STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155262	A. BUILDING 00 B. WING	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SULLIVAN NURSING FACILITY, THE	505 W WOLFE ST SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 17, 18, 19, 20, and 21, 2024 Facility number: 000163 Provider number: 155262 AIM number: 100291380 Census Bed Type: SNF/NF: 43 SNF: 7 Total: 50 Census Payor Type: Medicare: 8 Medicaid: 26 Other: 16 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 2, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not consititute an admission by this facility of the facts allegaed or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is July 26th, 2024. The facility respectfully requests paper compliance for all deficiencies in this Plan of Correction.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sally Robertson	Administrator	07/18/2024

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

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	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 2 of 24 residents reviewed for care plan meetings (Residents 19 and 30). Findings include: 1. During an interview, on 6/17/24 at 2:06 p.m., Resident 19 indicated he did not remember being invited to or attending a care plan meeting recently. He indicated it had been a while since he had one. Resident 19's record was reviewed on 6/19/24 at 9:48 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 5/12/24, indicated the resident was cognitively intact. Census information indicated the resident was admitted to the facility on 6/30/23.	F 0657	=”” b=””> What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; A care plan meeting was completed for Resident 19 on July 16th, 2024. Resident 30's care plan meeting was completed July 15th, 2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken; The SSD/designee completed an audit of care plan meetings. Those residents identified during the audit will have a care plan meeting scheduled by the SSD/Designee.	07/26/2024

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	A Care Plan note, dated 3/20/24 at 4:20 p.m. indicated a care plan meeting was conducted on this day for Resident 19. Resident 19's record lacked documentation of additional quarterly care plan meetings being conducted for the last year from June 2023 to June 2024. The resident had one care plan meeting for the entire year. During an interview, on 6/19/24 at 11:07 a.m., the Regional Nurse Consultant indicated she could not find where Resident 19 had additional quarterly care plan meetings for the last year. She indicated the facility did not have a Social Service Director at this time and she wasn't sure how long she had been gone. She indicated the care plan meetings should be conducted quarterly. 2. On 6/18/24 at 9:43 a.m., during observation and interview Resident 30 indicated he had not participated in a care plan meeting. On 6/19/24 9:59 a.m., the medical record of Resident 30 was reviewed. The resident was admitted to the facility on 1/18/24. The record indicated a care plan was established with goals and interventions. The record indicated two care plan meetings were completed from May 2023 to June 2024. The medical record lacked documentation of additional quarterly care plan meeting. A quarterly MDS assessment, dated 4/25/24, indicated the resident was cognitively intact. On //2024 at 0:00 p.m., the Regional Nurse Consultant provided a document, titled, "Baseline Care Plan Assessment/Comprehensive Care Plans," dated 9/18/18, and indicated it was the policy currently being used by the facility. The		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur The ADM/Designee in-serviced the Interdisciplinary team on the care plan meeting process and the policy “Baseline Care Plan Assessment/Comprehensive Care Plan” on 07/19/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective actions will be monitored to ensure the deficient practice will not recur Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will be addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	policy indicated, "...2. Within 72 hours following the admission of the resident ...Social services or designee will schedule a summary of the Base Line Care Plan ...c) In the event that the resident and/or representative refuses to participate in the care plan meeting or refuses to sign the summary; the MDS coordinator or designee will document the refusal in the medical record ...6. The facility Social Service Director or designee will notify the resident of their scheduled care plan conference and will invite and encourage the resident to attend ...These notifications will be documented for reference ...9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum ...." 3.1-35(e)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the 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 observations, record reviews, and interviews, the facility failed to ensure that a physician was notified of a resident's change in condition related to edema for 1 of 1 resident's reviewed (Resident 46). Finding includes: On 6/17/24 at 11:04 a.m., Resident 46 was observed sitting up on the right side of his bed,	F 0684	**It is the policy of this facility to notify the physician of a residents change of condition related to edema.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;**	07/26/2024

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	the resident had edema (swelling) to his bilateral feet and ankles. The resident indicated he had noticed some swelling off and on to his feet and ankles and he tried to elevate his legs in bed as much as he could. The resident indicated he was not taking a diuretic (helps reduce fluid buildup in the body) and wasn't sure if the staff had noticed the swelling. On 6/18/24 at 1:30 p.m., Resident 46 was observed sitting up in his wheelchair in his room. Edema was noted to his bilateral feet and ankles. On 6/19/24 at 2:30 p.m., Resident 46 was observed sitting up in his wheelchair in his room and was watching tv. Edema was noted to his bilateral feet and ankles. On 6/20/24 at 1:56 p.m., Resident 46 was sitting in his wheelchair across from the nurse's station. Edema noted to his bilateral feet and ankles. The resident indicated he was tired, and his legs felt weak from working with physical therapy. Resident 46's record was reviewed on 6/19/24 at 8:57 a.m. The profile indicated the resident's diagnosis included, but were not limited to, malignant neoplasm of prostate (a disease in which malignant [cancer] cells form in the tissues of the prostate), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). An admission Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was cognitively intact and required assistance of two people for personal hygiene, bed mobility, and transfers. The assessment indicated the resident was not on a diuretic.		Resident 46 was evaluated by nurse on duty on 6/20. The nurse on duty notified MD and new orders were received to treat change in condition on 6-20-2024. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DON/ designee educated staff on 7/11/24 facility policy and procedure on change in condition and assessing residents with edema and weight gains. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practice will not recur;** The DON/Designee will audit the nurse progress notes 5 times a	

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	A care plan, dated 4/15/24, indicated the resident had a diagnosis of atrial fibrillation. Interventions included, but were not limited to, observe for signs and symptoms of atrial fibrillation such as, fatigue, edema, and weight gain. A Hospital discharge note, dated 5/17/24, indicated to notify physician of increased swelling in feet/ankles/legs and consistent weight gain of 2 pounds in one day. The record lacked documentation of the physician being notified of recent weight gain in the last 30 days and lacked documentation of edema to bilateral feet and ankles. A practitioner encounter assessment, dated 5/29/24, indicated the resident had no edema in his extremities. A physician's order, dated 6/3/24, indicated record weekly weight every dayshift on Monday. Review of resident 46's weights were documented as follows: 6/17/24 - 143.6 pounds 6/3/24 - 130.8 pounds 5/22/24 -126.8 pounds 5/16/24 - 121.8 pounds 5/4/24 - 113.3 pounds 4/16/24 - 118.0 pounds 4/3/24 - 117.0 pounds Resident 46's record lacked documentation of a weight being obtained on 6/10/24 as ordered. The record lacked documentation of the physician being notified of recent weight gain in the last 30 days. A dietary progress note, dated 6/13/24 at 4:09		week x 4 weeks for resident change of condition and/or edema and notification of physician and changes in weight, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will be corrected as needed. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	p.m., indicated Resident 46 had gained 15.4% in weight over the last 30 days and it was a desirable outcome due to the resident's low BMI (body mass index). No recommendations given at this time. A physical, medicine, and rehabilitation progress note, dated 6/13/24 at 4:47p.m., indicated the resident had no edema and was receiving physical and occupational therapy. A physical, medicine, and rehabilitation progress note, dated 6/18/24 at 4:49 p.m., indicated the resident had no edema and was receiving physical and occupational therapy. During an interview, on 6/20/24 at 2:12 p.m., the Regional Nurse Consultant indicated the resident had notable edema to his bilateral feet and ankles and she would have the nurse perform an assessment and notify the doctor and family representative of the edema. During an interview, on 6/20/24 at 2:36 p.m., Physical Therapist (PT) 19 indicated she hadn't noticed any swelling to Resident 46's bilateral feet and ankles. She indicated she only sees him once or twice a week for therapy. During an interview, on 6/20/24 at 2:56 p.m., Certified Nurse's Assistant (CNA) 20 indicated she had noticed Resident 46's swelling off and on and would just put him in bed and elevate his legs to help the swelling go down. On 6/20/24 at 2:44 p.m., the Regional Nurse Consultant provided an undated document titled, "Change in Resident's Condition or Status," and indicated it was the policy currently being used by the facility. The policy indicated, " ...It is the			

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	policy of the facility to ensure the resident's attending physician and representative are notified of changes in the resident's condition or status ...there is a significant change in the resident's physical, mental or psychological status ...6. The nurse will record in the record any changes in the resident's medical condition or status ...." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident was supervised while administering her medications for 1 of 1 residents reviewed for accidents (Resident 104). Findings include: During the initial pool observation, on 6/17/24 at 11:21 a.m., Resident 104 was observed administering her own medication from her medication cup. The resident's nurse was not present in the room at the time of the observation. At the same time, the resident indicated the nurses often would just leave her medication cup with her medications, in her room for her to take.	F 0689	**It is the policy of this facility to provide supervision while administering medications.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** The DON/Designee assessed resident 104, no negative outcomes related to the cited practice on 06/21/2024 were noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	07/26/2024

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	During a random observation, on 6/18/24 at 8:59 a.m., the resident was observed with an empty medication cup sitting in front of her on her overbed table. At the same time, the resident indicated the nurse had brought her medications to her, again this morning, and had not stayed in the room while she was taking them. She could not remember ever being evaluated for taking her medication without supervision. Resident 104's record was reviewed on 6/19/24 at 11:05 a.m. The profile indicated the resident's diagnoses included, but were not limited to, nonrheumatic aortic valve stenosis (occurs when the aortic valve [allows blood to flow from the heart into the aorta] narrows and blood cannot flow normally), congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should), chronic kidney disease (when the kidneys are damaged and can't filter blood the way they should), and need for assistance with personal care. An admission Minimum Data Set (MDS) assessment, dated 6/17/24, was still in progress. The assessment lacked documentation of the resident's ability to self-administer her medications. The resident's care plans lacked documentation of the resident's ability to self-administer her medications. The profile lacked documentation of the resident having been assessed for the self-administration of medications. The physician orders lacked documentation of an order for self-administration of medications.		**actions will be taken** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DON/ designee educated nursing staff on 7/11/24 facility policy and procedure on medication administration and supervising residents during medication administration. Additionally, any staff member that fails to comply with the points of this in-service will be further eduated and/or disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practice will not recur;** Medication pass audit will be completed on random shifts 10 times a week x 4 weeks, then 5 time weekly x 4 weeks, then once month x 4 months. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any	

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	The resident's June 2024 Medication Administration Record (MAR) indicated the resident received the following morning medications: a. Allopurinol (used to prevent or lower high uric acid levels in the blood) 300 milligrams (mg) tablet by mouth at 9:00 a.m. daily for Gout (a type of inflammation caused by an elevated amount of uric acid, either because a person's kidneys do not adequately remove uric acid from their body, or because their body simply makes too much of it). b. Amlodipine besylate (used to treat hypertension [high blood pressure]) 5 mg tablet by mouth at 9:00 a.m., daily. c. Bumetanide (used to remove excess fluid from the body) 1 mg tablet by mouth at 9:00 a.m., daily for edema (medical term from swelling). d. Centrum (multivitamin with minerals) 1 tablet by mouth at 9:00 a.m., daily for supplement. e. Clopidogrel bisulfate (medication to prevent formation of blood clots) 75 mg tablet by mouth at 9:00 a.m., daily. f. Cyanocobalamin (to treat and prevent vitamin B12 [keeps body's blood and nerve cells healthy) deficiency anemia 1000 microgram (mcg) tablet by mouth at 9:00 a.m., daily for supplement. g. Cymbalta (used to treat depression) 60 mg capsule by mouth at 9:00 a.m., daily for depression. h. Gemtesa (used to treat overactive bladder) 75 mg tablet by mouth at 9:00 a.m., for urine		written Action Plan will be monitored by the Administrator weekly until resolution.	

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	retention. i. Isosorbide mononitrate (used to treat hypertension) 30 mg tablet by mouth at 9:00 a.m., daily for hypertension. j. Losartan potassium (used to treat hypertension) 25 mg tablet by mouth at 9:00 a.m., daily for hypertension. k. Metoprolol tartrate (used to treat hypertension) 25 mg tablet by mouth at 9:00 a.m., daily for hypertension. l. Montelukas sodium (used to treat allergy symptoms, such as trouble breathing, tight chest, wheezing, coughing, and runny nose) 10 mg tablet by mouth at 9:00 a.m., daily for allergies. m. Oxybutynin chloride ER (used to treat overactive bladder) 10 mg tablet by mouth at 9:00 a.m., daily for overactive bladder. n. Potassium chloride ER (used to treat low potassium) 20 milliequivalent (meq) tablet by mouth daily at 9:00 a.m., for supplement. Review of the June 2024 MAR indicated Licensed Practical Nurse (LPN) 3 had administered the resident's medication on 6/17/24, and LPN 4 had administered the medications on 6/18/24. During an interview, on 6/19/24 at 10:33 a.m., the Regional Nurse Consultant indicated the nurses should never leave medications for a resident to take without supervision. During an interview, on 6/19/24 at 12:22 p.m., LPN 4 indicated she had taken the medications into Resident 104's room and had been notified that			

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	the pharmacy had arrived. She left the room to meet the pharmacy representative. She understood that she should have stayed with the resident when she administered her medications. On 6/19/24 at 10:50 a.m., the Regional Nurse Consultant provided a document, dated March 2023, titled, "Drug Administration-General Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: 1. Medications are...administered...only by licensed nursing...3. Residents are allowed to self-administer medications when specifically authorized by the attending physician in accordance with facility procedures for self-administration of medications...." 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure respiratory equipment was stored in a plastic bag, and failed to ensure a physician order for continuous positive airway pressure (CPAP) settings was obtained for 1 of 1 resident reviewed for respiratory (Resident 22).	F 0695	**It is the policy of this facility to ensure respiratory equipment is stored in a plastic bag when not is use and to obtain a physician order for a resident using a CPAP.** **What corrective actions will be**	07/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155262	A. BUILDING 00 B. WING	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SULLIVAN NURSING FACILITY, THE	505 W WOLFE ST SULLIVAN, IN 47882

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	Findings include: During initial interviews on 6/18/24 at 10:08 a.m., observed Resident 22's continuous positive airway pressure (CPAP) machine (wearable respiratory device that uses mild air pressure to keep breathing airways open while you sleep) with a partially filled humidification chamber on the bedside table. The tubing and mask were unbagged and undated. Resident 22 indicated she required assistance from staff to put it on and take off, and the equipment had not been bagged since she moved in. During random observation on 6/19/24 at 11:54 a.m., Resident 22's CPAP mask and tubing were observed to be unbagged and undated. During random observation on 6/20/24 at 10:28 a.m., Resident 22's CPAP mask and tubing were observed to be unbagged and undated. On 6/20/24 09:36 a.m., Resident 22's record was reviewed. Her diagnoses included, but were not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and obstructive sleep apnea (repeated stop and start of breathing when the throat muscles relax and block the airway many times during sleep). A physician order, dated 4/27/24, indicated the CPAP to be worn at bedtime and for naps every shift. The chart lacked documentation of an order for the settings level or humidification. A care plan, dated 5/1/24, indicated resident had obstructive sleep apnea with interventions that		**accomplished for those residents found to have been affected by the deficient practice;** Nurse on duty obtained an order for CPAP settings on 6/21/24. Respiratory equipment was then stored properly for resident 22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** DON/ designee completed audit on 6/21/24 for residents with CPAP and orders verified and residents with respiratory equipment to ensure it was stored in a plastic bag. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** DON/ designee educated nursing staff on 7/11/24 facility policy and procedure on respiratory equipment storage and obtaining a physician order CPAPs. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practice will not recur;** Respiratory audit will be completed by the DON/Designee	

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	included, but were not limited to, observe for signs and symptoms of difficulty breathing, observe for signs and symptoms of low oxygen, and treatment as ordered. An admission Minimum Data Set assessment, dated 5/3/24, indicated Resident 22 was cognitively intact, and used a non-invasive mechanical ventilator (CPAP). During an interview on 6/20/24 at 10:47 a.m., Licensed Practical Nurse (LPN) 21 indicated they were to follow the same protocol for CPAP's as they do oxygen tubing, any tubing should be bagged and dated. She observed Resident 22's CPAP tubing and mask to be unbagged and undated, she indicated no storage bag was in the resident's room. During an interview on 6/20/24 at 11:30 a.m., observed Resident 22's CPAP equipment with LPN 21. She indicated that the mask and tubing were not bagged or labeled, but it should have been. LPN 21 indicated the machine settings read that it was set at four. Resident 22 indicated she thought it was supposed to be set at three. LPN 21 indicated that she was not familiar with the machine and would need to find out what the settings were supposed to be. When she checked the electronic medical record, she indicated that the physician orders only read to put the CPAP on and off at bedtime and when napping, it did not include settings or humidification, so she needed to contact the physician about the orders. On 6/20/24 at 11:20 a.m., the Regional Nurse Consultant provided an undated document, titled, "Continuous Positive Airway Pressure (CPAP)," and indicated it was the policy currently being used by the facility. The policy indicated, "		5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then monthly x 4 months. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	...Purpose: To improve ventilation on patients with obstructive sleep apnea (OSA), airway obstruction and upper airway resistance ...Guideline: CPAP therapy must have a written physician's order. The order must include the level of CPAP, FIO2 if needed, and humidifier if needed. 2. The patient should be assessed before and after therapy has been initiated for any hazards or adverse effects such as pneumothorax and gastric distention. 3. Continuous positive airway pressure, CPAP, provides positive pressure to the airways of a spontaneously breathing patient, maintaining a continuous pressure during expiration and inspiration permitting the airways to remain open allowing for improved ventilation ...Procedure: 1. Verify physician's order in the patient's chart. The order must include the level of CPAP, e.g. 5cmH2O ...15. When that CPAP machine is not in use the face mask is stored in a plastic bag at the bedside ...." 3.1-47(a)(6)			
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			

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	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 physician documentation to justify a declination of a pharmacy recommendation for 1 of 5 residents reviewed for unnecessary medications (Resident 8). Findings include: Resident 8's record was reviewed on 6/18/24 at 2:28 p.m. The profile indicated the resident's diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder (when the nerves and muscles don't work together very well. which results in the bladder may not fill or empty correctly). A pharmacy recommendation, dated 6/11/23, indicated to consider discontinuing the resident's Vesicare (a medication (med) indicated to treat an overactive bladder with urinary incontinence, urgency, and frequency). The physician disagreed with the recommendation and documented "Continue med." The form lacked documentation of any further justification. During an interview, on 6/19/24 at 10:33 a.m., the Regional Nurse Consultant indicated she was unable to find any physician documentation to justify the declination for discontinuing the resident's Vesicare.	F 0757	**It is the policy of this facility to ensure there is documentation by the physician to justify the declination of the pharmacy recommendation.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** DON/ designee assessed resident 8 on 06/21/2024 and no negative outcomes. Resident to continue medication. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	07/26/2024

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	On 6/19/24 at 10:50 a.m., the Regional Nurse Consultant provided an undated document, titled, "Distribution of Medication Regimen Review Report," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...4...If the physician disagrees with the recommendation or no change is being made, the physician must document rationale in the resident's medical record. 5. The Director of Nursing will follow-up with any nursing actions needed relative to the physician's response...." 3.1-48(a)(3) 3.1-48(a)(4)		DON/ designee provided physician education on pharmacy recommendations process on documentation to justify declinations on 7/11/24. **How the corrective actions will be monitored to ensure the deficient practice will not recur;** Pharmacy recommendation audit will be completed monthly x 6 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.			

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	Based on record review and interview, the facility failed to ensure physician ordered lab tests had been completed for 1 of 5 residents reviewed for unnecessary medications (Resident 42). Findings include: Resident 42's record was reviewed on 6/18/24 at 3:11 p.m. The profile indicated the resident's diagnoses included, but were not limited to, congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should), atrial fibrillation (AFIB-caused by extremely fast and irregular heartbeats), type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), hypertension (high blood pressure), hyperlipidemia (when the body has too many lipids [fats] in your blood), and gastro-esophageal reflux disease (GERD- a chronic gastrointestinal disorder characterized by the regurgitation of gastric contents into the esophagus). A pharmacy recommendation, dated 12/6/23, indicated to recommend lab testing related to medications ordered, included, but were not limited to: a. A Digoxin (a medication used to manage and treat heart failure and certain arrhythmias) level every 6 months. The physician approved the recommendation. b. Hemoglobin (Hgb) A1C (lab test used to evaluate a person's level of glucose [blood sugar]control) related to insulin (medication to lower glucose) use every 3 months. The physician approved the recommendation.	F 0773	**It is the policy of this facility to ensure lab test are completed per the physician orders.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** DON/ designee completed an audit to ensure that other residents were not affected by alleged same deficient practice on 6/21/24. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** DON/Designee completed a 90 day look back of Pharmacy recommendations for labs and physician notified on 06/21/2024 . **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Regional Nurse Consultant in-serviced the DON/Designee on completing labs that the /physician recommended on a Pharmacy Recommendations on 7/11/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective actions will be monitored to ensure the**	07/26/2024

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	c. A BMP (basic metabolic panel-lab test to check the body's fluid balance and levels of electrolytes, and see how well the kidneys are working), every 6 months. The physician approved the recommendation. d. Magnesium (specific type of electrolyte found in cells and bones) level every 6 months. The physician approved the recommendation. e. Lipid (fats in the blood) profile (measures the amount of lipids in the blood), every 6 months. The physician approved the recommendation. f. CBC (complete blood count- used to test for, diagnose, and monitor many different conditions), every 6 months. The physician approved the recommendation. A physician's order, dated 12/21/23, indicated the following labs were ordered: Hgb A1C and BMP every 4 month(s) starting on the 17th.The record lacked documentation of the order having been completed. A physician's order, dated 12/21/23, indicated the following labs were ordered: CMP, CBC, Magnesium level, and Digoxin level every 6 month(s) starting on the 17th for regular monitoring. The record lacked documentation of the order having been completed. A physician's order, dated 1/17/24, indicated the following labs were ordered: Lipid panel every 12 month(s) starting on the 17th. The record lacked documentation of the order having been completed. A physician's order, dated 1/23/24, indicated the hospital was to draw Digoxin level, BMP,		**deficient practice will not recur;** The DON/Designee will audit Pharmacy recommendations monthly x 6 months for physician recommendations for labs. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	Magnesium level, Lipid profile, and CBC every 6 months (January and June) starting on the 23rd for 1 day(s) for medication monitoring. The record lacked documentation of the order having been completed. A physician's order, dated 1/23/24, indicated the hospital was to draw Hgb A1C every 3 months (January, April, July, October) every 3 month(s) starting on the 23rd for 1 day(s). The record lacked documentation of the order having been completed. A physician's order, dated 3/18/24, indicated draw Hgb A1C every 3 months for medication monitoring, every night shift every 3 month(s) starting on the 18th for 1 day(s). The record lacked documentation of the order having been completed. A physician's order, dated 3/18/24, indicated draw Digoxin level, and CBC every 6 months for medication monitoring, every night shift every 6 month(s) starting on the 18th for 1 day(s). The record lacked documentation of the order having been completed. During an interview, on 6/19/24 at 10:25 a.m., the Regional Nurse Consultant indicated they were unable to locate any documentation of the lab results for the time period of the lab orders. On 6/19/24 at 10:50 a.m., the Regional Nurse Consultant provided an undated document titled, "Distribution of Medication Regimen Review Report," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ... 5. The Director of Nursing will follow-up with any nursing actions needed relative to the physician's response...."			

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	3.1-49(f)(1) 3.1-49(g)			
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 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 observations, interviews, and record reviews, the facility failed to discard expired items, failed to maintain completed temperature logs, failed to maintain and monitor sanitizer concentration levels, failed to label and date food items that were received without a manufacturer's expiration date, and failed to store food at a minimum of six inches from the floor for 1 of 2 kitchen observations. Findings include:	F 0812	**It is the policy of this facility to discard expired items, maintain temperature logs, maintain and monitor sanitizer concentration, date and label food for items that do not have expiration dates from the manufacturer.** **What corrective actions will be accomplished for those residents found to have been**	07/26/2024

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	1. During an initial kitchen tour with Cook 11 on 6/17/24 at 9:48 a.m., observed the walk-in refrigerator temperature logs to lack a.m. and p.m. temperature documentation for 6/16/24. On 6/17/24 at 10:05 a.m., observed the walk-in freezer temperature logs to lack p.m. temperature documentation for 6/14/24, and lacked a.m. and p.m. temperature documentation for 6/15/24 and 6/16/24. Cook 11 indicated it was typically the responsibility of the cook to complete the temperature logs and should be completed each shift. On 6/20/24 at 1:23 p.m., the Regional Nurse Consultant provided a document, dated 4/2017, titled, "Storage of Refrigerated/Frozen Foods,", and indicated it was the policy currently being used by the facility. The policy indicated, " ...Monitoring of food temperatures and functioning of the refrigeration/freezer units will be in place ...." 2. During the initial kitchen tour with Cook 11 on 6/17/24 at 9:48 a.m., observed thawed raw chicken with a date of 6/8/24. She indicated it should have been thrown out and were normally on top of that but have been short staffed. During an interview on 6/19/24 at 10:28 a.m., the Dietary Director indicated frozen food was to be dated for the day it was pulled from the freezer to be thawed, and believed it thaws for seven days. Staff were expected to check for expired and undated items daily. On 6/18/24 at 8:30 a.m., the Administrator provided an undated document, titled, "Policy: Food Safety,", and indicated it was the policy		**affected by the deficient practice;** The dietary manager completed temperatures on the walk-in refrigerator on 6/17/2024, threw out the thawed chicken on 6/17/2024, disposed of any foods that were thawed and had no manufacturer expiration dates, removed boxes from the floor in the walk-in freezer, disposed of the sanitizer bucket. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Dietary Manger in-serviced the dietary staff on the following polices: Storage of Refrigerated/Frozen Foods, Sanitizing Buckets, and Food Safety and Sanitation" by 07/26/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.	

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	currently being used by the facility. The policy indicated, " ...Food will be labeled and dated to monitor food safety ...Food or beverage items that have exceeded manufactures expiration date will be discarded. Food items that do not have a manufacturer's expiration date will be labeled and dated with a received and use by date. All food items should be consumed or discarded after 3 days ...." On 6/19/24 at 11:24 a.m., the Dietary Director provided an undated document, titled, "Refrigerator/Freezer Storage Chart," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Clean your refrigerator regularly to reduce food odors. Remove spoiled foods immediately so decay cannot pass to other foods ...Use foods quickly. Don't depend on maximum storage time ...." On 6/19/24 at 11:24 a.m., the Dietary Director provided a document, dated 4/2017, titled, "Food Safety & Sanitation ...Policy: First In First Out (FIFO)," and indicated it was the policy currently being used by the facility. The policy indicated, " ...stock must be used before the expiration date. Items not used by the expiration date will be discarded ...." On 6/20/24 at 1:23 p.m., the Regional Nurse Consultant provided a document, dated 4/2017, titled, "Storage of Refrigerated/Frozen Foods", and indicated it was the policy currently being used by the facility. The policy indicated, " ...Foods in the refrigerator will be covered, labeled and dated. Foods will be used by its use-by-date, frozen or discarded ...." 3. During the initial kitchen tour with Cook 11, on 6/17/24 at 10:05 a.m., observed the dry storage		**How the corrective actions will be monitored to ensure the deficient practice will not recur;** The Dietary Manager/Designee will audit temperature logs 5 times a week x 4 weeks, then 3 time a week x 4 weeks, then weekly x 4 months. The Dietary Manager/Designee will audit the sanitizing bucket for the correct PPM 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a month x 4 months. The Dietary Manager/Designee will audit the walk-in refrigerator/freezer for boxes on the floor, dates opened and expiration dates for foods 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will be corrected as necessary. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155262	A. BUILDING 00 B. WING	06/21/2024

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	bread rack. No manufacturer expiration dates or dates items were received located on any of the bread items. She indicated they did not date the bread, but they went through it quickly. She did not know when the bread expired or when it had been received. During an interview on 6/19/24 at 11:08 a.m., the Dietary Director indicated they received bread shipments every week, stored it in the freezer for no longer than two weeks, and pulled bread to thaw the night before use. She indicated the bread should have had an expiration date printed on it, but when she observed the packaging, she indicated none of them had manufactured or expiration dates printed on them like she thought. She was not sure what the related facility policy was. On 6/18/24 at 8:30 a.m., the Administrator provided an undated document, titled, "Policy: Food Safety", and indicated it was the policy currently being used by the facility. The policy indicated, " ...Food will be labeled and dated to monitor food safety ...Food or beverage items that have exceeded manufactures expiration date will be discarded. Food items that do not have a manufacturer's expiration date will be labeled and dated with a received and use by date. All food items should be consumed or discarded after 3 days ...." On 6/20/24 at 1:23 p.m., the Regional Nurse Consultant provided a document, dated 4/2017, titled, "Storage of Refrigerated/Frozen Foods", and indicated it was the policy currently being used by the facility. The policy indicated, " ...Foods in the refrigerator will be covered, labeled and dated. Foods will be used by its use-by-date, frozen or discarded ...."			

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	4. During the initial kitchen tour on 6/17/24 at 9:48 a.m. with Cook 11, observed a box of broccoli cuts and a box of sheet cakes on the floor of the walk-in freezer, she indicated the boxes should not be on the floor. During an interview on 6/19/24 at 10:28 a.m., the Dietary Director indicated the boxes on the walk-in freezer should not have been there, but staff just put things wherever they wanted. On 6/20/24 1:23 p.m., the Regional Nurse Consultant provided a document, dated 4/2017, titled, "Storage of Dry Foods/Supplies" and indicated it was the policy currently being used by the facility. The policy indicated, " ...Foods and goods shall be stored at a minimum of 6" off the floor and 18" from the ceiling and clear of ceiling sprinklers, sewer pipes and vents ...." On 6/20/24 at 1:23 p.m., the Regional Nurse Consultant provided a document, dated 4/2017, titled, "Storage of Refrigerated/Frozen Foods", and indicated it was the policy currently being used by the facility. The policy indicated, " ...Monitoring of food temperatures and functioning of the refrigeration/freezer units will be in place ...Foods in the refrigerator will be covered, labeled and dated. Foods will be used by its use-by-date, frozen or discarded. Foods should be stored at a minimum of 6" from the floor ...." 5. During the initial kitchen tour on 6/17/24 at 10:15 a.m., Dietary Assistant 13 indicated they tried to test sanitizing solution concentration levels regularly but did not maintain a testing log. On 6/17/24 at 10:24 a.m., Dietary Assistant 13 tested a bucket of sanitizer solution, she held the			

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	strip in the water for thirty seconds, read the result to be 500 ppm, and indicated she believed it should be at 500 ppm. She filled a new bucket with sanitizing solution and read the instructions on the test strip container. The test strip container label indicated to submerge the strip for ten seconds, remove, and read. She submerged the test strip and counted for 10 seconds, looked at it, put it back in the water, and repeated the dipping process 3 times before taking it out to read it at 400 ppm. During an interview on 6/19/24 at 10:28 a.m., the Dietary Director indicated where she worked before had a sanitation chemical testing log, but she had yet to find one for the facility but believed they test throughout the day On 6/19/24 at 10:48 a.m., the Dietary Director provided a document, dated 4/2017, titled, "Policy: Sanitizing Buckets", and indicated it was the policy currently being used by the facility. The policy indicated, " ...The facility will follow manufacturer's recommendation on the amount of sanitizing solution used. Sanitizer concentrations are recommended and use of test strips to monitor accuracy of the sanitizer ...Quats ...Sanitizer concentration range ...150-200 ppm ...." 3.1-21(i)(2) 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			

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	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, 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.			

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	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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, record review, and interview the facility failed to maintain infection prevention measures during meal service administration for 2 of 2 meal service observations, failed to maintain infection prevention measures for 2 of 2 residents observed during medication administration (Residents 16 and 49), and failed to ensure staff washed hands for at least 20 seconds for 3 of 3 random observations of staff hand hygiene. Findings include: 1. On 6/17/24 at 12:30 p.m., the noon meal dining service was observed in the main dining room.	F 0880	**It is the policy of this facility to ensure the staff maintain infection control practice during meal service.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** The DON/Designee assessed resident 16 and 49 on 6/21/2024, no negative outcome related to the cited practice. **How other residents having the potential to be affected by**	07/26/2024

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	Observed Certified Nurse Aide (CNA) 7 passing ice to the residents. The CNA touched her ear and hair and continued passing ice to a resident. The CNA then placed the ice scoop into the ice bucket. The CNA failed to sanitize her hands after touching her ear and hair. On 6/17/24 at 12:43 p.m., CNA 7 adjusted oxygen tubing for Resident 7 then continued to assist another resident with meal service. The CNA failed to sanitize hands prior to assisting another resident with meal service. On 6/20/24 at 1:31 p.m., during an interview CNA 7 acknowledged the ice scoop was to be placed in a container on the cart. She acknowledged she placed the ice scoop in the ice bucket instead of the designated container. The employee indicated when assisting a resident, she would normally use hand sanitizer or wash hands between residents. On 6/21/2024 at 11:50 a.m., the Regional Nurse Consultant provided an undated document, titled, "Policy and Procedure Meal Service," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure ...6. Staff providing direct resident care by passing meals/trays will wash their hands before serving the food ...Staff will wash their hands after ...assisting another resident with their meal/tray delivery and set up. Those authorized to deliver/serve trays will refrain from touching their own person such as face/hair or clothes during the serving of trays. This action would require hand hygiene prior to serving the next tray ...." On 6/20/2024 at 2:45 p.m., the Regional Clinical Director provided a document, titled, "Handling Ice," dated 2/12/15, and indicated it was the policy currently being used by the facility. The policy		**the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The DON/Designee in-serviced Kay Eastham, Activity Assistant, on hand hygiene during meal service on 6/21/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. All staff educated on infection control practices July 11th, 2024. **How the corrective actions will be monitored to ensure the deficient practice will not recur;** The DON/Designee will observe hand hygiene during 10 random meal services weekly x 4 weeks, then 5 random meal services weekly x 4 weeks, then one meal service a week x 4 months. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and	

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	indicated, "...Ice Scoop ...The ice scoop should be stored according to state and local regulations ...." 2. On 6/20/24 at 11:25 a.m., Licensed Practical Nurse 8 prepared to check the blood sugar of Resident 16. The LPN washed her hands and applied gloves. She then pricked the finger of the resident to obtain blood sample to check the resident's blood sugar. Once completed she removed and discarded gloves. On 6/20/24 at 11:37 a.m., LPN 7 prepared to check the blood sugar of Resident 49. The LPN applied gloves and pricked the resident's finger, obtained blood sample and completed blood sugar test. The LPN failed to wash her hands between Residents 16 and 49. On 6/20/24 at 11:45 a.m., during an interview LPN 7 acknowledged she did not wash her hands or use hand sanitizer between residents. On 6/21/2024 at 10:41 a.m., the Regional Nurse Consultant provided a document, titled, "5.2 Medication Administration," dated March 2023, and indicated it was the policy currently being used by the facility. The policy indicated, "...Before the medication pass ...2. Cleanse your hands before beginning and before contact with each resident ...."3. During a random observation, on 6/17/24 at 11:14 a.m., the Certified Nurse's Assistant (CNA) 7 entered the bathroom (leaving the door open) by the nurses' station and washed her hands for less than 20 seconds and turned off the water faucet with her bare hands. She then left the bathroom and went to the linen closet to obtain linens. She then proceeded into a resident's room to provide care. During a random observation, on 6/17/24 at 11:42		any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	a.m., the Licensed Practical Nurse (LPN) 14 entered the bathroom (leaving the door open) by the nurses' station and washed her hands for less than 20 seconds and turned off the water faucet with her bare hands. She then left the bathroom and went to her medication cart down the hallway. During a dining observation, 6/17/24 at 12:08 p.m., CNA 7 entered the bathroom (leaving the door open) by the nurses' station and washed her hands for less than 20 seconds and turned off the water faucet with her bare hands. She then left the bathroom and went to the beverage cart and prepared an iced tea for a resident. She placed the iced tea on a lunch tray for a resident. She served the tray to a female resident sitting in the small dining area across from the nurse's station. During an interview, on 6/20/24 at 1:35 p.m., LPN 3 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. During an interview, on 6/20/24 at 1:37 p.m., CNA 18 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. The entire process should take at least 60 seconds. On 6/20/24 at 2:44 p.m., the Regional Nurse Consultant provided an undated document, titled, "Hand Hygiene Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...ii. Apply generous amount of soap to hands and run hands together vigorously for at least 20 seconds ...iv ...dry thoroughly with a disposable towel ...v. Use towel to turn off faucet and exit area ...vi. The duration			

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	of the entire procedure should be approximately 40-60 seconds, per evidenced based practice ...." 3.1-18(l)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray	F 9999	**F9999 – Personnel** It is the policy of this facility to ensure Mantoux testing is completed on new employees. **What corrected action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified to be affected by the cited deficiency. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The BOM/HR/Designee will completed an audit of employee files for completion of the 1st and 2nd TB test by 7/26/2024. Tests are to be administered by 7/26/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The ADM/Designee educated BOM/HR on new staff members receiving a 2 step TB testing.	07/26/2024

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	and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure a second step TB (tuberculin) skin test (a tool for screening for tuberculosis and for tuberculosis diagnosis) was completed within three weeks after the first test was administered for 5 out of 10 employees reviewed. Findings include: On 6/21/24 at 11:00 a.m., review of employee files was completed. The record for environmental (Housekeeping) employee 23, hire date of 4/25/24, lacked documentation of the second step TB test. The record for Certified Nurse Aide (CNA) 24, hire date of 2/20/24, lacked documentation of the second step TB test. The record for CNA 25, hire date of 5/21/24, lacked documentation of the second step TB test. The record for Registered Nurse (RN) 26, hire date of 1/11/24, lacked documentation of the second step TB test. The record for CNA 27, hire date of 5/21/24, lacked documentation of the second step TB test.		Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The BOM/HR will audit new employee files weekly x 6 months for completion of the 1st and 2nd step TB test. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI meeting, monitoring will be reviewed, and any concerns will be corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	On 6/21/24 at 10:00 a.m., during an interview the regional nurse consultant indicated each new employee was required to have a 1st and 2nd step TB test upon hire. She acknowledged the record lacked documentation of the second TB test being administered to 5 of 10 employees reviewed. The facility failed to provide a policy for TB testing of employees.			