STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155221	A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE HEALTH & REHAB	1120 E DAVIS DR 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. This visit included a State Residential Licensure Survey. Survey dates: March 20, 21, 22, 25, 26, and 27, 2024 Facility number: 000126 Provider number: 155221 AIM number: 100266400 Census Bed Type: SNF: 54 Residential: 28 Total: 82 Census Payor Type: Medicare: 16 Medicaid: 23 Other: 43 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 5, 2024.	F 0000	***Westminster Village Terre Haute wishes to have this submitted plan of correction (POC) stand as its allegation of compliance. Preparation and/or execution of this POC does not constitute admission to, nor agreement with either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.***	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure an Minimum Data Set (MDS) assessment was coded accurately for 1 of 17 MDS assessments reviewed (Resident 2).	F 0641	**F641 Accuracy of Assessments** The MDS for Resident #2 has been modified and resubmitted. An audit of MDSs for	04/23/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Williams	Administrator	04/19/2024

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	Finding includes: Resident 2's record was reviewed on 3/25/24 at 8:53 a.m. The profile indicated the resident's diagnoses included, but were not limited to, transient ischemic attack (TIA-occurs when blood flow to a part of the brain stops for a brief time). A quarterly MDS assessment, dated 2/21/24, indicated the resident received an anticoagulant (AC- a medication that is used to prevent and treat blood clots in blood vessels and the heart). A physician's order, dated 3/29/24, indicated aspirin (an oral antiplatelet drug [medications that prevent blood clots from forming]) enteric coated (EC-a polymer applied to oral medication. which serves as a barrier to prevent the gastric acids in the stomach from dissolving or degrading drugs after being swallowed) 81 milligrams (mg). Staff were to give 1 tablet by mouth daily related to personal history of TIA. A historical review of the resident's physician's orders, dated April 2023 through March 2024, indicated the resident had been prescribed the aspirin, as ordered above. The record lacked documentation of an AC medication having ever been prescribed. During an interview, on 3/25/24 at 9:37 a.m., the MDS Coordinator indicated she had reviewed the resident's current medication orders. The resident had not been prescribed an AC medication. The MDS assessment had been coded incorrectly. On 3/25/24 at 9:43 a.m., the MDS Coordinator provided a document, dated October 2023, titled, "CMS's (Center for Medicare and Medicaid		residents receiving antiplatelet medications was completed to ensure accurate coding with no issues identified. The MDS Coordinator has been re-educated regarding accurate MDS coding for residents receiving antiplatelet medications. The Director of Nursing or designee will conduct an audit on three (3) residents to ensure accurate MDS coding for residents receiving antiplatelet medication 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review. Date of Compliance-4/23/24	

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	Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," and indicated it was the policy currently being used by the facility. The policy indicated, "...N0415E1. Anticoagulant (e.g., Warfarin, heparin, or low-molecular weight heparin [types of anticoagulant medications]): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period...N041511. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin...)was taken by the resident at any time during the 7-day look-back period...." 3.1-31(c)(13)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and			

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	(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to obtain a supporting diagnosis for an indwelling Foley Catheter (a thin, flexible catheter used especially to drain urine from the bladder) for 1 of 3 residents reviewed for catheters (Resident 52). Findings include: On 3/21/24 at 9:10 a.m., during observation and interview with Resident 52, the resident indicated the indwelling Foley catheter was placed when she was in the hospital, but she could not recall why she had a catheter and indicated she had not had a catheter prior to going to the hospital. On 3/27/24 at 2:00 p.m., the Director of Nursing (DON) indicated the facility did not obtain a supporting diagnosis when the resident returned from the hospital because they were waiting on the follow-up appointment with urology to obtain the diagnosis. She indicated the physician would not give them the diagnosis and referred them to urology. On 3/25/24 at 11:27 a.m., Resident 52's record was reviewed. Diagnosis included but were not limited	F 0690	**F690 Bowel/Bladder Incontinence, Catheter, UTI (D)** A supporting diagnosis for an indwelling catheter has been obtained for Resident #52 An audit was completed for residents with indwelling foley catheters to ensure a supporting diagnosis was obtained with no issues identified. The clinical management have been re-educated regarding obtaining a supporting diagnosis for an indwelling foley catheter. The Director of Nursing or designee will conduct an audit of five (5) residents to ensure a supporting diagnosis for an indwelling foley catheter was obtained weekly for 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review. Date of Compliance-4/23/24	04/23/2024

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	to, displaced fracture of the lower end of right femur (a break in the long bone of the upper thigh), chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), atrial fibrillation (an irregular heart rhythm (arrhythmia) that begins in the upper (atria) of your heart, major depressive disorder (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks), urine retention (a condition in which you cannot empty all the urine from your bladder), dysuria (painful urination). The medical record lacked documentation of notification to physician requesting a supporting diagnosis for an indwelling catheter. The medical record also lacked documentation of a supporting diagnosis for indwelling Foley catheter upon return from the hospital up to the date of the current review. Physician orders included but were not limited to, 3/11/24, Foley Catheter - Size18 Fr (French) 10 ml (milliliters) balloon (inflated with water to anchor catheter tube in the bladder) every shift, change Foley catheter every night shift starting on the 28th and ending on the 28th every month for as needed, if resident was unable to void, may re-insert Foley catheter and notify MD (medical doctor), as needed. A Minimum Data Set (MDS) a standardized assessment tool that measures health status in nursing home residents, dated 3/12/24, indicated the resident was cognitively intact and had an indwelling catheter during the assessment look back period. The MDS indicated the resident did not have a diagnosis of neurogenic bladder, renal failure, or urinary obstruction. A care plan, dated 1/28/24, indicated the resident			

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	had incontinence related to decline in mobility and femur fracture. Needed assist with toileting and incontinent care. Interventions included, but were not limited to, assist with toileting and incontinent care as needed, ensure the resident has an unobstructed path to the bathroom. Monitor and document intake and output as ordered and report abnormalities to MD (Medical Doctor). Monitor/document for signs and symptoms of UTI (urinary tract infection); pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Documentation lacked a care plan for an indwelling Foley catheter. On 3/27/2024 at 1:47 p.m., the Assistant Director of Nursing (ADON) provided a document, titled, "Catheter Care, Urinary," dated August 2022, and indicated it was the policy currently being used by the facility. The policy indicated, "...Catheter Evaluation ...1. Review and document the clinical indications for catheter use prior to inserting ...2. Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place. Use the standardized tool for documenting clinical indications for catheter use ...." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to address a significant weight discrepancy for 1 of 2 residents reviewed for nutrition (Resident 1). Finding includes: Resident 1's record was reviewed on 3/22/24 at 10:29 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified diastolic (congestive) heart failure (occurs if the left ventricle muscle becomes still or thickened), cerebral infarction affecting right dominant side (a left-brain stroke happens when blood supply to left side of brain is stopped. The left side of brain is in charge of the right side of the body), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). An annual minimum data set assessment (MDS- part of the federally mandated process for clinical assessment of all residents in Medicare and	F 0692	**F690 Bowel/Bladder Incontinence, Catheter, UTI (D)** A supporting diagnosis for an indwelling catheter has been obtained for Resident #52 An audit was completed for residents with indwelling foley catheters to ensure a supporting diagnosis was obtained with no issues identified. The clinical management have been re-educated regarding obtaining a supporting diagnosis for an indwelling foley catheter. The Director of Nursing or designee will conduct an audit of five (5) residents to ensure a supporting diagnosis for an indwelling foley catheter was obtained weekly for 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will	04/23/2024

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	Medicaid certified nursing homes), dated 3/7/24, indicated the resident had impairment on one side. The assessment lacked documentation of weight loss or gain. A physician order, dated 3/1/24, indicated daily weights every dayshift. Notify doctor of 3 lb (pound) weight gain in 24 hours or 5 lb weight gain in one week. A physician order, dated 3/18/24, indicated the resident was to have a regular diet with regular thin liquid consistency. Review of the resident's weights indicated she weighed 176 pounds on most recent MDS assessment dated 3/7/24. Subsequent weights included, but were not limited to the following: a. On 3/18/24 at 3:37 p.m., the resident had been weighed by Licensed Practical Nurse (LPN) 7. Her weight was 175.4 pounds. b. On 3/19/24 at 4:48 p.m., the resident had been weighed by Registered Nurse (RN) 17. Her weight was 153.8 pounds. c. On 3/20/24 at 12:47 p.m., the resident had been weighed by LPN 18. Her weight was 154.8 pounds. d. On 3/21/24 at 12:01 p.m., the resident had been weighed by RN 17. Her weight was 155.4 pounds. e. On 3/22/24 at 11:32 a.m., the resident had been weighed by LPN 7. Her weight was 153.2 pounds. The record lacked documentation that the significant weight discrepancies in the resident's weights between 3/18/24 to 3/22/24, had been addressed by the facility.		be forwarded to the QA&A Committee for review. Date of Compliance-4/23/24	

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The most recent dietary/nutrition note was dated 12/16/23 and therefore did not reflect the recent discrepancies in the resident's weight.

During an interview, on 3/22/24 at 1:26 p.m., LPN 7 indicated the residents were usually weighed by nursing staff. If the staff noted a big difference in a resident's weight, they would re-weigh the resident during that same shift and or notify the doctor. She was aware that on 3/20/24 one of the scales needed re-calibrated but she wasn't aware of which one it was because they had 2 scales on the unit.

During an interview, on 3/22/24 at 2:18 p.m., Assistant Director of Nursing (ADON) indicated the nurse should have put a progress note into the computer when she noted the weight difference. She thought the weight difference on Resident 1 was an error because only one scale got re-calibrated the other day. The nursing staff should have noted the difference and re-weighed the resident when there was a weight discrepancy. She indicated they would re-weigh the resident today and make sure the scale was correct.

On 3/22/24 at 2:50 p.m., the Administrator provided a document with a revised date of March 2011, titled, "Weighing and Measuring the Resident," and indicated it was the policy currently being used by the facility. The policy indicated, " ...The purpose of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition ...6. Be sure that the weight scale is calibrated (balanced to zero) ...1. Report significant weight loss/weight gain to the nurse supervisor ...."

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	3.1-46(a)(1)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a post dialysis assessment was completed on 1 of 1 resident reviewed for dialysis (Resident 23). Finding includes: Resident 23's record was reviewed on 3/25/24 at 1:26 p.m. The profile indicated the resident's diagnoses included, but were not limited to, end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar and using it for energy), and hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). A quarterly Minimum Data Set (MDS) assessment (MDS-part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 1/11/24, indicated the resident was cognitively intact and was marked as being on dialysis. A physician order, dated 2/17/23, resident to receive dialysis on Monday, Wednesday, and	F 0698	**F698 Dialysis (D)** A post dialysis assessment has been completed for Resident #23 An audit was completed of residents receiving dialysis to ensure a post dialysis assessment has been completed with no issues identified. Licensed nurses have been re-educated on completing a post dialysis assessment for residents following each dialysis treatment. The Director of Nursing, or designee will conduct an audit of five (5) residents to ensure a post dialysis assessment was completed for residents receiving dialysis 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review. Date of Compliance-4/23/24	04/23/2024

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	Friday, leaving at 6 a.m. via facility vehicle. A physician order, dated 2/17/23, check for positive bruit and thrill (a thrill or buzz is like a vibration caused by blood flowing through the fistula and can be felt by placing your fingers just above the incision line) to right upper arm every shift related to end stage renal disease. A care plan, dated 5/19/22, indicated the resident is currently receiving hemodialysis (process of filtering the blood of a person whose kidneys are not working normally). Interventions included, but were not limited to, monitor for signs and symptoms of fluid overload, send communication to dialysis center, and weigh resident per order. Review of dialysis communication forms, dated February 2024 and March 2024, indicated the forms lacked a post dialysis assessment being completed by nursing staff on the following dates: a. 2/2/24 b. 2/5/24 c. 2/12/24 d. 2/19/24 e. 2/21/24 f. 2/23/24 g. 2/28/24 h. 3/1/24 i. 3/4/24			

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	j. 3/6/24 k. 3/8/24 l. 3/15/24 m. 3/20/24 During an interview, on 3/25/24 at 1:45 p.m., Licensed Practical Nurse (LPN) 11 indicated a pre and post dialysis assessments should be completed on the dialysis communication form by the nursing staff. The dialysis communication forms can be found in the resident's dialysis binder. During an interview, on 3/25/24 at 2:03 p.m., Resident 23 indicated the staff did an assessment today when he returned from dialysis, but the nursing staff doesn't always do an assessment when he returns to the facility from dialysis. During an interview, on 3/25/24 at 2:15 p.m., the Director of Nursing (DON) indicated the communication binder goes to the dialysis center with the residents. The dialysis communication form should have a pre assessment completed on the resident prior to going to dialysis and then the dialysis center was to fill out the middle section and upon return to the facility the staff should do a post dialysis assessment. She was not aware that the staff was not completing the post dialysis assessment on the resident. On 3/25/24 at 2:55 p.m., the DON provided a document, with a revised date of February 2023, titled, "Hemodialysis Catheters- Access and Care of," and indicated it was the policy currently being used by the facility. The policy indicated, " ...The nurse should document in the resident's			

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	medication record every shift as follows: 1. Location of catheter. 2. Condition of dressing ...3. If dialysis was done during shift. 4. Any part of report from dialysis nurse post-dialysis being given. 5. Observations post-dialysis ...." 3.1-37(a)			
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 verbal physician's orders were counter signed per pharmacy recommendations for 2 of 5 residents reviewed for unnecessary medications (Resident 37 and 11).	F 0757	**F757 Drug Regimen is Free from Unnecessary Drugs (D)** The verbal physician's orders have been counter signed per pharmacy recommendations by the physician for Residents #37	04/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155221	A. BUILDING 00 B. WING	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE HEALTH & REHAB	1120 E DAVIS DR TERRE HAUTE, IN 47802

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	Findings include: 1. On 3/22/24 at 8:55 a.m., record reviewed for resident 37. Record indicated diagnosis included but were not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), vascular dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), focal epilepsy (a disorder of the brain characterized by repeated seizures), hypertension (high blood pressure), hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. This makes your metabolism slow down. Also called underactive thyroid). Physician Orders included but were not limited to, Cyanocobalamin Tablet 1000 mcg (micrograms) by mouth one time a day related to vitamin B deficiency, levetiracetam Tablet 250 mg (milligrams) Give 250 mg by mouth at bedtime related to epilepsy, Cholecalciferol Tablet 1000 unit Give 1 tablet by mouth one time a day related to vitamin D deficiency, Lisinopril Tablet 40 mg 1 tablet by mouth one time a day related to hypertension, Buspirone HCl Tablet 7.5 mg Give 7.5 mg by mouth two times a day related to anxiety, Potassium Tablet Give 20 mEq (milliequivalent) by mouth in the morning for potassium, Metformin HCl Oral Tablet 850 mg (Metformin HCl) Give 850 mg by mouth one time a day related to type 2 diabetes, Metformin HCl ER Oral Tablet Extended Release 24 Hour 500 mg, Give 500 mg by mouth one time a day related to type 2 diabetes, Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin		and #11 An audit was completed of verbal physician's orders counter signed per pharmacy recommendations by the physician with no issues identified. The clinical Interdisciplinary Team have been re-educated regarding verbal physician orders being counter signed per pharmacy recommendations. The Director of Nursing or designee will conduct an audit to ensure verbal physicians orders have been counter signed per pharmacy recommendations monthly for 6 months. Results of the audits will be forwarded to the QA&A Committee for review. Date of Compliance-4/23/24	

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	Glargine) Inject 14 unit subcutaneously at bedtime related to type 2 diabetes, Meloxicam Oral Tablet 7.5 mg, Give 7.5 mg by mouth one time a day related to arthritis. A quarterly Minimum Data Set, (MDS) a standardized assessment tool that measures health status in nursing home residents, dated 11/9/22, indicated the resident had limited cognition On 5/19/23 the pharmacist recommended a dose reduction for Effexor 37.5 mg to every other day. The form lacked documentation of a counter signature, of the verbal order, by the physician. 2. On 3/22/24 at 10:22 a.m., Resident 11's record was reviewed. Record indicated diagnosis included but were not limited to, Chronic Obstructive Pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), anxiety disorder (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), hyperlipidemia (high cholesterol is an excess of lipids or fats in your blood), hypothyroidism (a common condition where the thyroid doesn't create and release enough thyroid hormone into your bloodstream. This makes your metabolism slow down. Also called underactive thyroid), major depressive disorder (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks).			

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	An annual Minimum Data Set (MDS) a standardized assessment tool that measures health status in nursing home residents, dated 2/2/24, indicated the resident had limited cognition. On 4/6/23 a consultant pharmacist review indicated Omeprazole 20 mg (milligrams) change to Pantoprazole 20 mg. The form lacked documentation of a counter signature, of the verbal order, by the physician. On 6/21/23 a consultant pharmacist review indicated a reduction in Prozac 20 mg daily. The verbal order indicated the MD disagreed with the recommendation. The form lacked documentation of a counter signature, of the verbal order, by the physician. On 8/9/23 a consultant pharmacist review indicated the Pulmicort order included rinse mouth and spit. The form lacked documentation of a counter signature, of the verbal order, by the physician. On 11/9/23 a consultant pharmacist review indicated a bipolar diagnosis is to be linked with an order for Seroquel to support its use. The form lacked documentation of a counter signature, of the verbal order, by the physician. On 3/22/2024 at 9:48 a.m., the Administrator provided a document, titled, "Verbal Orders," dated February 2020, and indicated it was the policy currently being used by the facility. The policy indicated, "...Verbal orders shall only be given in an emergency or when the attending physician is not immediately available to write or sign the order ...6. The practitioner will review and countersign verbal orders during his or her next			

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	visit ...." 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order			

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	unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure verbal physician's orders, for psychotropic medications (medications or other substances that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) had been signed by the physician for 2 of 5 residents reviewed for unnecessary medications (Resident 47 and 16). Findings include: 1. Resident 47's record was reviewed on 3/21/24 at 2:07 p.m. The profile indicated the resident's diagnoses included, but were not limited to, Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a condition in which a person has	F 0758	**F758 Free from Unnecessary Psychotropic Meds/PRN Use (D)** The verbal physician's orders for psychotropic medications have been counter signed per pharmacy recommendations by the physician for Residents #47 and #16 An audit was completed of verbal physician's orders for psychotropic medications counter signed per pharmacy recommendations by the physician with no issues identified. The clinical Interdisciplinary Team have been re-educated regarding verbal physician orders for psychotropic medications being counter signed per	04/23/2024

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	excessive worry and feelings of fear, dread, and uneasiness), and borderline personality disorder (a mental health condition in which a person has long-term patterns of unstable or explosive emotions). A quarterly minimum data set assessment (MDS-part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 2/16/24, indicated the resident received medications, which included, but were not limited to, antipsychotic medication (used to treat psychotic symptoms such as hallucinations [sights, sounds, smells, tastes, or touches that a person believes to be real but are not real], and delusions [false beliefs]), antianxiety medication (used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress), and antidepressant medication (used to treat symptoms of depression such as feeling down and hopeless). A current physician's order, dated 6/23/23, indicated olanzapine (Zyprexa-antipsychotic medication) tablet 5 milligrams (mg). Give 5 mg by mouth one time daily for borderline personality disorder. A current physician's order, dated 2/16/24, indicated buspirone (Buspar-antianxiety medication) HCL (hydrochloride) tablet 5 mg. Give 5 mg by mouth three times daily for anxiety disorder. A current physician's order, dated 3/15/24, indicated sertraline HCl (Zoloft-antidepressant medication) tablet 50 mg. Give 50 mg by mouth one time daily along with 25 mg to equal 75 mg		pharmacy recommendations. The Director of Nursing or designee will conduct an audit to ensure verbal physicians orders for psychotropic medications have been counter signed per pharmacy recommendations monthly for 6 months. Results of the audits will be forwarded to the QA&A Committee for review. Date of Compliance-4/23/24	

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	daily for major depressive disorder. A current physician's order, dated 3/15/24, indicated sertraline HCl tablet 25 mg. Give 25 mg by mouth one time daily along with 50 mg to equal 75 mg daily for major depressive disorder. A pharmacy recommendation, dated 9/12/23, indicated to consider a dosage reduction of the resident's Zyprexa (olanzapine) from 5 mg QHS (at bedtime) to 2.5 mg QHS. A verbal order, dated 9/14/23, indicated a disagreement for the dose reduction due to a recent dose reduction of the resident's Buspar (buspirone) during the previous psychiatric visit. The form lacked documentation of a counter signature, of the verbal order, by the physician. A pharmacy recommendation, dated 9/12/23, indicated to consider a dosage reduction of the resident's Zoloft (sertraline) from 50 mg daily to 25 mg daily. A verbal order, dated 9/14/23, indicated a disagreement for the dose reduction due to a recent dose reduction of the resident's Buspar (buspirone) during the previous psychiatric visit. The form lacked documentation of a counter signature, of the verbal order, by the physician. 2. Resident 16's record was reviewed on 3/21/24 at 2:29 p.m. The profile indicated the resident's diagnoses included, but were not limited to, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression (it involves depressed mood or loss of pleasure or interest in activities for long periods of time), and chronic respiratory failure with hypoxia (condition where there's not enough oxygen or too much carbon dioxide in your body).			

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	A quarterly Minimum Data Set (MDS) assessment, dated 12/22/23, indicated the resident had received anti-anxiety (used to treat anxiety symptoms) and anti-depressant (used to treat depressive symptoms) medications. A current physician order, dated 4/11/23, indicated Sertraline (anti-depressant medication) tablet. Give 75 mg (milligram) by mouth one time a day for depression. A current physician order, dated 3/12/24, indicated Xanax (anti-anxiety medication) 0.25 mg. Give 0.25 mg by mouth every 4 hours as needed for behaviors related to anxiety disorder. A pharmacy recommendation, dated 3/13/23, A pharmacy recommendation, dated 7/17/23, indicated to consider a dosage reduction of the resident's Zoloft (Sertraline) from 25 mg daily to 12.5 mg daily. A verbal order, dated 3/13/23, indicated a disagreement for the dose reduction due to the resident's recent loss of independence and being unable to live at home. The Resident continues with depression symptoms. This form lacked documentation of a counter signature, of the verbal order, by the physician. A pharmacy recommendation, dated 7/17/23, indicated to consider a dosage reduction of the resident's Zoloft from 75 mg daily to 50 mg daily. A verbal order, dated 7/17/23, indicated a disagreement for the dose reduction due to resident's current dose was effective in maintaining depression. This form lacked documentation of a counter signature, of the verbal order, by the physician. A pharmacy recommendation, dated 9/19/23, indicated to consider a dosage reduction of the			

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	resident's Xanax from 0.25 mg at bedtime to 0.125 mg at bedtime. A verbal order, dated 9/19/23, indicated a disagreement for the dose reduction due to the resident having anxiety at night related to shortness of breath symptoms. The form lacked documentation of a counter signature, of the verbal order, by the physician. A pharmacy recommendation, dated 1/17/24, indicated to consider a dosage reduction of the resident's Zoloft from 75 mg daily to 50 mg daily. A verbal order, dated 1/17/24, indicated a disagreement for the dose reduction due to resident's continued signs and symptoms of depression. This form lacked documentation of a counter signature, of the verbal order, by the physician. During an interview, on 3/22/24 at 9:52 a.m., the Administrator (ADM) indicated she was not aware if there was a policy regarding pharmacy recommendations and verbal orders, but she would provide a policy if available. On 3/22/24 at 9:48 a.m., the ADM provided a document with a revised date of February 2014, titled, "Verbal Orders," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Verbal orders shall only be given in an emergency or when the attending physician is not immediately available to write or sign the order ...6. The practitioner will review and countersign verbal orders during his or her next visit ...." 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observations, interviews, and record reviews, the facility failed to ensure medications were stored and labeled properly and the facility failed to ensure expired medications were disposed for 2 of 3 medication carts reviewed for medication storage (Residents 47 and 14). Findings include: 1. On 3/25/24 at 9:01 a.m., the 200 hall second medication cart contained an undated and opened Lispro (medication used to lower blood sugar) insulin pen. The insulin pen contained a label that indicated it was for Resident 47. The cart also	F 0761	**F761 Label/Store Drugs and Biologicals (D)** The expired medications for Residents #47 and #14 have been disposed. An audit of medications carts to ensure medications are stored and labeled properly and to ensure expired medications had been disposed was completed with no issues identified. Licensed nurses and QMAs have been re-educated on proper storage/labeling of medications	04/23/2024

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	contained a Lantus (insulin medication) insulin pen that had an open date of 2/22/24. The insulin pen contained a label that indicated it was for Resident 47. During an interview, on 3/25/24 at 9:04 a.m., Licensed Practical Nurse (LPN) 7 indicated insulin pens should have an open date placed on them when they are used, and insulin medication was good for 28 days once it was opened. The insulin pen that was dated for 2/22/24 should have been discarded. Resident 47's record was reviewed on 3/25/24 at 10:48 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A physician order, dated 2/16/24, indicated Humalog (insulin medication) Kwik Pen subcutaneous solution pen-injector 100 unit/ml (milliliter). Inject 12 units subcutaneously (under the skin) in the morning. A physician order, dated 2/15/24, indicated Lantus SoloStar (insulin medication) subcutaneous solution pen-injector 100 unit/ml. Inject 14 units subcutaneously at bedtime. 2. On 3/25/24 at 9:06 a.m., the 200 hall first cart contained an unopened and non-refrigerated Lispro (insulin medication) pen. The insulin pen contained a label that indicated it was for Resident 14. During an interview, on 3/25/24 at 9:08 a.m., LPN 10 indicated insulin that was not opened, should be refrigerated until used. She was not aware of how long the insulin pen had been in the		and disposal of expired medication. The Director of Nursing or designee will conduct an audit of two (2) medication carts to ensure proper storage/labeling of medications and disposal of expired medications 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review. Date of Compliance-4/23/24	

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	medication cart unopened for Resident 14. During an interview, on 3/25/24 at 9:45 a.m., Director of Nursing (DON) indicated insulin should be dated once opened and should remain in the refrigerator until it was opened. She indicated insulin was good for 28 days once opened. Resident 14's record was reviewed on 3/25/24 at 11:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus. A physician order, dated 3/16/24, indicated insulin Lispro injection solution 100 unit/ml. Inject per sliding scale subcutaneously with meals. On 3/25/24 at 10:14 a.m., the Administrator provided and identified a document as a current facility policy, titled, "Medication Storage," revised date 07/12. The policy indicated, " ...11. Insulin vials should be stored in the refrigerator until opened. Date insulin vials when first opened ...." On 3/25/24 at 10:31 a.m., the DON provided and identified an undated document as a current facility policy, titled, "Expiration Dating Guidelines." The policy indicated, " ...expiration date of insulin ...28 days after opening ...." 3.1-25(j) 3.1-25(o)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	155221	A. BUILDING 00 B. WING	03/27/2024

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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
	§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 and interview, the facility failed to prepare and serve food in a sanitary manner on 3 of 3 kitchen observations. Findings include: On 3/20/24 at 9:43 a.m., during initial dietary observation. Observed the following. a. Employee 5 had a beard cover not covering all of his mustache b. Food on the steam table was uncovered c. Debris on the floor throughout food prep area d. Dark debris on the outside and inside of the food warmer. Dried dark debris on the inside and bottom of the convection oven e. Review of dishwasher temperature log indicated the documentation from 1/1/24 to 3/20/24 lacked entries of wash temperatures.	F 0812	**F812 Food Procurement, Store/Prepare/Serve-Sanitary (E)** Dietary staff #5, and #17 have been educated regarding the policy & procedure of properly wearing a beard restraint. All dietary staff with facial hair have been educated according to the policy & procedure of Food Borne Illness-employee hygiene and sanitary practices. The director of dining services, or designee will audit by observation all dietary staff during cooking, preparing, or assembling food, or any staff in the prep, assembly, cook area, 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months.	04/23/2024

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	155221	A. BUILDING 00 B. WING	03/27/2024

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	The Dietary Director was unable to provide a dishwasher temperature log for 2/15/24 to 2/29/24. On 3/20/24 at 11:58 a.m., During routine dining observation in the 1st floor dining room, observed, Employee 6, wash his hands and turned the water off with his bare hand. On 3/20/24 at 12:10 p.m., observed Employee 3 wash her hands and turn off water with bare hands. On 3/20/24 at 12:14 p.m., observed Employee 6 serving food without gloves on while touching inside of plates with bare hands. On 3/26/24 at 11:50 a.m., during a routine kitchen observation. a. Observed Employee 17 with his beard covering not covering his mustache. Employee 17 indicated he was not aware the mustache must also be covered. b. A heavy coating of brown and black debris on wheel casters of stove and utility cart holding cooking items. c. Dark debris on the outside and inside of the food warmer. d. Dried dark debris on the inside and bottom of the convection oven. e. The charbroil grill was covered in caked on dark debris. f. The vent hood above the stove was covered in dark debris and grease debris. The Dietary Director acknowledged the equipment		Results of the audits will be forwarded to the QA&A committee for review. Food on the steam table has been covered. The dietary staff/cooks have been educated regarding the policy & procedure of Food Borne Illness. The director of dining services, or designee will audit the steamtable to ensure all food is covered, until food is ready to be served, 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A committee for review. Debris on the floor, food prep area, inside/outside food warmer, debris on inside and bottom of convection oven, wheel casters of stove and utility cart, and charbroil grill, has been cleaned and removed. All dietary staff have been educated on the sanitation policy and sanitation check off assignment. The director of dining services, or designee will audit the sanitation check off assignments for completion 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review.	

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	had not been cleaned properly and indicated a deep clean of the kitchen was completed weekly. The Director was unable to provide a cleaning schedule indicating these areas had been cleaned. On 3/27/24 during routine observation of pureed food preparation, observed Employee 16 wash her hands, turned off the water with a paper towel then dried her hands with the same paper towel. On 3/26/24 at 2:31 p.m., the Administrator provided a document, titled, "Sanitation," dated November 2022, and indicated it was the policy currently being used by the facility. The policy indicated, "...The food service area is maintained in a clean and sanitary manner ...3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions ...." On 3/26/24 at 2:31 p.m., the Administrator provided a document, titled, "Preventing Food Borne Illness-Employee Hygiene and Sanitary Practices," dated November 2022, and indicated it was the policy currently being used by the facility. The policy indicated, "...Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness ... Handwashing/Hand Hygiene ...6. Employees must wash their hands ...d. before coming in contact with any food surfaces ...Gloves and Direct Food Contact ...8. Contact between food and bare (ungloved) hands is prohibited ...15. Hair Nets ...beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens ...."2a. During a dining observation on the second floor, on 3/20/24 at 11:31 a.m., the Dietary Director washed her hands for a total of 7 seconds and		Employee #6, #3, #16, dietary director, CNA #4 have been educated on proper handwashing techniques according to our current policy & procedure. All employees have been educated and participated in return demonstrations on proper handwashing techniques. 5 employee audits of return demonstrations on proper handwashing techniques will be observed by the IP nurse, or designee 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review. All dining service staff have been educated on the policy & procedure of keeping consistent temp dishwashing logs as it pertains to sanitation. The dining director or designee will audit the dishwashing temp logs for completion 3 times a week for 4 weeks, weekly for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review. Date of compliance-4/23/24	

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	turned off the water faucet with her bare hands. She then prepared a drink for a female resident and placed it on the table in front of the resident. On 3/20/24 at 11:42 a.m., the Dietary Director washed her for a total of 8 seconds and turned off the water faucet with her bare hands. She then left the dining room and proceeded down the elevator. On 3/20/24 at 11:44 a.m., Certified Nursing Assistant (CNA) 4 washed her hands for a total of 15 seconds and turned off the water faucet with her bare hands. The CNA then served a plate of food to a male resident in the dining room. On 3/20/24 at 11:51 a.m., CNA 4 washed her hands for a total of 15 seconds and turned off the water faucet with her bare hands. The CNA remained in the dining room during meal service. 2b. During a dining observation on the first floor, on 3/20/24 at 12:09 p.m., the Dietary Director touched her hair moving it back and then washed her hands for 7 seconding turning off the water faucet with her bare hands. On 3/20/24 at 12:26 p.m., the Dietary Director washed her hands for a total of 7 seconds and then turned off the water faucet with her bare hands. The director then left the dining room exiting down the hallway. During an interview, on 3//22/24 at 1:27 p.m., Licensed Practical Nurse (LPN) 7 indicated staff should scrub their hands with soap and water and never touch the water faucet with their bare hands. The staff should use a dry paper towel to turn off the faucet. 2c. During a second dining observation on the			

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	second floor, on 3/26/24 at 11:37 a.m., CNA 4 washed her hands for the appropriate amount of time but then turned off the water faucet with her bare hands. On 3/26/24 at 11:39 a.m., CNA 4 washed her hands for the appropriate amount of time but then turned off the water faucet with her bare hands. The CNA then served a plate of food to a male resident in the dining room. During an interview, on 3/26/24 at 11:44 a.m., LPN 14 indicated staff should wash their hands for at least 20 seconds and make sure to completely dry their hands with a paper towel, then get a second paper towel to turn off the water faucet. Staff should not touch the water faucet with their bare hands. On 3/27/24 at 1:19 p.m., the Administrator provided a document with a revised date of 6/15/16, titled, "Handwashing Skills Check Off List," and indicated it was the policy currently being used by the facility. The policy indicated, " ...e. Lather all areas of hands and wrists rubbing vigorously for 20 seconds routine ...g. Dry hands with paper towel ...g. Turn off faucet with the paper towel. Discard towel immediately ...." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment 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			

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	must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. 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 maintain a separation between clean linen, from the soiled linen area for 1 of 1 observation of the laundry area. Finding include: On 3/26/24 at 9:36 a.m., during observation of the soiled laundry area, several barrels containing linens were uncovered, which had been placed against the wall in front of the washing machines. The washing machines were in use with soiled laundry at the time of the observation. On 3/26/24 at 9:45 a.m., during interview with Employee 12, the employee indicated the linens	F 0880	**F880 Infection Control (D)** All clean linens are kept in barrels with lids. Lids have been added to be attached to the barrels as a means of always securing them to protect the clen linen. All environmental staff have been educated regarding the policy & procedure of handling laundry and bedding. The clean and soiled laundry areas will be audited by the environmental services director or designee for proper handling and storing of clean laundry 3 times a week for 4 weeks, weekly	04/23/2024

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	and clothing within the laundry barrels had been washed and were clean. She indicated she was waiting to put them into the dryer. The employee indicated she was aware the lids had not been placed on the barrel to protect the clean linen and acknowledged the barrels containing the washed clean linen, were within the soiled laundry area. On 3/26/2024 at 10:08 a.m., the Administrator provided a document, titled, "Laundry and Bedding, Soiled," dated September 2022, and indicated it was the policy currently being used by the facility. The policy indicated, "...Transport ...6. Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness ...Storage ...1. Clean linen is stored separately, away from soiled linens, at all times ...3. Clean linen is kept separate from contaminated linen ...." 3.1-18(b)(1)		for 4 weeks, then monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review. Date of compliance-4/23/24	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 20, 21, 22, 25, 26, and 27, 2024 Facility number: 000126 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 5, 2024.	R 0000	***Westminster Village Terre Haute wishes to have this submitted plan of correction (POC) stand as its allegation of compliance. Preparation and/or execution of this POC does not constitute admission to, nor agreement with either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.***	

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R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to ensure the infection control program was completed on the assisted living residents for 28 of 28 residents who resided at the facility. Finding include: On 3/26/24 at 10:18 a.m., during interview with the Supervising Nurse with the Assisted Living (AL) facility, the employee indicated she had not done any infection control or antibiotic stewardship tracking. On 3/26/24 at 1:00 p.m., during interview with the Infection Prevention Nurse 8 at the skilled nursing facility (SNF). The employee indicated she did not do the infection control tracking or the antibiotic stewardship for the AL. Review of the infection control program within the SNF, there was no documentation of infection surveillance of the AL. On 3/27/24 at 9:47 a.m., the Administrator provided an undated document titled "AL infection protocol" and indicated it was the	R 0407	**R407 Infection Control Noncompliance** The facility has established an infection control program that includes the following A system that enables the facility to analyze patterns of known infectious symptoms. Assisted Living staff have been in-serviced on infection prevention and control, including universal precautions. The AL director or designee will conduct an audit of all infections to ensure those residents are being followed in the infection control program with appropriate interventions. Three random residents will be audited 3 times a week for 4 weeks, weekly for 4 weeks, and monthly for 4 months. Date of compliance-4/23/24	04/23/2024

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	infection control protocol. The document indicated, "...If a resident in AL is started on antibiotic for an infection, there will be a progress note put in as to what the infection is ...In the event that there is a trend and we develop multiple infections of the same type, we would then provide staff education on proper handwashing and PPE (Personal Protective Equipment) requirements to help prevent the spread of infection ...."			