STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155062	A. BUILDING 00 B. WING	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - LAPORTE CARE CENTER	1700 I STREET LA PORTE, IN 46350

(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. This visit included the Investigation of Complaint IN00393549. Complaint IN00393549 - Unsubstantiated due to lack of evidence. Survey dates: February 20, 21, 22, 23, and 24, 2023. Facility number: 000023 Provider number: 155062 AIM number: 100289400 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 4 Medicaid: 45 Other: 11 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/28/23.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents	F 0554	F554 Resident Self-Administration of Medications-Clinically Appropriate	03/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Bradford	RN, BSN, Director of Nursing	03/16/2023

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	had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Residents 26) Finding includes: On 2/21/23 at 9:25 a.m., there were two inhalers sitting on top of the residents dresser. Resident 26 indicated she administered them by herself whenever she felt like she needed them. Resident 26's record was reviewed on 2/21/23 at 3:25 p.m. Diagnoses included, but were not limited to, displaced fracture of second cervical vertebra, chronic obstructive pulmonary disease, and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 1/26/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 10/3/22, indicated Arnuity Ellipta aerosol powder breath activated 100 microgram/actuation, 1 puff inhale orally at bedtime. A Physician's Order, dated 10/3/22, indicated Anoro Ellipta aerosol powder breath activated 62.5-25 microgram/actuation, 1 puff inhale orally at bedtime. There were no orders for self-administration of medications. There was no self-administration assessment completed for the inhalers. Interview with the Director of Nursing on 2/23/23 at 9:51 a.m., indicated she had no further		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Immediate action taken for the resident found to have been affected: Medications were immediately removed from the room for identified resident #26 and secured in the medication cart per the Director of Nursing (DNS). A Medication Self-administration assessment was completed for resident #26 and a physician order was obtained for self-administration. plan of care was updated to reflect this change and a lockbox was provided for this resident to secure her inhalers. 2. Identification of other residents having the potential to be affected: An immediate facility wide audit of all resident rooms was conducted per the DNS to ensure that there were no additional medications at bedside unless the medication self-administration assessment had been completed, a	

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	information to provide. 3.1-11(a)		physician's order was in place, and the plan of care up to date. No other deficiencies were identified. 3) Measures put into place/ System changes: All Licensed Nursing staff and Qualified Medication Aides (QMA) were re-educated by the Director of Education (DCE) on the policy and procedure for Resident Self-Administration of Medication. The DNS or designee to complete random room audits to identify if medications are stored at bedside without a self-administration assessment, order, and plan of care in place per the Self-Administration policy/procedure. The rounds will be completed 2 times per week for 1 month then weekly for 2 months then monthly for 3 months. The rounds will be random and will include all 3 shifts and all units. Any deficiencies identified will be corrected immediately with re-education provided as needed. Any identified deficiencies will be corrected immediately with re-education provided as needed. 4) How the corrective actions will be monitored: The DCE will provide the results of these reviews and audits to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance. 5) Date	

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			of compliance: 3/23/2023	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure dependent residents received help with Activities of Daily Living (ADLs) related to long fingernails for 1 of 1 residents reviewed for ADLs. (Resident 27) Finding includes: Interview with Resident 27 on 2/21/23 at 11:09 a.m., indicated his nails were too long on his contracted (fingers bent) right hand and they were digging into his palm. The nails on the right hand were observed to be longer than on the left hand. Resident 27's record was reviewed on 2/21/23 at 3:45 p.m. Diagnoses included, but were not limited to, stroke, heart disease, and olecranon bursitis of right elbow (extra fluid in the bursa). The Quarterly Minimum Data Set (MDS) assessment, dated 12/16/22, indicated the resident was moderately cognitively impaired for daily decision making. The resident required limited assistance with one person physical assist for bed mobility, transfer, and dressing. He required supervision with one person physical assist for personal hygiene. He had a functional limitation in range of motion affecting one side of both the upper and lower extremity. A Care Plan, dated 9/2/21, indicated the resident	F 0677	F677 ADL Care for Dependent Residents The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Immediate action taken for the resident found to have been affected: Resident #27 nails were immediately trimmed per Licensed Nurse. 2. Identification of other residents having the potential to be affected: The facility has determined that all residents have the potential to be affected. A facility wide audit was immediately completed per the DNS and DCE to determine if any other residents that needed ADL care with no other deficiencies	03/23/2023

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	had a physical functioning deficit/self care impairment related to weakness, chronic obstructive pulmonary disease, history of a stroke, and right elbow bursitis. Interventions included, but were not limited to, assist with self care. Interview with the Director of Nursing on 2/23/23 at 10:54 a.m., indicated the CNA cut the resident's fingernails today and said that he often refuses those nails to be cut, however she did not document the refusals. 3.1-38(a)(3)(E)		identified. 3) Measures put into place/ System changes: Direct care staff were re-educated by the Director of Education (DCE) on proper Nail Care for residents who are unable to perform their own nail care. The DNS or designee to complete random ADL rounds focusing on grooming and nail care. The rounds will be completed 2 times per week for 1 month then weekly for 2 months then monthly for 3 months. The rounds will be random and will include all 3 shifts and all units. Any deficiencies identified will be corrected immediately with re-education provided as needed. Any identified deficiencies will be corrected immediately with re-education provided as needed. 4) How the corrective actions will be monitored: The DCE will provide the results of these reviews and audits to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance. 5) Date of compliance: 3/23/2023	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 2 residents reviewed for skin conditions (non-pressure related). (Resident 114) Finding includes: On 2/21/23 at 2:01 p.m., Resident 114 was observed to have small scattered areas of reddish/purple discoloration to the top of her left and right hands. On 2/22/23 at 9:38 a.m., the resident was observed with fading reddish/purple discoloration to the ring finger on her left hand. The scattered areas of reddish/purple discoloration remained to her hands. The record for Resident 114 was reviewed on 2/22/23 at 1:34 p.m. Diagnoses included, but were not limited to, difficulty walking, low back pain, and anemia. The Admission Minimum Data Set (MDS) assessment, dated 2/15/23, indicated the resident was moderately impaired for daily decision making and required extensive assistance with bed mobility and transfers. A Physician's Order, dated 2/15/23, indicated the resident was to have a weekly skin review. A Weekly Skin Review, dated 2/21/23, indicated the resident's skin was intact. There was no	F 0684	F684 Quality of Care The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident #114 bruising was assessed on 2/24/23 per the Director of Nursing Services (DNS) and the physician was notified with new order received to monitor bruising weekly and notify MD if significant increase in size of bruise and/or if an increase in pain or a decline in range of motion is noted to area until resolved.	03/23/2023

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	documentation related to the discoloration to the resident's hands and ring finger. A Skin assessment, dated 2/23/23, indicated the resident was noted to have scattered fading discolorations to the bilateral upper extremities. There was also an area around the left ring finger that was discolored. The resident would be placed on shift monitoring for the areas until they were totally faded. Interview with the Director of Nursing on 2/24/23 at 11:20 a.m., indicated the areas of discoloration should have been assessed and monitored in a more timely manner. 3.1-37(a)		2) How the facility identified other residents: A facility wide audit was conducted per the DNS and the wound nurse to identify any other residents with alterations in skin integrity that do not have treatment orders or routine monitoring orders were in pla with no other deficiencies identified. 3) Measures put into place/ System changes: A. All Licensed Nursing staff were re- per the DCE on the Skin Integrity guideline including notification of the MD and family for any new areas and on-going monitoring of any identified alterations in skin integrity and how to complete and document a full body skin assessment. B. DNS or designee to review all nurses' notes, skin assessments, and orders	

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			daily with Clinical Start Up to identify any noted changes in skin integrity to ensure that MD and POA notification have occurred, an assessment of the area has been completed and that a treatment order is in if necessary, and/or a monitoring order is in place in PCC for alterations not requiring a treatment. C. DNS or wound nurse to complete a skin assessment of all new admits within 48 hours of admission and a random skin assessment of at least 3 residents that the completed weekly skin assessment is accurate and that all residents with alterations in skin integrity have MD and POA notification, a treatment in place if necessary, and/or that on-going monitoring is occurring of the identified areas. These audits will continue 2x/weekly x 1 month, then weekly x 2 months, then monthly x 3 months. Any identified deficiencies will be corrected immediately with re-education provided as needed.	

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			4) How the corrective actions will be monitored: The DNS will provide the results of these reviews and audits to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance. 5) Date of compliance: 3/23/2023	
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			

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	assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure residents with a limited range of motion had a sling applied as ordered by the Physician for 1 of 2 residents reviewed for limited range of motion (ROM). (Resident 42) Finding includes: On 2/21/23 at 11:20 a.m. and 12:37 p.m., Resident 42 was observed in her wheelchair. The resident's right arm was resting next to her and she did not have a sling in use to the right arm. On 2/22/23 at 10:00 a.m., 11:15 a.m., and 1:25 p.m., the resident was in her wheelchair. The resident's right arm was resting next to her and she did not have a sling in use. On 2/23/23 at 11:26 a.m., the resident was brought into the dining room by her son. She was seated in her wheelchair and the sling was not in use to her right arm. The record for Resident 42 was reviewed on 2/22/23 at 3:08 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia (paralysis on one side of the body) affecting the right dominant side. The Significant Change Minimum Data Set (MDS) assessment, dated 1/26/23, indicated the resident was moderately impaired for daily decision making and required extensive assistance with bed mobility and transfers. She had a functional limitation in ROM on one side of the upper and	F 0688	F688 Increase/Prevent Decrease in ROM/Mobility The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident #42 was assisted by the Director of Nursing (DNS) to place her arm back into her sling per MD order (resident noted to frequently remove her arm from the sling for short periods of time throughout the day). A Joint Mobility Assessment was completed per the DNS of resident's right upper extremity to identify if any adverse effects were noted related to not always having the sling on throughout the day per MD order. No decline in range of motion was noted per assessment. Resident's MD and her power of attorney (POA) were	03/23/2023

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	lower extremities. A Care Plan, last reviewed on 2/20/23, indicated the resident had active diagnoses of hemiparesis (muscle weakness)/hemiplegia to the right dominant side due to a stroke. Interventions included, but were not limited to, provide assistive devices as indicated. A Physician's Order, dated 1/11/23, indicated the resident was to wear a right arm sling when up for joint protection. The February 2023 Treatment Administration Record (TAR), indicated the sling had been signed out as being applied daily. Interview with the Director of Nursing on 2/23/23 at 2:15 p.m., indicated she applied the resident's sling every morning when she was working. She also indicated the resident would take the sling off and she would update the care plan to reflect that. 3.1-42(a)(2)		notified that resident frequently removes her arm from the sling. POA stated understanding and there were no new orders received from her MD. Resident's plan of care was updated to reflect that she frequently removes her arm from the sling and that the staff will assist her to replace the sling as needed as she allows. Therapy to evaluate resident to determine the need for the continuation of the sling or to identify another device that resident will be more willing to keep in place to protect her joint. 2) How the facility identified other residents: DNS and the Director of Clinical Education (DCE) conducted a facility wide audit to identify any other residents without anti-contractual devices in place per MD order with no other deficiencies identified. 3) Measures put into place/ System changes: DNS or designee to complete random audits related to anti-contractual devices to ensure all ordered devices are in place per MD order. These audits will be completed 3x a week for 1 month, then weekly for 2 months then monthly for 3 months. These audits will be random and will include all 3 shifts on all units. If any concerns or discrepancies are identified they will be corrected	

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			immediately, and re-education will be provided as necessary. 4) How the corrective actions will be monitored: The DNS will report any trends to the QAPI committee on a monthly basis for recommendations and resolutions. Results of these reviews and audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance. 5) Date of compliance: 3/23/2023	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 1 of 2 residents reviewed for respiratory services. (Residents 54) Finding includes: On 2/21/23 at 10:13 a.m., Resident 54 was observed in her wheelchair in her room with a	F 0695	p="" paraid="743210233" paraeid="{b7732d8f-26b0-4685-9aeb-e650cfc30b90}{180}">F695 Respiratory/Tracheostomy Care and Suctioning The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or	03/23/2023

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	nasal cannula on running at 1.5 liters per minute. The oxygen tubing was dated 2/18/23. On 2/21/23 at 1:56 p.m., Resident 54 was observed in her wheelchair in her room with the oxygen concentrator set at 1.5 liters per minute. The oxygen tubing was dated 2/18/23. Resident 54's record was reviewed on 2/22/23 at 1:31 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), heart failure, and dyspnea (labored breathing). The Quarterly Minimum Data Set (MDS) set assessment, dated 2/7/23, indicated the resident was cognitively intact for daily decision making. The resident used oxygen. A Physician's Order, dated 12/31/22, indicated oxygen at 2 liters per minute via nasal cannula continuously. A Care Plan, dated 7/23/22, indicated the resident had an alteration in respiratory status due to COPD, sleep apnea, and dyspnea. Interventions included, but were not limited to, administer oxygen as needed per physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. Interview with the Director of Nursing on 2/23/23 at 9:51 a.m., indicated the resident's oxygen should have been set to 2 liters per minute. 3.1-47(a)(6)		execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Oxygen flow rate was immediately corrected for resident # 54 per the Director of Nursing (DNS). Resident was assessed per the DNS for adverse effects with no shortness of breath or respiratory distress noted or voiced and resident's oxygen saturation level was noted at 96%. It was noted per DNS investigation that the ball on the concentrator moved between 1.5 liter and 2 liter depending on where the concentrator was positioned. Oxygen concentrator was immediately replaced per the DNS. 2) How the facility identified other residents: A facility wide audit was conducted per the DNS of all residents in the facility with oxygen therapy to identify any other residents who may have been affected with no other deficiencies identified. All the facility's oxygen concentrators were assessed per the facility's oxygen provider to ensure that they were all in good	

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			working order with no other deficiencies noted. 3) Measures put into place/ System changes: All nursing staff were re-educated on the Oxygen Administration Policy per the Director of Clinical Education (DCE). DNS applied a sticker with a number only (. 1, 2, 3,) on all oxygen concentrators to alert staff to the correct flow rate required for each resident receiving oxygen therapy per the physicians' order. Stickers will be updated per the licensed nurse receiving the order and reviewed per the DNS, or designee, daily with Clinical Start up. DNS or designee to complete oxygen rounds, including ensuring that the concentrator is working correctly 3x/week for 1 month then weekly for 2 months then monthly for 3 months. The rounds will be random and will be done on all 3 shifts on all units. Any deficiencies identified will be corrected immediately per the DNS or designee with re-education to be provided immediately for any staff member responsible for the deficient practice. 4) How the corrective actions will be monitored: The DNS will provide the results of these reviews and audits to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of	

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			the audits will be adapted or adjusted as needed to maintain compliance. 5) Date of compliance: 3/23/2023	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure an apical pulse and blood pressure was monitored per cardiac medication parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 12) Finding includes: The record for Resident 12 was reviewed on	F 0757	F757 Drug Regimen is Free from Unnecessary Drugs The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or	03/23/2023

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	2/24/23 at 9:10 a.m. Diagnoses included, but were not limited to, hypertension and cerebral palsy. The Quarterly Minimum Data Set (MDS) assessment, dated 12/19/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. A Physician's Order, dated 10/19/22, indicated the resident was to receive Propanolol (a heart medication) 10 milligrams (mg) twice a day for hypertension. The medication was to be held if the resident's systolic (top number) blood pressure was less than 110 and his heart rate was less than 60 beats per minute. The December 2022 Medication Administration Record (MAR), indicated the resident's blood pressure nor heart rate was documented prior to giving the medication. There was also no area on the MAR to document the resident's blood pressure and heart rate. The January and February 2023 MAR's also indicated the resident's blood pressure nor heart rate was documented prior to giving the medication. Interview with the Director of Nursing on 2/24/23 at 11:20 a.m., indicated the resident's blood pressure and heart rate should have been monitored prior to giving the medication. 3.1-48(a)(3)		agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Immediate action taken for the resident found to have been affected: The physician order Blood Pressure and Pulse parameters were immediately added to the Propranolol order in Point Click Care (PCC) per the Director of Nursing (DNS) for Resident #12. Resident #12 was assessed per the DNS for adverse reactions related to the deficient practice and vitals were noted to be within the physician prescribed parameters. Resident's Physician was notified of the administration of the Propranolol without documented vitals per order with no new orders received. Resident #12's power of attorney was also notified. 2. Identification of other residents having the potential to be affected: A facility wide audit was completed, per the DNS, of all medication orders requiring physician prescribed parameters for administration to identify any other deficiencies with no other deficiencies identified. 3. Measures put into place/	

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			System changes: All Licensed Nursing staff and Qualified Medication Aides (QMA) were re-educated by the Director of Education (DCE) on the policy and procedure for Medication Administration with a focus on obtaining and recording vital signs when applicable per physicians' orders and when applicable holding medications if outside of those parameters. The DNS or designee to review all new orders daily with Clinical Start-up to ensure that all medication orders requiring parameters for administration have the parameters entered in the order in PCC. The DNS or designee to review all vital signs outside of the parameters daily to ensure the vitals are documented, the medications are held if applicable, and that the physician has been notified if applicable per physicians' order. Any identified deficiencies will be corrected immediately with re-education provided as needed. 4) How the corrective actions will be monitored: The DNS will provide the results of these reviews and audits to QAPI monthly x 6 months or until 100% compliance is achieved x 3 consecutive months. Results of the audits will be adapted or adjusted as needed to maintain compliance. 5) Date of compliance: 3/23/2023	

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to store and prepare food under sanitary conditions related to dirty ovens and oven hood, wet serving trays stacked on top of each other, and the lack of hand hygiene before serving lunch for 1 of 1 kitchens. (The Main Kitchen) This had the potential to affect all 60 residents who resided in the facility and received food from the kitchen. Findings include: 1. On 2/20/23 at 10:00 a.m., the full kitchen sanitation tour with the Dietary Manager (DM) indicated the following:	F 0812	p="" paraid="765157127" paraeid="{caa38fba-9b85-4fad-b7a9-12ec60cb9a9e}{201}">F812 Kitchen Sanitation The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared	03/23/2023

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	a. There was a large amount of black and burned food substances on the bottom of both ovens. There was a large amount of grease and brown stains on the inside of both oven doors. b. There was a large amount of grease and dust noted in between the oven hood slats. c. There were approximately 60 serving trays that were stacked on top of each other that were still wet. Interview with the DM at that time, indicated they probably need to be standing up longer on the racks to dry before they were stacked up. 2. On 2/20/23 at 11:18 a.m., during the tray line, Dietary Cook 1 was observed wearing gloves to both hands. At that time, he unplugged both portable steam tables and pushed them to the other side of the room. He pulled back the foil and plastic wrap from the prepared food and added utensils to each pan wearing the same gloves. At 11:22 a.m., he started plating the food with the same gloved hands. He did not perform hand hygiene before serving the food. At 11:23 a.m., the cook opened the bag of hamburger buns and removed one with the same gloved hands after touching all the other equipment including plates, pans, and utensils. Interview with the Dietary Food Manager on 2/20/22 at 11:35 a.m., indicated all of the above was in need of cleaning. The cook should have performed hand hygiene prior to serving the food and should not have picked up the hamburger bun wearing his old gloves. 3. The resident pantry was observed on 2/24/23 at		and/or executed solely because it is required by the provisions of federal and state law. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The grease and brown stains on the inside of both oven doors were immediately cleaned/removed, the grease and dust in between the oven hood slats was immediately cleaned/removed, the wet serving trays were immediately recleaned and completely dried prior to stacking them. Dietary Cook 1 was immediately educated on the “maintaining a sanitary tray line” policy regarding hand hygiene/glove changing and the kitchen cleaning checklist. No ill effects were noted due to the alleged deficient practice. Outdated and unmarked items in the resident pantry refrigerator were immediately disposed of by the Activity Director. p="" paraid="261718443" paraeid="{d2e5b1d9-2cc2-4896-9742-c3543e7c54ba}{24}">How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All current residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will you	

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	10:00 a.m., with the Activity Director. There was 1/4 gallon of apple cider opened with no date that had "Activities" written on it. The sell by date was 12/2022. There were 4 opened bottles of water with no name or date on them. There was a jar of opened pickles with no name or date opened and use by date of March 2023. There were two opened 2 liter bottles of cola and root beer with no name and or date opened. Interview with the Activity Director at that time, indicated the bottles of soda were from the super bowl party and she had no idea whose bottles of water those were or the jar of pickles. The apple cider was overlooked and she did not know that was still in there. Interview with the DM on 2/24/23 at 10:13 a.m., indicated the Activity Department used that refrigerator and all of those items. The resident's food from home or take out was also kept there. The current 2022 "Use and Storage of Food Brought in by Family or Visitors" policy, provided by the Director of Nursing on 2/20/22 at 2:55 p.m., indicated all food items that were already prepared by the family or visitor brought in must be labeled with content and dated. 3.1-21(i)(3)		make to ensure that the deficient practice does not recur? All dietary staff were educated regarding kitchen sanitation and hand hygiene. Dietary manager/designee will audit the cleaning schedule for the ovens and oven hoods and dietary staff hand hygiene 3 times each week x 2 months then weekly x 4 months to ensure kitchen sanitation is maintained and hand hygiene and glove wearing/changing is being performed per policy. Audits will include all dietary shifts and weekends. The Activities Director and Activities assistant were re-educated on the Use and Storage of Food Brought in by Visitors. The Activities Director will audit the resident pantry refrigerator 2x/week for 3 months then weekly x 3 months to ensure that all stored items are labeled and dated and that there are no expired items. p="" paraid="1175837036" paraeid="{d2e5b1d9-2cc2-4896-9742-c3543e7c54ba}{105}">How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Dietary manager/designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the	

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			Quality Assurance committee that further monitoring is needed, audits will continue. Date of Compliance: 3/23/2023	