 has been educated on proper dressing change technique including handwashing. Resident 16 had Enhanced Barrier Precautions signage applied to door and PPE placed for Enhanced Barrier Precautions due to wound. • How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents were reviewed for need of Enhanced Barrier Precautions and signage/PPE	07/05/2024

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	treatment, kerlix and ace wrap. She then gathered the trash, removed her gloves and washed her hands. Prior to the dressing change the nurse did not don a gown. There was no isolation signage on the door and no isolation supplies noted in the room or just outside the room in the hallway. A record review was completed on 5/16/2024 at 1:53 P.M., for Resident 16. Diagnoses included, but were not limited to type 2 diabetes, peripheral vascular disease and chronic kidney disease. A Physician Order, dated 5/15/2024, indicated wound care for a stage 3 pressure ulcer: "cleanse the right heel with soap and water, pat dry, apply collagen to wound base, cover with ABD and wrap with rolled gauze. The dressing was to be changed daily and as needed. A Physician Order, dated 5/1/2024, indicated Enhanced Barrier Precautions (EBP), maintain EBP during high contact resident care activities. An undated active Care Plan indicated: " EBP due to the wound on the heel." An undated active Care Plan for at risk of complications related to right heel stage 3 included an intervention for staff to perform treatment as ordered. During an interview on 5/17/2024 at 2:00 P.M., LPN 9 indicated after she removed a soiled dressing, she should continue to follow the orders. ecause she had a wound, she did not put on the required personal protective equipment (PPE) because it was not available in the resident's room. She indicated she would have put it on if it had been in the room..		supplies taken for residents identified as needing Enhanced Barrier Precautions. Care plans updated as necessary. All active nurses were re-educated on the proper techniques for dressing change and obtaining a blood glucose to include handwashing. • What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All active nurses will be re-educated on proper procedures with dressing change and obtaining a blood glucose. All active clinical staff will be re-educated on Enhanced Barrier Precautions requirements/what qualifies a resident for EBP. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Infection Control Preventionist/designee will complete random audit of 1. Dressing change procedure; 2. Obtaining a blood glucose weekly for 4 weeks, then monthly x 5 to assure proper procedures are being followed. The Infection Control	

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	During an interview on 5/17/2024 at 2:37 P.M., the Director of Nursing indicated when a dressing change was done, she would expect the staff member to gather supplies, wash their hands, remove the soiled dressings, then remove their gloves and wash their hands and put clean gloves on, then cleanse the wound per treatment order, secure, pick-up trash, remove gloves and wash their hands. When completing a treatment in an EBP room, a gown and gloves should be worn during a wound dressing change. On 5/20/2024 at 9:13 A.M., the DON indicated they do not have a policy on dressing changes, but they followed the standard of practice, physician orders and handwashing. On 5/20/2024 at 11:29 A.M., the DON provided a policy titled, "Hand Hygiene," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Hand hygiene occurs before and after direct resident contact. Hand hygiene occurs after contact with blood, body fluids, secretions, excretions, and equipment, or contaminated articles....." On 5/21/2024 at 8:37 A.M., the DON provided a policy titled, "Enhanced Barrier Precautions," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Gloves and Hand Hygiene - Wear gloves during the course of providing high contact resident care. - Avoid contaminating other surfaces with gloved hand, - Remove gloves before leaving the resident's room and immediately wash hands with an antimicrobial agent or use waterless hand sanitizer. Gown- Wear gown during high contact resident care activities such as dressing,		Preventionist/designee will complete a random audit of residents on EBP to assure signage in place and PPE placed for staff as well as staff properly donning PPE with high contact resident care activities 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate. Compliance Date: 7/5/2024	

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	bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care. - Remove gown before leaving the room and immediately perform hand hygiene....." 3.1-18(l)			