STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD STATE ROAD 60 SELLERSBURG, IN 47172

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 7, 8, 9, 10, 11, and 15, 2024. Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census bed type: SNF/NF: 100 Total: 100 Census Payor type: Medicare: 15 Medicaid: 77 Other: 8 Total: 100 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 23, 2024.	F 0000		
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review and interview, the facility failed to ensure that care was provided related to mobility and mouth care for 2 of 11 residents reviewed for Activities of Daily Living. (Residents 46 and 250) Findings include, 1. During an observation on 10/8/24 at 11:30 a.m., Resident 46 was observed in the bed. He had a	F 0677	**F 677** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of**	11/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Jackson	Administrator	11/04/2024

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	below the knee amputation on the left leg. The resident indicated he did not get up out of the bed and he would like to get up. He wasn't sure why no one got him up. The record for Resident 46 was reviewed on 10/9/24 at 8:25 a.m. The resident's diagnoses included, but were not limited to, orthopedic aftercare following a surgical amputation, acquired absence of the left leg below the knee, and muscle weakness. The Annual Minimum Data Set (MDS) assessment, dated 9/6/24, indicated the resident was moderately cognitively intact. The resident required complete dependence of staff for transfers. The resident required a wheelchair for mobility. The physician's order, dated 5/30/24, indicated to encourage the resident to get out of bed daily, one time a day for mobility. The resident needed to be supervised while he was up in his wheelchair. The care plan, with a start date of 9/3/22 and a revision date of 9/30/24, indicated the resident required assistance's with ADLs. The interventions included, but were not limited to, the resident required staff assistance of two for putting on and taking off footwear, transfers, required the use of a mechanical lift with the assistance of two staff members, and mobility. The Social Service note, dated 9/6/24 at 4:25 p.m., indicated the resident communicated well with staff and used his call light appropriately when needing assistance. The resident indicated that his sleep routine had improved since the last assessment. He added that he does feel tired and		**Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey conducted on October 7, 8, 9, 10, 11, and 15, 2024. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Resident 46 and 250 were not harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who are unable to carry out ADL care per self could be affected by deficient practice. All residents interviewed to ensure ADL preferences obtained. Any concerns	

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	experiences some sadness about his mobility limitations. During an interview on 10/10/24 at 2:15 p.m., Certified Nursing Aide (CNA) 4 indicated the resident loved it when he got up. He did refuse if he wasn't feeling good. He was not safe in his wheelchair and needed supervision. She indicated he enjoyed going to the dining room to eat dinner. When dinner was over, she would take him back to the hall lobby and let him watch the big television while she was charting. She indicated she thought physical therapy was going to evaluate the resident for a deeper chair. During an interview on 10/11/24 at 9:15 a.m., the Physical Therapy Director indicated last summer OT (Occupational Therapy) and PT (Physical Therapy) worked several months with the resident. He was evaluated for a different chair and received one that was bigger and deeper. He had to have a leg rest with his left prosthesis leg on for stability. If his feet were on the footrest, he did good. His prosthetic leg was on for sitting in the chair and not for walking. The staff had been educated on getting the resident up in his chair with a Hoyer lift. The resident forgot his left leg had been amputated. He tried to get up and that was why he needed supervision while up in the chair. She indicated OT had educated and monitored the resident and staff from July to November of 2023. She was not sure why the resident wasn't getting up because there was no reason he couldn't get up. Any time the resident needed re-evaluated, they would do that. The resident did tend to refuse getting up out of bed. He had short term memory loss and forgot he agreed to get up then he would refuse. 2. During an observation on 10/10/24 at 11:00 a.m.,		addressed immediately. All residents observed for the need of oral care. Any concerns addressed immediately. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not Recur:** The DNS/Designee held an in-service for Direct care staff to provide education and expectations as it relates to the policy “Routine Resident Care.” Including completion of all direct care staff completing oral care procedure check off. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The DNS/ Designee will audit 5 resident per week x 4 weeks, then 4 residents per week x 4 weeks, then 2 residents per week x 4 weeks for no less than 3 months and compliance is maintained to ensure proper oral care completed. The DNS / Designee will audit 5 resident per week x 4 weeks, then 4 residents per week x 4 weeks, then 2 residents per week x 4 weeks for no less than 3 months and compliance	

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	Resident 250's hair looked greasy and tangled. Her hair had not been combed. The resident's mouth and lips were dry in appearance. Her mouth was dry and had dried mucous around her lips, tongue and the roof of her mouth. During an observation on 10/11/24 at 1:10 p.m., the resident's mouth and lips were dry. The resident's mouth had dried flaky mucous on her teeth. The record for Resident 250 was reviewed on 8/6/22 at 11:22 a.m. The resident's diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, the need for assistance with personal care, tracheotomy, cerebral infarction, other sites of candidiasis, and a carrier of Carbapenem-Resistant Acinetobacter Baumannii (CRAB). The Admission MDS assessment, dated 9/3/24, indicated the resident was rarely or never understood. The resident was totally dependent on staff for her ADLs. The physician's order, dated 8/28/24 at 6:00 a.m., indicated staff were to provide mouth care every shift. During an interview on 10/11/24 at 1:15 p.m., RN 6 indicated oral care should be done every two hours and as needed. When Respiratory Therapy did tracheotomy care they would provide oral care. The current Routine Resident Care policy, indicated ..." i. Assisting or provides for personal care 1. bathing 2. dressing 3. eating and hydration 4. toileting... f. Assisting in techniques of ambulation and in providing exercises as directed		is maintained to ensure residents requiring ADL assistance were assisted out of bed upon request. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	by the physical therapist, speech therapist, or occupational therapist between visits... i. Assisting with special devices such as prosthesis, eating devices, other..." 3.1-38 (a)(3)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure the prevention of Urinary Tract Infections and proper perineal care for 2 of 6 residents reviewed for bowel and bladder. (Residents 4 and 36) Findings include: 1. The record for Resident 4 was reviewed on 10/10/24 at 2:50 p.m. The resident's diagnoses included, but were not limited to, cerebral palsy, neuromuscular dysfunction of the bladder, muscle weakness, need for assistance with personal care, anemia, and candidiasis. The current care plan, start date 6/28/23, indicated the resident had an indwelling urinary catheter related to a neurogenic bladder. The interventions, dated 6/29/23, indicated to place the resident in Enhanced Barrier Precautions when dressing/bathing/showering/transferring/personal hygiene, changing linens, toileting, and peri-care, providing care to the urinary catheter, and to provide catheter care every shift and PRN (as needed), and to notify the medical provider if the urine was abnormal in color, consistency, or odor. The current physician's order, dated 8/2/23, indicated staff were to provide indwelling catheter care every shift and PRN with soap and water.	F 0690	**F690** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey conducted on October 7, 8, 9, 10, 11, and 15, 2024. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA**	11/18/2024

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	Secure the straps, if applicable, and document the output every shift. The Quarterly Minimum Data Set (MDS) assessment, dated 4/17/24, indicated the resident was severely cognitively impaired and was dependent on staff for toileting hygiene. The urinalysis results, dated 9/21/24, indicated the resident had one plus bacteria of the urine, three plus leukocyte esterase, and trace amounts of blood and protein. The physician's orders, dated 9/21/24, indicated to administer 1 gram of ceftriaxone (antibiotic) intravenously, every 24 hours for 5 days for leukocytosis (high white blood cell count). The culture and sensitivity, dated 9/26/24, indicated the urine had resulted in greater than 100,000 CFU/mL (colony forming units per milliliter) of providencia stuartii (gram negative bacteria most commonly caused by contact with contaminated persons or objects) with possible extended spectrum beta lactamases (ESBL), which were enzymes indicating resistance to most beta-lactam antibiotics. The physician's order, dated 9/29/24, indicated to administer 300 mg of cefdinir (antibiotic) by way of g-tube, every morning and at bedtime, for 10 days for a UTI (urinary tract infection). During an observation of incontinence care on 10/10/24 at 10:18 a.m., for Resident 4 by CNAs (Certified Nurse Aides) 7 and 8. Both CNAs performed hand hygiene and PPE (personal protective equipment) was applied. The catheter bag was placed at the foot of the bed. The resident's brief was unfastened. CNA 7 used		**STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** Residents 4 and 36 was not harmed by the alleged deficient practice. **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who require assistance with perineal care could be affected by the alleged deficient practice. All staff who provide perineal care completed a skills check off for male and female with and without catheter ensure each staff members follow proper perineal care procedures. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not Reoccur:** The DNS/Designee held an in-service for all nursing staff to provide education and expectations as it relates to the “Perineal Care Male and Female” policy and procedures. STEP 4 Corrective actions to be	

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	wipes and swiped the left crease 5 times with the same area of the wipe. She obtained a wipe and with 11 swipes with the same area of the wipe, she cleaned the scrotum. She obtained a clean wipe and with 3 swipes of the same area of the wipe, she cleaned the scrotum. She folded the wipe and with 8 swipes with the same area of the wipe, she cleaned the scrotum again. She obtained a clean wipe and swiped down the penis, toward the tip of the penis. She obtained a clean wipe and with 2 pulls down the tubing, she cleaned the tubing. The penis was not cleaned. She sprayed the scrotum and with 13 swipes of the same area of the wipe, she cleaned the scrotum. She obtained another clean wipe and with 6 swipes of the same area of the wipe, she cleaned the scrotum. She obtained a clean wipe, and with 15 swipes with the same area of the wipe, she cleaned the scrotum. The resident was turned onto his left side and the rectal area was cleaned. The CNA applied barrier cream to the rectal area. No redness was observed to the bottom or groin. CNA 7 removed her gloves and used hand sanitizer. She applied fresh gloves. CNA 7 lifted the catheter bag to CNA 8 by lifting it above the resident's bladder and placed it on the left side of the bed. Urine was observed flowing up the tubing, toward the resident. The PPE was removed and hand sanitizer was applied by the CNAs. The trash was removed to the soiled utility room. The trash cans were overflowing onto the floor in the soiled utility room. Both CNAs performed handwashing. During an interview on 10/10/24 at 10:39 a.m., CNA 7 indicated she would clean the creases, then wipe the area under the rectum, on the scrotum. She would then clean the top of the penis and wipe the area around the catheter, by holding the catheter tubing and pulling out away from the tip of the penis. She would then apply		monitored to ensure the deficient practice will not recur: The DNS/designee will audit 5 residents a weeks x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 weeks for no less than 3 months and compliance is maintained to ensure perineal care is completed without concerns. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	cream on the resident. She would turn the resident onto their side and clean their bottom. She would then use hand sanitizer and place clean gloves on. She would finish dressing the resident. When using wipes she would use the wipe once for each swipe, then fold and use. Then a new wipe would be obtained. She felt that during the care on the resident, she didn't change her gloves after the care to apply the cream. 2. The record for Resident 36 was reviewed on 10/11/24 at 11:44 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, severe morbid obesity due to excessive calories, schizophrenia, muscle wasting and atrophy, muscle weakness, metabolic encephalopathy, resistance to beta lactam antibiotics, candidiasis, streptococcus group B, pseudomonas (aeruginosa, pseudo mallei), and anemia. The current care plan, start date of 3/11/21, indicated the resident was incontinent of urine related to impaired mobility. The interventions, dated 5/10/23, included, but were not limited to, apply barrier creams as needed, check the resident for incontinence. Wash, rinse and dry the perineum, and change their clothing PRN after incontinent episodes, observe for signs and symptoms of UTI, and observe and report to the medical provider if one was identified. The Annual MDS assessment from a previous admission, dated 3/1/24, indicated the resident was cognitively intact. The resident required substantial to maximal assistance for toileting hygiene. The urinalysis, dated 5/3/24, indicated the resident's results had a small one plus blood and			

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	large three plus leukocyte esterase. The culture and sensitivity, dated 5/3/24, indicated Klebsiella pneumoniae ESBL with a growth of greater than 100,000 CFU/mL. The nurse's note, dated 8/19/24 at 12:15 p.m., indicated the resident arrived to the facility by ambulance with two attendants. The resident would open her eyes occasionally when spoken to and was aroused with physical stimuli. The record indicated, dated 8/19/24, the resident had an infection and was receiving an intravenous antibiotic for a UTI with ESBL. On 8/19/24, an order was received for an intravenous antibiotic for a UTI with ESBL. The physician's note, dated 8/22/24 at 1:00 a.m., indicated the resident's laboratory results resulted in a high blood urea nitrogen (BUN) level of 58 mg/dL (milligrams per deciliter) and a high creatinine level of 1.3 mg/dL. The record indicated on 8/25/24, the resident had an infection and received an intravenous antibiotic for a UTI with ESBL. The Admission MDS assessment, dated 8/26/24, lacked documentation of a cognitive status. The physician's note, dated 8/29/24 at 1:00 a.m., indicated the resident was followed by a nephrologist for elevated serum creatinine levels on 8/22/24. The urinalysis culture and sensitivity indicated the urine had resulted in greater than 100,000 CFU/mL of Klebsiella pneumoniae ESBL. The resident had resistance to third generation cephalosporins, monobactams, and cephamycins.			

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	The physician's order, dated 10/6/24, indicated the nursing staff were to administer 875-125 mg of Amoxicillin-Potassium Clavulanate by gastrostomy tube every morning and at bedtime for hydronephrosis for 10 days. The current Perineal Care Male and Female policy, included, but was not limited to, "... Equipment and Supplies: If using disposable perineum wipes: a) Disposable wipes b) Towel c) Personal Protective Equipment (e.g. gown, gloves, mask, eye protection, etc., as needed)... b) Continue to wash perineum moving from inside outward to the thighs... Male Residents:... 2- Wash perineal area starting with urethra and working outward. 3- If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area... 5- Wash and rinse urethral area using a circular motion. 6- Continue to wash the perineal area including the penis, scrotum and inner thighs... 9- Gently dry perineum following same sequence... 13- Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. 14- Dry area thoroughly..." The current Catheter Care policy, included, but was not limited to, "... The risk of bacteremia in residents with indwelling catheters is 3-36 times more likely than residents without an indwelling catheter. Biofilm is the most important cause of bacteriuria in residents with catheters. Reducing the biofilm by performing daily care may help prevent symptomatic infections and incorporate antibiotic stewardship recommendations to reduce unnecessary drugs and antibiotics to reduce resistant strains of infections, as well as maintain the dignity of hygiene of the resident..."			

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	Cross Reference F880 3.1-41(a)(2)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure insulin was administered as ordered by the physician on multiple days for 3 of 7 residents reviewed for pharmacy services. (Residents 207, 83, and 204) Findings include: 1. The record for Resident 207 was reviewed on 10/15/24 at 8:27 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy and foot ulcer, sepsis, and elevated white blood cell count. The physician's order, dated 9/20/24, indicated staff were to administer Humalog per sliding scale subcutaneously per before meals. Give 4 units for blood sugar readings of 151 - 200 mg/dL (milligrams per deciliter), 6 units for blood sugar readings of 201 - 250 mg/dL, 8 units for blood sugar readings of 251 - 300 mg/dL, 10 units for blood sugar readings of 301 - 350 mg/dL, and give 12 units for blood sugar readings greater than 350 mg/dL and call the physician or nurse practitioner. The physician's order, dated 9/20/24, indicated staff were to administer the resident's 35 units of Lantus SoloStar pen-injector, subcutaneously, two times a day for diabetes mellitus. The physicians' order, dated 9/20/24, indicated staff were to administer the resident's 20 units of	F 0755	**F755** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey conducted on October 7, 8, 9, 10, 11, and 15, 2024. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:**	11/18/2024

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	Humalog subcutaneously with meals for diabetes mellitus. The care plan, dated 9/24/24, indicated the resident had diabetes with neuropathy and a diabetic ulcer. The interventions, dated 9/24/24, included, but were not limited to, administer insulin injections per orders and to rotate the injection sites. The resident's blood sugar readings ranged from 111 mg/dL on 9/25/24 to 399 mg/dL on 10/8/24. The September 2024 MAR (Medication Administration Record) indicated the following concerns for the twice daily, 35 units of Lantus SoloStar pen-injector: - The resident's Lantus was scheduled (due) on 9/21/24 at 8:00 p.m. The Lantus was administered on 9/21/24 at 10:55 p.m., by RN 13. - Due on 9/24/24 at 8:00 a.m., the Lantus was administered on 9/24/24 at 9:45 a.m., by RN 15. - Due on 9/25/24 at 8:00 p.m., the Lantus was administered on 9/26/24 at 12:13 a.m., by RN 16. - Due on 9/26/24 at 8:00 a.m., the Lantus was administered on 9/26/24 at 9:53 a.m., by LPN (Licensed Practical Nurse) 17. - Due on 9/26/24 at 8:00 p.m., the Lantus was administered on 9/26/24 at 9:34 p.m., by LPN 18. - Due on 9/27/24 at 8:00 a.m., the Lantus was administered on 9/27/24 at 12:37 p.m., by RN 19. - Due on 9/27/24 at 8:00 p.m., the Lantus was administered on 9/28/24 at 2:58 a.m., by LPN 20. - Due on 9/28/24 at 8:00 p.m., the Lantus was administered on 9/28/24 at 11:33 p.m., by LPN 20. - Due on 9/29/24 at 8:00 p.m., the Lantus was administered on 9/29/24 at 11:32 p.m., by RN 13. - Due on 9/30/24 at 8:00 a.m., the Lantus was administered on 9/30/24 at 9:31 a.m., by RN 14.		/p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive insulin could be affected by deficient practice. A 30 day look back of all residents who receive insulin medication administered was completed to ensure proper documentation. Any identified concerns were immediately addressed. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DON/Designee held an in-service for licensed nurses to provide education and expectations as it relates to the “Medication Administration” policy to include proper documentation when administering insulin medication. **STEP 4 Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nurses/ Designee will audit 5 resident per week x 4 weeks, then 4 residents per week	

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	155659	A. BUILDING 00 B. WING	10/15/2024

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	- Due on 9/30/24 at 8:00 p.m., the Lantus was administered on 9/30/24 at 11:40 p.m., by LPN 20. The September 2024 MAR (Medication Administration Record) indicated the following concerns for the Humalog injection per sliding scale before meals: - The resident's Humalog was due on 9/21/24 at 7:00 a.m. The Humalog was administered on 9/21/24 at 8:24 a.m., by RN 21. - Due on 9/22/24 at 7:00 a.m., the Humalog was administered on 9/22/24 at 8:16 a.m. by RN 21. - Due on 9/24/24 at 7:00 a.m., the Humalog was administered on 9/24/24 at 9:43 a.m., by RN 15. - Due on 9/25/24 at 7:00 a.m., the Humalog was administered on 9/25/24 at 9:10 a.m., by RN 36. - Due on 9/26/24 at 7:00 a.m., the Humalog was administered on 9/26/24 at 9:53 a.m., by LPN 17. - Due on 9/27/24 at 7:00 a.m., the Humalog was administered on 9/27/24 at 8:40 a.m., by RN 19. - Due on 9/27/24 at 11:00 a.m., the Humalog was administered on 9/27/24 at 12:37 p.m., by RN 19. - Due on 9/27/24 at 4:00 p.m., the Humalog was administered on 9/27/24 at 5:39 p.m., by RN 19. - Due on 9/28/24 at 7:00 a.m., the Humalog was administered on 9/28/24 at 8:32 a.m., by RN 19. - Due on 9/28/24 at 4:00 p.m., the Humalog was administered on 9/28/24 at 5:47 p.m., by RN 19. - Due on 9/29/24 at 7:00 a.m., the Humalog was administered on 9/29/24 at 8:17 a.m., by RN 19. - Due on 9/29/24 at 4:00 p.m., the Humalog was administered on 9/29/24 at 5:56 p.m., by RN 19. - Due on 9/30/24 at 4:00 p.m., the Humalog was administered on 9/30/24 at 5:49 p.m., by RN 19. The September 2024 MAR (Medication Administration Record) indicated the following concerns for the Humalog Injection 20 units with meals:		x 4 weeks, then 2 residents per week x 4 weeks for no less than 3 months and compliance is maintained to ensure proper documentation of as needed pain medications. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	- The resident's Humalog was due on 9/24/24 at 7:30 a.m. The Humalog was administered on 9/24/24 at 9:45 a.m., by RN 15. - Due on 9/24/24 at 11:30 a.m., the Humalog was administered on 9/24/24 at 4:12 p.m., by RN 15. - Due on 9/24/24 at 4:30 p.m., the Humalog was administered on 9/24/24 at 4:12 p.m., by RN 15. - Due on 9/25/24 at 7:30 a.m., the Humalog was administered on 9/25/24 at 9:11 a.m., by RN 36. - Due on 9/26/24 at 7:30 a.m., the Humalog was administered on 9/26/24 at 9:53 a.m., by LPN 17. - Due on 9/26/24 at 11:30 a.m., the Humalog was administered on 9/26/24 at 1:26 p.m., by LPN 17. - Due on 9/27/24 at 7:30 a.m., the Humalog was administered on 9/27/24 at 12:27 p.m., by RN 19. - Due on 9/27/24 at 11:30 a.m., the Humalog was administered on 9/27/24 at 4:44 p.m., by RN 19. - Due on 9/27/24 at 4:30 p.m., the Humalog was administered on 9/27/24 at 5:57 p.m., by RN 19. - Due on 9/28/24 at 4:30 p.m., the Humalog was administered on 9/28/24 at 5:47 p.m., by RN 19. - Due on 9/29/24 at 11:30 a.m., the Humalog was administered on 9/29/24 at 3:22 p.m., by RN 19. The RN then administered the 4:30 p.m., dose at 5:56 p.m. - Due on 9/30/24 at 4:30 p.m., the Humalog was administered on 9/30/24 at 5:49 p.m., by RN 14. 2. The record for Resident 83 was reviewed on 10/10/24 at 1:14 p.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, polyneuropathy, morbid obesity due to excess calories, and dependence on renal dialysis. The care plan, dated 9/5/24, indicated the resident had diabetes. The interventions, dated 9/5/24, included, but were not limited to, administer medications per the medical provider's orders, obtain blood sugars per orders, and report			

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	abnormal findings to the medical provider, the resident and the resident representative. The physician's order, dated 9/4/24, indicated for staff were to administer the resident's 10 units of insulin glargine pen injector subcutaneously at bedtime for diabetes mellitus. The physician's order, dated 9/4/24, indicated for staff were to administer the resident's 5 units of Humalog subcutaneously, before meals for diabetes mellitus. The review of the resident's blood sugar reading between 9/4/24 and 10/11/24 indicated a range from 123 on admission to 351 mg/dL recently. The September 2024 MAR indicated the following concerns for 10 units of insulin glargine before meals: - The resident's insulin glargine was due on 9/6/24 at 9:00 p.m. The glargine was administered on 9/6/24 at 11:29 p.m., by LPN 20. - Due on 9/7/24 at 9:00 p.m., the glargine was administered on 9/7/24 at 10:45 p.m., by LPN 20. - Due on 9/8/24 at 9:00 p.m., the glargine was administered on 9/9/24 at 12:26 a.m., by RN 16. - Due on 9/9/24 at 9:00 p.m., the glargine was administered on 9/10/24 at 12:09 a.m., by RN 16. - Due on 9/10/24 at 9:00 p.m., the glargine was administered on 9/10/24 at 11:22 p.m., by RN 16. - Due on 9/11/24 at 9:00 p.m., the glargine was administered on 9/12/24 at 2:17 a.m., by RN 16. - Due on 9/12/24 at 9:00 p.m., the glargine was administered on 9/13/24 at 12:51 a.m., by LPN 20. - Due on 9/14/24 at 9:00 p.m., the glargine was administered on 9/14/24 at 11:23 p.m., by LPN 20. - Due on 9/15/24 at 9:00 p.m., the glargine was administered on 9/16/24 at 5:38 a.m., by RN 16.			

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	- Due on 9/16/24 at 9:00 p.m., the glargine was administered on 9/17/24 at 12:25 a.m., by RN 16. - Due on 9/17/24 at 9:00 p.m., the glargine was administered on 09/17/24 at 11:55 p.m., by RN 16. - Due on 9/18/24 at 9:00 p.m., the glargine was administered on 9/19/24 at 3:09 a.m., by RN 16. - Due on 9/22/24 at 9:00 p.m., the glargine was administered on 9/22/24 at 11:10 p.m., by RN 25. - Due on 9/23/24 at 9:00 p.m., the glargine was administered on 9/24/24 at 3:40 a.m., by RN 16. - Due on 9/24/24 at 9:00 p.m., the glargine was administered on 9/25/24 at 1:58 a.m., by RN 16. - Due on 9/25/24 at 9:00 p.m., the glargine was administered on 9/26/24 at 3:06 a.m., by RN 16. - Due on 9/27/24 at 9:00 p.m., the glargine was administered on 9/28/24 at 3:36 a.m., by LPN 20. - Due on 9/28/24 at 9:00 p.m., the glargine was administered on 9/28/24 at 10:45 p.m., by LPN 20. - Due on 9/29/24 at 9:00 p.m., the glargine was administered on 9/30/24 at 2:45 a.m., by QMA (Qualified Medication Aide) 22. - Due on 9/30/24 at 9:00 p.m., the glargine was administered on 10/1/24 at 12:29 a.m., by LPN 20. The September 2024 MAR indicated the following concerns 5 units Humalog injection before meals: - The resident's Humalog was due on 9/5/24 at 7:00 a.m. The Humalog was administered on 9/5/24 at 8:50 a.m., by RN 23. - Due on 9/5/24 11:00 a.m., the Humalog was administered on 9/5/24 at 11:55 a.m., by RN 23. - Due on 9/6/24 at 11:00 a.m., the Humalog was administered on 9/6/24 at 12:20 p.m., by RN 14. - Due on 9/8/24 at 7:00 a.m., the Humalog was administered on 9/8/24 at 9:11 a.m., by LPN 17. - Due on 9/9/24 at 7:00 a.m., the Humalog was administered on 9/9/24 at 10:24 a.m., by LPN 17. - Due on 9/10/24 at 7:00 a.m., the Humalog was administered on 9/10/24 at 8:44 a.m., by RN 19.			

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	- Due on 9/11/24 at 11:00 a.m., the Humalog was administered on 9/11/24 at 2:05 p.m. by QMA 24. - Due on 9/12/24 at 7:00 a.m., the Humalog was administered on 9/12/24 at 9:38 a.m., by LPN, 17. - Due on 9/14/24 at 7:00 a.m., the Humalog was administered on 9/14/24 at 8:22 a.m., by RN 19. - Due on 9/15/24 at 7:00 a.m., the Humalog was administered on 9/15/24 at 10:06 a.m., by QMA 24. - Due on 9/15/24 at 11:00 a.m., the Humalog was administered on 9/15/24 at 12:13 p.m., by RN 19. - Due on 9/16/24 at 11:00 a.m., the Humalog was administered on 9/16/24 at 1:11 p.m., by LPN 17. - Due on 9/17/24 at 11:00 a.m., the Humalog was administered on 9/17/24 at 12:12 p.m., by RN 19. - Due on 9/17/24 at 4:00 p.m., the Humalog was administered on 9/17/24 at 5:26 p.m., by RN 19. - Due on 9/18/24 at 7:00 a.m., the Humalog was administered on 9/18/24 at 10:23 a.m., by RN 19. - Due on 9/18/24 at 4:00 p.m., the Humalog was administered on 9/18/24 at 5:24 p.m., by RN 19. - Due on 9/19/24 at 7:00 a.m., the Humalog was administered on 9/19/24 at 8:20 a.m., by RN 19. - Due on 9/19/24 at 11:00 a.m., the Humalog was administered on 9/19/24 at 12:25 p.m., by RN 15. - Due on 9/20/24 at 7:00 a.m., the Humalog was administered on 9/20/24 at 9:05 a.m., by RN 37. - Due on 9/20/24 at 4:00 p.m., the Humalog was administered on 9/20/24 at 5:20 p.m., by RN 37. - Due on 9/21/24 at 7:00 a.m., the Humalog was administered on 9/21/24 at 9:29 a.m., by LPN 18. - Due on 9/21/24 at 11:00 a.m., the Humalog was administered on 9/21/24 at 12:55 p.m., by LPN 18. - Due on 9/22/24 at 7:00 a.m., the Humalog was administered on 9/22/24 at 11:25 a.m., by QMA 24. - Due on 9/25/24 at 7:00 a.m., the Humalog was administered on 9/25/24 at 9:33 a.m., by RN 38. - Due on 9/27/24 at 7:00 a.m., the Humalog was administered on 9/27/24 at 9:25 a.m., by RN 19. - Due on 9/28/24 at 7:00 a.m., the Humalog was administered on 9/28/24 at 10:20 a.m., by RN 14.			

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	- Due on 9/29/24 at 7:00 a.m., the Humalog was administered on 9/29/24 at 9:18 a.m., by LPN 18. - Due on 9/30/24 at 7:00 a.m., the Humalog was administered on 9/30/24 at 11:57 a.m., by QMA 24. - Due on 9/30/24 at 11:00 a.m., the Humalog was administered on 9/30/24 at 1:29 p.m., by RN 14. - Due on 9/30/24 at 4:00 p.m., the Humalog was administered on 9/30/24 at 5:42 p.m., by QMA 24. The October 2024 MAR indicated the following concerns for 10 units of insulin glargine before meals: - The resident's insulin glargine was due on 10/1/24 at 9:00 p.m. The glargine was administered on 10/1/24 at 11:08 p.m., by LPN 20. - Due on 10/2/24 at 9:00 p.m., the glargine was administered on 10/2/24 at 11:38 p.m., by LPN 20. - Due on 10/4/24 at 9:00 p.m., the glargine was administered on 10/5/24 at 3:30 a.m., by RN 25. - Due on 10/5/24 at 9:00 p.m., the glargine was administered on 10/5/24 at 10:46 p.m., LPN 26. - Due on 10/6/24 at 9:00 p.m., the glargine was administered on 10/7/24 at 1:16 a.m., by RN 16. - Due on 10/7/24 at 9:00 p.m., the glargine was administered on 10/8/24 at 2:59 a.m., by RN 16. - Due on 10/8/24 at 9:00 p.m., the glargine was administered on 10/9/24 at 2:32 a.m., by RN 16. - Due on 10/9/24 at 9:00 p.m., the glargine was administered on 10/10/24 at 2:43 a.m., by RN 16. - Due on 10/10/24 at 9:00 p.m., the glargine was administered on 10/10/24 at 11:03 p.m., by LPN 20. The October 2024 MAR indicated the following concerns 5 units Humalog injection before meals: - The resident's Humalog was due on 10/2/24 at 7:00 a.m. The Humalog was administered on 10/2/24 at 8:52 a.m., by RN 19.			

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	- Due on 10/4/24 at 7:00 a.m., the Humalog was administered on 10/4/24 at 10:31 a.m., by RN 14. - Due on 10/7/24 at 7:00 a.m., the Humalog was administered on 10/7/24 at 10:15 a.m., by QMA 24. - Due on 10/7/24 at 11:00 a.m., the Humalog was administered on 10/7/24 at 1:43 p.m., by QMA 24. - Due on 10/7/24 at 4:00 p.m., the Humalog was administered on 10/7/24 at 6:12 p.m., by RN 14. - Due on 10/8/24 at 7:00 a.m., the Humalog was administered on 10/8/24 at 9:13 a.m., by RN 19. - Due on 10/9/24 at 7:00 a.m., the Humalog was administered on 10/9/24 at 8:17 a.m., by RN 19. - Due on 10/9/24 at 11:00 a.m., the Humalog was administered on 10/9/24 at 1:03 p.m., by RN 19. - Due on 10/9/24 at 4:00 p.m., the Humalog was administered on 10/9/24 at 5:16 p.m., by RN 19. - Due on 10/10/24 at 7:00 a.m., the Humalog was administered on 10/10/24 at 8:36 a.m., by RN 14. - Due on 10/10/24 at 11:00 a.m., the Humalog was administered on 10/10/24 at 12:43 p.m., by RN 14. 3. The record for Resident 204 was reviewed on 10/10/24 at 8:29 a.m. The resident's diagnoses included, but were not limited to, acquired absence of the left leg below the knee, type 2 diabetes mellitus with neuropathy, morbid obesity due to excess calories, diabetic ulcers of the right toes and foot. The care plan, dated 10/5/24, indicated the resident had a left below the knee amputation, diabetic foot ulcer to the right heel and great toe. The intervention, dated 10/5/24, included, but was not limited to, administer medications as ordered. The physician's order, dated 10/5/24, indicated staff were to administer the resident's 4 units of Humalog KwikPen subcutaneously before meals for diabetes mellitus.			

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	The physician's order, dated 10/5/24 indicated staff were to administer the resident's Humalog per sliding scale subcutaneously if the blood sugar was greater than 400, notify the physician and inject as per sliding scale with 2 units for a blood sugar of 151 - 200 mg/dL, 4 units for a blood sugar of 201 - 250 mg/dL, 4 units for a blood sugar of 251 - 300 mg/dL, 5 units for a blood sugar of 301 - 350 mg/dL, 6 units for a blood sugar of 351 - 400 mg/dL before meals and at bedtime. If the blood sugar was less than 60, notify the physician. The physician's order, dated 10/5/24, indicated staff were to administer the resident's 25 units of Lantus subcutaneously daily for diabetes mellitus. The resident's blood sugar readings indicated the resident ranged between 203 mg/dL to 394 mg/dL. The October 2024 MAR (Medication Administration Record) indicated the following concerns for the twice daily, 25 units of Lantus SoloStar pen-injector: - The resident's Lantus was due on 10/05/24 ordered at 7:00 p.m. The lantus was received on 10/05/24 at 10:56 p.m., by LPN 26. - Due on 10/06/24 at 7:00 p.m., the Lantus was administered on 10/06/24 at 8:49 p.m., by RN 16. - Due on 10/07/24 at 7:00 p.m., the Lantus was administered on 10/07/24 at 8:50 p.m., by RN 16. - Due on 10/08/24 at 7:00 p.m., the Lantus was administered on 10/09/24 at 12:06 a.m., by RN 16. - Due on 10/09/24 at 7:00 p.m., the Lantus was administered on 10/09/24 at 9:30 p.m., by RN 16. The October 2024 MAR indicated the following concerns for the 4 units Humalog Kwikpen injection before meals and per sliding scale before meals and at bedtime if the blood sugar was			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	greater than 400 mg/dL: - The resident's Humalog was due on 10/5/24 at 7:00 a.m. The Humalog was administered on 10/5/24 at 10:46 a.m., by LPN 27. - Due on 10/05/24 at 7:00 a.m., the Humalog was administered on 10/5/24 at 10:45 a.m., by LPN 27. - Due on 10/5/24 at 9:00 p.m., the Humalog was administered on 10/5/24 at 10:56 p.m., by LPN 26. - Due on 10/6/24 at 7:00 a.m., the Humalog was administered on 10/6/24 at 8:46 a.m., by LPN 27. - Due on 10/6/24 at 7:00 a.m., the Humalog was administered on 10/6/24 at 8:47 a.m., by LPN 27. - Due on 10/6/24 at 4:00 p.m., the Humalog was administered on 10/6/24 at 3:46 p.m., by LPN 27. - Due on 10/7/24 at 7:00 a.m., the Humalog was administered on 10/7/24 at 9:21 a.m., by RN 14. - Due on 10/7/24 at 7:00 a.m., the Humalog was administered on 10/7/24 at 9:21 a.m., by RN 14. - Due on 10/7/24 at 11:00 a.m., the Humalog was administered on 10/7/24 at 12:32 p.m., by RN 14. - Due on 10/7/24 at 11:00 a.m., the Humalog was administered on 10/7/24 at 12:33 p.m., by RN 14. - Due on 10/8/24 at 11:00 a.m., the Humalog was administered on 10/8/24 at 12:16 p.m., by RN 19. - Due on 10/8/24 at 11:00 a.m., the Humalog was administered on 10/8/24 at 12:17 p.m., by RN 19. - Due on 10/8/24 at 4:00 a.m., the Humalog was administered on 10/8/24 at 5:21 p.m., by RN 19. - Due on 10/8/24 at 4:00 p.m., the Humalog was administered on 10/8/24 at 5:22 p.m., by RN 19. - Due on 10/8/24 at 9:00 p.m., the Humalog was administered on 10/9/24 at 12:06 a.m., by RN 16. - Due on 10/9/24 at 7:00 a.m., the Humalog was administered on 10/9/24 at 11:20 a.m., then the 11:00 a.m. dose was administered at 11:30 a.m., by RN 19. - Due on 10/9/24 at 9:00 p.m., the Humalog was administered on 10/10/24 at 12:46 a.m., by RN 16.			

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	155659	A. BUILDING 00 B. WING	10/15/2024

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	The review of the October MAR on 10/9/24 at 10:15 a.m., the resident had not received his Humalog injection on time. An observation of the resident at this time indicated that breakfast had already been served and removed from the resident's room. During an interview on 10/8/24 at 9:44 a.m., Resident 204 indicated his blood sugars were running high at the facility. During an interview on 10/9/24 at 11:28 a.m., Resident 204 indicated he wasn't sure if he got his insulin this morning or if he got his accu check. He wasn't sure when he got his insulin after he went to sleep the previous night. During an interview on 10/10/24 at 8:35 a.m., Resident 204 indicated he had not received a finger stick, or insulin this morning. The nurse was observed at the beginning of the hall with the medication cart, preparing medications to administer. Breakfast had already been served and removed. The review of the October MAR on 10/10/24 at 8:46 a.m., indicated Resident 204 had still not received his Humalog injection this morning. Breakfast had already been served and removed from the residents' room. During an interview on 10/11/24 at 8:30 a.m., Resident 204 indicated he had just received his insulin. He had already eaten his breakfast when he received his insulin. The nurse performed his accu check just prior to his injection of insulin. The empty breakfast tray was sitting on his bedside table and the nurse was observed preparing to administer medications, two doors down the hall, past the resident's room.			

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	During a confidential interview between 10/7/24 and 10/15/24, Staff C indicated it was difficult to complete medication administration due to the number of residents. On occasion there were issues with keeping up with both the accu checks and insulin administration. Those were performed together. There were times that the residents received insulin after the meals were served. If an insulin was administered late, the resident could have hyperglycemia when they ate, or they could have had a low blood sugar and would have needed orange juice or something to raise their blood sugar. During a confidential interview between 10/7/24 and 10/15/24, Staff D indicated it could be hard to get medications completed on the days that were busy. During a confidential interview between 10/7/24 and 10/15/24, Staff E indicated they had no issues with providing medications. They had administered insulin only a few times late but couldn't remember the dates. During a confidential interview between 10/7/24 and 10/15/24, Staff F indicated the blood sugars were obtained and the insulin would be given at the same time. They were late at times if something was going on in the facility. The insulin administration should be documented when they were administered. If an insulin was late, there was the chance of the blood sugar running high. The current Medication Administration policy, included, but was not limited to, " ... Procedure: I. General Procedures: a. Administer medication only as prescribed by the provider ... ff. Medications			

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	will be administered within the time frame of one hour before up to one hour after time ordered. i. For medication to be taken around meals: 1. Before Meals: provide medications thirty (30) minutes before meal time ... IV. Documentation a. Documentation of medication will be current for medication administration. b. Documentation of medications will follow accepted standards of nursing practice." 3.1-48(a)(6)			
F 0803 SS=E Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed Based on observation, record review and interview, the facility failed to make a reasonable effort to meet the preferences of the residents' meal choices in that scheduled menu items were being substituted due to unavailability with the same food items being served almost daily during 4 of 4 observations. This deficient practice affected 83 of 100 residents who received meals from the kitchen. Findings include: During confidential interviews with residents, between 10/7/24 and 10/15/24, the following concerns were voiced: - Resident D indicated hamburgers were served 4 days in a row and the wanted the ravioli instead. The broccoli was not completely cooked; the same food was served multiple times a week; and the hot foods were not hot and the cold foods were not cold. - Resident E indicated voiced multiple concerns of never getting the correct meal and the same food	F 0803	**F 803** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey conducted on October 7, 8, 9, 10, 11, and 15, 2024 . Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk**	11/18/2024

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	was served multiple times per week. -Resident F indicated the food was just not good. - Resident G indicated ice cream was not on the lunch tray; the broccoli was not completely cooked; there was no sauce or butter on the ravioli and it was very dry. The ravioli was dried up on the edges and curled up. - Resident H indicated the food was not good today and that the same food was served multiple times per week. - Resident J indicated there was barely any food on the plate, and small portions were served at times. They often did not follow the menus, the food was cold at times, the potatoes were frequently not done or hard, especially the baked potatoes and hash browns. - Resident K indicated although being a dialysis patient and tomatoes and potatoes were frequently served which were against the renal diet. They indicated that it felt like they were not getting enough to eat due to not eating the potatoes and tomatoes. They were served beef stew the other day which had potatoes and tomatoes in it and were not able eat it. The broccoli served yesterday was too hard to eat; and the plain ravioli was dry and hard around the edges. They could not eat half of it. The review of the menu for 10/7/24, indicated the lunch meal was to be the following: - Bruschetta Chicken - Seasoned Green Beans - Garlic Roasted Red Potatoes		**review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who received meals have the potential to be affected. Staff was immediately educated on following Production Sheets and recipes and to add 10% additional to count. Regional Manager continued to monitor. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDM/Designee held an in-service for all staff to provide education and expectations as it relates to the" Following Menu Production Sheets" Policy and procedures as it relates to proper menu and resident choices. **STEP 4 Collective Actions to be monitored to ensure the deficient practice will not recur:**	

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	During an observation of the lunch meal serviced on 10/7/24 at 11:35 a.m., the items listed on the menu were being served. During a second observation of the lunch meal being served on 10/7/24 at 12:15 p.m., the following was observed: - The Dietary Manager and Cook 32 were observed serving teriyaki chicken, stewed tomatoes and mashed potatoes instead of the menu items. Cook 32 indicated he had ran out of everything that was supposed to be served and was using whatever he had on hand. He indicated he followed the recipes and the count sheet when preparing all the items and did not know why he ran out. The residents were not informed they were not getting the menu items, nor were they asked if they wanted the teriyaki chicken, stewed tomatoes and mashed potatoes or something else. During an interview with the Regional Dietary Manager on 10/9/24 at 10:45 a.m., she indicated she was not aware that the cook ran out of chicken, green beans and red potatoes as she was only told that they were short two pieces of chicken. Nor was she aware of the items being substituted because they were handy. The review of the menu for 10/9/24, indicated the lunch meal was to be the following: - Cheese Ravioli with marinara sauce - Caesar salad - Garlic bread sticks - Mandarin oranges During the lunch food temperature observation on 10/9/24 at 11:34 a.m., a random temperature check of a bowl of Caesar salad on one of the residents'		The ED/designee will observe 5 Residents Trays a week x 4 weeks, then 3 Residents Trays a week x 4 weeks, then 1 Residents Tray a week x 4 weeks for no less than 3 months and compliance is maintained to ensure staff are adhering to the “Meeting Residents Preferences, The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	trays indicated the temperature was 64 degrees Fahrenheit. The Regional Dietary Manager instructed the staff to remove every bowl that was already on the lunch trays which had been set up earlier and to dispose of it. The Dietary Manager was observed to place all the bowls of salad back into the walk in refrigerator. He indicated he thought that he could still use salads if he got them cold again. A decision was made to substitute broccoli as the vegetable instead of the Caesar salad. The review of the evening (supper) menu for 10/14/24, indicated Au Gratin potatoes were scheduled to be served. The review of the scheduled lunch menu for 10/15/24, the following was to be served: - Marinated chicken thighs - Spinach - Oven browned potatoes The review of the posted menu for lunch on 10/15/24, indicated a change had been made from oven roasted potatoes to Au Gratin potatoes which also had been served the night before. During an interview with Cook 35 on 10/15/24 at 1:15 p.m., she indicated they had run out of potatoes therefore the oven browned potatoes were substituted with the Au Gratin potatoes. The review of the facility's current policy on Food: Quality and Palatability revised on 2/2023, included, but were not limited to, "Policy Statement: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature...Procedures: 1.			

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	The Dining Serviced Director and Cook(s) are responsible for food preparation. Menu items are prepared according to the menu, production guidelines, and standardized recipes. 2. The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Point (HACCP) and time and temperature guidelines as outlined in the Federal Food Code...4. The Cook(s) prepare food in accordance with the recipes and season for region and/or ethic preferences, as appropriate. Cook(s) use proper cooking techniques to ensure color and flavor retention..." The review of the facility's current policy on Menus revised on 10/2022, included, but was not limited to, "Policy Statement: Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an appropriate planning guide. Procedures: 1. Menu cycles will be developed and tailored to the needs and requirements of the facility. 2. Menus will be periodically presented for resident review, including the resident council, menu review meetings, or other review board as indicated by the center. The menu will identify the primary meal, the alternate meal, and any always offered food and beverage items....6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. 7. A menu substitution log will be maintained on file. 8. Menus will be posted in the Dining Services department, dining rooms, and resident/patient care areas..." Cross Reference F804			

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	3.1-21(a)(1) 3.1-21(a)(2) 3.1-21(a)(4)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation and interview, the facility failed to ensure meals were at appropriate temperatures and palatable for residents during 2 of 2 temperature checks and 1 of 1 meal test trays. This had the potential to affect 83 of 100 residents who ate meals at the facility. Findings include: 1. During confidential interviews with residents while on the initial tour of the facility on 10/7/24 between 9:45 a.m. and 11:00 a.m., the following concerns were voiced: - Resident A indicated the food was cold when it reached them, it looked unappealing, and the taste was worse. If they asked for a substitute, it could be worse than the main meal. Their family member told them it looked like the food they got in prison. They were a diabetic and were not getting enough to eat. - Resident B indicated the food was often cold due to it sitting on the halls when brought from the kitchen. They indicated it was not worth it to ask the staff to heat it up. 2. During the lunch food temperature observation on 10/7/24 at 11:30 a.m., with Cook 32, the following food temperatures were obtained by Cook 32. The temperatures did not meet the required serving temperatures:	F 0804	**F804** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey conducted on October 7, 8, 9, 10, 11, and 15, 2024 . Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:**	11/18/2024

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	- Puree chicken was 150 degrees Fahrenheit - the item was removed and placed back into the steamer; at 11:40 a.m. The item was now 171 degrees Fahrenheit. - Puree green beans were 132 degrees Fahrenheit - the item was removed and placed back into the steamer; at 11:41 a.m., the item was now 163 degrees Fahrenheit. - Potato soup was 133 degrees Fahrenheit - it was decided to not serve the soup. 3. During the lunch food temperature observation on 10/9/24 at 11:34 a.m., the following food temperatures were obtained which did not meet the required serving temperatures: - Caesar salad was 64 degrees Fahrenheit - the Regional Dietary Manager instructed the staff to remove every bowl that was already on the lunch trays which had been set up earlier and dispose of it. The Dietary Manager was observed to place all the bowls of salad back into the walk in refrigerator. He indicated he thought that he could still use salads if he got them cold again. - Mixed vegetable salad was 69 degrees Fahrenheit - Potato salad was 82 degrees Fahrenheit Both items were immediately removed by the cook and the Dietary Manager was informed. At 11:45 a.m., the Dietary Manager put a pan of steamed broccoli into the steam table to be served instead of the Caesar salad. At 11:55 a.m., he indicated the temperature was 171 degrees Fahrenheit when he took it out of the steamer and was now 142 degrees Fahrenheit..		/p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** Residents who received mealhave the potential to be affected. RDM did immediate education on food temps and proper plating of food. Any food not at correct temperature was discarded. **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDM/DM/Designee/ held an in-service for all staff to provide education and expectations as it relates to the Food: “Quality and Palatability” policy and procedures. **STEP 4 Collective Actions to be monitored to ensure the deficient practice will not recur:** The ED/designee will observe 5 staff Trays a weeks x 4 weeks, then 3 staff Trays a week x 4 weeks, then 1 Tray a week x 4 weeks for no less than 3 months and compliance is maintained to ensure staff are adhering to the Food: “Quality and Palatability” policy.	

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	On 10/9/24 at 12:02 p.m., test tray was placed on the 300 unit meal cart to determine the temperature of the food. A check of the temperature of the food items by the Regional Dietary Director at 12:32 p.m., after the last tray was served, indicated the following temperatures: - Broccoli was 114 degrees Fahrenheit - Ravioli with sauce was 125.8 degrees Fahrenheit - Mandarin oranges were 55 The Regional Dietary Manager indicated at this time, that the food items were not at a temperature that was considered appetizing. A taste of the food items at 12:39 p.m., indicated the ravioli needed more sauce, was sticky as the ravioli was clumped together, and was dry tasting. The broccoli was very undercooked and difficult to chew. The bread stick was soft and easy to chew and the mandarin oranges were cold and sweet. During confidential interviews with residents, between 10/7/24 and 10/15/24, the following concerns were voiced: - Resident D indicated hamburgers were served 4 days in a row and the wanted the ravioli instead. The broccoli was not completely cooked; the same food was served multiple times a week; and the hot foods were not hot and the cold foods were not cold. - Resident E indicated voiced multiple concerns of never getting the correct meal and the same food was served multiple times per week. -Resident F indicated the food was just not good.		The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	- Resident G indicated ice cream was not on the lunch tray; the broccoli was not completely cooked; there was no sauce or butter on the ravioli and it was very dry. The ravioli was dried up on the edges and curled up. - Resident H indicated the food was not good today and that the same food was served multiple times per week. - Resident J indicated there was barely any food on the plate, and small portions were served at times. They often did not follow the menus, the food was cold at times, the potatoes were frequently not done or hard, especially the baked potatoes and hash browns. - Resident K indicated although being a dialysis patient and tomatoes and potatoes were frequently served which were against the renal diet. They indicated that it felt like they were not getting enough to eat due to not eating the potatoes and tomatoes. They were served beef stew the other day which had potatoes and tomatoes in it and were not able eat it. The broccoli served yesterday was too hard to eat; and the plain ravioli was dry and hard around the edges. They could not eat half of it. The review of the facility's current policy on Food: Quality and Palatability included, but were not limited to, "Policy Statement: Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature...Procedures: 1. The Dining Serviced Director and Cook(s) are responsible for food preparation. Menu items are prepared according to the menu, production guidelines, and			

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	standardized recipes. 2. The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Point (HACCP) and time and temperature guidelines as outlined in the Federal Food Code...4. The Cook(s) prepare food in accordance with the recipes and season for region and/or ethic preferences, as appropriate. Cook(s) use proper cooking techniques to ensure color and flavor retention..." Cross Reference F803 3.1-21(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure food was served and stored under sanitary conditions during 3 of 3 kitchen observations. This deficiency had the potential to affect 83 of 100 residents currently receiving meals from the kitchen. Findings include: 1. During the initial tour of the kitchen while accompanied by the Dietary Manager and the Regional Dietary Manager on 10/07/24 at 9:15 a.m. , the following concerns were observed: - The Dry storage room in the corner next to a shelving unit and the canned goods rack, was a white drain. The inside of this drain, the tiles surrounding the drain, the pipe above the drain, and the wall from the door to the pipe had greenish/gray in color substance. - The floor behind and under the steamer had a heavy accumulation of yellow food particles and a	F 0812	**F812** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey conducted on October 7, 8, 9, 10, 11, and 15, 2024 . Please accept this plan of correction as the provider's credible allegation of compliance.**	11/18/2024

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	heavy buildup of dirt and food particles brownish/black in color. - The steamer had multiple white streaks which ran down all sides of the unit. The drain tray in front of the steamer had brown and tan food particles and pieces of foil in it. - A blue floor plate, which held the stove wheel in place, as identified by Cook 32 and the tiles surrounding the plate had brown and tan food particles on them. - The oven doors had multiple white streaks that ran down the doors. There were areas of black burnt on substances in the bottom of both ovens. - The top of the trash can by the steamer and hand wash sink had heavy soil and food particles on the lid. - The left side of the ice maker had a moderate coating of white/gray substance on the vent. - The stove top had yellow/tan food particles on the top and the burners. There also areas of black burnt on debris. - Four of six tray carts had dark brown liquid, a straw and clear liquid spills inside on the bottoms. White streaks ran down the length of the carts. - The entire floor edges and corners of the kitchen, dry storage room, wheels of the stove, steamer, preparation tables and convection oven had a build-up of black particles/grime. 2. During an observation of the kitchen while accompanied by the Dietary Manager on 10/7/24 at 11:30 a.m., the following concerns were		**The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who received mealshave the potential to be affected. RDM educated staff on cleaning rounds and responsibilities. Addressed wall in dry storage. **/p>** **STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDM/DM/Designee/ held an in-service for all staff to provide education and expectations as it relates to the policy on "Environment" (Food procurement, Store/Prepare/Serve-Sanitary) **STEP 4 Collective Actions to be monitored to ensure the deficient practice will not recur:**	

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	observed: - The same issues identified at 9:15 a.m. remained an issue. The wall in the dry storage room behind the shelving unit from the door to the pipe was now cleaned with no observed greenish/gray in color substance on the wall. 3. During an observation of the kitchen on 10/9/24 at 10:05 a.m., the following concerns were observed: - The same issues identified on 10/7/24 at 9:15 a.m. and 11:30 a.m. remained a concern. - The outside of the thickener, sugar, flour, and brown sugar canisters were sticky to the touch with crumbs on top. - The double preparation sink was greasy inside to the touch, which was able to be wiped away with a paper towel. - The outside of six of six food carts had brown and white streaks down the length of the carts. A review of the as completed Weekly Cleaning Schedule for 10/6/24 to 10/12/24, indicated the following tasks were signed off as having been completed: Cooks: - Tuesday (10/8/24) Day - Clean Convection Oven - Wednesday (10/9/24) Day - Clean Grill Top. - Thursday (10/10/24) Night - Under Cooks Station - Saturday (10/12/24) Day - Conventional Oven; Nights - Stove Drip Pan AM Aides: - Monday (10/7/24) Day - Underneath Aide		The ED/ designee will do 5 observation rounds a weeks x 4 weeks, then 3 Observation Rounds a week x 4 weeks, then 1 Observation Round a week x 4 weeks for no less than 3 months and compliance is maintained to ensure staff are adhering to the "Environment Policy." The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	Station - Friday (10/11/24) - Clean Trash Can and clean handwashing sinks PM Aides: - Thursday (10/10/24) - Clean Underneath Station - Saturday (10/12/24) - Trash Cans The cleaning schedule failed to address cleaning the Dry Storage Room, the food carts which held the trays, the double preparation sink, the stove, and the floor underneath the equipment. A review of the facility's current policy on Environment last revised on 9/2027 included, but was not limited to : "Policy Statement: All food preparation areas, food service areas,...will be maintained in a clean and sanitary condition. Procedure: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including, floors, walls,...2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing all food service equipment and surfaces...4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces..." 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure appropriate infection control measures were followed during high contact care for 8 of 11 staff observations of infection control. (CNA 39, CNA 40, CNA 9, CNA 8, CNA 7, CNA 29, CNA 30 and CNA 4)	F 0880	**F880** **Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the**	11/18/2024

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	Findings include, 1. During the initial tour of the facility on 10/7/24 at 9:15 a.m., observation of the 400 Unit indicated 11 of 15 residents were in enhanced barrier precautions (an infection control techniques to reduce the spread of multidrug resistant organisms) and 1 of 15 residents was in droplet precautions (set of infection control measures to prevent the spread of pathogens that are transmitted through respiratory droplets). During an observation on 10/7/24 between 10:00 a.m. and 10:15 a.m., CNA (Certified Nurse Aide) 39 was walking exited a resident's room with a bag of soiled linen in her right hand. She walked down the 400 Hallway towards the soiled linen room and the bag was transferred to her left hand. The CNA then as a staff member was walking out of the soiled linen room the CNA walked in the doorway and discarded the bag of soiled linens. She then immediately turned around and walked out of the doorway and down the 400 Hall towards another resident's room. No hand washing or hand sanitizing was observed. During an observation of the 400 Hallway on 10/7/24 between 10:15 a.m. and 10:30 a.m., CNA 40 was observed to be holding a bag of soiled linen in her left hand as she walked out of a resident's room. The CNA walked past two residents' rooms and then used hand sanitizer rubbing both hands together while holding the bag in left fingertips. She then walked to the soiled line room and disposed of the bag. After disposing of the bag she turned and walked down the hallway with another CNA towards the residents' rooms. No other hand washing, or hand sanitizing was observed.		**truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Survey conducted on October 7, 8, 9, 10, 11, and 15, 2024 . Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **William Jackson HFA** **STEP 1 Corrective action for the residents found to have been affected by the deficient practice:** /p> **STEP 2 Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected. A walking round was completed immediately to ensure no further infection control issues were identified throughout the facility.	

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	During an observation of the 400 Hallway on 10/8/24 at 12:00 p.m., two CNA's were observed exiting a resident room with bags of trash and resident care items. CNA 7 carried the bags to the soiled linen room and disposed of the bags. The CNA did not perform hand washing or sanitize her hands. CNA 7 entered another resident's room and CNA 8 went to the nurse's station where she picked up papers and then laid them back on the desk. During an observation on 10/8/24 at 2:00 p.m., CNA 9 was observed exiting a resident's room with a bag of trash. She then proceeded to use the hand sanitizer while holding the bag of trash. a. The record for Resident 91 was reviewed on 10/8/24 at 8:26 a.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia, the need for personal assistance with personal care, and tracheotomy care. The Quarterly MDS (Minimum Data Set) assessment, dated 9/24/24, indicated the resident was rarely or never understood as she was unresponsive. She was totally dependent for all her ADLs (Activities of Daily Living) and was unable to assist with these activities. The physician's order, dated 9/23/24, indicated to use enhanced barrier precautions related to open wounds and indwelling medical devices: Gastrointestinal-tube and tracheotomy. When dressing, bathing, showering, transferring in room, therapy, personal hygiene, changing linen, providing hygiene, changing briefs and assisting with toileting every shift. The physician's order, dated Amoxicillin-POT		**STEP 3 Measures/systemic changes put into place to ensure the deficient practice does not recur:** The DNS/Designee held an in-service for all staff to provide education and expectations as it relates to the “Infection Prevention Program” policy and procedures as it relates to proper infection control practices. **STEP 4 Collective Actions to be monitored to ensure the deficient practice will not recur:** The DNS/designee will observe 5 staff members a weeks x 4 weeks, then 3 staff members a week x 4 weeks, then 1 staff member a week x 4 weeks for no less than 3 months and compliance is maintained to ensure staff are adhering to the infection control policy. The Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	Clavulanate tablet 875-125 mg (milligrams) via G-tube (gastrostomy tube) was to be given every 12 hours times 7 days for pneumonia and UTI (Urinary Tract Infection). The start date was 10/2/24. The nurse's note dated 8/14/24 at 1:00 a.m., Vancomycin HCl (Hydrocloride) intravenous solution reconstituted 1 gm intravenously in the morning for leukocytosis until 08/16/24 at 5:59 a.m., in 100 ml (milliliters) of normal saline over 60 minutes for leukocytosis, from 8/14/24 to 8/16/24. During an interview on 10/8/24 at 9:00 a.m., the RDCO (Regional Director of Clinical Operations) indicated she had observed CNA 9 on 10/7/24 working the ventilation unit and she had used hand sanitizer with the dirty trash bag in her hands. She indicated she had educated the CNAs on 10/6/24 on hand hygiene after she was made aware there was an issue with respiratory and UTI infections on the ventilation/tracheostomy unit. b. The record for Resident 250 was reviewed on 8/6/22 at 11:22 a.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, the need for assistance with personal care, tracheostomy, cerebral infarction, other sites of candidiasis, and a carrier of CRAB (Carbapenem-Resistant Acinetobacter Baumannii). The Admission MDS assessment, dated 9/3/24, indicated the resident was rarely or never understood as she was nonresponsive. The resident was totally dependent on staff for her ADLs. The physician's order, dated 8/27/24, indicated to provide oral and tracheal suction every shift and			

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	every two hours as needed and perform oral care every shift and as needed. Enhanced barrier precautions related to a history of Candida Auris, CRAB, colostomy, tracheotomy, gastrointestinal tube, open wounds, a midline and when dressing, or bathing, showering, transferring, therapy, personal hygiene, changing linen, providing hygiene, and changing briefs or assisting with toileting every shift. The physician's order, dated 10/15/24, indicated to administer Ceftazidime intravenous solution reconstituted 1 gm intravenously every 8 hours for Acinetobacter Baumannii Crab in sputum for 7 days. Droplet precautions related to CRAB in sputum. The start date was 10/15/24. During an interview on 10/9/24 at 10:00 a.m., the RT (Respiratory Therapist) indicated hand hygiene was the most important procedure to prevent the spread of infection especially when care for tracheotomy residents. They tried not to break the Heat Moisture Exchange any more than they must. The tracheotomies were moist and warm, and bacteria thrive in that environment. tracheostomy care was provided every 12 hours and as needed. Nurses were allowed to provide trach care and to suction when needed. He indicated 95 percent of the time an RT was in the facility. The infection CRAB was easily transmitted, and the ventilation residents were more susceptible to infections. c. The record for Resident 36 was reviewed on 10/8/24 at 11:21 a.m. The resident's diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, and resistance to other specified Beta Lactam antibiotics, candidiasis, a carrier of carbapenem-resistant Enterobacter ales, acute			

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	infections, streptococcus group B, other bacterial agents, pseudomonas, and a tracheostomy. The physician's order, dated 10/2/24, indicated Doxycycline Monohydrate Oral Capsule 100 mg give 1 capsule via G-Tube two times a day for pneumonia for 7 days. The physician's order, indicated dated 10/6/24, indicated enhanced barrier precautions related to a history of CRE (Carbapenem-Resistant Enterobacterales), CRAB, CRPA (Carbapenem Resistant Pseudomonas Aeruginosa), Candidas Auris, tracheotomy, g-tube, a right chest IJ (Internal Jugular) dressing, bathing, showering, transferring, therapy, personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting every shift. The physician's order, dated 10/6/14, indicated to administer Amoxcillin-Potassium Clavulanate oral tablet 875-125 mg and give 1 tablet via g-Tube every morning and at bedtime for hydronephrosis for 10 administrations. d. The record for Resident 92 was reviewed on 10/8/24 at 8:50 a.m. The resident's diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, methicillin resistant staphylococcus aureus infection, pseudomonas, and Osteomyelitis of the vertebra, sacral and sacrococcygeal region on admission. The Quarterly MDS assessment, dated 9/6/24, indicated the resident was rarely or never understood. The resident required complete dependence on staff for her ADL's. The physician's orders, with a start date of 7/8/24 and dated 10/9/24, indicated enhanced barrier			

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	precautions related to a history of Candidas auris and pseudomonas aeruginosa MDRO (Multi Drug Resistant Organisms), indwelling medical device-tracheotomy, gastrointestinal tube, a right chest port, a midline, (IV site) and open wounds. If Vancocin Pulvules (Vancomycin) was ordered orally, change the order to vancomycin slurry. The review of the respiratory surveillance form, dated 10/11/24 at 8:30 a.m., indicated eleven out of fifteen residents residing on the ventilation unit (400 Unit) had been or are currently on antibiotics for an infection. During an interview on 10/11/24 at 9:40 a.m., the IP (Infection Control Nurse) indicated the 400 Unit was the vent unit and they were very sick residents. Most of the residents had a history of MDRO. When a culture was done it seemed like the MDROs always came up. She would review the cultures and make sure the resident was on the right antibiotic. The IP indicated she did not agree with the observations of the staff not washing their hands. The staff had been educated that they could have one clean and one dirty hand. The ventilation resident do not get showers. They get bed baths with hibiclens and the hibiclens were not rinsed off. The staff had been educated on PPEs and the disposal of the PPEs. The IP indicated currently the residents on the 400 Unit have been treated for their infections and were not currently on antibiotics. During an interview on 10/15/24 at 11:30 a.m., the Respiratory Therapy Director indicated the main way to prevent the spread of infections was handwashing and proper PPEs. He indicated when he saw someone not following infection control procedures he would educate the staff member. He indicated the ventilation unit did have a high			

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	number of infections on the unit. He indicated when RT checked the resident's oxygen with a pulse oximeter, they were to clean the pulse oximeter with a bleach wipe before using it on another resident. He indicated he believed handing washing was the most important aspect of preventing the spread of infection. 2. During observation of the 300 Hallway of staff hand hygiene on 10/10/24 between 10:00 a.m. and 10:30 a.m., the following was observed: - CNA 29 was observed coming out of Room 315 after providing incontinence care. She was carrying a plastic bag of soiled brief and wipes. She was observed to sanitize one hand while holding the soiled bag with the other hand and then transferred the soiled bag to her clean hand while she sanitized the other hand. She then double bagged the soiled items and proceeded to throw it away in the soiled utility room. No hand washing or sanitizing was observed to have occurred either in the soiled utility room nor from the sanitizer unit on the wall outside the soiled utility room. - CNA 30 was observed to enter the soiled utility room carrying a bag of soiled incontinent items to dispose of. No hand washing or sanitizing was observed to have occurred either in the soiled utility room or from the sanitizer unit on the wall outside the soiled utility room. During an interview with the Infection Preventionist on 10/11/24 at 9:40 a.m., she indicated she kept a binder which contained her random observations of staff performing hand sanitizing or washing prior to entrance to a resident's room and upon leaving the room. If she saw staff were doing it wrong, she indicated she would provide education on the spot to them.			

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	3. During an observation on 10/10/24 at 1:42 p.m., CNA 4 performed perineal care on the resident. She performed handwashing and applied gloves. Using wipes, the CNA cleaned the groin, then swiped down the right crease with the same area of the wipe. She did not dry the resident. She then had the resident roll onto her left side and with 4 swipes with the same area of the wipe, cleaned the buttocks. The resident rolled onto her back and the brief was fastened. The resident was not dried, and the brief was fastened. The CNA removed her gloves and performed handwashing. During an interview on 10/11/24 at 10:48 a.m., CNA 4 indicated she would clean the resident from front to back. She normally used wipes for perineal care. She didn't dry the resident when using a wipe. If she cleaned the resident with a washcloth, she would dry the resident. When using a wipe, she would use one wipe for each swipe. The record for Resident 60 was reviewed on 10/11/24 at 10:00 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with complications, hypertension, need for assistance with personal care, and herpes viral infection. The current care plan, with a start date of 4/14/23, indicated the resident was incontinent of urine. The interventions, dated 4/14/23, included, but was not limited to, wash, rinse and dry the perineum, and apply barrier creams as needed. The Quarterly MDS assessment, dated 5/30/24, indicated the resident was cognitively intact. The resident required partial to moderate assistance for toileting hygiene. The Infection Control policy, dated 3/9/2000, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	last revised on 2/4/22, indicated ..." The goals of the facility infection prevention program are to: a. Reduce the spread of infectious disease within the facility through implementation of the Stand and Transmission-based Precautions b. Improve antibiotic stewardship as part of the ICIP plan c. Comply with federal, state and local community disease reporting requirements d. Monitor occurrences of infection and implement appropriate control measures e. Investigate outbreaks and report to the QAPI committee f. Identify and correct problems relating to infection prevention practices g. Maintain compliance with state and federal regulations relating to infection prevention ... b. Surveillance of Infections ii. Prevention of spread of infections is accomplished by education and implementation for the use of hand hygiene, standard precautions, and transmission-based precautions as appropriate, with treatment and follow-up and employee work restrictions for illness ..." The current Perineal Care Male and Female policy, included, but was not limited to, "... Equipment and Supplies: If using disposable perineum wipes: a) Disposable wipes b) Towel c) Personal Protective Equipment (e.g. gown, gloves, mask, eye protection, etc., as needed)... Female Residents:... 2-Wash perineal area, wiping from front to back. a) Separate labia and wash area downward from front to back... d) Gently dry the perineum... 5- Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. 6- Rinse and dry thoroughly..." Cross Reference F690			