STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155234	A. BUILDING 00 B. WING	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTRIDGE HEALTH CARE CENTER	125 W MARGARET AVE TERRE HAUTE, IN 47802

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 26, 27, 28, 29, and March 1, 2024. Facility number: 000139 Provider number: 155234 AIM number: 100266410 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 2 Medicaid: 40 Other: 3 Total: 45 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 8, 2024.	F 0000	**Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law.** **Please accept this Plan of Correction as our credible allegation of compliance.** **Please find enclosed this Plan of Correction for this survey.** **Due to the low scope and severity of the survey findings, the Facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.**	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to ensure a call light device was in reach for 1 of 16 residents reviewed	F 0558	F 558 ***What corrective action(s) will be accomplished for those***	03/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Bloesing	administrator	03/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	for call light placement (Resident 34). Findings include: On 2/26/24 at 2:52 p.m., Resident 34's call light was observed to be draped on the outlet against the wall and out of reach. The resident indicated that staff stopped giving one to her recently, so she needed to ask for things when they came in. The resident indicated that she could not move her arms or legs very much and could not turn herself in bed without assistance. The resident was observed to be laying on her left side and the bed was positioned diagonally away from the call light device. On 2/27/24 at 11:57 a.m., Resident 34's call light was observed to be draped on the outlet against the wall and out of reach from the resident. On 2/28/24 at 11:04 a.m., Resident 34 requested help getting assistance from staff, her call light was observed to be draped on the outlet against the wall and out of reach from the resident. Resident 34's record was reviewed on 2/27/24 at 11:49 a.m. The profile indicated that the resident's diagnoses included, but were not limited to, right knee contracture (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), left knee contracture, muscle weakness, stiffness of left hand, and gastrostomy status (the placement of a feeding tube through the skin and the stomach wall). An annual Minimum Data Set (MDS) assessment, dated 1/1/24, indicated Resident 34 was cognitively intact and had functional limitation in range of motion in the upper extremity (shoulder,		***residents found to have been affected by the deficient practice;*** The noted resident, number 34, was not negatively affected by the alleged deficient practice. Resident number 34 was provided call light immediately. Resident 34's call light was monitored to ensure it was in reach and accessible to her at all times while in room. ***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;*** No residents were affected by the alleged deficient practice; however, all residents have the potential to be affected. An audit for all residents' call lights has been completed to ensure they are within reach and accessible when the resident is in the room. Any noted discrepancies were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility's policy for call light placement has been reviewed, and no changes are indicated. All staff will be re-educated on the facility's policy. The in-service will focus on call lights being in reach for all residents at all times while residents in their rooms. A	

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	elbow, wrist, hand) on both sides and in the lower extremity (hip, knee, ankle, foot) on both sides. She was dependent and required assistance for turning and repositioning in bed, and her vision was moderately impaired. During an interview with the Director of Nursing (DON) on 2/28/24 at 2:44 p.m., she indicated that Resident 34 did not use her call light very often and she was not ordered to have a soft touch call light. Resident 34's call light was observed with the DON. The call light was draped on the outlet against the wall and out of reach of the resident. The DON indicated that it should not be on the wall and then placed it within reach of the resident. On 3/1/24 at 10:12 a.m., the Regional Nurse Consultant (RNS) provided and identified a document as a current facility policy, titled, "Call Light" dated 10/2014. The policy indicated, " ...Purpose: Resident will have a call light to summon facility personnel to ensure the resident's needs will be met ... Procedure ... 8. Call lights must remain functional and within reach of each resident. Call lights must not be disabled. Call lights must not be removed from resident's reach ...." 3.1-3(v)(1)		monitoring tool has been implemented. ***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 be responsible for completing the monitoring tool to ensure that all resident's call lights are within reach while resident is in room per facility's policy. Call lights will be audited 5 times per week for 100% of the residents for 4 weeks, then 3 times per week for 100% of the residents for 4 weeks, then weekly for 100% of the residents for 4 weeks, then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these audits and any corrective action will be discussed during the facility's QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan			

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	of care. Based on interview and record review, the facility failed to ensure pressure ulcer treatments were completed by qualified staff and staff followed proper standards of practice for 1 of 1 residents reviewed for pressure ulcer care (Resident 29). Findings include: During an interview, on 2/26/24 at 10:54 a.m., Resident 29 indicated he had an open area to his bottom, and it had been there for a few months. He indicated it was a facility acquired pressure ulcer. During an interview, on 2/28/24 at 10:20 a.m., the Qualified Medication Aide (QMA) 6 indicated she had already completed Resident 29's dressing change to his open area in the morning and it was a dayshift dressing change daily. During an interview, on 2/29/24 at 9:11 a.m., Registered Nurse (RN) 14 indicated a QMA would need to let the nurse know that a dressing change needed to be completed because QMAs were not licensed to perform a pressure ulcer dressing change. During an interview, on 2/29/24 at 10:13 a.m., Resident 29 indicated there were two QMAs who normally completed the pressure ulcer dressing change to his bottom, and they were QMA 5 and QMA 6. During an interview, on 2/29/24 at 10:25, the Regional Nurse Consultant indicated it was against the company's policy for a QMA to complete a dressing change on a pressure ulcer that was greater than a stage I (pressure related alteration of intact skin with non-blanchable	F 0659	F 659 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** The noted resident, number 29, was not negatively affected by the alleged deficient practice. Resident number 29's wound treatment was completed by a licensed nurse and signed off as by said licensed nurse. Resident number 29's wound treatment has been monitored to ensure that qualified licensed personnel complete treatment. ***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;*** No residents were affected by the alleged deficient practice; however, all residents with wounds greater than stage I have the potential to be affected. All residents' wound orders will be reviewed to ensure that licensed personnel are completing and signing off the aforementioned. Any noted discrepancies will be immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility's policy for qualified	03/29/2024

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	redness over a bony prominence) pressure ulcer. Resident 29's record was reviewed on 2/28/24 at 10:43 a.m. The profile indicated the resident diagnoses included, but were not limited to, Type 2 diabetes mellitus without complications (a chronic condition that affects the way the body processes blood sugar), chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems), and pressure ulcer of sacral region (pressure injuries occur when a bony prominence, such as sacrum, is subjected to prolonged pressure and can result in soft tissue injury). An annual Minimum Data Set (MDS) assessment, dated 2/7/24, indicated the resident was cognitively intact and had a stage III (full thickness tissue loss where subcutaneous fat may be visible) pressure ulcer. A care plan, dated 11/22/23, indicated the resident was at risk for the development of pressure ulcers related to the history of stage IV (severe full thickness tissue loss where muscles, bones, and/or tendons may be visible) pressure ulcer on sacrum. Interventions included, but were not limited to, low air loss mattress, pressure reducing cushion to chair, and staff to observe skin condition while providing care. Review of initial pressure ulcer assessment sheet, dated 12/12/23, indicated a stage III pressure ulcer to left coccyx. The wound measured 3 centimeters (cm) by (x) 1.5 cm with a depth of 1.8 cm. A physician order, dated 12/12/23 with an end date of 12/28/23, indicated wet to dry dressing to sacral wound, change daily and as needed for soilage.		persons titled “Qualified Medication Aide, Scope of Practice” has been reviewed and no changes are indicated at this time. All QMA’s and licensed nurses will be re-educated on the facility policies. The in-service will focus on scope of practice with a special focus on wound care scope of practice. A monitoring tool has been implemented. ***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 be responsible for completing the monitoring tool to ensure that all residents receiving wound care are properly monitored for appropriate personnel completing care per facility’s policy. The personnel completing wound care will be audited 5 times per week for all residents with wound care for 4 weeks. Then 3 times per week for all residents with wound care for 4 weeks. Then 1 time per week for all residents with wound care for 4 weeks. Then reviewed monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility’s QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis	

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	A physician order, dated 12/28/23 with an end date of 2/22/24, indicated cleans open area with normal saline, may use wound cleanser, pat dry. Apply skin prep to peri-wound (tissue surrounding wound). Apply wet to dry gauze, cover with Mepilex, once a day. Review of December 2023, MAR's (Medication Administration Record) indicated QMA 6 documented as completing the dressing change to Resident 29's stage III pressure ulcer 7 out of 19 days. QMA 11 documented completing the dressing change 5 out of 19 days. QMA 16 documented completing the dressing change 4 out of 19 days. A care plan, dated 1/11/24, indicated the resident had a pressure ulcer. Interventions included but not limited to, dressing change daily per medical doctor order, notify physician of any signs and symptoms of infection, and pressure relieving devices in place. Review of January 2024, MARs indicated QMA 5 documented completing the dressing change to Resident 29's stage 3 pressure ulcer 1 out of 28 days. QMA 6 documented completing the dressing change 11 out of 28 days. QMA 16 documented completing the dressing change 6 out of 28 days. Review of weekly skin assessment, dated 2/23/24, indicated the current wound measured 3 cm x 1.4 cm with a depth of 0.9 cm. A physician order, dated 2/22/24, indicated cleanse open area with normal saline, may use wound cleanser, pat dry, and apply skin prep to peri-wound. Cut Puracol wound dressing into		of compliance until 100% compliance is achieved.	

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	rope and fit into wound bed. Cover with Mepilex, once a day. Review of February 2024, MARs indicated QMA 6 documented as completing the dressing change to Resident 29's stage III pressure ulcer 19 out of 28 days. QMA 16 documented completing the dressing change 1 out of 28 days. During an interview, on 3/1/24 at 9:26 a.m., QMA 16 indicated she had not performed any dressing changes on a wound greater than stage I because it was not allowed with her license. During an interview, on 3/1/24 at 9:28 a.m., QMA 11 indicated she would not perform any dressing changes that were not allowed under her license as a QMA. During an interview, on 3/1/24 at 9:38 a.m., the Director of Nursing (DON) indicated a QMA may only complete a dressing change on a wound that was a stage I or less. She was aware that the QMA's were signing off on the MAR that they were completing the dressing change to Resident 29's wound and that they would be educated on not signing off things that were beyond their scope of practice. On 2/29/24 at 11:01 a.m., the Regional Nurse Consultant provided an undated document titled, "Qualified Medication Aide, Scope of Practice," and indicated it was the current policy being used by the facility. The policy indicated, " ...The following tasks shall NOT be included in the QMA scope of practice " ...(6) Administer a treatment that involves advanced skin conditions, including stage II, stage III, stage IV decubitus ulcers ...."			

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	On 2/29/24 at 11:01 a.m., the Regional Nurse Consultant provided a document, with a year of 2023 titled, "Job Description, Qualified Medication Aide," and indicated it was the current policy being used by the facility. The policy indicated, " ...6. Administer medications/treatments as taught per Indiana QMA curriculum ...." 3.1-35(g)(1)			
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 unless a reduction in mobility is demonstrably unavoidable. Based on record review, observation, and interview, the facility failed to provide treatment to prevent further decrease in range of motion for 1 of 2 sampled residents reviewed for range of motion (Resident 32). Findings include:	F 0688	F 688 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** The noted resident, number 32, was not negatively affected by the	03/29/2024

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	On 2/26/24 at 11:10 a.m., during a routine observation, Resident 32 was sitting in a wheelchair. The left hand was contracted in a fist position, nails were long and touching the inside of the palm of the hand. No anti-contractual device was in Resident 32's hand. During an observation on 2/28/24 at 11:00 a.m., Resident 32 was sitting in a wheelchair in the activity lounge area. The left hand was contracted in a fist position, no anti-contracture device was in the left hand. During an interview, on 2/27/24 at 2:44 p.m., the Director of Nursing (DON) indicated if a resident had a contracture of the limbs, therapy evaluated the resident, and the therapist would decide if the resident needed an anti-contracture device. During an interview on 2/28/24 at 11:13 a.m., the Certified Occupational Therapy Assistant (COTA) indicated when a resident needed to be assessed the evaluation request was given to the therapist. Before the evaluation was completed and the therapist obtained an order from the physician to evaluate and treat the resident. The evaluation was completed by the therapist or the COTA. The information was placed in the hard copy chart. The COTA acknowledged the resident was to be evaluated on 2/28/24 for the contracture of the left hand. She received a referral to evaluate the resident last week, but she had not gotten to it yet. During an interview on 2/28/24 at 11:24 a.m., Certified Nurse Aide (CNA) 13 indicated the resident did not have an anti-contracture device in her left hand. She indicated the resident would probably not allow them to place anything in her		alleged deficient practice. Resident number 32 has been evaluated by occupational therapy and anti-contracture care of the left hand. An anti-contracture device was recommended and put in place. Resident number 32 was monitored for use of and management of anti-contracture device. ***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;*** No residents were affected by the alleged deficient practice; however, all residents with contractures have the potential to be affected. All residents with contractures were assessed for to ensure that comprehensive patient-centered care regarding joint mobility reflects the patients' condition. Any noted discrepancies were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility's policy for Joint Mobility Screen has been reviewed and no changes are indicated at this time. All staff will be re-educated on the facility policies. The in-service will focus on monitoring residents for the necessity of anti-contracture	

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	hand. During an interview on 2/28/23 at 1:47 p.m., the Regional Nurse Consultant indicated she spoke to the COTA last week about the resident's contracture of her left hand. She thought an order was obtained for an evaluation. She acknowledged the contracture was not recent and an evaluation with treatment order by the physician had not been obtained. On 2/29/24 at 10:51 a.m., Resident 32's medical record was reviewed. Resident 32 was admitted on 5/5/23. Diagnoses, dated 5/5/23, include, but are not limited to, Hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body), and hemiparesis (a relatively mild loss of strength) following nontraumatic subarachnoid hemorrhage (subarachnoid hemorrhage is bleeding in the area between the brain and the thin tissues that cover the brain) affecting left non-dominant side, muscle weakness (generalized), hypertension (high blood pressure), chronic obstructive pulmonary (a group of diseases that cause airflow blockage and breathing-related problems), unspecified psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality), not due to a substance or known physiological. Resident had a diagnosis, dated 6/1/23, of dysphagia (difficulty swallowing), oropharyngeal phase (the middle part of the throat, behind the mouth). The record lacked documentation of orders to complete range of motion (ROM), or prevention of contractures. A quarterly Minimum Data Set, (MDS), dated 1/3/24, indicated the resident was cognitively		devices and management of anti-contracture devices. A monitoring tool has been implemented. ***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 be responsible for completing the monitoring tool to ensure that all residents are monitored for the necessity of anti-contracture devices and management of anti-contracture devices per facility's policy. The management of anti-contracture devices will be audited 5 times per week for residents with anti-contracture devices for 4 weeks. Then 3 times per week for residents with anti-contracture devices for 4 weeks. Then 1 time per week for residents with anti-contract devices for 4 weeks. Then residents with anti-contracture devices will be audited monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	

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	impaired and had mobility impairment to the left upper side. A care plan, dated 5/5/23, indicated the resident was at risk for complications related to hemiplegia/hemiparesis related to impaired physical mobility. Interventions included, but were not limited to, range of motion to be performed and repositioning of affected limb(s) by nursing staff due to impaired physical mobility. Documentation lacked evidence that range of motion had been provided by the nursing staff. On 3/1/2024 at 10:30 a.m., the Director of Nursing (DON) provided a document titled, "Joint Mobility Screen," dated 10/2014, and indicated it was the policy currently being used by the facility. The policy indicated, " ...Purpose ...To identify those residents who may be at risk for contractures/decreased range of motion ...Procedure ...2. Possible interventions included but were not limited to active or passive range of motion at least twice daily, O.T./P.T. (occupational therapy/physical therapy) screening and or treatments ...assessment of contractures on a regular basis ...3. Applicable recommendations will be made to the attending physician and orders obtained accordingly per their discretion ...4. Interventions will be addressed on the individual care plan ...5. The joint mobility screen shall be re-evaluated/completed ...as necessary relative to ...significant change in condition affecting range of motion, etc...." 3.1-42(a)(1) 3.1-42(a)(2) 3.1-42(a)(3)			
F 0812 SS=D	483.60(i)(1)(2) Food			

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	155234	A. BUILDING 00 B. WING	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTRIDGE HEALTH CARE CENTER	125 W MARGARET AVE TERRE HAUTE, IN 47802

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Bldg. 00	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 the wash temperature of the chemical sanitizing dish machine (a dishwashing machine that applies potable water and a chemical sanitizing solution to the surfaces of wares to achieve sanitization), met the required temperature for 1 of 2 kitchen observations. Findings include: During the initial kitchen tour, on 2/26/24 at 9:59 a.m., the dish machine temperature dial indicated a top temperature of 80 degrees Fahrenheit (a scale for measuring temperature, in which water freezes at 32 degrees and boils at 212 degrees), during the	F 0812	F 812 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** None of the residents were negatively affected by the alleged deficient practice. The thermometer on the dish machine dial was found to be defective and was immediately replaced with a calibrated thermometer. The mechanical boiler thermostat leading to the dish machine was immediately increased in temperature. The thermometer on	03/29/2024

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	wash cycle. Four separate wash cycles were attempted. None reached a wash temperature higher than 80 degrees Fahrenheit. On 2/26/24 at 10:01 a.m., the Dietary Manager used a manual thermometer to measure the dish machine wash temperature. The thermometer registered a top temperature of 80 degrees Fahrenheit. At the same time, the Dietary Manager indicated he believed the minimum temperature should be between 100 and 120 degrees Fahrenheit. On 2/28/24 at 8:50 a.m., the Dietary Manager provided the dish machine temperature logs, dated February 2024, and indicated they were the logs of the temperatures that had been taken during the wash cycles for the dish machine. The logs documented the dish machine temperature had been measured at 100 degrees Fahrenheit for all days during the month. On 2/28/24 at 8:50 a.m., the Dietary Manager provided an undated document, titled, "CMA Dish Machines," and indicated it was the manufacturer's guidelines for the dish machine currently in use by the facility. The document indicated, "...CMA Dish Machine Model AH Details...Water Temperature 120-140 degrees Fahrenheit.... 3.1-21(i)(3)		the dish machine dial will be monitored to ensure it was always within the correct temperature range. ***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;*** There were no residents affected by the alleged deficient practice; however, all residents have the potential to be affected. An audit was conducted on the dish machine to ensure that temperatures remain within acceptable range. If deficient practice was noted, it was immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility's policy follows CMA Dish Machines manufacturer's guidelines. The aforementioned has been reviewed and no changes are indicated at this time. The dietary staff will be re-educated on the facility policies with a special focus on monitoring temperature levels. A monitoring tool has been implemented. ***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 Administrator or designee will	

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			be responsible for completing the monitoring tool to ensure that dish washer water temperature is between 120-140 degrees Fahrenheit per facility's policy. The associated audits will occur 5 times per week for 4 weeks. Then 3 times per week for 4 weeks. Then weekly for 4 weeks. Then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these audits and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
F 0880 SS=E 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,			

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	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 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.			

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	§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. 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 and interview, the facility failed to ensure clean linen was carried away from the body and failed to ensure soiled linen was in a container while transporting in the hallway during 5 of 5 random observations for linen handling. Findings include: During a random observation on 2/28/24 at 10:01 a.m., Certified Nursing Assistant (CNA) 21 retrieved a stack of linens from the clean linen closet located in the 100 hall, she then held the linens against her body while transporting them to a resident's room. During a random observation on 2/28/24 at 11:00 a.m., CNA 21 retrieved a stack of linens from the clean linen closet located in the 100 hall, she held the linens against her body while transporting. During a random observation on 2/29/24 at 9:50 a.m., Employee 3 was observed coming out of a resident's room on the 200 hallway wearing gloves and holding soiled linens that were unbagged against her body. She left the resident's room and indicated she needed to take the linens to the	F 0880	F 880 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** None of the residents were negatively affected by the alleged deficient practice. All staff have been re-educated regarding the handling of clean and soiled linen according to the facility policy. ***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;*** There were no residents affected by this alleged deficient practice, but all residents have the potential to be affected. The staff has been monitored to ensure they are handling clean and soiled linen according to the facility's policy. Any noted discrepancies are immediately corrected.	03/29/2024

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	hopper. During a random observation on 2/29/24 at 2:48 p.m., CNA 20 retrieved a stack of linen from the clean linen closet located in the 100 hall, transported the linens against her body while entering a resident's room, walked out of the room still holding the linens against her body and transported them to a shower room. During a random observation on 3/01/24 at 8:45 a.m., CNA 21 retrieved a stack of linen from the clean linen closet located in the 100 hall and transported the linens against her body. During an interview on 2/28/24 at 3:01 p.m., Employee 8 indicated that staff were not to carry linens against their body and soiled linens were supposed to be transported in a plastic bag. During an interview on 3/1/24 at 9:55 a.m., CNA 22 indicated when they remove dirty linen it was to be put in a bag and then taken to the hopper room and placed in the linen barrel. When they remove linen from the clean linen closet, they were supposed to hold the items away from their body, never against their body. On 3/1/24 at 10:12 a.m., the Regional Nurse Consultant (RNS) provided and identified a document as a current facility policy titled, "Linen, Handling," dated 12/2015. The policy indicated, " ... The facility shall handle linen in a manner to prevent the spread of infection ... Procedure ...2. Linen will not be carried against the body ...7. Soiled linen will be placed in a container (i.e., linen barrel, plastic bag, etc.) prior to taking it into the hallway ...." 3.1-18(b)(1)		***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** The facility's policy for linen handling has been reviewed, and no changes are indicated. All staff will be re-educated according to the facility's policy. The in-service will provide a special focus on handling clean and soiled linen at all times. A monitoring tool has been implemented. ***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 be responsible for completing the monitoring tool to ensure that all staff is handling clean and soiled linen per facility's policy. Linen handling will be audited as follows: 5 staff twice a day for 5 days per week for 4 weeks. Then 5 staff daily for 5 days per week for 4 weeks. Then 5 staff 3 days per week for 4 weeks. Then 5 staff 1 day per week for 4 weeks. Then 5 staff reviewed monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these audits and any corrective action will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the	

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			monitoring practices on the basis of compliance until 100% compliance is achieved.	