STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155150	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COLUMBIA CITY SKILLED NURSING FACILITY	640 W ELLSWORTH ST COLUMBIA CITY, IN 46725

(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: September 26, 27, 28, and 29, 2023 Facility number: 000071 Provider number: 155150 AIM number: 100273140 Census Bed Type: SNF: 5 SNF/NF: 32 Total: 37 Census Payor Type: Medicare: 1 Medicaid: 21 Other: 15 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review compelted October 3, 2023	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for			

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

Laurie Barnes | Executive Director | 10/17/2023

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

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	each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review the facility failed to ensure dignity was provided for 2 of 8 residents reviewed (Resident 6 and Resident 12). Findings include:	F 0550	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction	10/20/2023

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	1. During an observation on 9/26/23 at 9:56 AM Resident 6 was observed lying in bed with a catheter bag hanging on the bedframe facing the doorway. Yellow liquid was visible in the bag from the hallway. Resident 6's record was reviewed on 9/27/23 at 9:26 AM. Diagnoses included malignant neoplasm of the upper outer quadrant of the left female breast, embolus and thrombosis of arteries of the extremities, and neuromuscular dysfunction of the bladder. A review of Resident 6's current quarterly Minimum Data Set (MDS) dated 8/2/23 indicated her Basic Interview for Mental Status (BIMS) score was 7 (cognitively impaired). The MDS indicated Resident 6 used an indwelling catheter. 2. During an observation on 9/26/23 at 9:54 AM, Resident 12 was observed lying in bed with a catheter bag hanging on the bedframe facing the doorway. Yellow liquid was visible in the bag from the hallway. During an observation and interview on 9/27/23 at 1:59 PM, yellow liquid was observed from the hall outside Resident 12's room in the catheter bag hanging from the side of the bed. The Director of Nursing (DON) indicated catheter bags should be covered and urine should not be visible from the hallway. Resident 12's record was reviewed on 9/29/23 at 9:19 AM. Diagnoses included chronic kidney disease, neuromuscular disease of the bladder, and age-related cognitive decline. A review of Resident 12's current quarterly		and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is October 20, 2023. **Facility is respectfully requested paper compliance for all deficiencies in this POC.** **F550** It is the intent of the is facility to ensure dignity is provided to residents with an indwelling foley catheter. **Corrective action for residents affected:** A privacy foley catheter cover was provided for residents 6 and 12 on September 27, 2023 by the DON, **How other residents of the facility were identified to potentially be affected by the practices are:** All residents with indwelling foley catheters or other means of urine collection have the potential to be affected by this alleged deficiency. An audit was completed on October 2, 2023, by the DON and privacy bags were provided. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur by.** The DON/Designee in-services	

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	Minimum Data Set (MDS) indicated his Basic Interview for Mental Status (BIMS) score was 1 (cognitively impaired). The MDS indicated Resident 12 used an indwelling catheter. A current policy titled Dignity dated 8/29/23 provided by the Director of Nursing on 9/27/23 at 2:35 PM indicated urinary drainage bags should not be uncovered and visible from the hall. 3.1-3(t)		nursing staff on or before 10/20/23 on the following: 1 Dignity 2 Catheters privacy covers. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the facility will monitor system:** The Director of nursing and or designee will conduct an audit of residents with catheters for dignity 5 times a week x 4 weeks, then 3 times a week for 4 weeks, then once a week x 6 months. If the facility is within 95% in compliance after the 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been 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.	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family			

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	members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on observation, interview, and record review the facility failed to ensure a private setting for a resident council meeting for 4 of 16 residents reviewed (Resident 9, Resident 11, Resident 15, and Resident 22).	F 0565	**F565** It is the intent of this facility to provide the residents a private setting to conduct resident council meetings. **Corrective action for residents affected:** Residents 9, 11, 15 and 22 were	10/20/2023

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	Findings include: During an observation on 9/26/23 at 1:40 PM, the Administrator introduced the resident council in a large open room on the lower level of the facility. The room contained an elevator and was open to a hallway where the kitchen, laundry, and housekeeping stations were located. A staff area was observed at the other end of the room. Residents 9, 11, 15 and 22 were introduced as the resident council. The Activity Director (AD) was present and was notified the meeting was private and no staff were to be present. On 9/26/23 at 1:50 PM, the Administrator and an unidentified female entered the room from the elevator and walked to the staff area. After a few minutes, they returned into the room and left the room via the elevator. Over the course of the meeting, the Regional Nurse Consultant, two unidentified dietary employees, an unidentified laundry aide, Housekeeper 5, and Qualified Medicine Aide 6 walked into the meeting area and used the elevator. The meeting was stopped with each interruption. In an interview on 9/26/23 at 2:25 PM, Resident 15 indicated staff should only be present in the council meetings if invited by the council. She indicated no staff were invited to be present at this meeting. Resident 9's record was reviewed on 9/29/23 at 10:08 AM. Diagnoses included type 2 diabetes, chronic kidney disease, and hypertension. A review of Resident 9's current quarterly Minimum Data Set (MDS) dated 6/28/23 indicated her Basic Interview for Mental Status (BIMS) score was 13 (mild cognitive impairment).		assessed on September 27,2023 with no negative outcome related to this deficient practice. This will be completed by the SSD/ACT on or before October 20, 2023. **How other residents of the facility were identified to potentially be affected by the practices are:** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. . **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The ADM/designee in-serviced all staff on resident rights to organize and participate in resident groups in the facility in private on or before October 20, 2023. The residents will be re-educated on their resident rights at the next resident council meeting. This will be completed by Activities on October 19, 2023. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the facility will monitor system:** The Activity Director and/or designee will conduct an audit monthly times 6 months to ensure the resident council meetings are held in private each month. If the	

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	Resident 11's record was reviewed on 9/29/23 at 10:01 PM. Diagnoses included chronic kidney disease, heart failure, unspecified, and chronic obstructive pulmonary disease. A review of Resident 11's current quarterly MDS dated 6/24/23 indicated her BIMS score was 11 (mild cognitive impairment). Resident 15's record was reviewed on 9/29/23 at 9:56 AM. Diagnoses included chronic obstructive pulmonary disease, peripheral vascular disease, and polyneuropathy. A review of Resident 15's current annual MDS dated 8/23/23 indicated her BIMS score was 15 (cognitively intact). Resident 22's record was reviewed on 9/29/23 at 10:04 AM. Diagnoses included displaced fracture of the base of neck of right femur, sequela, chronic pain syndrome, and major depressive disorder, single episode, unspecified. A review of Resident 22's current quarterly MDS dated 8/2/23 indicated her BIMS score was 15 (cognitively intact). In an interview on 9/26/23 at 2:30 PM, the AD indicated he was aware the resident council meeting should be held in a private area and not interrupted by staff. He indicated an empty resident room could have provided more privacy. In an interview on 9/28/23 at 2:49 PM, the Administrator indicated the resident council meeting should have been held in a more private space that was not prone to frequent staff use with a door that could be closed for privacy.		facility is within 95% compliance after the 6 months, monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been 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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	A current policy titled Resident Council Policy dated 2/9/16 provided by the Director of Nursing on 9/28/23 at 3:00 PM indicated the facility should provide a private space for resident meetings. 3.1-3(i)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other			

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	applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review the facility failed to ensure privacy of medical records for 2 of 5 residents reviewed (Resident 6 and Resident 10). Findings include: 1. During an observation on 9/27/23 at 8:54 AM a medication cart was unattended just outside the dining room with the computer screen open to Resident 10's information. Resident 10's picture, medication list and other medical information was visible. Licensed Practical Nurse (LPN) 2 returned to the cart at 8:57 AM. Resident 10's record was reviewed on 9/29/23 at 10:17 AM. Diagnoses included traumatic subarachnoid hemorrhage with loss of consciousness, unspecified duration sequela, type 2 diabetes mellitus without complications, and chronic kidney disease. A review of Resident 10's current quarterly Minimum Data Set (MDS) dated 6/28/23 indicated his Basic Interview for Mental Status (BIMS) score was 13 (mild cognitive impairment). 2. During medication pass observation on 9/27/23 at 9:21 AM, LPN 2 left the medication cart to wash her hands during medication preparation and left the computer screen open to Resident 6's information. Resident 6's picture, medication list	F 0583	**F583** It is the policy of this facility to adhere to all HIPPA compliance requirements in order to safeguard the PHI of all residents from unauthorized use or disclosure. **Corrective action for residents affected:** Facility has taken the necessary steps to ensure that HIPPA compliance has been maintained for Residents #6 and #10. Residents were assessed by the DON on September 28,2023, no negative outcome related to this deficient practice. **How other residents of the facility were identified to potentially be affected by the practices are:** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** An audit of all monitors was completed to ensure that all screens when not in use would	10/20/2023

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	and other medical information was visible. The medication cart was positioned in the hallway in full view of passersby. LPN 2 returned to the cart, finished preparing the medication and took it to the Resident 6's room. The computer screen remained open to Resident 6's personal information. Resident 6's record was reviewed on 9/27/23 at 9:26 AM. Diagnoses included malignant neoplasm of the upper outer quadrant of the left female breast, embolus and thrombosis of arteries of the extremities, and neuromuscular dysfunction of the bladder. A review of Resident 6's current quarterly Minimum Data Set (MDS) dated 8/2/23 indicated her Basic Interview for Mental Status (BIMS) score was 7 (cognitively impaired). In an interview on 9/27/23 at 9:30 AM, LPN 2 indicated she should have activated a locked screen to hide private health information when she was not directly attending to her medication cart. A current policy titled Dignity dated 8/29/23 provided by the Director of Nursing on 9/27/23 at 2:35 PM indicated residents should not have their personal information able to be viewed by passersby, including information displayed on a computer screen on a medication cart. 3-1(p)(5)		minimize or go blank. The DON and/or Designee will in-service the nursing staff on the “Dignity” policy and the residents right to privacy on or before 10/20/2023. Additionally, any employee who fails to meet the points of the in-service will be further educated/disciplined as indicated. The DON and/or Designee will audit medication cart computers for privacy five times weekly for four weeks, then 3 times a week for 4 weeks then weekly for 6 months. If the facility is within 95% compliance after the 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been 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.	
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills			

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	sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed ensure adequate staffing levels to implement fall prevention interventions and provide personal assistance preferred by the residents. for 4 of 6 residents reviewed (Resident 138, Resident 12, Resident 15, and Resident 30) Findings include: 1. On 9/26/23 at 10:46 AM, Resident 138's call light was observed to be on. On 9/26/23 at 10:53 AM, Resident 138's call light was answered by Certified Nurse Aide (CNA) 4.	F 0725	**F725** It is the intent of this facility to ensure adequate staffing levels are maintained to implement fall prevention interventions and provide personal assistance preferred by the resident. **Corrective action for residents affected:** Resident # 138 was changed on September 26, 2023, resident # 12's nails were trimmed on September 26,2023 resident #30 and 15 were assessed by the DON/designee and no negative	10/20/2023

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	CNA 4 was overheard telling Resident 138 they could not be changed due to the mechanical lift required 2 staff members. CNA 4 indicated the other nurse aid was on break. On 9/26/23 at 11:00 AM, CNA 4 was overheard telling Licensed Practical Nurse (LPN) 2 and LPN 3 Resident 138's call light had been activated repeatedly. CNA 4 indicated they could not assist Resident 138 due to the mechanical lift requiring 2 staff members and the other nurse aide being on break. 2. In an interview on 9/26/23 at 1:46 PM Resident 12's son indicated the facility has had issues with short staffing since the facility was bought by another company. The son indicated since the sale, Resident 12 had only received nail care at his request. He indicated Resident 12 had endured long wait times to get out of bed related to the resident required a mechanical lift for transfers that necessitated 2 staff members. Resident 12 often had to wait for as long as 2 hours for the availability of a second staff member to utilize the mechanical lift. Resident 12's son indicated the facility does not have enough nurses. The son indicated sometimes the QMAs must pass medicine before they can assist with personal care. 3. On 9/27/23 at 11:46 AM, Resident 30 was observed attempting to get up from their recliner. A housekeeper intervened and activated the call system. No nursing staff were observed in the hallway or at the nurse station. 4. In an interview on 9/27/23 at 12:44 PM, Resident 15, identified as interviewable by the facility, indicated they frequently had to wait 30-45 minutes to have their call light answered. Resident		outcome related to deficient practice were noted on September 26, 2023. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The ED will be re-educated relative to Sufficient Staffing by the RDO on or before October 19, 2023, including but not limited to provision of sufficient staffing based on resident acuity to meet the needs and preferences of residents. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the facility will monitor system:** ED/Designee will monitor staffing levels 5 days a week for 4 weeks, then 3 days a week for 4 weeks, then once a week x 6 months. If the facility is within 95% compliance after 6 months, the monitoring will be stopped. Results of the monitoring will be	

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	155150	A. BUILDING 00 B. WING	09/29/2023

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	15 indicated the facility was often short of help. A review of the Facility Assessment on 9/28/23 at 8:02 PM indicated the facility was to have direct care staffing as follows: Licensed nurses-Registered Nurse (RN) or Licensed Practical Nurse (LPN) 2 nurses on 1st shift (17-19 residents to each nurse) 2 nurses on 2nd shift (17-19 residents to each nurse) 1-2 nurses on 3rd shift (15-37 residents to each nurse) Nurse Aides- 1 aide to 10-12.5 residents on 1st shift 1 aide to 10-12.5 residents on 2nd shift 1 aide to 12-18.5 residents on 3rd shift A review of the facility's time cards for the week of 9/22/23-9/28/23 indicated the following: Friday 9/22/23 2nd shift: 1 RN- 3:45 PM-9:46 PM. No other Licensed Nurse was scheduled on the shift between 2 and 10 PM. Saturday 9/23/23 1st shift: 1 LPN-6:00-3:15 PM. No other Licensed Nurse was scheduled on the shift between 2 and 10 PM. Saturday 9/23/23 2nd shift: 1 RN 2:00 PM-10:00 PM. No other Licensed Nurse was scheduled on the shift between 2 and 10 PM. Sunday 9/24/23 1st shift: 1 LPN 6:00 Am-2:15 PM. No other Licensed Nurse was scheduled on the shift between 2 and 10 PM. Monday 9/25/23 2nd shift: 1 RN 2:00 PM-11:00 pm 2 CNAs 2:00 PM-10:00 PM 1 CNA 6:00 PM-10:00 PM. No other Licensed Nurse or CNA was scheduled on the shift between 2 and 10 PM. Tuesday 9/26/23 2nd shift 1 LPN 2:00 PM-10:00 PM		reviewed at the monthly QAPI meetings. Any concerns will have been 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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	1 RN 6:00 PM-10:00 PM. No other Licensed Nurse was scheduled on the shift between 2 and 10 PM. Wednesday 9/27/23 2nd shift 1 RN 6:00 PM-10:00 PM 1 RN 8:00 PM-11:00 PM. No other Licensed Nurse was scheduled on the shift between 2 and 10 PM. Thursday 9/28/23 2nd shift 1 RN 2:00 pm-10:30 PM 1 RN 6:00 PM-10:00 PM. No other Licensed Nurse was scheduled on the shift between 2 and 10 PM. In an interview on 9/29/23 at 12:29 PM, the Director of Nursing (DON) indicated the facility was attempting to hire nursing staff. The DON indicated the facility did not have a staffing policy. The DON indicated they were aware of 20 of 37 residents having had recent falls. The DON indicated there were 6 residents who required 2 staff members to transfer with mechanical lifts. 3.1-17(b)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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,			

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	identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility 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.			

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	§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, interview, and record review the facility failed to ensure infection prevention strategies were implemented consistently. 25 of 37 residents currently residing in the facility consume meals prepared in the kitchen. Findings include: During an observation beginning on 9/27/23 at 8:41 AM, Cook 8 was observed removing plates, cups, and silverware from tables with ungloved hands. No hand hygiene was observed during the process of removing items from each of the tables in the dining room. Cook 8 was observed wiping her hands on her uniform pants after handling dirty dishes used by a resident. After clearing the tables, Cook 8 picked up a cloth with sanitizer solution and wiped the tables. No hand hygiene was performed before or after wiping the tables. In an interview on 9/27/23 at 10:21 AM, Cook 8 indicated she had never worn gloves while bussing tables and had not thought about	F 0880	F880 It is the expectation of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases. **Corrective action for residents affected:** All residents were assessed and no negative outcomes related to this deficient practice by the DON/Designee on or before October 20, 2023. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility.	10/20/2023

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	performing hand hygiene because she used sanitizer solution on the tables. She indicated she didn't realize she had wiped her hands on her pants. During an observation and interview on 9/27/23 at 12:11 PM, an ice scoop was observed resting in the ice supply. Licensed Practical Nurse 3 indicated the ice scoop should have been placed in the cup next to the ice supply. During an observation on 9/27/23 at 12:13 PM Certified Nurse Aide 11 washed her hands for 11 seconds and delivered lunch trays to residents. On 9/27/23 at 12:16 PM, a portable oxygen tank attached to the back of an unidentified resident's wheelchair fell on the floor. Qualified Medicine Aide (QMA) 6 picked up the tank and placed it back on the chair. She then picked up a chair and placed it next to a table for a visitor. She then touched a resident's walker by the handles and pushed it toward a wall for storage. She went to a different resident's wheelchair, touched it on the handles and adjusted her chair to sit more squarely at the table. She then handed the resident her drinking cup. No hand hygiene between touching resident items and offering a resident their drinking cup. During an observation on 9/27/23 at 9:21 AM, Resident 138 approached Licensed Practical Nurse (LPN) 2 during medication pass. LPN 2 touched his IV tubing, the port cap, adjusted a mesh wrap to cover and secure it to his arm. She then opened the medicine cart drawer, handled an inhaler package and packages of medicine in pill form. She picked up a medicine cup with pills in it and placed it inside the medicine cart. After this, she washed her hands and returned to the		**The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The Dietary Manager/Designee will in-service the dietary staff on Hand Hygiene, use of gloves while removing dirty dished from tables and will sanitizing tables after meal service on or before 10/20/2023. Additionally, any staff that fails to comply with the points of this in-service will further educated/disciplined as indicated. The DON/Designee will in-service all staff on hand hygiene during meals service and during medication administration and replacing the ice scoop in the holder after use on or before 10/20/2023. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated.	

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	medicine cart. She took the medicine cup form the cart, added another pill, finished her preparation, and delivered it to Resident 6. LPN 2 did not perform had hygiene between touching the IV, the mesh wrap and handling medications. During an interview on 9/27/23 at 9:30 AM, LPN 2 indicated she should have secured the cup of medication in the cart and performed hand hygiene before touching resident 138 and performed hand hygiene again after contact with him before returning to the medication cart. In an interview on 9/28/23 at 2:49 PM the Administrator indicated hand hygiene should be performed between tasks involving different residents, after touching items that have been on the floor and before touching residents' dishes or utensils while providing dining assistance. She indicated hand hygiene should be performed after touching dirty dishes and utensils and before performing a cleaning task. Handwashing should also occur after contact with a resident. She indicated handwashing should include at least 20 seconds of washing. A current policy titled Hand Hygiene Guidelines, dated 8/21/13 provided by the Director of Nursing on 9/27/23 at 12:24 PM indicated when hands are visibly soiled or exposure to an organism is suspected hands should be washed with soap. The policy indicated handwashing should include rubbing hands together vigorously for at least 20 seconds. The Director of Nursing indicated she did not locate a policy for bussing tables in the dining room or a policy detailing additional handwashing opportunities. 3.1-18(l)			