STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	10/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE KENTUCKIANA	2210 GREENTREE N CLARKSVILLE, IN 47129

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 23, 24, 25, 26, 27, and 30, 2023. Facility number: 000100 Provider number: 155191 AIM number: 100266130 Census Bed Type: SNF/NF: 57 Residential: 83 Total: 140 Census Payor Type: Medicare: 6 Medicaid: 42 Other: 9 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 4, 2023.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for			

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

Stephanie Wise | Administrator | 11/17/2023

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

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	requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to			

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	room changes between its different locations under §483.15(c)(9). Based on observation, record review, and interview, the facility failed to ensure notification to the representative of a resident's change in condition for 1 of 22 residents reviewed for notification of changes. (Resident 54) Findings include: The record for Resident 54 was reviewed on 10/30/23 at 8:39 a.m. The diagnoses included, but were not limited to, muscle weakness, hypertension, dementia, Alzheimer's with late onset, and chronic kidney disease. The activities note, dated 6/27/23 at 10:28 a.m., indicated the resident was alert and made all her needs known. She sat up in her wheelchair most days in the hallway by the nurses' station and talked to most everyone. She could wheel herself around freely. She would do arts and crafts and play bingo and listen to music. She would come into the activities office and get a snack and hang out. The activities note, dated 9/14/23 at 12:14 p.m., indicated the resident seemed confused most days, however she would sit in the hall by the nurses' station and talk to everyone. She would come into the activities office and hang out and liked snacks. She was always friendly with activities staff. The Quarterly MDS (Minimum Data Set) assessment, dated 9/29/23, indicated the resident was moderate cognitively impaired, used a wheelchair with partial to moderate assistance where the helper did less than half the work, and needed substantial to maximum assistance with	F 0580	**Please accept this plan of correction as our credible allegation of compliance. The facility respectfully requests a desk review to determine compliance.** **The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.** **Plan of Correction F 580** **I. Action taken for those residents identified:** Regarding Resident #54, a message was left for the family on 10/19/23 to contact the facility with no return call. On 10/20/23, a resident representative came to the facility as was updated on the resident's condition. **II. How other residents are identified:** An audit of all current residents' progress notes for the past 30 days was completed for documentation of family notification of residents with a change in condition. Any issues identified of records lacking documentation of the notification, the responsible party was updated on the residents' condition.	11/17/2023

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	transfers and mobility related activities of daily living. The nurse's note, dated 10/12/23 at 8:53 a.m., indicated nursing staff requested the resident to be seen by the nurse practitioner (NP) related to her leaning to the right while up in her wheelchair and a decline in her functional condition. New orders were received during the visit for laboratory testing and urinalysis. Staff would continue to monitor. The record lacked documentation of any notification to the resident's representative of the change in the resident's condition or new orders until the nursing note on 10/19/23. The nurse's note, dated 10/19/23 at 1:00 p.m., indicated a voice mail message was left for the resident's representative requesting a return call regarding a non-emergent matter. The record lacked documentation of any further attempts to contact the resident's representative or other emergency contacts. The nurse's note, dated 10/20/23 at 6:16 p.m., indicated the resident's family member was there to see her and had questions regarding her current condition and said she was going to have the resident's representative call the nurse. The nurse spoke with the resident's representative regarding her current condition. She informed her of the negative urinalysis results, her continued leaning to the right and loss of ability to function at times. She explained a CT (computed tomography) scan could let them know if she had a stroke or not. She also explained it could just be her dementia progressing. The representative decided to have the Nurse Practitioner see the		**III. System in place:** The policy and procedure "Change in Resident Condition or Status" will be followed by facility team members. The resident/residents' representative will be notified if there is a change in conditions. If the resident's first contact is unreachable, the staff will proceed to the next contact as applicable. The resident whose family is in need of being contacted will be placed on the 24-hour report sheet until contact is made. The nursing team will be provided with training related to the procedures as outlined in the policy. Any team member who is found not to be in compliance, will be re-educated and counseled as necessary with progressive discipline. The IDT will review resident progress notes during the morning meeting for documentation of family notification as needed. Any issues identified in the morning meeting will be addressed with the staff for additional necessary action/notification. **IV. How the facility will monitor and Quality Assurance program:** The facility will monitor by having an IDT stand down meeting in the afternoon, during which resident progress notes for change of condition revisions/updates discussed in the morning clinical	

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	resident again on the following Monday and see if she thought a CT scan was necessary. She wanted to be notified after she was seen to see what the NP thought before she made a decision. During an observation, on 10/24/23 at 8:35 a.m., CNA (Certified Nurse Aide) 9 was attempting to feed Resident 54 while she was in bed. The resident was observed to be leaning to the right, mumbling when spoken to, and was not participating well in eating her breakfast when cued. CNA 9 indicated the resident was not very responsive and had declined. During an interview on 10/26/23 at 10:28 a.m., the resident's representative indicated overall they were concerned for the resident having a stroke. If she had a stroke there was nothing they could do, they did not want to put her through the pressures of being sent out, but she did not feel like there was a whole lot of communication. On 10/20/23 she was at a work function and her family member called and was beside herself because the resident was leaning to the right and mumbling. The first thing she said was it sounded like she had a stroke. No one from the facility had called her. She received no messages, and they did not call any other family on the list. She could have been reached. The facility said they had called and left a message, but she did not receive any calls or messages. She spoke with LPN (Licensed Practical Nurse) 7 on 10/20/23 who told her the resident was leaning to the right on 10/12/23 and about the blood work. They did not notify her of the change or the orders on 10/12/23. During an interview on 10/26/23 at 1:59 p.m., LPN 7 indicated the resident had been her normal self before she went on vacation, however when she came back, she noticed the resident was leaning		meeting will be audited by the DON/Designee for family notification. Should concern(s) be identified, immediate corrective action shall be taken. The Director of Nursing/Designee will provide the results from the audits to the Quality Assurance Performance Improvement Committee (QAPI). These findings will be reviewed for recommendations by the Quality Assurance Performance Improvement Committee (QAPI). These findings and review will be completed monthly and submitted to QAPI for a period of four months. The Committee will provide guidance for further action as needed. The QAPI team will meet once a month until facility attains 100% compliance for 4 consecutive months. The Director of Nurses/Designee will be responsible for the coordination and monitoring.	

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	to the right and it progressively worsened. One day she'd be sitting up straight and normal, the next she'd be back to just mumbling and completely out of it. She was letting food fall out of her mouth, and they now had to use a lift for her transfers. It all came on suddenly, or it came on gradually and they didn't notice it until it was significant. The last few days she had been having to put her medications in applesauce. Her normal was being alert, feeding herself completely. She ate everything in front of her and told staff if she had to use the restroom. She was alert, coherent, able to hold a conversation, and transferred with a stand and pivot. Someone said they left messages for the resident's representative, but when she talked to them, she said they left her no messages. It was a whole run around. She would notify family of changes as soon as she noticed them. She would document the notification in a progress note. If she called and left a voicemail she would call again and continue to try and reach them to discuss it. She would contact other contacts on the emergency list. She would also document each attempt. During an interview, on 10/30/23 at 8:24 a.m., Unit Manager 8 indicated she'd asked the NP to look at the resident for her leaning to the right and being tired. The resident's representative was hard to get ahold of. She called her on 10/12/23 to notify her, and she believed she'd left two voicemails. She notified family when they got orders. She would document every time she made a phone call, that was their standard. She did not contact any of the other emergency contacts on her face sheet. It was her error that notification was not documented on the initial 10/12/23 when the physician was contacted. The most current Change in a Resident's			

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	Condition or Status policy, included, but was not limited to, "... Our facility shall promptly notify... representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) ... 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when... b. There is a significant change in the resident's physical, mentally, or psychosocial status... 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status..." 3.1-5(a)(2) 3.1-5(a)(3)			
F 0641 SS=B 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 interview and record review, the facility failed to ensure accurate documentation of the MDS (Minimum Data Set) assessment for Section N for antiplatelet therapy for 9 of 24 residents whose MDS records were reviewed for accuracy. (Residents 58, 31, 57, 51, 53, 28, 38, 20, and 10) Findings include: 1. The record for Resident 58 was reviewed on 10/25/23 at 3:08 p.m. The diagnoses included, but were not limited to, cerebrovascular disease, hemiplegia and hemiparesis affecting the left dominant side, and immobility syndrome. The physician's orders, dated 9/1/23, indicated the resident received aspirin 81 mg (milligram) and	F 0641	**Plan of Correction F 641** **I. Action Taken for the residents identified:** Regarding Residents # 58, 31, 57, 51, 53, 28, 38, 20, and 10, MDS assessments for these residents were modified. This modification did not affect a change in the resident's case mix status or require revision of the residents' plan of care. II. **How other residents are identified:** No residents were affected by the coding error of section N. No changes in the plan of care were required.	11/17/2023

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	clopidogrel 75 mg, once daily. The Admission MDS assessment, dated 9/7/23, indicated the resident received an anticoagulant 6 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). The medications aspirin and clopidogrel were classified as a platelet-aggregation inhibitors. The record lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy on Section N of the MDS. 2. The record for Resident 31 was reviewed on 10/26/23 at 9:07 a.m. The diagnoses included, but were not limited to, venous insufficiency, cardiomyopathy, and hypertension. The physician's order, dated 3/31/23, indicated the resident received clopidogrel 75 mg tablet, once daily. The Quarterly MDS assessment, dated 9/20/23, indicated the resident received an anticoagulant 7 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). The medication clopidogrel was classified as platelet-aggregation inhibitors.		An audit was completed of all residents, section N on the most recent OBRA Assessment. No other residents were identified to be marked incorrectly for section N. **III. System in place:** The MDS coordinator was re-inserviced on the requirements of section N of the MDS by the MDS consultant. The MDS Coordinator will mark Section N correctly after reviewing the medication administration record. Following the re-inservice and understanding of the intent of section N. **IV. How the facility will monitor and quality assurance program:** The MDS Coordinator/Designee will run a report once per week for MDS assessments section N for accuracy of the data. Any issues identified by this report will be addressed by modification if needed at that time. The results from the MDS Coordinator or designee's weekly audits of the MDS assessments. The documentation will be presented to the Quality Assurance Performance Improvement Committee (QAPI). The findings will be reviewed, and recommendations made by the Quality Assurance Performance Improvement Committee (QAPI) on a monthly basis or until the	

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	The record lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy on section N of the MDS assessment. 3. The record for Resident 57 was reviewed on 10/25/23 at 3:00 p.m. The diagnoses included, but were not limited to, atherosclerotic heart disease of the native coronary artery without angina, hypertension and abnormalities of gait and mobility. The physician's order, dated 5/11/23, indicated the resident received clopidogrel 75 mg, once daily, for atherosclerotic heart disease of native coronary artery without angina pectoris. The Quarterly MDS assessment, dated 8/17/23, indicated the resident received an anticoagulant 7 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). The medication clopidogrel was classified as platelet-aggregation inhibitors. The record lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy on section N of the MDS assessment. 4. The record for Resident 51 was reviewed on 10/26/23 at 9:04 a.m. The diagnoses included, but were not limited to, cerebrovascular disease, aftercare following surgery on the skin and subcutaneous tissue-groin debridement, a personal history of other venous thrombosis and		facility has ha 100% compliancy for 4 consecutive months. The Director of Nurses/Designee will be responsible for the coordination and monitoring.	

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	embolism, a personal history of transient ischemic attack (TIA), and cerebral infarction, heart failure, unspecified, and peripheral vascular disease. The physician's orders, dated 7/20/23, indicated the resident received an aspirin tablet, delayed release, 81 mg and a clopidogrel tablet, 75 mg, once daily. The Quarterly MDS, dated 9/20/23, indicated the resident received an anticoagulant 7 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). The medications aspirin and clopidogrel were classified as platelet-aggregation inhibitors. The clinical lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy. Section N of the MDS assessment. 5. The record for Resident 53 was reviewed on 10/25/23 at 2:12 p.m. The diagnoses included, but were not limited to, acute ischemic heart disease, atherosclerotic heart disease of native coronary artery without angina pectoris, and bradycardia. The Annual MDS assessment, dated 10/5/23, indicated the resident received an anticoagulant 7 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).			

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	The Medication Administration Records (MARs) between 4/29/23 and 10/25/23 indicated the resident received Plavix 75 mg on a daily basis. The Plavix was classified as a platelet-aggregation inhibitor. The record lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy on Section N of the MDS. 6. The record for Resident 28 was reviewed on 10/26/23 at 1:34 p.m. The diagnoses included, but were not limited to, atherosclerotic heart disease of native coronary artery without angina pectoris. The Quarterly MDS assessment, dated 9/2/23, indicated the resident received an anticoagulant 7 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). The Medication Administration Records (MARs) between 4/29/23 and 10/25/23 indicated the resident received the Plavix 75 mg on a daily basis. The Plavix was classified as a platelet-aggregation inhibitor. The record lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy on Section N of the MDS. 7. The record for Resident 38 was reviewed on 10/24/23 at 2:09 p.m. The diagnoses included, but were not limited to, a personal history of transient			

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ischemic attack (TIA) and cerebral infarction.

The care plan, dated 1/7/19 and last revised 8/18/23, indicated the resident was at risk for abnormal bruising or bleeding related to anticoagulant therapy. The interventions, dated 5/8/23, indicated to contact the doctor as needed, to perform labwork per doctor's order, and to observe for signs and symptoms of abnormal bruising or bleeding every shift.

The Quarterly MDS assessment, dated 8/24/23, indicated the resident received an anticoagulant 7 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).

The physician's order, dated 5/19/23, indicated to administer Plavix (clopidogrel) 75 mg once daily.

The Plavix (clopidogrel) was classified as a platelet-aggregation inhibitor.

The record lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy on Section N of the MDS.

During an interview on 10/26/23 at 1:48 p.m., RN 10 indicated the resident took Plavix as an antiplatelet. She would monitor the resident for bruising or bleeding.

8. The record for Resident 20 was reviewed on 10/25/23 at 10:56 a.m. The diagnoses included, but were not limited to, hypertensive heart disease, atrial fibrillation, atherosclerotic heart disease, and

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	an abdominal aortic aneurysm. The physician's order, dated 1/9/23, indicated to administer clopidogrel 75 mg daily. The clopidogrel was classified as a platelet-aggregation inhibitor. The Significant Change MDS assessment, dated 7/21/23, indicated the resident received an anticoagulant 7 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). The record lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy on Section N of the MDS. 9. The record for Resident 10 was reviewed on 10/25/23 at 1:19 p.m. The diagnoses included, but were not limited to, hypertensive heart disease with heart failure, cerebrovascular disease, chronic combined systolic (congestive) and diastolic (congestive) heart failure, presence of cardiac pacemaker, and nonrheumatic aortic (valve) stenosis. The review of the Quarterly MDS assessment, dated 9/1/23, indicated the resident received an anticoagulant 7 days per week. The assessment indicated for antiplatelet therapy staff would check the form indicating if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation			

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	period (or since admission/entry or reentry if less than 7 days). The physician's orders, dated 1/5/23, indicated to administer aspirin, delayed release, 81 mg and clopidogrel 75 mg, daily. The aspirin and clopidogrel were classified as platelet-aggregation inhibitors. The record lacked documentation indicating an accurate assessment of the resident's antiplatelet therapy on Section N of the MDS. During an interview on 10/30/23 at 8:20 a.m., the MDS Coordinator indicated for her assessments, she would talk with the resident to gather information, as well as reviewing the MAR and TAR (Treatment Administrative Record). She was confused about the coding of medication on the new form. The Plavix was the antiplatelet with the Coumadin and Eliquis being the anticoagulant. She may have coded wrong before she figured out what she was doing. It had not been brought to her attention by her MDS consultant. She talked to him weekly and assessments were reviewed by him each week. He had not brought any issues with coding to her attention. She would make corrections as needed. She didn't have a policy that she followed, but she did follow the RAI (Resident Assessment Instrument) manual. 3.1-31(b)			
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			

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	comprehensive assessment of a resident, the 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 record review and interview the facility failed to ensure a resident's treatment was timely for 1 of 5 residents reviewed for Quality of Care. (Resident 31) The record for Resident 31 was reviewed on 10/26/23 at 9:07 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease, other skin changes, and obesity. The fax sheet cover, dated 6/17/23, indicated the facility sent a fax for Resident 31 of a urinalysis and culture results to the physician. The staff inquired if the physician wanted to continue antibiotics and informed the physician the resident was having symptoms of a yeast infection. On 6/19/23, the physician responded with a fax. The fax was dated as received on 6/19/23 at 4:51 p.m. and indicated to continue the antibiotics and to start Diflucan (antifungal) 150 mg (milligram), one time. The record lacked documentation indicating the faxed order (dated 6/17/23) was received and the resident received the treatment for a yeast infection in a timely manner. The resident was not treated for five days (dated 6/22/23). The transmission log, dated 6/20/23 at 9:53 p.m., indicated the facility sent the same fax as on 6/17/23. The physician faxed back and indicated to	F 0684	**Plan of correction F 684** **I. Action Taken for the residents identified:** Regarding resident 31, as stated in the 2567, the resident received the one-time dose of the medication. **II. How other residents are identified:** An audit was completed on all residents for the last 30 days regarding timely administration of oral antifungal medications. No other residents were identified. **III. System in place:** The nursing staff were re-inserviced on calling the MD or NP timely, timely treatment and following up. The facility has an onsite Nurse Practitioner Program to provide more timely response and access to residents. This NP program started July 2023. Nursing staff will continue to follow up with the physician or NP as needed. Nurses were re-inserviced on the use of the EDK to initiate initial doses of medication and re-inserviced on the Nurse Practitioner Program. Any team member who is found not to be in compliance will be re-educated and counseled as	11/17/2023

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	refer to the faxed response sent on 6/19/23. The nurse's note, dated 6/21/23 at 7:01 a.m., indicated the physician replied regarding current order for antibiotics. He wrote please refer to the response in the orders from 6/19/23. The physician ordered a one-time dose of Diflucan 150 mg, by mouth to treat for a yeast infection. The nurse's note, dated 6/22/23 at 2:22 p.m., indicated the resident was to continue the antibiotic for a urinary tract infection. A new order was received on 6/22/23 to give a one dose of Diflucan 150 mg for a yeast infection. The review of the MAR (Medication Administration Record), dated 6/22/23, indicated the Diflucan 150 mg was given at 2:22 p.m. During an interview on 10/26/23 at 11:40 a.m., the DON (Director of Nursing) indicated the pharmacy delivered medications once a day. If the order went in late the medication would be delivered the next day. If the facility needed the medication before delivery, they would get the medication from a local pharmacy. During an interview on 10/26/23 at 1:30 p.m., RN 13 indicated when a nurse sent a fax to the doctor, she would add it to the pertinent charting list. If they received an order back from the physician, she would document the order in the computer and document in the nurse's notes. She did not know why the resident's order had been missed. Someone should have seen the faxed orders. The facility had a NP (Nurse Practitioner) on call seven days a week and twenty-four hours a day available. The resident should not have had to wait 5 days for the medication.		necessary with progressive discipline. The IDT will review resident physician orders and progress notes from the previous day to ensure timely treatment has occurred. Any issues identified in the morning meeting will be addressed with the staff for need for additional follow-up/action. **IV. How the facility will monitor and quality assurance program**: The facility will monitor by having a stand down meeting in the afternoon, during which resident progress notes and orders will be audited for follow up from the morning meeting by the DON/Designee for timely treatment. Should concern(s) be identified, immediate corrective action shall be taken. The Director of Nursing /Designee will provide the results from the audits to the Quality Assurance Performance Improvement Committee (QAPI). These findings will be reviewed for recommendations by the Quality Assurance Performance Improvement Committee (QAPI). These findings and review will be completed monthly and submitted to QAPI for a period of 4 months. The Committee will provide guidance for further action as needed. The QAPI team will meet once a month until we reach 100%	

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	During an interview on 10/30/23 at 1:00 p.m., the DON indicated the faxed request was sent to the physician on 6/17/23. The physician sent a faxed order back on 6/19/23. The resident received the medication on 6/22/23. The resident went 3 days without the medication instead of five days. A NP was not available until July. The physician was available and could have been called for the medication. The Physician Drug Orders policy, dated 1/23, included, but was not limited to, "... Prescriptions will be processed only when a clear and complete order, from a person lawfully authorized to prescribe, is received. Verbal telephone orders will be received only by licensed nurse or pharmacist and confirmed in writing by the physician on a timely basis..." 3.1-37(a)		compliancy for 4 consecutive months. The Director of Nurses/Designee will be responsible for the coordination and monitoring.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents			

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	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 ensure the kitchen was maintained in a sanitary manner for 3 of 3 observations. This deficient practice had the potential to affect all 57 residents currently residing at the facility. Findings include: 1. During the initial tour of the kitchen on 10/23/23 at 9:30 a.m., the following concerns were observed: - There was a heavy buildup of white under the dishwasher and dirty dish counter. - The back splatter guard of the stove had a moderate buildup of brown and black grease to it. - There was a coating of brown substance on the top of the flat top griddle. Dietary Cook 4 indicated "That needs to be cleaned. We don't use that that often. We set stuff on it and that makes it turn brown. We use it for grilled cheeses sometimes. It was cleaned about a week ago." - There was a heavy buildup of grease on the table under the griddle. The cook indicated she needed to clean that up. - There was a moderate buildup of grease and grime on the side of the Vulcan oven as well as the wall behind, and the floor underneath of it. - There was a heavy coating of dust observed to	F 0812	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **F812** The facility does store, prepare, distribute and serve food in accordance with food service safety. **I Action taken for those residents identified:** No residents were identified. The kitchen was thoroughly cleaned and repairs made to include but not be limited to: The heavy lime buildup under the dishwasher and dirty dish counter was removed. The back splatter guard on the stove was cleaned. The flat top griddle was cleaned. The flat top griddle table was cleaned. The Vulcan stove was cleaned as well as the wall behind it and the floor around it. The wall, fan and hoses in both	11/17/2023

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	be swaying, hanging on the wall, fan and hose in the walk-in freezer and fridge. - In the walk-in fridge there were two molded grapes, a puddle of an unidentifiable substance which was growing white fuzzy mold approximately 1 to 2 inches tall, and a gallon of milk on the floor under the metal rack. - There were black spots, appearing to be mildew, to the vents in the ceiling outside the dry storage, in front of the reach in fridge, and above the steam table. - The steam table was coated in a layer of brown and white buildup, which was streaking down the steam table base. - There was a heavy buildup of grime along the baseboards and in the corners and along the walls throughout the kitchen. 2. During a follow-up tour of the kitchen, on 10/26/23 at 9:15 a.m., the following concerns remained: - There was a heavy buildup of white under the dishwasher and dirty dish counter. - The back splatter guard of the stove had a moderate buildup of brown and black grease to it. - There were black spots, appearing to be mildew, to the vents in the ceiling outside the dry storage, in front of the reach in fridge, and above the steam table. - There was a heavy buildup of grease on the table under the griddle. Dietary Cook 4 indicated "I got the griddle clean right after you left, I didn't		the walk-in freezer and refrigerators were cleaned. The milk was removed and debris under racks in the walk-in refrigerator were cleaned up. The ceiling vents outside of the dry storage room, in front of the reach-in refrigerator and above the steam table were wiped down. The steam table and base were cleaned. The baseboards, corners and walls in the kitchen were cleaned. **II How other residents are identified:** No residents identified or affected. **III System in place:** The dietary staff were provided with cleaning schedules and training regarding kitchen sanitation that was completed on 11/10/2023. The Dietary Manager and/or Designee will be responsible for the coordination of cleaning schedules and completion of tasks. IV **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for monitoring by completing a kitchen sanitation tour/audit twice weekly. Should concerns be identified, immediate corrective action shall be taken. The results of these audits and	

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	get under I need maintenance to get under there." - There was a moderate buildup of grease and grime on the side of the Vulcan oven as well as the wall behind, and the floor underneath of it. - There was a heavy coating of dust observed to be swaying, hanging on the wall, fan and hose in the walk-in freezer and fridge. - In the walk-in fridge there were two molded grapes, a puddle of an unidentifiable substance which was growing white fuzzy mold approximately 1 to 2 inches tall, and a gallon of milk on the floor under the metal rack. - The steam table was coated in a layer of brown and white buildup, which was streaking down the steam table base. - There was a heavy buildup of grime along the baseboards and in the corners and along the walls throughout the kitchen. 3. During a follow-up tour, on 10/27/23 at 9:00 a.m., all the above concerns as observed on 10/26/23 remained unchanged. During an interview on 10/27/23 at 9:05 a.m., Dietary Aide 5 indicated they tried to clean the floors at least once a week. It depended on how bad it got. Their garbage disposal backed up the other day and she cleaned the floor up as good as she could. The white buildup on the floor had been there for years. They had the people and they had the time to clean it. They used to have staffing issues and didn't have time to clean everything like they should, but they had more people now.		any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of 6 months.	

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	During an interview with the Dietary Manager on 10/27/23 at 9:50 a.m., she indicated the floor looked a lot better than it used to. They said it was due to the hard water they used to have. They now had a water softener and staff were working to try and clean up the lime buildup. It was just taking time. Maintenance was supposed to come out and clean the vents every week. She didn't know why they had the mildew buildup. They were only deep cleaning the kitchen once a month when they had the staff. Staff should be sweeping and mopping under and behind equipment, but if they were not deep cleaning it might be pushing stuff up under the equipment. The person who put up stock was supposed to sweep and mop under the racks in the fridges and freezer. Her goal was to get the kitchen as clean and shiny as it used to be, but it had been a challenging year. She first had to get staff in the building. They used to work the whole kitchen with 6 people. They did not have cleaning schedules. She used to use them, but staff were basically just checking off tasks and not completing them and she had quit using them. She could not provide any current cleaning checklists for the kitchen. The most current Dietary Sanitation Practices policy, included but was not limited to, "... All kitchen employees will practice standard sanitary procedures... 9. Clean equipment and work units after use... 12. Daily, weekly and monthly cleaning are performed including any additional specific assignments that are designated by the food service director... 13. The kitchen, dining area and appliances are cleaned following facility policy..." 3.1-21(i)(3)			

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F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;			

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	(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility failed to ensure residents were offered pneumococcal vaccinations as recommended by the CDC (Centers for Disease Control) for 4 of 5 residents reviewed for pneumococcal immunizations. (Residents 31, 32, 41, and 50) Findings include: 1. The record for Resident 31 was reviewed on 10/23/23 at 10:40 a.m. The record indicated Resident 31 was 86 years old and had received Prevnar 13 (PCV13 (pneumococcal conjugate vaccine) on 11/6/19. Upon admission on 7/14/21, the resident's Responsible Party signed the consent form declining the administration of the pneumococcal vaccine. No further attempts were made since 7/14/21 for the resident to receive the recommended second dose of either PCV20 or PPSV23 (pneumococcal polysaccharide vaccine)	F 0883	**Plan of Correction F 883** **I Action taken for those residents identified:** Regarding Residents #32, 39, 50 and 41, the Physician was notified of the pneumonia vaccine per the PneumoRecs VaxAdviser App for each individual resident. The resident/responsible party was provided education and a Pneumonia Vaccine Consent/Declination form. Vaccines were given as ordered by the physician. **II How other residents are identified:** All residents were added in to the PneumoRecs VaxAadvisor App to identify which PNA vaccine the resident qualified for. Any resident determined due for a Pneumonia Vaccine, the physician was	11/17/2023

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	after one year as recommended by the current CDC guidance. 2. The record for Resident 32 was reviewed on 10/23/23 at 10:50 a.m. The record indicated Resident 32 was 93 years old and had received one dose of a pneumococcal vaccine on 6/11/19 at an outside setting. Upon admission on 6/8/21, the resident signed the consent form declining the administration of the pneumococcal vaccine. No further attempts were made since 6/8/21 for resident to receive the recommended second dose of either PCV20 or PPSV23 (pneumococcal polysaccharide vaccine) after one year as recommended by the current CDC guidance. An interview with the Infection Preventionist on 10/26/23 at 11:30 a.m., indicated she was unable to locate what type of pneumococcal vaccine the resident had received. 3. The record for Resident 41 was reviewed on 10/26/23 at 11:00 a.m. The record indicated the resident was 65 years old and had received the PPSV 23 (pneumococcal polysaccharide vaccine) on 3/30/20. The record lacked documentation of any offer for the resident to receive the recommended second dose of either PCV20 or PCV15 after one year as recommended by the current CDC guidance. 4. The record for Resident 50 was reviewed on 10/23/23 at 11:10 a.m. The record for Resident 50 indicated the resident was 89 years old and had received the Prevnar 13 vaccine on 11/22/20. The record lacked documentation of any offer for		notified and education and pneumonia vaccine consent/declination form was provided. **III System in place:** The Infection Preventionist Nurse was inserviced on immunizations to include pneumonia vaccine on 11/1/2023 Licensed nurses were inserviced on immunizations. The new Pneumonia Vaccine consent/declination form and education pamphlets were placed in the admission packet for new residents. The first week of every month, the IP Nurse will review immunization schedule of all resident immunizations. This will be ongoing. All residents due for Pneumonia Vaccines will be provided with education, consents and the physician will be notified for the appropriate orders. **IV How the facility will monitor and quality assurance program:** The DON or designee will monitor compliance by review of the monthly report to ensure residents who gave consent received the Pneumonia Vaccine. Any issues identified at the time of the review will be addressed at that time. The Director of Nursing/Designee will provide the results from the audits to the Quality Assurance Performance Improvement	

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	the resident to receive the recommended second dose of either PCV20 or PPSV23 (pneumococcal polysaccharide vaccine) after one year as recommended by the current CDC guidance. In an interview with the Infection Preventionist on 10/26/23 at 9:10 a.m., she indicated they became aware a month ago of the need to be offering additional doses of the pneumococcal vaccine. They had been so focused on getting the new COVID-19 vaccine to administer as their priority and then they would focus on giving the additional pneumococcal vaccines. In a second interview with the Infection Preventionist on 10/26/23 at 10:50 a.m., she indicated they have not updated administering Pneumococcal vaccines since March 2022. Guidance for Pneumococcal Vaccine Timing for Adults was obtained from the CDC's website on 10/26/23. The guidance included, but was not limited to, "... Make sure your patients are up to date with pneumococcal vaccination... Adults greater than 65 years old Complete pneumococcal vaccine schedules... Prior vaccines... PPSV23 only... Option A... PCV20... Option B... PCV15... PCV13 Only... Option A... PCV20... Option B... PPSV23..." 3.1-13(a)		Committee (QAPI). These findings will be reviewed for recommendations by the Quality Assurance Performance Improvement Committee (QAPI). These findings and review will be completed monthly and submitted to QAPI for a period of 4 months. The Committee will provide guidance for further action as needed. The QAPI team will meet once a month until we reach 100% compliance for 4 consecutive months. This monitoring will be ongoing and presented quarterly thereafter. The Director of Nursing in coordination with the Infection Prevention Nurse will be responsible for the coordination and monitoring for compliance.	
F 0908 SS=E Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure adequate maintenance of essential	F 0908	**The filing of this plan of correction does not constitute**	11/17/2023

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	kitchen equipment for 3 of 3 observations. This deficient practice had the potential to affect all 57 residents currently residing at the facility. Findings include: During the initial tour on 10/23/23 at 9:30 a.m., in the walk-in freezer there was a heavy accumulation of ice on the floor spanning from wall to wall. Maintenance Assistant 6 was using a long-handled dustpan to break up and scoop up the ice before depositing it into a 13-gallon trash can which was halfway full of ice. The broken ice remaining on the floor was approximately one-quarter of an inch thick and appeared to have accumulated out approximately 4 feet from the fan at the back of the fridge. There was a heavy stream of water flowing from the condenser pipe and onto the floor. Maintenance Assistant 6 indicated he wasn't sure how long the ice had been accumulating. He had been notified on the radio of the issue just a few minutes prior to the observation. During an interview on 10/23/23 at 9:45 a.m., the Dietary Manager indicated the ice had been an issue for about three weeks. They had an issue in the past and the facility had replaced the condenser. Since they had done that, it was now building up ice again. They had to chop up the ice every Monday and Thursday. The ice that was in there currently had built up since the prior Thursday. Someone over the weekend must have moved the bucket they kept there to catch the accumulating ice. That's why it was so bad. It wouldn't be a problem if someone didn't move the bucket. During an interview on 10/26/23 at 11:25 a.m., the Maintenance Director indicated back in June they		**that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **F908** The facility maintains all mechanical, electrical, and patient care equipment in safe operating condition. **I Action taken for those residents identified:** No residents were identified. The ice was removed from the floor of the freezer. The condensate drain line was cleaned and ice plug removed. The ice formations were removed from the outside of the pipe and condenser hose under the fan. Pipe was cleaned and pipe wrap replaced. Refrigeration vendor called in to check systems. Unit is working properly. Frost was removed from the door. A new gasket system was placed on door. **II How other residents are identified:** No residents were identified or affected. **III System in place:** Maintenance provided a cleaning schedule and education regarding	

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	had to replace the compressor because it was freezing up. They got that done and then they had been cleaning the condensate line on a regular basis. It just so happened on the first day of survey it was plugged. He had someone going in every shift to check the freezer. They kept the trash can there as a precaution in case it backed up. When they cleaned the condensate line it looked like mud. They had been cleaning it out monthly. As it got hotter it got worse. Dietary should be monitoring it as well. He should have been notified before the ice got as bad as it did. Whatever had happened over the weekend, they were not notified by dietary staff. The line would get clogged, the water would build up and freeze, and when it would defrost it had nowhere to go. He had not reached out to anyone to service the drain. He had talked to upper management, but he had to get a budget approved. They did not have any contracts for servicing. He had someone going in every Wednesday checking all the equipment and lately had to have them come in daily. During an observation on 10/26/23 at 9:15 a.m., the walk-in freezer was observed to still have a trash can under the pipe with ice accumulating in it. There were multiple, new ice formations on the condenser hose with an icicle forming which was about 4 inches long. There was frost beginning to form on the door of the freezer. During an observation on 10/27/23 at 9:00 a.m., in the walk-in freezer there was a bucket trash can however there was no ice in it this time. There were multiple, new ice formations, as well as the same ones from the day prior, on the condenser hose with multiple icicle formations. The frost on the door was heavier than the day prior.		equipment maintenance. It was completed 11/10/2023. The Maintenance Supervisor and/or Dietary Manager will be responsible for the coordination of cleaning schedules and completion of tasks. IV **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for monitoring by completing a kitchen sanitation tour/audit twice weekly. Should concerns be identified, immediate corrective action shall be taken. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of 6 months.	

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	The most current Malfunctions and Repairs policy, included, but was not limited to, "... All malfunctions and need for repairs are reported to the dietary manager and maintenance department. Procedure: 1. When a piece of equipment malfunctions, the dietary manager is notified. 2. The dietary manager notifies the maintenance department by phone or in writing if needed, letting them know how quickly that piece of equipment is needed. 3. If repairs require outside help or the purchase of parts, this must be communicated with the facility administrator..." 3.1-19(bb)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 23, 24, 25, 26, 27, and 30, 2023. Facility number: 000100 Residential Census: 83 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 4, 2023.	R 0000		
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.			

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	Based on observation and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner for 3 of 3 observations. This deficient practice had the potential to affect all 83 residents currently residing at the facility. Findings include: 1. During the initial tour of the kitchen on 10/23/23 at 9:30 a.m., the following concerns were observed: - There was a heavy buildup of white under the dishwasher and dirty dish counter. - The back splatter guard of the stove had a moderate buildup of brown and black grease to it. - There was a coating of brown substance on the top of the flat top griddle. Dietary Cook 4 indicated "That needs to be cleaned. We don't use that that often. We set stuff on it and that makes it turn brown. We use it for grilled cheeses sometimes. It was cleaned about a week ago." - There was a heavy buildup of grease on the table under the griddle. The cook indicated she needed to clean that up. - There was a moderate buildup of grease and grime on the side of the Vulcan oven as well as the wall behind, and the floor underneath of it. - There was a heavy coating of dust observed to be swaying, hanging on the wall, fan and hose in the walk-in freezer and fridge. - In the walk-in fridge there were two molded grapes, a puddle of an unidentifiable substance which was growing white fuzzy mold	R 0144	**Please accept this plan of correction as our credible allegation of compliance. The facility respectfully requests a desk review to determine compliance.** **The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. R0144 The facility does store, prepare, distribute and serve food in accordance with food service safety. **I Action taken for those residents identified:** No residents were identified. The kitchen was thoroughly cleaned and repairs made to include but not be limited to: The heavy lime buildup under the dishwasher and dirty dish counter was removed. The back splatter guard on the stove was cleaned. The flat top griddle was cleaned. The flat top griddle table was cleaned. The Vulcan stove was cleaned as well as the wall behind it and the floor around it.	11/17/2023

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	approximately 1 to 2 inches tall, and a gallon of milk on the floor under the metal rack. - There were black spots, appearing to be mildew, to the vents in the ceiling outside the dry storage, in front of the reach in fridge, and above the steam table. - The steam table was coated in a layer of brown and white buildup, which was streaking down the steam table base. - There was a heavy buildup of grime along the baseboards and in the corners and along the walls throughout the kitchen. 2. During a follow-up tour of the kitchen, on 10/26/23 at 9:15 a.m., the following concerns remained: - There was a heavy buildup of white under the dishwasher and dirty dish counter. - The back splatter guard of the stove had a moderate buildup of brown and black grease to it. - There were black spots, appearing to be mildew, to the vents in the ceiling outside the dry storage, in front of the reach in fridge, and above the steam table. - There was a heavy buildup of grease on the table under the griddle. Dietary Cook 4 indicated "I got the griddle clean right after you left, I didn't get under I need maintenance to get under there." - There was a moderate buildup of grease and grime on the side of the Vulcan oven as well as the wall behind, and the floor underneath of it.		The wall, fan and hoses in both the walk-in freezer and refrigerators were cleaned. The milk was removed and debris under racks in the walk-in refrigerator were cleaned up. The ceiling vents outside of the dry storage room, in front of the reach-in refrigerator and above the steam table were wiped down. The steam table and base were cleaned. The baseboards, corners and walls in the kitchen were cleaned. **II How other residents are identified:** No residents identified or affected. **III System in place:** The dietary staff were provided with cleaning schedules and training regarding kitchen sanitation that was completed on 11/10/2023. The Dietary Manager and/or Designee will be responsible for the coordination of cleaning schedules and completion of tasks. IV **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for monitoring by completing a kitchen sanitation tour/audit twice weekly. Should concerns be identified, immediate corrective action shall be taken.	

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	- There was a heavy coating of dust observed to be swaying, hanging on the wall, fan and hose in the walk-in freezer and fridge. - In the walk-in fridge there were two molded grapes, a puddle of an unidentifiable substance which was growing white fuzzy mold approximately 1 to 2 inches tall, and a gallon of milk on the floor under the metal rack. - The steam table was coated in a layer of brown and white buildup, which was streaking down the steam table base. - There was a heavy buildup of grime along the baseboards and in the corners and along the walls throughout the kitchen. 3. During a follow-up tour, on 10/27/23 at 9:00 a.m., all the above concerns as observed on 10/26/23 remained unchanged. During an interview on 10/27/23 at 9:05 a.m., Dietary Aide 5 indicated they tried to clean the floors at least once a week. It depended on how bad it got. Their garbage disposal backed up the other day and she cleaned the floor up as good as she could. The white buildup on the floor had been there for years. They had the people and they had the time to clean it. They used to have staffing issues and didn't have time to clean everything like they should, but they had more people now. During an interview with the Dietary Manager on 10/27/23 at 9:50 a.m., she indicated the floor looked a lot better than it used to. They said it was due to the hard water they used to have. They now had a water softener and staff were working to try and clean up the lime buildup. It		The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of 6 months.	

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	was just taking time. Maintenance was supposed to come out and clean the vents every week. She didn't know why they had the mildew buildup. They were only deep cleaning the kitchen once a month when they had the staff. Staff should be sweeping and mopping under and behind equipment, but if they were not deep cleaning it might be pushing stuff up under the equipment. The person who put up stock was supposed to sweep and mop under the racks in the fridges and freezer. Her goal was to get the kitchen as clean and shiny as it used to be, but it had been a challenging year. She first had to get staff in the building. They used to work the whole kitchen with 6 people. They did not have cleaning schedules. She used to use them, but staff were basically just checking off tasks and not completing them and she had quit using them. She could not provide any current cleaning checklists for the kitchen. The most current Dietary Sanitation Practices policy, included but was not limited to, "... All kitchen employees will practice standard sanitary procedures... 9. Clean equipment and work units after use... 12. Daily, weekly and monthly cleaning are performed including any additional specific assignments that are designated by the food service director... 13. The kitchen, dining area and appliances are cleaned following facility policy..."			
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation and interview, the facility failed to ensure adequate maintenance of essential kitchen equipment for 3 of 3 observations. This	R 0145	**The filing of this plan of correction does not constitute that the alleged deficiency did**	11/17/2023

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	deficient practice had the potential to affect all 83 residents currently residing at the facility. Findings include: During the initial tour on 10/23/23 at 9:30 a.m., in the walk-in freezer there was a heavy accumulation of ice on the floor spanning from wall to wall. Maintenance Assistant 6 was using a long-handled dustpan to break up and scoop up the ice before depositing it into a 13-gallon trash can which was halfway full of ice. The broken ice remaining on the floor was approximately one-quarter of an inch thick and appeared to have accumulated out approximately 4 feet from the fan at the back of the fridge. There was a heavy stream of water flowing from the condenser pipe and onto the floor. Maintenance Assistant 6 indicated he wasn't sure how long the ice had been accumulating. He had been notified on the radio of the issue just a few minutes prior to the observation. During an interview on 10/23/23 at 9:45 a.m., the Dietary Manager indicated the ice had been an issue for about three weeks. They had an issue in the past and the facility had replaced the condenser. Since they had done that, it was now building up ice again. They had to chop up the ice every Monday and Thursday. The ice that was in there currently had built up since the prior Thursday. Someone over the weekend must have moved the bucket they kept there to catch the accumulating ice. That's why it was so bad. It wouldn't be a problem if someone didn't move the bucket. During an interview on 10/26/23 at 11:25 a.m., the Maintenance Director indicated back in June they had to replace the compressor because it was		**in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. R0145 The facility maintains all mechanical, electrical, and patient care equipment in safe operating condition. **I Action taken for those residents identified:** No residents were identified. The ice was removed from the floor of the freezer. The condensate drain line was cleaned and ice plug removed. The ice formations were removed from the outside of the pipe and condenser hose under the fan. Pipe was cleaned and pipe wrap replaced. Refrigeration vendor called in to check systems. Unit is working properly. Frost was removed from the door. A new gasket system was placed on door. **II How other residents are identified:** No residents were identified or affected. **III System in place:** Maintenance provided a cleaning schedule and education regarding equipment maintenance. It was	

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	freezing up. They got that done and then they had been cleaning the condensate line on a regular basis. It just so happened on the first day of survey it was plugged. He had someone going in every shift to check the freezer. They kept the trash can there as a precaution in case it backed up. When they cleaned the condensate line it looked like mud. They had been cleaning it out monthly. As it got hotter it got worse. Dietary should be monitoring it as well. He should have been notified before the ice got as bad as it did. Whatever had happened over the weekend, they were not notified by dietary staff. The line would get clogged, the water would build up and freeze, and when it would defrost it had nowhere to go. He had not reached out to anyone to service the drain. He had talked to upper management, but he had to get a budget approved. They did not have any contracts for servicing. He had someone going in every Wednesday checking all the equipment and lately had to have them come in daily. During an observation on 10/26/23 at 9:15 a.m., the walk-in freezer was observed to still have a trash can under the pipe with ice accumulating in it. There were multiple, new ice formations on the condenser hose with an icicle forming which was about 4 inches long. There was frost beginning to form on the door of the freezer. During an observation on 10/27/23 at 9:00 a.m., in the walk-in freezer there was a bucket trash can however there was no ice in it this time. There were multiple, new ice formations, as well as the same ones from the day prior, on the condenser hose with multiple icicle formations. The frost on the door was heavier than the day prior. The most current Malfunctions and Repairs		completed 11/10/2023. The Maintenance Supervisor and/or Dietary Manager will be responsible for the coordination of cleaning schedules and completion of tasks. IV **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for monitoring by completing a kitchen sanitation tour/audit twice weekly. Should concerns be identified, immediate corrective action shall be taken. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of 6 months.	

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WESTMINSTER VILLAGE KENTUCKIANA	2210 GREENTREE N CLARKSVILLE, IN 47129

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	policy, included, but was not limited to, "... All malfunctions and need for repairs are reported to the dietary manager and maintenance department. Procedure: 1. When a piece of equipment malfunctions, the dietary manager is notified. 2. The dietary manager notifies the maintenance department by phone or in writing if needed, letting them know how quickly that piece of equipment is needed. 3. If repairs require outside help or the purchase of parts, this must be communicated with the facility administrator..."			