STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WATERS OF GREENCASTLE, THE	1601 HOSPITAL DR GREENCASTLE, IN 46135

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00413552, IN00414142, IN00414261, and IN00414612 Complaint IN00413552 - No deficiencies related to the allegations are cited. Complaint IN00414142 - No deficiencies related to the allegations are cited. Complaint IN00414261 - No deficiencies related to the allegations are cited. Complaint IN00414612 - No deficiencies related to the allegations are cited. Survey dates: August 7, 8, 10, 11, 14, 15, 2023 Facility number: 000109 Provider number: 155202 AIM number: 100266290 Census Bed Type: SNF: 63 Total: 63 Census Payor Type: Medicare: 3 Medicaid: 50 Other: 10 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 24, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of the facts alleged 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 12, 2023. This provider respectfully request that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after September 12, 2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Etienne	Administrator	09/08/2023

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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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 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			

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	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 residents' rights to privacy and dignity were maintained for 3 of 3 residents when completing blood glucose testing (Residents 27, 41, and 52). Findings include: 1. On 8/7/23 at 11:28 a.m., Resident 27 was observed propelling herself down the main hallway, when Licensed Practical Nurse (LPN) 4 asked Resident 27 to stop at the medication cart to complete a blood glucose test (measures how much sugar was in the blood). LPN 4 donned (put on) gloves, without sanitizing her hands, retrieved a glucometer (a device for measuring the concentration of glucose (sugar) in the blood by using a small drop of blood, placed on a disposable test strip in the glucometer) from the medication cart, cleaned the glucometer machine with a disinfectant wipe, and placed the glucometer directly onto the medication cart, without a barrier. LPN 4 cleaned Resident 27's finger with an alcohol pad, pricked the resident's finger with a lancet, obtained a blood sample, completed the glucometer reading, cleaned the resident's finger with an alcohol pad, and then removed her gloves. LPN 4 with her bare hand, cleaned the glucometer with a disinfectant wipe, then placed the glucometer back into a container and then placed the container in a drawer in the medication cart. LPN 4 was not observed to sanitize her hands, during the blood glucose test. On 8/14/23 at 12:27 p.m., Resident 27's record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus (DM).	F 0550	**F550:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy of this facility to treat each resident with the highest degree of dignity, respect, and care that enhances their quality of life. At close of survey, residents # 27,41, and 52 interviewed and all denied feelings of infringement of their privacy/dignity. Education provided to Nurse #4 at time of survey related to preservation of privacy/dignity during blood glucose testing. **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:** All residents who have orders for blood glucose testing have the potential to be affected. All residents with orders for blood glucose testing will be included in compliance auditing. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	09/12/2023

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	A quarterly Minimum Data Set (MDS) assessment, dated 7/19/23, indicated the resident was cognitively intact and required supervision-oversight, encouragement, or cueing of one person for locomotion on and off the unit. A care plan, dated 7/9/21, indicated, the resident had a diagnosis of DM with risk for hypo/hyperglycemia (low/high blood sugar) with an intervention included, but not limited to, check blood sugar per physician order. A physician's order, dated initiated 7/9/21, indicated, blood glucose monitoring before meals and HS (bedtime) for the diagnosis of DM. 2. On 8/7/23 at 11:32 a.m., Resident 41 was observed propelling himself down the main hallway, when Licensed Practical Nurse (LPN) 4 asked Resident 41 to stop at the medication cart to complete a blood glucose test (measures how much sugar was in the blood). LPN 4 donned (put on) gloves, without sanitizing her hands, retrieved a glucometer (a device for measuring the concentration of glucose (sugar) in the blood by using a small drop of blood, placed on a disposable test strip in the glucometer) from the medication cart, cleaned the glucometer machine with a disinfectant wipe, and placed the glucometer directly onto the medication cart, without a barrier. LPN 4 cleaned Resident 41's finger with an alcohol pad, pricked the resident's finger with a lancet, obtained a blood sample, completed the glucometer reading, cleaned the resident's finger with an alcohol pad, and then removed her gloves. LPN 4 with her bare hand, cleaned the glucometer with a disinfectant wipe, then placed the glucometer back into a container and then placed the container in a drawer in the		Education to nurses and QMAs related to providing privacy and dignity during blood glucose testing was conducted on 8/7/2023 by the DON. Additionally, any staff that fails to comply with the points of this in-service will be further educated/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 DON or designee will perform observation audits of 5 residents with orders for blood glucose testing each week for 4 weeks, then three residents a week for four weeks and then 3 residents monthly for four months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can 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. **By what date will the systematic changes be completed:**	

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	medication cart. LPN 4 was not observed to sanitize her hands, during the blood glucose test. On 8/7/23 at 11:37 a.m., LPN 4 indicated, per the facility policy, staff were allowed to perform blood glucose testing on residents in the hallway. All residents have their own glucose meters. She had forgotten to wash her hands and should have washed or sanitize her hands between residents. Resident 41's record was reviewed, on 8/9/23 at 3:37 p.m. Diagnosis included, but was not limited to, diabetes mellitus (DM). A quarterly Minimum Data Set (MDS) assessment, dated 7/21/23, indicated the resident had a moderate cognitive impairment and required extensive assistance of one person for locomotion on the unit and limited assistance of one person for locomotion off the unit. A physician's order, dated 1/16/23, indicated blood glucose monitoring four times a day for the diagnosis of DM. A care plan, dated 1/17/23, indicated, the resident had a diagnosis of DM with risk for hypo/hyperglycemia (low/high blood sugar) with an intervention included, but not limited to, check blood sugar per physician order. On 8/8/23 at 8:28 a.m., the Administrator (ADM) indicated, staff were to complete accuchecks/blood glucose testing on residents in a private area for dignity. Staff should wash hands, when visibly soiled and before and after direct contact with residents. 3. On 8/07/23 at 11:56 a.m., observed Licensed Practical Nurse (LPN) 4, assisted Resident 52 in his wheelchair, from the main dining room, and		September 12, 2023	

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	wheeled him into the main hallway in front of the reception desk. LPN 4 donned gloves and cleaned a glucometer machine (an instrument for measuring the concentration of glucose in the blood) with disinfectant wipes. The nurse picked up the glucometer, a testing strip, and stuck the resident's finger with a lancet, obtained a blood sample and completed the glucometer reading. She cleansed the finger of the resident with an alcohol prep pad (a two-layer pad which contain 70% isopropyl alcohol. Prep Pads help clean the skin and can be used on cuts, scrapes, and abrasions prior to bandaging), and assisted the resident back to the dining room. On 8/14/23 at 11:43 a.m., record review resident had diagnoses of but not limited to, type 2 diabetes mellitus (DM), (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) dated 4/7/2022. Type 2 diabetes mellitus with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes) dated 7/26/2023. Physician orders, dated 8/1/23, NovoLOG FlexPen, (insulin medication) Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 100 - 120 = 0; 121 - 160 = 2; 161 - 200 = 4; 201 - 240 = 6; 241 - 280 = 8; 281 - 320 = 10; 321 - 360 = 12; 361 - 400 = 15 contact MD (medical doctor), subcutaneously before meals for DM subcutaneously At breakfast and Lunch for DM breakfast and lunch only. Do not give at qhs (at bedtime). A care plan, dated 10/12/22, indicated, the resident had a diagnosis of diabetes with risk for Hypo/or Hyperglycemia. Nursing intervention, dated			

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	10/12/22, check blood sugars per order. A Medicare 5-day Minimum Data Set Assessment (MDS), a standardized assessment tool that measures health status in nursing home residents, dated 7/28/23, indicated the resident was on insulin and had a diagnosis of type 2 diabetes mellitus. On 8/7/23 at 3:29 p.m., the Administrator provided an undated document titled, "Policy and Procedure Cleaning/Disinfecting/Maintaining Glucose Meters" and indicated this was the current policy of the facility. The policy indicated "...Procedure cleaning and disinfecting...4. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids. 5. Dispose of the towelette. 6. Obtain a second towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood borne pathogens. The meter must be maintained wet for 2 minutes with the Super Sani cloth wipe. When utilizing any other type of sanitizing (bleach) wipe, the meter must be maintained wet paper towelette manufacturer's recommendation. A 1/10 bleach solution requires a 10-minute contact time ...When glucometers are being discontinued from isolation, the glucometer is to be discarded in biohazard...10. Dispose of the used towelette. 11. Remove gloves. 12. Wash hands (may use ABHR [alcohol based hand rub])...." 3.1-3(a) 3.1-3(b)(1) 3.1-3(b)(1)(2)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment			

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	§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of			

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	comfortable sound levels. Based on observation, interview, and record review, the facility failed to provide comfortable water temperatures of more than 105 degrees Fahrenheit (F) and less than 115 degrees F in 8 of the 9 shared resident bathrooms on the secured memory care area observed for unsafe water temperatures. Findings include, During the initial tour, on 8/7/23 at 11:15 a.m., Resident 40 was observed standing at the sink in his shared bathroom. Steam was observed rising from the water, the resident indicated the water was too hot to touch. Water temperature was 129.6 Fahrenheit (F). Temperature with the Maintenance Director on 8/7/23 at 12:25 p.m. was 122.9 F. On 8/07/23 11:19 a.m., water temperature in the bathroom sink on the 100 hall was 129.0 F. A visitor observed steam rising from the water and the thermometer temperature and indicated it was too hot for Resident 63. On 8/07/23 at 11:36 a.m., water temperature in the bathroom sink shared between rooms 120 and 122 was 130.6 F. Temperature with the Maintenance Director on 8/8/23 at 9:48 a.m. was 100.3 F. On 8/07/23 at 11:53 a.m., water temperature in the bathroom sink shared between rooms 101 and 103 was 129.0 F. Temperature with the Maintenance Director on 8/08/23 at 9:49 a.m. was 103.4 F. On 8/07/23 at 11:57 a.m., water temperature in the bathroom sink shared between rooms 105 and 107 was 118.2 F. Temperature with the Maintenance	F 0584	**F584** – It is the intent of the facility to ensure to provide comfortable water temperatures of more than 105 degrees and less than 115 degrees F in the shared resident bathrooms on the secured memory care area to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 8/9/2023 the Maintenance Supervisor/designee made adjustments to the water system to ensure temperatures are between 105 and 115 degrees Fahrenheit in Resident room 40 (121) to meet set standards. The Administrator verified the work on 8/9/2023. b. On 8/9/2023 the Maintenance Supervisor/designee made adjustments to the water system to ensure temperatures are between 105 and 115 degrees Fahrenheit in the bathroom sink on the 100 hall to meet set standards. The Administrator verified the work on 8/9/2023. c. On 8/9/2023 the Maintenance Supervisor/designee made adjustments to the water system to ensure temperatures are between 105 and 115 degrees Fahrenheit in the bathroom sink shared between rooms 120 & 122 to meet set standards. The Administrator verified the work on 8/9/2023. d. On 8/9/2023 the	08/16/2023

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	Director on 8/08/23 at 9:54 a.m. was 101.2 F. On 8/07/23 at 12:06 p.m., water temperature in the bathroom sink shared between rooms 108 and the dining room was 124.5 F. Temperature with the Maintenance Director on 8/08/23 at 9:51 a.m. was 103.4 F. On 8/09/23 at 9:33 a.m., water temperature in the bathroom sink shared between rooms 124 and 126 was 104.4 F. On 8/09/23 at 9:31 a.m., Housekeeper 27 was observed cleaning a shared bathroom between rooms 120 and 122. She had not noticed the water temperature in the resident's bathrooms either being too hot or too cold, she used a special cleaner and did not usually turn on resident water in the sinks. During an interview on 8/08/23 at 9:57 a.m., the Maintenance Director indicated, he thought resident bathroom sink water temperatures were supposed to be between 110-120 F. He was not sure but would ask. He indicated he thought the fluctuations were due to residents getting showers and the holding tank. He had adjusted the water value the day before, but the difference in temperatures from hot to cooler could also have been from routine water use on the unit once residents got up in the morning and water being used during showers. During an interview on 8/08/23 at 10:24 a.m., Registered Nurse (RN) 11 indicated, she had never noticed the resident's bathroom water being too hot or tepid, she did not wash her hands in their bathrooms or assist them to wash their hands in their bathrooms.		Maintenance Supervisor/designee made adjustments to the water system to ensure temperatures are between 105 and 115 degrees Fahrenheit in the bathroom sink shared between rooms 101 & 103 to meet set standards. The Administrator verified the work on 8/9/2023. e. On 8/9/2023 the Maintenance Supervisor/designee made adjustments to the water system to ensure temperatures are between 105 and 115 degrees Fahrenheit in the bathroom sink shared between rooms 105 & 107 to meet set standards. The Administrator verified the work on 8/9/2023. f. On 8/9/2023 the Maintenance Supervisor/designee made adjustments to the water system to ensure temperatures are between 105 and 115 degrees Fahrenheit in the bathroom sink shared between rooms 108 and the dining room to meet set standards. The Administrator verified the work on 8/9/2023. g. On 8/9/2023 the Maintenance Supervisor/designee made adjustments to the water system to ensure temperatures are between 105 and 115 degrees Fahrenheit in the bathroom sink shared between rooms 124 & 126 to meet set standards. The Administrator verified the work on 8/9/2023.	

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	A Domestic Hot Water Temperature Log, Daily Check, dated July 2023, indicated 18 of 44 temperatures documented as being in resident rooms were between 115.1 - 127.1. There were no documented temperatures for weekend dates, or in the afternoon hours on Monday 7/17/23 and Tuesday 7/18/23. Form instructions indicated initial to right of row. There were no initials documented. During an interview with the Maintenance Director and Administrator (ADM) on 8/9/23 at 10:15 a.m., the Maintenance Director indicated he did not check water temperatures and record with a visitor on 8/7/23, then restated he had checked temperatures and observed some resident bathroom temperatures out of range but had not recorded them as he had already recorded temperatures in the morning on his log. The ADM indicated the water temperatures were supposed to run between 100 F - 120 F. On 8/9/23 at 11:57 a.m., the ADM provided Physical Plants--Daily Inspections instructions, undated, and indicated the instructions for Domestic Water Temperatures were currently to be followed by the Maintenance Director. The instructions indicated, "Take water temperature readings daily [once during morning rounds and once in the afternoon during the high usage times] from 1 area of each hot water system and document in the Domestic Water Temperature log to be kept on file." On 8/9/23 at 11:57 a.m., the ADM provided a blank Maintenance Supervisor Orientation Checklist, updated 3/26/21, and indicated the water temperatures section was the one currently to be followed by the Maintenance Director. The Specific Responsibilities and Duties indicated,		2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All resident rooms were checked and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 8/9/2023 the Administrator in-serviced the Maintenance Supervisor/designee on the requirement to provide the residents with comfortable water temperatures of more than 105 degrees and less than 115 degrees F in the shared resident bathrooms to meet set standards. b. Maintenance Supervisor/designee will conduct daily checks to ensure residents' water temperatures are more than 105 degrees and less than 115 degrees F in the shared resident bathrooms as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance	

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WATERS OF GREENCASTLE, THE	1601 HOSPITAL DR GREENCASTLE, IN 46135

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	"Water Temperatures 1. Check daily to maintain between 105 - 115 degrees. 2. Anything above 115 must be reported to Administrator and Vice President of Property Management immediately...." On 8/9/23 at 11:57 a.m., the ADM provided a copied paper, undated, and indicated it was a copy of the current state regulation regarding water temperatures. The regulation indicated, "Hot water temperatures for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred [100] degrees Fahrenheit and one hundred twenty [120] degrees Fahrenheit." 3.1-19(r)(1) 3.1-19(r)(2)		Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is** 8/16/2023**.**	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review, and interview, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) for 1 of 19 residents' MDS assessments reviewed (Resident 32). Findings include: On 8/9/23 at 11:30 a.m., Resident 32 was observed seated in a wheelchair with a urinary drainage bag hanging on the wheelchair with the drainage tube	F 0641	**F641:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy and practice of the facility to ensure the accuracy of the Minimum Data Set (MDS) per regulatory requirements. At time of survey, MDS for resident # 32 was reviewed and updated to reflect “not rated” for the suprapubic catheter.	09/12/2023

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	observed extending from underneath Resident 32's shirt to the drainage bag. Resident 32's record was reviewed on 8/10/23 at 2:25 p.m. The profile indicated, the resident had been admitted on 9/26/22, for diagnoses which included, but were not limited to, multiple sclerosis (disabling disease of the brain and spinal cord in which the immune system eats away at the protective covering of nerves) and neurogenic bladder (urinary condition in which a person lacks bladder control due to a brain, spinal cord, or nerve condition). A physician's order, dated 9/27/22, indicated Resident 32 had suprapubic catheter (a surgically created placement of a drainage tube into the urinary bladder and the skin used to drain urine from the bladder) and to change as needed for occlusion for the diagnosis of neurogenic bladder. A care plan, dated 9/27/22, indicated the resident had a diagnosis of neurogenic bladder with the need for a suprapubic catheter, with interventions included, but not limited to, catheter care every shift and as needed. A quarterly Minimum Data Set (MDS) assessment, dated 6/16/23, indicated the resident had an indwelling catheter and was always incontinent of bladder. During an interview, on 8/11/23 at 2:47 p.m., the MDS Coordinator indicated, the assessment, the assessment had been coded incorrectly. Resident 32 had a urinary catheter and was not incontinent of urine. She should have documented "not rated" for urinary incontinence on the MDS assessment.		**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:** All residents with urinary appliances have the potential to be affected. MDS review completed for those residents with urinary appliances. MDS assessments noted as accurate upon review. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** MDS nurse or designee will review new physician orders 5 days a week in efforts to capture changes and update the MDS accordingly. **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 MDS Nurse or designee will perform MDS audits for 5 residents with orders for urinary incontinence each week for 4 weeks, then three residents a week for 4 weeks weeks and then 3 residents monthly for 4 months. MDS or designee will report to the QAPI committee on a monthly basis for 6 months to assess need for ongoing auditing.	

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	On 8/11/23 at 3:20 p.m., the MDS Coordinator provided and identified a document as a current facility policy, titled, "CMS's (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, Section H0300," dated October 2019. The policy indicated, "...H0300 Urinary Continence...Coding Instructions...Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter...."		**By what date will the systematic changes be completed:** September 12, 2023	
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. (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,			

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	including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to ensure the care plans were revised for concerns and interventions for 3 of 19 residents' care plans reviewed (Residents 14, 41 and 32). Findings include: 1. On 8/08/23 at 10:15 a.m., during initial observation Resident 14, did not have a palm pillow (layers of MicroSpring Textile rolled to 1 1/2" think pillow prevents digging fingernails into palms. Adjustable soft band with Velcro) applied to the contracted (a permanent shortening (as of muscle, tendon, or scar tissue) producing deformity or distortion) left hand. The fingernails on the left hand were long and jagged and were pressing into the palm of the hand. On 8/09/23 at 11:30 a.m., observed the resident sitting in a wheelchair in the main dining room. Palm pillow was not applied to the left hand. Fingernails on both hands were long and jagged. On 8/10/23 at 10:00 a.m., observed the resident sitting in a wheelchair. The call light was placed on the left side of her upper left arm. The resident's left hand was contracted, palm pillow was not applied to the left hand. Fingernails of both hands were long and jagged. On 8/11/23 at 11:00 a.m., observed the resident sitting in a wheelchair. Palm pillow soft hand pillow device was applied to the contracted left hand. Fingernails on the right and left hands were cut to a level which prevented them from pushing into the palm of the hands.	F 0657	**F657:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy and practice of the facility to ensure all comprehensive care plan revisions per regulatory requirements. At time of survey, care plans for residents 14, 32, and 41 were reviewed and updated as warranted. **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:** All residents with palm pillow/splintlike devices, CPAP, and pressure injuries have the potential to be affected. Care plan review and audit completed for those residents with “palm pillows”, splints, CPAP, and pressure injuries. Care Plans updated as needed by the DON/Designee on 8/14/2023. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education provided on Care Plan	09/12/2023

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	On 8/10/23 at 11:40 a.m., medical record review. Diagnoses included but were not limited to vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) left side, contracture of the left wrist, and contracture of the left hand. A Physician's order, dated 6/29/22, indicated an order for, patient to wear " Palm Pillow" hand splint on the left hand at all times during day except for meals, hygiene care and ROM (range of motion) to prevent skin integrity issues and to help prevent further contractures. Instructions indicated to dry the resident's hand before applying splint each time and to monitor for any signs and symptoms of redness or swelling. On 8/10/23 at 10:04 a.m., Certified Nurse Aide (CNA) 10 indicated she had not seen a brace or splint on the residents left hand and it was not indicated on her assignment record. On 8/10/23 at 10:06 a.m., Registered Nurse (RN) 9 indicated she was a PRN (as needed) staff member, and she did not know if the resident was to have a palm pillow applied to her contracted left hand. On 8/10/23 at 10:09 a.m., the Director of Nursing (DON) indicated she did not know if the resident had an order for a palm pillow to be applied in her contracted left hand.		to the MDS Coordinator, DON and ADON on 8/16/2023 by the MDS Regional Consultant. All Clinical Staff was educated on device application and CPAP on 8/10/2023 by the DON. Any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. MDS nurse or designee will review new physician orders 5 days a week in efforts to capture changes and update care plans accordingly. **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 DON or designee will perform audits of the care plans of 5 residents with orders for “palm pillow”/splintlike devices, CPAP/BIPAPs, and pressure injuries each week for 4 weeks, then three residents a week for four weeks and then 3 residents monthly for four months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can 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	

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	A care plan, dated 6/9/2016, titled contracted left hand indicated the resident had a contracture of the left hand and arm, secondary to decrease mobility and history of CVA (cerebral vascular accident, stroke). Goal was for the resident to have no further contractures and the contracture to not worsen. Interventions included inform MD (medical doctor) of any changes to contracture, restorative care as needed, and therapy as needed. The care plan lacked documentation indicating an intervention of palm pillow or splint to the left hand. A quarterly Minimum Data Set (MDS) assessment a standardized assessment tool that measures health status in nursing home residents, dated 5/29/23, lacked documentation of palm pillow or anticontracture splint to contracted left hand. An annual MDS, dated 2/1/23, lacked documentation of palm pillow to contracted left hand. On 8/10/23 at 3:08 p.m., the MDS nurse indicated section O of the MDS, restorative services would identify a brace or splint that were being used for the resident. She indicated she was not aware the resident had an order for a palm pillow and had not identified it on the MDS. 2. On 8/8/23 at 11:44 a.m., Resident 41's CPAP mask was observed unbagged on the resident's bed. Resident 41 indicated, he used the CPAP machine with the mask every night to help him breath while sleeping. On 8/11/23 at 10:59 a.m., Resident 41's CPAP mask was observed unbagged on the nightstand. On 8/11/23 at 11:28 a.m., the Director of Nursing (DON) indicated, Resident 41 wore the CPAP throughout the day, when he was napping and		by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date will the systematic changes be completed:** September 12, 2023	

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	took it off and put it on by himself. The facility needed to educate staff and the resident to bag the CPAP mask when not in use. Resident 41's record was reviewed, on 8/9/23 at 3:37 p.m. The profile indicated the resident had been admitted to the facility, on 1/16/23, for diagnoses included, but were not limited to, dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), sleep apnea (sleep disorder in which breathing repeatedly stops and starts) and chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe). A quarterly Minimum Data Set (MDS) assessment, dated 7/21/23, indicated the resident had a moderate cognitive impairment, was an extensive assistance of one person for bed mobility, limited assistance of one person for transfers, and an extensive assistance of one person for personal hygiene. A physician's order, dated 1/16/23, indicated CPAP at bedtime for the diagnosis of sleep apnea. A sleep apnea care plan, initiated on 1/27/23 and revised on 3/30/23, with interventions included, but not limited to, keep head of bed raised as tolerated and oxygen per physician's order and a goal of the resident would be free of respiratory distress, lacked documentation or interventions for the CPAP usage. On 8/14/23 at 11:10 a.m., the DON indicated, the resident should have CPAP interventions for the			

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	sleep apnea care plan. The CPAP should be bagged and stored per the facility policy. On 8/14/23 at 11:53 a.m., the DON provided and identified an undated document as a current facility policy, titled, "Continuous Positive Airway Pressure (CPAP)." The policy indicated, " ...Purpose: To improve ventilation on patients with obstructive sleep apnea (OSA), airway obstruction and upper airway resistance...15. When the CPAP machine is not in use the face mask is stored in a plastic bag at the bedside ...." 3. Resident 32's record was reviewed, on 8/10/23 at 2:25 p.m. The profile indicated the resident had been admitted to the facility, on 9/26/22, with diagnoses included, but not limited to, quadriplegia (paralysis that affects all a person's limbs and body from the neck down), multiple sclerosis (progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue) and had an unstageable pressure ulcer (an ulcer that has full thickness tissue loss but is either covered by extensive necrotic tissue or by an eschar [dead tissue that has fallen off (sheds) from healthy skin]) to the right gluteal fold/perineum (the horizontal skin crease that forms below the buttocks, separating the upper thigh from the buttocks and the tiny patch of sensitive skin between the genitals and anus) and was on hospice (end of life) services. A quarterly Minimum Data Set (MDS) assessment, dated 6/16/23, indicated the resident had a moderate cognitive impairment, was an extensive assistance of two persons for bed mobility, toilet use, dressing, and personal			

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	hygiene, was total dependence of two persons for transfers and bathing, was on hospice services, and had a pressure ulcer. A physician's order, dated 8/2/23, indicated to apply Triad Hydrophilic wound paste topically to the pressure ulcer and cover with a bandage in the evening for wound care. A skin and wound progress note, by the wound nurse practitioner, dated 7/11/23 at 9:47 a.m., indicated the resident had a pressure ulcer to the perineal/buttocks that had separated into 2 areas as the wound was healing with epithelial tissue (new skin tissue) separating the wound beds and was classified as a stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle). A pressure ulcer to the perineum care plan, initiated on 9/28/22 and revised on 11/28//22, with a goal of wound will not show signs/symptoms of infection and will improve with next review had interventions included, but not limited to, complete wound treatment per physician's order and resident to be followed by the wound nurse practitioner. The care plan lacked documentation of interventions for the wound separation into 2 areas of the wound. On 8/14/23 at 10:53 a.m., the MDS Corporate Consultant indicated, since Resident 32 was admitted with the stage 4 pressure ulcer, even though it split it would still be listed as 1 pressure ulcer. There should be a more specific care plan for the pressure ulcers. The Director of Nursing (DON), on 8/14/23 at 12:20 p.m., provided and identified a document as a current facility policy, titled, "Baseline Care Plan			

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	Assessment/Comprehensive Care Plans," dated 11/25/17. The policy indicated, "...Policy...The Comprehensive Care Plan will further expand on the resident's risks, goals, and interventions using the 'Person-Centered' Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs...The facility Interdisciplinary team in conjunction with the resident, resident's family, surrogate or representative as appropriate along with a 'hands on' caregiver, such as a Certified Nursing Assistant will discuss and develop quantifiable objectives along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable for the resident...9. The Comprehensive Care plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues...." 3.1-35(a) 3.1-35(c)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to trim the fingernails of a resident's contracted hand to prevent the nails from pressing into the palm of the hand for 1 of 24 residents reviewed for activities of daily	F 0677	**F677:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	09/12/2023

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	living (Resident 14). Finding includes: On 8/08/23 at 10:15 a.m., during initial observation Resident 14, did not have a palm pillow (layers of MicroSpring Textile rolled to 1 1/2" think pillow prevents digging fingernails into palms. Adjustable soft band with Velcro) applied to the contracted (a permanent shortening (as of muscle, tendon, or scar tissue) producing deformity or distortion) left hand. The fingernails on the left hand were long and jagged and were pressing into the palm of the hand. On 8/09/23 at 11:30 a.m., observed the resident sitting in a wheelchair in the main dining room. Palm pillow was not applied to the left hand. Fingernails on both hands were long and jagged. On 8/10/23 at 10:00 a.m., observed the resident sitting in a wheelchair. The call light was placed on the left side of her upper left arm. The resident's left hand was contracted, and palm pillow was not applied to the left hand. Fingernails of both hands were long and jagged. On 8/11/23 at 11:00 a.m., observed the resident sitting in a wheelchair. Palm pillow soft hand pillow device was applied to the contracted left hand. Fingernails on the right and left hands were cut to a level which prevented them from pushing into the palm of the hands. On 8/10/23 at 11:40 a.m., Resident 14's medical record was reviewed. Diagnosis included but were not limited to vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), anxiety (a feeling of fear, dread, and		**practice:** It is the practice of the facility to ensure ADL care for residents is performed per regulatory requirements. At time of survey, fingernails for resident # 14 were trimmed shorter. It is to be noted that upon trimming there was no redness, nail imprints, or loss of skin integrity noted to palms of hands prior to trimming. **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:** All residents with contractures have the potential to be affected. Fingernail length for residents with contractures audited on 8/10/2023 by the DON/Designee and were found within acceptable limits at time of survey. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Education provided by the DON/Designee on 8/10/2023 to nursing staff related to acceptable nail length for residents and the process of trimming nails. 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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	uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) left side, contracture of left wrist, and contracture of left hand. On 8/08/23 at 10:32 a.m., Certified Nurse Aide (CNA) 7 indicated showers were given one to two times per week. The shower schedule information was provided on the pocket worksheet of the CNA. The CNA indicated Resident 14's nails were trimmed on shower days and the CNA's were only allowed to trim the fingernails. If the resident was a diabetic the nurse would cut their nails. On 8/09/23 at 11:43 a.m., CNA 13 indicated showers were given two days a week depending on the resident's schedule. The information was provided on the CNA assignment sheet and the fingernails would be trimmed on the resident's shower day. Diabetic resident's fingernails were cut by the nurse. The podiatrist would cut the toenails of the diabetic residents. On 8/15/23 at 10:15 a.m., the facility Administrator provided an undated document titled "Nail Care", and indicated, this is the current policy of the facility. The policy indicated. "Policy...This includes clean, smooth nails at a well-groomed safe length acceptable to the resident...NOTE: ONLY A LICENSED NURSE CAN TRIM THE NAILS OF A DIABETIC RESIDENT...Procedure...9. Trim nails and file for smoothness as needed...14. Document on ADL worksheets or PCC...." 3.1-38(a)(3)		**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 DON or designee will perform audits of fingernail length for 5 residents each week for 4 weeks, then three residents a week for four weeks, and then 3 residents monthly for four months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can 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. **By what date will the systematic changes be completed:** September 12, 2023	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medication was labeled properly for 2 of 2 medication carts and 1 of 2 medication storage rooms reviewed for medication storage (Resident 8 and 24), and the facility failed to ensure expired medications were disposed of for 1 of 2 medication storage rooms reviewed. Findings include:	F 0761	**F761:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy and practice of the facility to ensure injectable medications are stored and labeled in accordance with	09/12/2023

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	1a. On 8/10/23 at 9:31 a.m., the closed unit medication cart contained 2 undated and opened insulin (medication used to lower blood sugar) pens. The insulin pens contained labels that indicated they were ordered for Resident 24. During an interview, on 8/10/23 at 9:32 a.m., Registered Nurse (RN) 11 indicated insulin pens were supposed to have an open date on them and were good for 28 days once they were opened. She was not aware of the date Resident 24's insulin pens were opened. She would dispose of the pens in the medication cart and get new ones from the medication storage refrigerator. Resident 24's record was reviewed on 8/10/23 at 10:03 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A physician order, dated 7/4/23, indicated Levemir (insulin medication) 100 unit/ml (milliliter), by subcutaneous (under the skin) injection. Inject 10 units at bedtime. A physician order, dated 7/7/23, indicated Novolog (insulin medication) 100 unit/ml, by subcutaneous injection per sliding scale two times a day. 1b. On 8/11/23 at 9:30 a.m., the medication cart on the east wing of skilled unit contained an undated and unopened insulin pen. The insulin pen contained a label that indicated it was ordered for Resident 8. During an interview, on 8/11/23 at 9:32 a.m., Assistant Director of Nursing (ADON) indicated the insulin pen should remain in the refrigerator		regulatory requirements. At time of survey, noted injectable medications (insulins, flu shots, aplisol) were removed and discarded per protocol. **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:** All medication storage areas audited at close of survey with all areas (carts/medication rooms) in compliance. Nurses and QMAs educated on 8/10/2023 by the DON/Designee related to appropriate storage, labeling, and expiration dates for injectable medications. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses and QMAs educated related to appropriate storage, labeling, and expiration dates for injectable medications by the DON/Designee on 8/10/2023. Night shift nurse(s) and QMAs will audit injectable medications in medication carts and medication rooms nightly for expiration, labeling, and appropriate storage of injectable medications. Additionally, any staff that fails to comply with the points of this in-service will be further	

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	until opened and once opened should be labeled with the date. She indicated insulin was good for 28 days once opened. She was unaware of how long Resident 8's insulin pen had been in the cart, but it was delivered to the facility from the pharmacy on 8/4/23. Resident 8's record was reviewed on 8/11/23 at 11:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Type 2 diabetes mellitus. A physician order, dated 5/24/23, indicated Semglee (insulin medication) 100 unit/ml by subcutaneous injection. Inject 54 units subcutaneously at bedtime. 2. On 8/10/23 at 9:35 a.m., the closed unit medication storage room contained an opened and undated multi use vial of Aplisol (a sterile aqueous solution of a purified protein fraction for intradermal administration as an aid in the diagnosis of tuberculosis) solution. During an interview, on 8/10/23 at 9:35 a.m., RN 11 indicated the Aplisol vial should be dated when it was opened. She was unaware of how long the solution was good for once it was opened. She indicated the solution was used by the facility for new admissions. During an interview, on 8/10/23 at 1:30 p.m., Director of Nursing (DON) indicated the Apilsol vial should be dated by staff when it was opened. She was not aware of how long the solution was good for once it was opened. During an interview, on 8/10/23 at 3:04 p.m., Administrator (ADM) indicated the Aplisol solution was good for 30 days from the open date.		educated/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 DON or designee will perform audits of the medication storage areas 5 times each week for 4 weeks, then three times a week for four weeks and then 3 times monthly for four months. . If the facility is within 95% compliance at the end of the 6 months; then monitoring can 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. **By what date will the systematic changes be completed:** September 12, 2023	

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	The facility follows manufacturer guidelines for medication use, labeling, and storage. 3. On 8/10/23 at 9:35 a.m., the closed unit medication storage refrigerator contained 6 prefilled syringes of flu vaccine. The vaccines had an expiration date of 6/30/23. During an interview, on 8/10/23 at 9:35 a.m., RN 11 indicated she was unaware there were flu vaccines in the refrigerator, and they should have been disposed of due to it being past the expiration date. On 8/10/23 at 1:20 p.m., the ADM provided and identified an undated document as a current facility policy, titled, "Guidelines for Insulin Pens." The policy indicated, " ...Procedure:..3. Upon opening for the first time, the insulin pen will have a date sticker applied ...The date will reflect the date the seal was broken for use ...6 ...Insulin pens will be considered expired after 28 days ...." On 8/10/23 at 1:20 p.m., the ADM provided and identified a document as a current facility policy, titled, "3.1: Medication Storage in the Facility," dated March 2023. The policy indicated, " ...14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock by the facility ...." 3.1-25(j) 3.1-25(o)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements.			

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	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. A. Based on observation, interview, and record review, the facility failed to ensure proper handwashing in the kitchen, and sanitary practices while pureeing foods and measuring the temperature of food to be served from the kitchen, during 4 of 4 kitchen observations. This deficient practice had the potential to effect 11 of 11 residents who received pureed food, and 63 of 63 residents who received food from the kitchen. B. Based on observations, interview, and record review, the facility failed to use proper hand hygiene when 3 certified nursing aides (CNA's) were observed assisting 6 residents to eat during 1 of 2 dining room observations (Residents 34, 36, 14, 30, 9, and 37). Findings include:	F 0812	**F812:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy and practice of the facility to ensure proper handwashing and hand hygiene during meal preparation and while assisting residents to eat during meals in accordance with regulatory requirements. At time of survey, all staff were educated on the protocol and skills check off for appropriate handwashing/hand hygiene during meals and food preparation.	09/12/2023

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	A1. During a random continuous observation of the kitchen, on 8/7/23 from 10:07 a.m. to 10:31 a.m., Dietary Aide 5 was observed taking a soiled drinking pitcher from the dining room window and without wearing gloves, removed the soiled straw by the mouthpiece and tossed it in an open garbage container positioned partially under a stainless steel drain board (area for scraping or rinsing food into garbage containers or disposer). Dietary Aide 5 loaded a plastic rack with soiled dishes and ran it through the dishmachine (warewashing machine). She then went to the refrigerator and removed a drink pitcher and poured an unidentified pink liquid into multiple clean plastic glasses being prepared for the next meal. Dietary Aide 5 went back to the dishwashing area and scrubbed out a soiled pan. She then set up drinks and prepared trays with cereal, napkins, and silverware on lunch meal trays. Dietary Aide 5 was not observed to be wearing gloves or to wash her hands during the observation as she moved back and forth between the dirty dishmachine area and clean food preparation areas where she assisted the day cook by touching items on the counters and in the refrigerator, clean glasses, trays, and silverware. On 8/7/23 at 10:10 a.m., Dietary Aide 5 indicated as there were just 2 staff members in the kitchen at this time, she was responsible for washing dishes and helping with whatever was needed in the kitchen. On 8/7/23 at 10:10 a.m., a garbage container in the kitchen was positioned partially under a stainless steel drain board in the dirty dishmachine area, the lid was on the ground under the drain board against the wall. Subsequent observations of the kitchen on 8/10, and 8/14 indicated the garbage container with soiled paper products and food,		**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:** All residents have the potential to be affected. At time of survey, clinical staff was educated on the protocol and skills check off for appropriate handwashing/hand hygiene during meals. This was completed on 8/7/2023 by the DON/Designee for all clinical staff. Dietary staff was educated on the protocol and skills check off for the appropriate handwashing/hand hygiene and kitchen sanitation rules during food preparation. This education was provided by the Dietary Manager on 8/30/2023. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff were educated on the protocol and skills check off for appropriate handwashing/hand hygiene during meals and food preparation processes. Clinical staff educated on 8/7/2023 by the DON/Designee. Kitchen Staff educated on 8/30/2023 by the Dietary Manager. All Staff educated on 8/17/2023 by the Administrator. Additionally, any staff that fails to comply with the	

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	was never observed to be covered with a lid. On 8/10/23 at 11:01 a.m., Dietary Aide 18 was observed to be making peanut butter and grape jelly sandwiches. She then removed her gloves, threw the gloves and other items into an open garbage container, then moved the garbage container underneath the drain board with her bare hands. Dietary 18 then returned to the workstation, poured leftover jelly into a pan, covered the pan with plastic wrap, and placed the pan in the refrigerator. She was not observed to wash her hands after removing her gloves, touching the garbage container, and then pouring the jelly into a pan and placing it in the refrigerator. On 8/10/23 at 11:03 a.m., Cook 19 was observed to enter the kitchen, walk through the food preparation area, entered the dietary office, and back to the food preparation area where she obtained and donned a hair net from a cabinet containing spices. Cook 19 was observed to wash her hands, she turned the faucets on and off with her bare hands. Observation of the dietary staff washing their hands, indicated, a. On 8/10/23 at 1:47 p.m., Dietary Aide 19 was observed to wash her hands, she turned the faucets on and off with her bare hands. Subsequent observations of hand washing on this date at 1:53 p.m., 1:58 p.m., and 2:02 p.m., she was observed to turn the faucets on and off with her bare hands. b. On 8/10/23 at 2:08 p.m., Dietary Aide 5 was observed to wash her hand for less than 5 seconds, she turned the faucets on and off with her bare hands. c. On 8/10/23 at 2:08 p.m., Dietary Aide 20 was		points of this in-service will be further educated/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 Dining Manager, DON or designees will perform audits of appropriate handwashing/ hand hygiene during the meal preparation process and assistance with feeding residents 5 times each week for 4 weeks, then three times a week for four weeks and then 3 times monthly for four months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can 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. **By what date will the systematic changes be completed:** September 12, 2023	

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	observed to wash his hands, he turned the faucets on and off with his bare hands. A second observation of the dietary staff washing their hands, indicated, a. On 8/14/23 at 10:23 a.m., Dietary Aide 5 was observed to wash her hands, she turned the faucets on and off with her bare hands. b. On 8/14/23 at 10:24 a.m., Cook 19 was observed to wash her hands, she used a towel to dry her hands, used the same wet paper towel to turn off the faucets. She was not wearing a hair net. c. On 8/14/23 at 10:32 a.m., Cook 19 was observed to wash her hands, she used a towel to dry her hands, used the same wet paper towel to turn off the faucets. She was observed to then don a hair net. d. On 8/14/23 at 10:37 a.m., Cook 19 was observed to wash her hands, she used a towel to dry her hands, used the same wet paper towel to turn off the faucets. e. On 8/14/23 at 10:40 a.m., Dietary Aide 20 was observed to wash his hands, he used a paper towel to dry his hands, used the same wet towel to turn off the faucets. A handwashing poster taped above the kitchen handwashing sink indicated, wash your hands with soap and water for at least 20 seconds, there were no further instructions. During an interview on 8/14/23 at 10:43 a.m., the Dietary Manager (DM) indicated staff were required to have hair nets on before entering the kitchen that was why hair nets were stored outside the kitchen for easy access. Proper hand washing procedure included turn on the water with a dry paper towel, let the water flow a few seconds to clear the water and bring it up to temp, wash hands for 20 - 30 seconds, leave water			

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	running while using a paper towel to dry hands, then turn off faucets with a new dry paper towel. Staff were to make sure hands were dry before donning gloves, and hands were to be washed every time gloves were changed. The dishwasher was to wash their hands between washing dishes and helping in the rest of the kitchen, as they were going from dirty to clean areas. The garbage containers were supposed to always have a lid on when not in use. A2. On 8/14/23 at 10:20 a.m., Cook 19 was observed mixing food in a large metal bowl, indicated she was making spaghetti sauce for dinner. The cook was not wearing a hair net. On 8/10/23 at 2:10 p.m., Cook 19 was observed to check the temperature of and puree beef stroganoff for dinner. She was observed to remove a food thermometer from a basket that contained items to include thermometers, pens, and scissors. Cook 19 was not observed to clean the thermometer before putting it into the beef stroganoff and temping the food at 164 degrees Fahrenheit (F), she indicated it should be 165 F. Food temperatures were not observed to be logged. On 8/14/23 at 10:30 a.m., Cook 21 was observed checking the temperature of meat in the oven. She was observed to clean a thermometer by rubbing an alcohol prep up and down the thermometer probe, then laid the thermometer on a food tray on the island among other cooking utensils without replacing the thermometer probe cover. Cook 21 demonstrated the technique for cleaning a food thermometer and checking the temperature of meat. Indicated, remove thermometer cover, and clean the probe with an alcohol prep. Place the			

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	probe into the center of product, wait until the digital numbers stop moving, then clean probe ready for next temp. Demonstrated cleaning thermometer probe by running alcohol prep up and down the probe multiple times. On 8/14/23 at 10:39 a.m., Cook 21 was observed checking the temperature of a tray of meat, she did not clean the thermometer after having been laid without the probe cover on a tray among other cooking utensils. She was observed to remove a second tray of meat from the oven, put the meat into a metal pan and placed it on the steam table, she was not observed to check the temperature of the 2nd tray of meat. The food temperatures were not observed to be logged. On 8/14/23 at 11:03 a.m., review of food temperature logs with the DM, dated 8/7/23 - 8/14/23. The food temperature logs lacked documentation of temperatures observed for lunch food on 8/14/23 that had been observed being placed on the steam table. The DM indicated, cooks were only documenting final temperatures before food was served, they did not document holding temperatures. DM indicated she had been instructed by a regional supervisor, only final temperatures needed logged, they were not required to log holding temps. Acknowledged, by using this process, cooks would have no way of knowing if food dropped below acceptable holding temperatures, or if the food would need to be re-heated or re-cooked. Food temperature logs, dated 8/7 - 8/14, indicated the column titled final internal preparation temperatures were filled out with food temperatures. The 2 columns titled meal service holding temps were blank on all forms. The forms also lacked re-temping documentation, time food			

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	temperatures were checked, or initials of person temping the food as instructed on the form. During an interview on 8/14/23 at 10:43 a.m., the DM indicated, when the cook was checking the temperatures of food, the thermometer was calibrated every day to reset by putting the thermometer into cold and hot water. The food thermometer was cleaned before and after temping food with alcohol wipes or with sanitizer. The entire thermometer was to be cleaned from the top (handheld area) to tip of the probe, then cleaned with a 2nd wipe from probe to tip. The cleaning prep was not to be rubbed up and down, potentially re-contaminating the probe. Let the thermometer dry before use. Probe was inserted into the thickest part of the food, wait for the digital temperature to stop, and record the temperature on the food log. If food was not hot enough, the food was to be reheated and re-temped before being placed on the steam table or being served. The thermometer was to be stored in the thermometer sleeve between uses, it was not appropriate to lay the thermometer down without the cover on the counters or among other kitchen items where it could get exposed to contaminants. The cook was supposed to check the temperature of food when placing it on the steam table, every 30 minutes while holding, and again before serving. Food on the steam table was not supposed to be held for more than 2 hours or if the food dropped below 135 F. Food temperatures were supposed to be logged every time taken. If food temperatures dropped below 135 F on the steam table, the food must be tossed and recooked. On 8/14/23 at 3:15 p.m., the Regional Director of Operations indicated, to his knowledge the dietary staff did not calibrate the food thermometer before			

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	using to temp food, they just turned it on and used. There was no policy, procedure, or staff training documentation on calibrating or cleaning of the food thermometers. A3. Dining room mealtimes were posted at dining room entrance, indicated breakfast at 6:45 a.m., lunch at 11:45 a.m., and dinner at 4:45 p.m. On 8/10/23 at 11:15 a.m. Cook 19 indicated she tried to have all food pureed for the evening meal by 2:00 p.m. On 8/10/23 at 2:10 p.m., Cook 19 was observed to scoop beef stroganoff into a metal container to puree and put the remaining pan of stroganoff onto the steam table. Cook 19 scooped the stroganoff into a blender using a rubber spatula, turned on the blender, checked the consistency of the stroganoff, then retrieved 2% milk from the refrigerator at the prompting of the Administrator (ADM) and added it to the puree mixture. Cook 19 then used the rubber spatula to scrape the stroganoff from the blender into a pan, used her finger to remove the stroganoff from the spatula into the pan, and removed food that was on the rim of the pan with her finger and put it into the pan. Cook 19 was observed to wear the same gloves from the time she took the stroganoff from the oven, through the pureeing process, while retrieving milk from the refrigerator, and while scooping food with her fingers into the serving pan. She was not observed to replace her gloves or wash her hands during the observation. On 8/14/23 at 1:46 p.m., ADM provided copy of pureed list of residents, indicated on this date there were 11 residents receiving pureed diets. There were no residents receiving nutrition via tube feeding, and 52 residents were receiving			

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	regular diets. During an interview on 8/14/23 at 10:43 a.m., the DM indicated when the cook pureed vegetables, she was required to first assure the internal temperature of the food. Food was then taken and put into the food processor, food was pulsed to texture, she was to follow the recipe for what was used to thin food as needed, re-temp the food after adding liquid, and if food was too thin add bread. The food was scooped out of the food processor into a metal pan and placed on the steam table. Staff were not allowed to use their hands to scoop food off the spatula or outside of pan to put excess food into the pan that was to be served to residents. On 8/11/23 at 2:30 p.m., the ADM provided a Monitoring Food Temperatures for Meal Service policy, dated 2017, and indicated the policy was the one currently being used by the facility. The policy indicated, "Food temperatures will be monitored daily to prevent food borne illness and to ensure foods are served at palatable temperatures...2. The temperature for each food item shall be recorded on the Food Temperature Log. Foods that require a corrective action, like reheating; will have the new temperature recorded on the log...3. Proper procedures are used to ensure measured temperatures are accurate and contamination is avoided. a. A properly functioning, calibrated thermometer is used when taking temperatures...b. Thermometers are clean, rinsed, and sanitized before and after each meal use. An alcohol swab may be used to sanitize between uses during the same meal. c. When taking temperatures, the thermometer is inserted in the thickest part of the food...4. If hot food is not 135 F or higher when checked, they will be reheated to at least 165 F for a minimum of 15			

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	seconds. The item may be reheated only once and must be discarded or consumed within 2 hours..." Indiana State Department of Health, Food Protection Program (October 29, 2022), also retrieved 8/16/23 at United States Dietary Association (USDA.gov), indicated instructions for thermometer calibration by using the ice point method when placing thermometer into a container of ice water at 32 F, or boiling point method when putting thermometer into water that reaches a complete "rolling boil" at 212 F. Either method should permit calibration to within 1.0 F. "Remember: sanitize thermometers before use and in between uses, and calibrate thermometers frequently". Retail Food Establishment Sanitation Requirements, effective November 13, 2004, hand cleaning and drying procedure indicated clean hand and exposed portions of arms with a cleaning compound at a handwashing sink that is equipped as specified, by vigorously rubbing together the surfaces of their lathered hands and arms for at least 20 seconds. Hands should be washed after handling soiled surfaces, equipment, and utensils. During food preparation, as often as possible to remove soil and contamination and to prevent cross-contamination when changing tasks, when touching food and food-contact surfaces, before placing gloves on hands, and after engaging in other activities that contaminate the hands. B1. On 8/7/23 at 12:00 p.m., during the noon meal service observed Certified Nurse Aide (CNA) 3 feeding Resident 34 while feeding a second resident at the same time. The CNA failed to disinfect her hands between residents. The admission date of resident 34 was on 9/20/22. A quarterly Minimum Data Set (MDS) assessment (a			

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	standardized assessment tool that measures health status in nursing home residents), dated 7/3/23, indicated the resident required extensive assistance of one person to eat. On 8/7/23 at 12:00 p.m., during the noon meal service observed CNA 3 feeding Resident 36 while feeding a second resident at the same time. The CNA failed to disinfect her hands between residents. The admission date of resident 36 was on 3/12/21. A quarterly MDS, dated 5/29/23, indicated the resident required extensive assistance of one person to eat. B2. During an observation of lunch dining service in the main dining room, on 8/7/23 at 12:06 p.m., Certified Nursing Assistant (CNA) 24, assisted Residents 14 and 30 with eating their food, without hand sanitation and after touching the residents' clothing, the residents' wheelchairs, and wiping her hands on her pants, after giving bites of food to the residents. B 3. During an observation of lunch dining service in the main dining room, on 8/7/23 at 12:09 p.m., Certified Nursing Assistant (CNA) 16, assisted Residents 9 and 37 with eating their food, without hand sanitation and after touching the residents' clothing, the residents' wheelchairs, and wiping her hands on her pants and touching her face, after giving bites of food to the residents. On 8/8/23 at 8:35 a.m., the Administrator (ADM) indicated staff should sanitize their hands with alcohol-based hand gel between assisting each resident with their meal. At that time, the ADM provided and identified an undated document as a current facility policy, titled, "Dignity." The policy indicated, "...As an extension of appropriate interactions between staff and residents, the following will be practices of the			

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	facility...Dining...10.) When feeding resident(s), only 2 resident can be fed at once. Hand hygiene must take place if staff touch one of these residents; prior to going back to assisting the other of the two residents...." 3.1-21(a)(2) 3.1-21(i)(1) 3.1-21(i)(3)			
F 0826 SS=D Bldg. 00	483.65(b) Rehab Services Physician Order/Qualified Pers §483.65(b) Qualifications Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. Based on observations, record review and interviews, the facility failed to ensure the licensed occupational therapist had the knowledge, competencies to enter a completed physicians order into the medical record of 1 of 24 residents reviewed (Resident 14). Finding Includes: On 8/8/23 at 10:15 a.m., during initial observation Resident 14 did not have a palm pillow (layers of MicroSpring Textile rolled to 1 1/2" think pillow prevents digging fingernails into palms. Adjustable soft band with Velcro) applied to the contracted (a permanent shortening (as of muscle, tendon, or scar tissue) producing deformity or distortion) left hand. The fingernails on the left hand were long and jagged and were pressing into the palm of the hand. On 8/9/23 at 11:30 a.m., observed the resident sitting in a wheelchair in the main dining room.	F 0826	**F826:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of the facility to ensure knowledge of licensed therapist to enter therapy orders accurately. At time of survey, therapist was educated on the process of order entry. The order for resident # 14 was reviewed and clarified for accuracy. **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:** All residents that have orders for	09/12/2023

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	Palm pillow was not applied to the left hand. Fingernails on both hands were long and jagged. On 8/10/23 at 10:00 a.m., observed the resident sitting in a wheelchair. The call light was placed on the left side of her upper left arm. The resident's left hand was contracted, palm pillow was not applied to the left hand. Fingernails of both hands were long and jagged. On 8/11/23 at 11:00 a.m., observed the resident sitting in a wheelchair. Palm pillow soft hand pillow device was applied to the contracted left hand. Fingernails on the right and left hands were cut to a level which prevented them from pushing into the palm of the hands. On 8/10/23 at 11:40 a.m., medical record review. Diagnoses included but were not limited to vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), anxiety (a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress), hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) left side. Contracture of left wrist, contracture of left hand. A Physician's order dated 6/29/22 indicated, an order for, patient to wear " Palm Pillow" hand splint on the left hand at all times during day except for meals, hygiene care and ROM (range of motion) to prevent skin integrity issues and to help prevent further contractures. Instructions indicated to dry the patient's hand before applying splint each time. Please monitor for any signs and symptoms of redness or swelling. On 8/10/23 at 10:04 a.m., Certified Nurse Aide		therapy have the potential to be affected. At time of survey, review of orders for “palm pillows” and splintlike devices for accuracy was completed by the DON on 8/15/2023. Orders noted as accurate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Therapists (PT, OT, ST) were educated on the process of order entry to ensure order accuracy by the DON on 8/15/2023. Additionally, any staff that fails to comply with the points of this in-service will be further educated/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:** DON or designee will perform audits of new therapy orders 5 times each week for 4 weeks, then three times a week for four weeks and then 3 times monthly for four months. . If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been	

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	(CNA) 10 indicated she had not seen a brace or splint on the residents left hand and it was not indicated on her assignment record. On 8/10/23 at 10:06 a.m., Registered Nurse (RN) 9 indicated she was a PRN (as needed) staff member, and she did not know if the resident was to have a palm pillow applied to her contracted left hand. On 8/10/23 at 10:09 a.m., the Director of Nursing (DON) indicated she did not know if the resident had an order for a palm pillow to be applied in her contracted left hand. On 8/11/23 at 9:55 a.m., the Occupational Therapist (OT) indicated, she entered a physician's order for Resident 14 for something that was for both anticontracture and to prevent the nails from digging into resident's palm. She indicated she was not sure what she had originally ordered and would look at her original notes. The OT reviewed the care notes and the physician's order and acknowledged she entered a physician's order for a palm pillow splint and had not been instructed on how to enter an order into Point Click Care, which enabled the staff to document the order as completed in the medical record. She indicated she would enter a physician's order into the medical record and would print a copy of the physician's order for the physician to sign and would notify the nurse of the new physician's order. On 8/11/23 at 12:28 p.m., the OT provided a copy of the progress notes for Resident 14, dated 6/25/22 and 6/27/23, and indicated the resident was to have a palm pillow to prevent hands from becoming irritated from fingers and nails. She indicated she was focusing on the contracture of		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. **By what date will the systematic changes be completed:** September 12, 2023	

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	the arm and not so much on the hand. The OT indicated she was a Licensed Occupational Therapist and was authorized to enter telephone and verbal physician orders into the resident's medical record. She indicated she had an approval relationship with the physician, and she could enter orders without first notifying the physician and he would sign the order when he came into the facility. A care plan, dated 6/9/2016, titled contracted left hand indicated the resident had a contracture of left hand and arm secondary to decrease mobility and history of CVA (cerebral vascular accident, stroke). The care plan lacked documentation indicating an intervention of palm pillow or splint to the left hand. A Quarterly Minimum Data Set (MDS) assessment a standardized assessment tool that measures health status in nursing home residents dated 5/29/23, lacked documentation of palm pillow or anticontracture splint to contracted left hand. The annual MDS dated 2/1/23, lacked documentation of palm pillow to contracted left hand. On 8/10/23 at 3:08 p.m., the MDS nurse indicated section O of the MDS, restorative services would identify any brace or splints being used for the resident. She indicated she was not aware the resident had an order for a palm pillow and had not identified it on the MDS. On 8/11/23 at 1:40 p.m., the facility Administrator provided a document titled "PHYSICIAN ORDERS - (FOLLOWING PHYSICIAN ORDERS)" dated, July 2017 and indicated it was the current policy of the facility. "...Policy It is the policy of the facility to follow the orders of the physician...Procedure...2. As assessments are			

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	completed, orders will be received from the physician to address significant findings of the assessments...4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility...." 3.1-23(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, 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			

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	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. §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			

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	necessary. A. Based on observation, interview, and record review, the facility failed to ensure proper handling of oral and eye drop medication for 2 of 2 residents observed during the medication administration observation (Residents 63 and 42). B. Based on observation, interview, and record review, the facility failed to ensure hand sanitization was performed in between glucometer blood testing for 3 of 3 residents observed during medication administration (Residents 52, 27, and 41). Findings include: A1. During a medication administration observation, on 8/10/23 at 9:14 a.m., RN 11 was administering eye drops to Resident 63. The RN administered the eye drops to the resident with her bare hands. The resident received a drop in each eye and the nurse touched underneath each eye with her bare finger. During an interview, on 8/10/23 at 11:40 a.m., Director of Nursing (DON) indicated she would need to pull the policy on rather staff were to wear gloves during eye drop administration. Resident 63's record was reviewed on 8/10/23 at 3:30 p.m. The profile indicated the resident's diagnosis included, but were not limited to, unspecified glaucoma (a group of eye conditions that can cause blindness). A physician order, dated 6/20/23, indicated Alphagan P Ophthalmic Solution 0.1% (eye drop medication for glaucoma), instill 1 drop in both eyes two times a day.	F 0880	**F880:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy and practice of the facility to ensure proper handwashing and hand hygiene during medication administration and performance of blood glucose testing in accordance with regulatory requirements. At time of survey, staff were educated on the protocol for appropriate handwashing/hand hygiene during medication administration and performance of blood glucose testing by the DON/Designee. Resident 63, 42, 52, 27, and 41 were assessed and no negative outcome were noted. **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:** All residents have the potential to be affected. At time of survey, staff were educated on the protocol for appropriate handwashing/hand hygiene during medication administration and performance of blood glucose testing. On 8/7/2023 LPN #4 was specifically educated by the DON. On 8/7/2023 all nurses and QMA's	09/12/2023

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	A2. During a medication administration observation, on 8/10/23 at 9:25 a.m., RN 11 was preparing oral medications for Resident 42. The RN placed a potassium pill into a cup and she touched the pill with her bare hands to break it in half. She placed water into the cup with the pill to help dissolve the pill. RN 11 indicated it helped the resident to swallow the pill if it was not whole. During an interview on 8/10/23 at 11:40 a.m., DON indicated staff was not to touch oral medication with their bare hands. Resident 42's record was reviewed on 8/10/23 at 2:57 p.m. The profile indicated the resident's diagnosis included, but were not limited to, hypokalemia (a blood level that is below normal in potassium, an important body chemical). A physician order, dated 4/12/23, indicated Potassium Chloride extended release 20 milliequivalent (meq), give 1 tablet by mouth two times a day. On 8/10/23 at 1:20 p.m., the Administrator (ADM) provided an undated document, titled, "Eye Medications, Administration of," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Procedure:1. Put on gloves ...." On 8/10/23 at 4:15 p.m., the ADM provided a document, dated March 2023, titled, "5.1: Drug Administration General Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...a. A tablet splitter is used to avoid contact with the tablets ...." B1. On 8/07/23 at 11:56 a.m., observed Licensed Practical Nurse (LPN) 4, assisted Resident 52 in		were given education on blood glucose testing by the DON/Designee. On 8/10/2023 all nurses and QMA's were educated on medication handling and eye drop administration by the DON/Designee. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff were educated on the protocol and skills check off for appropriate handwashing/hand hygiene during medication administration and blood glucose testing. On 8/7/2023 LPN #4 was specifically educated by the DON. On 8/7/2023 all nurses and QMA's were given education on blood glucose testing by the DON/Designee. On 8/10/2023 all nurses and QMA's were educated on medication handling and eye drop administration by the DON/Designee. Additionally, any staff that fails to comply with the points of this in-service will be further educated/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:** DON or designee will perform	

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	his wheelchair, from the main dining room, and wheeled him into the main hallway in front of the reception desk. The LPN donned (for "to (put) on") gloves and cleaned a glucometer machine (an instrument for measuring the concentration of glucose in the blood) with disinfectant wipes. The nurse picked up the glucometer, a testing strip, and a lancet and stuck the resident's finger with a lancet, obtained a blood sample and completed the glucometer reading. She cleaned the finger of the resident with an alcohol prep pad (a two-layer pad which contain 70% isopropyl alcohol. Prep Pads help clean the skin and can be used on cuts, scrapes, and abrasions prior to bandaging), and assisted the resident back to the dining room. The nurse failed to remove soiled gloves, sanitize hands and donned clean gloves prior to completing the blood glucose test. On 8/14/23 at 11:43 a.m., record review resident had diagnosis's of but not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) dated 4/7/2022. Type 2 diabetes mellitus with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes) dated, 7/26/2023. A care plan dated 10/12/22, indicated, the resident had a diagnosis of diabetes with risk for Hypo/or Hyperglycemia. Nursing intervention dated, 10/12/22 check blood sugars per order. B2. On 8/7/23 at 11:28 a.m., Resident 27 was observed propelling herself down the main hallway, when Licensed Practical Nurse (LPN) 4 asked Resident 27 to stop at the medication cart to complete a blood glucose test (measures how		audits of appropriate handwashing/ hand hygiene during medication administration and blood glucose testing 5 times each week for 4 weeks, then three times a week for four weeks and then 3 times monthly for four months. . If the facility is within 95% compliance at the end of the 6 months; then monitoring can 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. **By what date will the systematic changes be completed:** September 12, 2023	

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	much sugar was in the blood). LPN 4 donned (put on) gloves, without sanitizing her hands, retrieved a glucometer (a device for measuring the concentration of glucose (sugar) in the blood by using a small drop of blood, placed on a disposable test strip in the glucometer) from the medication cart, cleaned the glucometer machine with a disinfectant wipe, and placed the glucometer directly onto the medication cart, without a barrier. LPN 4 cleaned Resident 27's finger with an alcohol pad, pricked the resident's finger with a lancet, obtained a blood sample, completed the glucometer reading, cleaned the resident's finger with an alcohol pad, and then removed her gloves. LPN 4 with her bare hand, cleaned the glucometer with a disinfectant wipe, then placed the glucometer back into a container and then placed the container in a drawer in the medication cart. LPN 4 was not observed to sanitize her hands, during the blood glucose test. On 8/14/23 at 12:27 p.m., Resident 27's record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus (DM). A quarterly Minimum Data Set (MDS) assessment, dated 7/19/23, indicated the resident was cognitively intact and required supervision-oversight, encouragement, or cueing of one person for locomotion on and off the unit. A care plan, dated 7/9/21, indicated the resident had a diagnosis of DM with risk for hypo/hyperglycemia (low/high blood sugar) with an intervention included, but not limited to, check blood sugar per physician order. A physician's order, dated initiated 7/9/21, indicated blood glucose monitoring before meals and HS (bedtime) for the diagnosis of DM.			

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	B3. On 8/7/23 at 11:32 a.m., Resident 41 was observed propelling himself down the main hallway, when Licensed Practical Nurse (LPN) 4 asked Resident 41 to stop at the medication cart to complete a blood glucose test (measures how much sugar was in the blood). LPN 4 donned (put on) gloves, without sanitizing her hands, retrieved a glucometer (a device for measuring the concentration of glucose (sugar) in the blood by using a small drop of blood, placed on a disposable test strip in the glucometer) from the medication cart, cleaned the glucometer machine with a disinfectant wipe, and placed the glucometer directly onto the medication cart, without a barrier. LPN 4 cleaned Resident 41's finger with an alcohol pad, pricked the resident's finger with a lancet, obtained a blood sample, completed the glucometer reading, cleaned the resident's finger with an alcohol pad, and then removed her gloves. LPN 4 with her bare hand, cleaned the glucometer with a disinfectant wipe, then placed the glucometer back into a container and then placed the container in a drawer in the medication cart. LPN 4 was not observed to sanitize her hands, during the blood glucose test. On 8/7/23 at 11:37 a.m., LPN 4 indicated, per the facility policy, staff were allowed to perform blood glucose testing on residents in the hallway. All residents have their own glucose meters. She had forgotten to wash her hands and should have washed or sanitize her hands between residents. Resident 41's record was reviewed, on 8/9/23 at 3:37 p.m. Diagnosis included, but was not limited to, diabetes mellitus (DM). A quarterly Minimum Data Set (MDS) assessment, dated 7/21/23, indicated the resident			

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	had a moderate cognitive impairment and required extensive assistance of one person for locomotion on the unit and limited assistance of one person for locomotion off the unit. A physician's order, dated 1/16/23, indicated blood glucose monitoring four times a day for the diagnosis of DM. A care plan, dated 1/17/23, indicated, the resident had a diagnosis of DM with risk for hypo/hyperglycemia (low/high blood sugar) with an intervention included, but not limited to, check blood sugar per physician order. On 8/7/23 at 3:29 p.m., the ADM provided and identified an undated document as a current facility policy, titled, "Policy and Procedure Cleaning/Disinfecting/Maintaining Glucose Meters." The policy indicated, "...The Glucose meters will be disinfected between each resident use to prevent the spread of microorganisms including blood borne pathogens...If a resident has their own meter, it still must be cleaned after each use...Two disposable wipes will be needed for each cleaning and disinfecting procedure; one wipe for cleaning and the second wipe for disinfecting...Note: Always create a dry 'barrier' between the meter and any surface on which it is placed during actual use or cleaning...Procedure: ...Cleaning and Disinfecting...1. Don nonsterile gloves...2. Inspect for blood/debris/dust/lint anywhere on the meter...3. Open the towelette container or package and remove one towelette...4. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids...5. Dispose of the towelette...6. Obtain a second towelette and wipe the entire surface of the meter 3 times horizontally and 3 times			

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	vertically to remove blood borne pathogens. The meter must be maintained wet for 2 minutes with the Super Sani cloth wipe...7. Once the exterior of the glucose meter has remained wet for the appropriate contact time, the meter may be wiped dry with a dry cloth...10. Dispose of the used towelette...11. Remove gloves...12. Wash hands (may use ABHR [alcohol-based hand rub]...." On 8/8/23 at 8:28 a.m., the Administrator (ADM) indicated, staff were to complete accuchecks/blood glucose testing on residents in a private area for dignity. Staff should wash hands, when visibly soiled and before and after direct contact with residents. The ADM, on 8/7/23 at 3:29 p.m., provided and identified a document as a current facility policy, titled, "Handwashing/Hand Hygiene," dated 2001. The policy indicated, "...This facility considers hand hygiene the primary means to prevent the spread of infections...2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: ...a. When hands are visibly soiled ...c. Before and after coming on duty ...7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...a. Before and after direct contact with residents...b. Before preparing or handling medications...c. Before performing any non-surgical invasive procedures...e. Before donning sterile gloves...h. After contact with a resident's intact skin ...i. After contact with blood or bodily fluids ...k. After contact with objects (e.g., medical equipment) in the immediate			

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	vicinity...l. After removing gloves...The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections...10. Single-use disposable gloves should be used: ...When anticipating contact with blood or body fluids...." 3.1-18(a) 3.1-18(b) 3.1-18(b)(1)			