STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. BUILDING 00 B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ESPECIALLY KIDZ HEALTH & REHAB	2325 S MILLER ST SHELBYVILLE, IN 46176

(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: March 31, April 1, and April 2, 2025 Facility number: 000273 Provider number: 15A011 AIM number: 100267870 Census Bed Type: NF: 114 Total: 114 Census Payor Type: Medicaid: 114 Total: 114 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 3, 2025.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to assist a resident with getting out of bed for 1 of 1 resident reviewed for choices and to ensure residents requiring	F 0677	F677 The facility will assist resident with ADLs. 1. Resident #22, #21 and #85 had lip balm applied and lip balm was stored in their drawers for staff to	04/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Wendel	HFA	04/14/2025

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	assistance with Activities of Daily Living (ADLs) receive adequate assistance with oral care. (Resident 22, Resident 21 and Resident 85) Findings include: 1. The clinical record for Resident 22 was reviewed on 3/31/25 at 11:45 a.m. Her diagnoses included, but were not limited to, cerebral palsy, profound intellectual disabilities, epilepsy, organic brain syndrome, spastic quadriparesis, and wound infection. The 3/6/25 Significant Change MDS (Minimum Data Set) assessment indicated she was moderately, cognitively impaired. She had unclear speech but was usually understood with difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. She sometimes understood others. Her hearing was adequate. She had upper and lower extremity impairment on both sides. She was dependent on staff for transfers from the bed to a chair. She used a wheelchair and was unable to walk. She also had a stage 4 pressure ulcer. The 3/18/25 hospital discharge notes indicated she had a sacral wound infection after a 2/4/25 surgery involving debridement and skin flap. She was discharged back to the facility on 3/18/25. The 3/14/25 hospital progress note indicated Resident 22's mother was at the bedside. The ADL (Activities of Daily Living) care plan, last reviewed 2/25/25, indicated the goal was for her to be provided with the necessary staff assistance to complete her ADLs. An observation and interview were conducted with Resident 22 on 3/31/25 at 11:04 a.m. Resident		use after oral care. Resident #22's order was clarified per the surgeon to allow resident to be up ad lib in her wheelchair. Staff made aware 2. All residents have the potential to be affected. Lip balm was placed in all resident's bedside table to ensure staff use after oral care. Staff educated. All resident's ADL order was reviewed and no further concerns noted as to when resident is to be up in wheelchair. 3. The Oral Care policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. Staff was educated on ensuring residents are up in wheelchair per physician order's. 4. The DON or designee will conduct rounds twice daily to ensure lip balm is applied on all residents after oral care is completed. The DON will conduct rounds twice daily to ensure residents are up in their wheelchair per their preference/order. The DON or his designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly	

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	22 was lying in bed, awake. She indicated she hadn't gotten out of bed yet today, but was ready to, by nodding her head yes, when asked. An interview was conducted with Resident 22's mother on 3/31/25 at 2:30 p.m. She indicated she wasn't sure when Resident 22 got out of bed at the facility. An observation of Resident 22 lying in bed was made on 4/1/25 at 10:36 a.m. and 4/1/25 at 1:50 p.m. An interview was conducted with CNA (Certified Nurse Aide) 2 on 4/1/25 at 1:51 p.m. He indicated he was assigned to care for Resident 22 today. He did not assist her to get out of bed today, because she was unable to get out of bed right now, due to her sacral wound repair. She was unable to be in her wheelchair. Ever since she returned from her 3/18/25 hospitalization, she had orders to just turn and reposition her in bed. Resident 22's physician's orders did not include an order to remain in bed. An interview was conducted with the DON (Director of Nursing) on 4/1/25 at 3:13 p.m. She reviewed Resident 22's 3/18/25 hospital notes and indicated they referenced her being bedbound, but not that she needed to remain in bed. She got up for bathing and in the evenings sometimes. She was going to make sure all staff who cared for her knew she was able to get out of bed. The DON provided the Care Plan Development and Review policy on 4/2/25 at 12:36 p.m. It indicated, "This facility shall then develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable		quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or maintained, the staff member will be re-educated one on one regarding the importance of using lip balm after oral care and getting residents up in wheelchair per order. Rounds will be increased to four times a day by administrator and DON if compliance is not obtained or maintained to ensure lip balm is being applied and residents are up in wheelchairs per order/preference. 5. The above corrective measures will be completed on or before April 9, 2025.	

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	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment..." 2. A record review conducted, on 4/1/25 at 11:12 a.m., indicated Resident 21's diagnoses included, but were not limited to, cerebral palsy and profound intellectual disabilities. A current care plan, initiated on 1/9/25, indicated Resident 21 required staff assistance with oral care with an intervention listed as " ... 3. Use lip balm as needed to keep lips moist and prevent cracking". A physician order, dated 9/26/22, indicated oral care was to be completed every shift. An observation was conducted of Resident 21 on 3/31/25 at 1:57 p.m. Resident 21 was sitting in the hallway in her wheelchair. She was observed with dry skin on her lips. An observation was conducted of Resident 21 in her room on 4/1/25 at 10:02 a.m. She was observed in her wheelchair and had dry skin on her lips. 3. A record review conducted, on 3/31/25 at 2:28 p.m., indicated Resident 85 diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs, as well as the trunk and face). A current care plan, dated 1/9/25, indicated Resident 85 required staff assistance with oral care with an intervention listed as "...3. Use lip balm as needed to keep lips moist and prevent cracking".			

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	A physician order, dated 9/28/22, indicated oral care was to be completed every shift. Observations were conducted of Resident 85 on 3/31/25 at 2:28 p.m. and 4/1/25 at 10:01 a.m. Resident 85 was sitting in her wheelchair in her room. She was observed with dry skin on her upper and lower lips. An interview was conducted with Licensed Practical Nurse (LPN) 5 on 4/1/25 at 10:20 a.m. She indicated all residents should have house lip balm in their drawers, unless otherwise indicated in the residents' orders. LPN 5 checked Resident 85's drawers for lip balm and did not find any. Then she went to check Resident 21's drawers for lip balm, and she did not find any. LPN 5 went to the storage closet and got lip balm for Resident 85 and Resident 21 and applied it to each of them. LPN 5 indicated Resident 21 and Resident 85's oral care orders included brushing the resident's teeth and applying lip balm three times a day as needed. A policy titled "Oral Care", dated 10/14, was proved by the DON on 4/2/25 at 11:44 a.m. The policy indicated " ...Policy: Nursing personnel is responsible to ensure that oral care is completed at least daily and as indicated for those resident unable to provide their own mouth care. Oral care is inclusive of brushing teeth/dentures. Administering mouthwash, and flossing, as indicated ..." 3.1-38(a)(3)(C) 3.1-38(b)(6)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident	F 0679	F679 The facility will ensure a	04/09/2025

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	Based on observation, interview and record review, the facility failed to ensure a resident was provided activities for 1 of 1 resident reviewed for activities. (Resident 71) Findings include: The clinical record for Resident 71 was reviewed on 3/31/25 at 2:00 p.m. The diagnoses included, but were not limited to, traumatic brain injury and quadriplegia (partial or complete paralysis of both the arms and legs). An activities care plan, revision date of 1/23/25, indicated Resident 71 "may benefit from activities for cognitive, social and sensory stimulation. Activities to include, but not limited to music, sensory stimulation, stories, tv, and massage. TV/Music will be on in room while awake as tolerated..." An observation was conducted of Resident 71 in his room on 3/31/25 at 11:15 a.m. The resident was in bed with his eyes open. The resident's television was not turned on nor was any music playing. An interview was conducted with Resident 71's Representative on 3/31/25 at 2:36 p.m. She indicated she visited the resident on Sundays. The resident was observed on those days in bed. She was told by the staff, "Sundays are lazy days." An observation was conducted of Resident 71 in his room on 4/1/25 at 11:15 a.m. The resident was observed dressed and in his chair with his eyes open. The resident's television was turned off and there was no music playing.		resident has provided activities. 1. Resident #22's remote was programmed and the TV turned on to program of resident's liking. 2. All residents have the potential to be affected. A completed round of the facility was conducted to ensure residents were participating in activities of their preferences. 3. The Activity policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the above procedure. 4. The administrator or designee will conduct rounds twice daily ensuring residents are participating in an activity at least the TV/radio being turned on. The administrator or designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or maintained, the staff member will be re-educated one on one regarding the importance of residents participating in activities. Rounds will be increased to four times a day by administrator and	

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	An observation was conducted of Resident 71 in his room on 4/2/25 at 8:46 a.m. The resident was dressed in bed with his eyes open. The resident's television was turned off and there was no music playing. An observation was conducted of Resident 71 in his room on 4/2/25 at 9:57 a.m. The resident was dressed and in his chair with his eyes open. The resident's television was turned off and there was no music playing. An observation was conducted of Resident 71 with Unit Manager (UM) 12 on 4/2/25 at 10:06 a.m. The resident was sitting in his chair with his eyes open. The resident's television was not turned on. UM 12 indicated, at that time, the resident loves his rap music. The television should be on. The resident's response to hearing the statement made about the love of rap music; he began to smile and move/dance in his chair. UM 12, at that time, looked all over the room to locate his remote control to his television without success. She attempted to utilize the remote that belonged to Resident 71's roommate. The roommate's remote was unable to work on Resident 71's television. UM 12 indicated she was going to speak with social services to see if she has an extra remote for him and/or order the resident a new remote. At that time, the therapy department had entered the resident's room to take the resident to attend therapy services. A restorative nursing tracking log, dated 4/2/25, indicated the resident had spent 20 minutes with therapy. An interview was conducted with the Assistant Executive Director (AED) on 4/2/25 at 1:40 p.m. She indicated Resident 71's Representative would		DON if compliance is not obtained or maintained to ensure residents are participating in activities. 5. The above corrective measures will be completed on or before April 9, 2025.	

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	like for the resident at times to have quiet time. An interview was conducted with Resident 71's Representative on 4/2/25 at 1:54 p.m. She indicated Resident 71 enjoyed all types of music. She was fine with the resident having quiet time as well as listening to music at a low volume. The resident's care plan did not indicate the resident preferred to be provided with quiet time. An activities policy was provided by the AED on 4/2/25 at 1:40 p.m. It indicated, "Policy: This facility should provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing to support residents in their choice of activities, both facility sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence an interaction in the community." 3.1-33(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, interview, and record review, the facility failed to ensure a resident's wheelchair had the necessary head support equipment for 1 of 1 resident reviewed for positioning (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 4/2/25 at 11:00 a.m. The diagnoses included,	F 0688	F688 The facility will ensure a resident's wheelchair has a necessary head suppor. 1 Resident #20's head rest was placed on his wheelchair. 2. All residents have the potential to be affected. A complete round was conducted in the facility to ensure all adaptive equipment for wheelchairs were in place. No further concerns were noted. See	04/09/2025

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	but were not limited to, spastic quadriplegic cerebral palsy (impaired movements characterized by paralysis of both arms and both legs, with muscle stiffness), neuromuscular scoliosis (irregular curving of the spine), and epilepsy (seizure disorder). A quarterly Minimum Data Set (MDS) assessment, dated 12/23/24, indicated Resident 20 had impairments with his upper and lower extremities. A current care plan titled "Adaptive Wheelchair", last reviewed on 3/20/25, noted "Resident requires the use of an adaptive wheelchair 2° [secondary] to the inability to maintain proper body positioning and alignment." A current care plan titled "Adaptive Wheelchair - Manual", last reviewed on 12/31/24, noted, "The following adaptations may include any or all of the following ...Standard Headrest, Heads-Up Headrest ..." On 4/1/25 at 9:19 a.m., Resident 20 was observed sitting in his wheelchair in his room, in front of the television. There was no headrest attached to his wheelchair. The resident kept falling asleep, and his head repeatedly lolled backward and then jerked forward. On 4/1/25 at 9:37 a.m., Resident 20 was still in his wheelchair, which had no headrest attached. His head was still lolling backward and then jerking forward repeatedly. On 4/2/25 at 10:31 a.m., Resident 20 was observed sleeping in his Posey bed (a fully enclosed bed to promote safety and reduce falls). His wheelchair was in his room, and it did not have a headrest		below for corrective measures. 3. The staff was inserviced on ensuring all adaptive equipment was placed on wheelchairs prior to getting the resident up in their wheelchairs. 4. The DON or designee will conduct rounds twice daily to ensure all adaptive equipment devices are on resident's wheelchair prior to getting the resident up in their wheelchair. The DON or designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or maintained, the DON will re-educated staff one on one on the importance of residents having their adaptive equipment placed on their wheelchair prior to getting the resident up in their wheelchair. Additional monitoring will occur if compliance not met by having the administrator conduct rounds twice a day in addition to the DON to ensure all adaptive equipment is placed on the wheelchair. 5. The above corrective measures will be completed on or before	

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	attached to it. In an interview on 4/2/25 at 10:38 a.m., Certified Nurse Aide (CNA) 2 indicated the wheelchair with no headrest belonged to Resident 20. There should be a headrest on the wheelchair, but maybe someone took it off to clean it and forgot to put it back on. The Physical Therapist (PT) would know more about what type of headrest the resident needed. In an interview on 4/2/25 at 10:40 a.m., Physical Therapist (PT) 9 indicated a head rest should be on Resident 20's wheelchair, because they were standard on all the wheelchairs there. She was not sure why it was not attached but would look into it. In an interview on 4/2/25 at 10:50 a.m., PT 9 indicated she found Resident 20's wheelchair headrest in his closet and re-attached it. She adjusted it so it was at the proper height for the resident's head. In an interview on 4/2/25 at 1:45 p.m., the Assistant Executive Director indicated they did not have a policy for adaptive equipment. 3.1-42(a)(2)		April 9, 2025.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure unopened food in the freezer was stored properly. This had the potential to affect 24 of 114 residents that receive food from the kitchen.	F 0812	F812 The facility will ensure unopened food in the freezer is stored properly. 1. The staff was immediately educated on how to properly store frozen items in the freezer. 2 . All residents have the potential	04/09/2025

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	Findings include: The facility kitchen was observed with Dietary Supervisor (DS) 6 on 3/31/25 at 10:15 a.m. During the tour, the walk-in freezer was observed with the following items not closed/secured: One box of tater tots, Two boxes of mixed vegetables, and One box of pork patties, An interview was conducted with DS 6 on 3/31/25 at 10:30 a.m. She indicated the box of tater tots, the mixed vegetables, and the pork patties should have been stored preventing air from reaching the product. A storage guidelines policy was provided by DS 6 on 3/31/25 at 11:00 a.m. It indicated, " ... Frozen items that are not individually wrapped such as cookie dough, biscuits, vegetables, fruit and meat should be placed in a 2-gallon storage bag or wrapped tightly in plastic wrap prior to returning to original box. All open boxes in the freezer must be resealed to prevent damage from frost. Boxes should never be left gaping open for any reason." A dietary policy and procedure, dated August 2024, was provided by the Assistant Executive Director on 4/2/25 at 11:50 a.m. It indicated, "Policy: A proper handling procedure for frozen food safety lessens the risk of acquiring foodborne diseases...6. Freezer burn is caused by air, which contacts the food surface, this does not make the food unsafe, it only diminishes the quality. Freezer burn may appear as grayish brown and leathery dry spots. Do not include said portions by cutting them off before or after cooking the food ..."		to be affected. All staff was immediately inserviced on how to properly storew food in the freezer. No further concerns were noted. See below for corrective measures. 3. The food storage policy and procedures was reviewed with no changes made. (See attachment E) The staff was inserviced on the above procedure. 4. The administrator or designee will conduct rounds in the kitchen twice daily ensuring all items in the freezer are stored properly and not open to air. The administrator or designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. **If compliance i**the staff member will be re-educated one on one to ensure they are knowledgeable about how to properly store food in the freezer. Additional monitoring will occur if compliance is not met by having the dietary manager conduct rounds in the kitchen twice daily opposite of the administrator to ensure food items are stored properly in the freezer.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-21(i)(2) 3.1-21(i)(3)		**5. The above corrective measures will be completed on or before April 9, 2025.**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control was maintained by utilizing hand hygiene during medication administration for 4 of 5 residents observed during medication administration. (Residents' 26, 38, 49, and 81) Findings include: 1. An observation was conducted of medication administration with Licensed Practical Nurse (LPN) 5 for Resident 81 on 4/1/25 at 8:40 a.m. LPN 5 prepared the resident's medication at the medication cart. LPN 5 utilized hand sanitizer and donned gloves. After, she touched the medication cart, the computer mouse, the narcotic box, and the medication cards with her gloved hands. During that time, she pulled the medication cards from the medication cart popping the resident's pill medications in her gloved hands and dropping the pill medications in the medication cup. She then crushed the pill medications. At that time, LPN 5 indicated the resident was receiving her pill medications through a gastrostomy tube (g-tube; a tube inserted in stomach to receive liquid food and medications). After, LPN 5 doffed her gloves; picked up a new set of gloves from her medication cart. She then walked into Resident 81's room; donned the pair of gloves and a gown (Personal	F 0880	F880 The facility will ensure infection control is maintained by utilizing hand hygiene during medication administration. 1. Resident #26, #38, #49 and #81 are free of any communicable illness. 2. All residents have the potential to be affected. Staff was educated immediately on the hand hygiene procedure including intervals of when to wash their hands. 3. The hand hygiene policy and procedure was reviewed with no changes made. (See attachment F) The staff was inserviced on the above procedure. 4. The DON or designee will complete 3 hand hygiene observations daily to ensure the staff properly conducts hand hygiene including intervals of when hands are to be washed. The DON or designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See	04/09/2025

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	15A011	A. BUILDING 00 B. WING	04/02/2025

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	Protective Equipment/PPE) located on the resident's wall. There was no observation of hand hygiene prior to donning a new set of gloves nor the gown. She then administered the medication through the resident's g-tube. 2. An observation was conducted of LPN 5 administering medications to Resident 49 on 4/1/25 at 9:06 a.m. LPN 5 was observed utilizing hand hygiene and donning a pair of gloves. She then pulled and prepped the resident's medication utilizing the gloved hands. LPN 5 pulled out pill medication cards and popped the pill medications directly in her gloved hands. She then placed the pills in a medication cup. During that time, LPN 5 touched the computer mouse, the keys to the medication cart, the medication cart, the lock on the medication cart, and the medication cards with her gloved hands. She then doffed her gloves; crushed the pill medications and then mixed the crushed pills with a puree mixed fruit. After, she went to the resident in the hallway and pushed the resident to her room. She administered the medications at that time to the resident by mouth in her room. There was no observation of hand hygiene prior to the administration of medications. 3. An observation was conducted of an administration of medications to Resident 26 with Qualified Medication Aide (QMA) 10 on 4/1/25 at 9:28 a.m. QMA 10 prepared the resident's pill medications at the cart. QMA 10 indicated that the resident received medications via a g-tube. She then went to the resident's room, donned gloves and a gown prior to administration. There was no hand hygiene observed prior to donning gloves and a gown. 4. An observation was conducted of an administration of medications to Resident 38 with		attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained or maintained, the staff member will be re-educated one on one regarding the importance of hand hygiene. Observations will be increased to eight observations of hand hygiene a day by administrator and DON if compliance is not obtained or maintained. 5. The above corrective measures will be completed on or before April 9, 2025.	

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	QMA 5 on 4/1/25 at 9:42 a.m. QMA 5 prepared the resident's medications. After, she went to the resident's room and donned a pair of gloves and a gown prior to administration. She then administered the pill medication via g-tube. There was no hand hygiene observed prior to donning gloves or gown prior to medication administration. An interview was conducted with the Director of Nursing on 4/1/25 at 1:25 p.m. She indicated the nursing staff should not be donning gloves at the medication cart. She should have changed her gloves and utilized hand hygiene. A hand hygiene policy was provided, on 4/2/25 at 8:55 a.m., by the Assistant Director of Nursing (ADON). It indicated, "Purpose: Hand hygiene is the single most important measure for preventing the spread of infection. Policy: This facility shall require personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated...Situations that require hand hygiene include, but are not limited to ...Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) ...Before and after entering isolation precaution settings ...Before and after handling peripheral vascular catheter and other invasive devices ...After removing gloves or aprons ..." A medication administration policy was provided by the ADON on 4/2/25 at 8:55 a.m. It indicated, "...Infection control: 1. Wash hands with soap and water. Prior to beginning med pass ...Before and after administering...meds, via feeding tubes ...2. use alcohol gel or foam between each resident unless using soap and water. 3. Never touch medications with hands..." 3.1-18(b)(1)			

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F 0921 SS=E Bldg. 00	3.1-18(l) 483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure a safe, comfortable, and homelike environment for 4 of 5 residents reviewed for homelike environment. (Residents 17, 30, 111, and 115) Findings include: 1. An observation was conducted of Resident 111's room on 3/31/25 at 10:50 a.m. There was a box fan facing her bed that was observed dusty with the left side of the fan missing a cover and exposing the fan blade. The blinds in Resident 111's room were broken with missing pieces to where spaces were left when the blinds were closed. An observation was conducted of Resident 111's room on 4/1/25 at 12:06 p.m. The box fan still contained dust and had the missing cover that exposed the fan blade. The blinds remained broken with missing pieces. 2. An observation was conducted of Resident 30's room on 3/31/25 at 11:08 a.m. There were broken blinds with missing pieces to where spaces were left when the blinds were closed. An observation was conducted of Resident 30's room on 4/1/25 at 12:06 p.m. The blinds remained broken with missing pieces. 3. An observation was conducted of Resident 115's room on 3/31/25 at 11:13 a.m. There were broken blinds with missing pieces to where	F 0921	F921 The facility will ensure a safe, comfortable, and homelike environment. 1. Resident #111 room had the fan removed and blinds replaced. Resident #30's blinds were replaced. Resident #115's blinds were replaced. Resident's fall mat was dusted. 2. All residents have the potential to be affected. A complete audit of all blinds, fall mats and fans were conducted to ensure they were dust free and in good repair. No concerns were noted. See below for corrective measures. 3. The staff was educated on the need to keep a homelike environment including keeping items dust free like fans and fall mats as well as ensuring blinds are not broke. 4 4. The administrator or designee will conduct rounds twice a day ensuring blinds are not broke, fans are in good repair and no dust, and fall mats are free of dust. The administrator or designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment	04/09/2025

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	spaces were left when the blinds were closed. An observation was conducted of Resident 115's room on 4/1/25 at 12:07 p.m. The blinds remained broken with missing pieces. 4. An observation was conducted of Resident 17's room on 3/31/25 at 11:11 a.m. There was a fall mat folded up and located to the side of the residents' back, while they were lying in bed, filling the space between the side of the bed and the wall. There was a layer of dust on the top of the folded up fall mat. An environmental tour was conducted with the Housekeeping Supervisor and the Maintenance Director on 4/1/25 at 2:50 p.m. Resident 111's room was noted with broken blinds and the box fan containing dust built up along with the missing piece that exposed the fan blade. Resident 30's room was noted with broken blinds. Resident 115's room was noted with broken blinds. Resident 17's room was noted with the fall mat folded up along the side of the bed in between the bed and the wall. The fall mat had a layer of dust at the top. The Maintenance Director indicated he was new to the position, and he reached out to a staff member to see what size blinds were needed in Resident 111, 30, and 115's room to see if they had any spare blinds to replace them with. The Housekeeping Supervisor indicated she was not aware Resident 111 had a box fan in her room. The Housekeeping Supervisor indicated dusting items in the residents' rooms were a part of the daily cleaning. An interview conducted with the Nurse Consultant, on 4/1/25 at 3:30 p.m., indicated there was no policy regarding the homelike environment. The facility follows the regulations		D) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. If compliance is not obtained and maintained, the corporate regional will educate the administrator one on one regarding the importance of maintaining a homelike environment. Increased monitoring will also occur if warranted with the regional director conducting rounds weekly to ensure homelike environment is maintained. 5 5. The above corrective measures will be completed on or before April 9, 2025.	

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	regarding a homelike environment. 3.1-19(f)(5)			