STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155283	A. BUILDING 00 B. WING	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WINTERSONG VILLAGE	1005 SOUTH EDGEWOOD DRIVE KNOX, IN 46534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 7, 8, 11, and 12, 2022. Facility number: 000181 Provider number: 155283 AIM number: 100266860 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicare: 2 Medicaid: 24 Other: 4 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/15/22.	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.			

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

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	§483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to ensure residents were free from neglect related to care not provided to a dependent resident as requested for 1 of 1 residents reviewed for allegations of abuse/ neglect. (Resident 11) Finding includes: On 7/11/22 at 9:30 a.m., an allegation of abuse/ neglect that had been reported to the Indiana Department of Health, related to care not provided to a dependent resident as requested, was reviewed. The incident occurred on 2/10/22 on the midnight shift. The resident indicated two CNA's would not assist her to the bathroom. The resident was upset and had cried when she was checked on again the next morning. Both CNA's were suspended immediately and an investigation was initiated. The abuse/ neglect allegation investigation included interviews from the nurse on duty (LPN 1), CNA 2 and CNA 3, and 5 surrounding alert and orientated residents. An interview from LPN 1 on 2/11/22, without a time, indicated the resident was assessed after the two CNA's had reported they had refused to take her to the bathroom. Per LPN 1's assessment indicated there were "no negative findings and her vitals were clear." At 6:15 a.m. on 2/11/22, he and CNA 4 went to Resident 11's room, she had cried, told them that the two CNA's the previous evening refused to take her to the bathroom and she expressed she was very upset.	F 0600	It is the standard of this facility to ensure all residents are free from abuse and neglect and receive care as they request it. What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice: Resident 11 will receive care as requested and psychosocial follow up as needed. How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All Staff to be inserviced on the facilities abuse and neglect prohibition policy. All nursing staff inserviced on assisting with ADLs and the importance of charting. CNA charting is being checked for completion aprox. one hour before each shift ends by the charge nurse. SSD inserviced by the	08/12/2022

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	The follow up, dated 2/25/22, indicated the investigation was conducted. The resident was very weak the night of the incident and the two CNA's tried to transfer her, but could not. The nurse was notified, the resident was assessed and was without any negative findings. All clinical staff was educated on promoting resident independence. All staff was in-serviced on resident rights and abuse. Her care plan was updated as warranted for the Social Service Director (SSD) to monitor her for psychosocial well being. There was not a notation that the allegation of abuse was substantiated or unsubstantiated. Resident 11's record was reviewed on 7/11/22 at 9:45 a.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), heart failure and back pain. The Quarterly Minimum Data Set assessment, dated 2/3/22, indicated the resident was cognitively intact, interviewable, frequently incontinent of bowel and bladder, and she was an extensive, two person assist with toileting and transfers. She had an assistive device, a wheelchair. The documented bladder report was reviewed from 2/6-2/12/22. The pattern indicated that she frequently had to use the bathroom in the early mornings. On 2/10/22 at 5:26 p.m., she was incontinent of her bladder and nothing was documented until then the next morning at 5:01 a.m. and she was continent with her bladder. An SSD progress noted, dated 2/11/22 at 12:56 p.m., indicated she had spoken to the resident's family member regarding the incident that had		Administrator on assuring psychosocial documentation is completed and documented. How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An auditing tool was created to monitor all CNA Charting for accuracy & completion. The director of nursing/designee will review CNA charting 5 days a week for 8 weeks, Weekly for 8 weeks, and Monthly for 2 months. An auditing tool was created to monitor that all dependent resident are recieving ADls/Care as requested. The Director of Nursing/Designee will interview 10 residents weekly for 8 weeks, bi-weekly for 12 weeks, and monthly for 2 months. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly. Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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	occurred. The staff would continue to monitor the resident closely. The record lacked an indication that any psychosocial follow up had occurred with the resident. A discharge summary for Physical Therapy, dated 3/8/22, indicated the resident received therapy form 1/25/22 until 3/8/22. She was able to ambulate with assistance of 40 feet and with a wheelchair for safety. Interview with Resident 11 on 7/11/22 at 1:19 p.m., indicated she could not remember the complete details of 2/10/22. She did remember that she had been upset due to she reported something to the nurse the next morning. She did need assistance to use the bathroom, and was observed at the time sitting in her recliner with her wheelchair five feet from her. Interviews via the phone were attempted on 7/12/22 at 8:20 a.m. to CNA 2 and CNA 3. On 7/12/22 at the time of the exit conference at 4:31 p.m., the two CNA's had not returned the phone call. Interview with the Administrator on 7/12/22 at 1:07 p.m., indicated the allegation for abuse was unsubstantiated. It was more of a "misunderstanding," when the CNA's told the resident they were not comfortable getting her up to use the bathroom, and that part was believed to have occurred. In-services were conducted on 2/14/22 for the two CNA's involved. The inservices were on bedside manner, promoting resident independence, resident dignity, offer other modes of independence when the usual one was not feasible to use. All staff members were			

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	inserviced on Abuse Prohibition and Resident rights on 2/11/22 and 2/14/22. Interview with the SSD on 7/12/22 at 1:22 p.m., indicated she completed a check in with the resident. The outcome was not documented, but the resident was upset due to she wanted to go home, and her family was unable to take care of her needs. The current policy, titled, "Abuse and Neglect Policy," indicated "Each resident has the right to be free from abuse, neglect, and misappropriation of resident property ... Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness ...." 3.1-27 (a)(3)			
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the			

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	resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, record review, and interview, the facility failed to ensure a resident was free from physical restraints related to a harness not assessed as a physical restraint for 1 of 1 residents reviewed for physical restraints. (Resident 22) Finding includes: On 7/7/22 at 4:38 p.m., Resident 22 was observed seated in her wheelchair. She had an over the shoulder vest-like harness in place. On 7/11/22 at 9:11 a.m., Resident 22 was observed seated in her wheelchair. She had the over the shoulder harness in place. She was unable to independently remove the harness. The nurse then removed the harness and staff assisted her with transferring. On 7/12/22 at 8:07 a.m., Resident 22 was observed seated in her wheelchair waiting for breakfast to be served. She had the over the shoulder harness in place. Resident 22's record was reviewed on 7/12/22 at 12:19 p.m. Diagnosis included, but were not	F 0604	It is the standard of this facility to ensure all residents are free from unessessary physical restraints. What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice: Resident 22's restraint was assessed for neccesity and will assessed a minimum of at least quarterly How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents with restraints have the potential to be affected by this alleged deficient practice. No other resident were affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All nursing staff were inserviced on	08/12/2022

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	limited to, Parkinson's Disease, anoxic brain damage, and anxiety. The Annual Minimum Data Set assessment, dated 6/1/22, indicated the resident was cognitively impaired, was wheelchair bound, had impairments to both upper and lower extremities, and a trunk restraint was used daily. A current Care Plan indicated physical restraints were in use. The resident had a pommel cushion on her chair and a restrictive vest due to constant uncontrolled sporadic movements of trunk and extremities. The Physician's Order Summary, dated 7/2022, indicated "...may use 5-point harness restraint when up in the wheelchair for meals. Check restraint every hour while up..." The most recent restraint assessment was completed 7/12/21. Interview with the Administrator on 7/12/22 at 9:45 a.m., indicated the last assessment was completed 7/12/21. A restraint assessment should have been completed quarterly. Policy titled, "Restraint Use/Reduction," was provided by the Administrator on 7/12/22 at 9:39 a.m. This current policy indicated, "Policy...The use of a physical restraint will be reviewed by the interdisciplinary team...and at least quarterly thereafter...." 3.1-26 (a) 3.1-26 (r) 3.1-26 (s)		the facilities "restraint use/reduction" policy. All restraint assessments will be reviewed quartley with the residents quartley MDS, upon admission, re-admission and with any significant change How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An auditing tool to monitor restraint assesments was made. The DON/Designee will monitor all restraint assesments monthly for 8 months. Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, record review and interview, the facility failed to develop a comprehensive Skin Care Plan for a resident with a history of skin issues for 1 of 16 resident care plans reviewed. (Resident 12) Finding includes: On 7/11/22 at 9:22 a.m., Resident 12 was observed seated in his room. He had two foam dressings on his right arm and two on his left arm. Both arms had extensive discolorations. He indicated he had fallen and had skin tears and bruising. The resident's record was reviewed on 7/11/22 at 9:25 am. The resident was admitted to the facility on 1/28/22. Diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease and heart disease. The Quarterly Minimum Data Set (MDS) assessment, dated 5/7/22, indicated the resident was cognitively intact. The Skin Documentation book indicated the resident had bruising from a fall that was being monitored on 5/31/22, and resolved on 6/17/22. They were currently monitoring the skin tears and bruising from a fall that occurred on 7/3/22. The record lacked a care plan related to the skin issues and current interventions. Interview with the MDS Nurse on 7/11/22 at 3:00 p.m., indicated the resident should have skin care	F 0656	It is the standard of this facility to ensure all residents have appropriate care plans in place to address skin issues. What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice: Resident 12 will have the appropriate care plans put into place. How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: An audit was completed to ensure all residents residing in the facility have approprite care plans in place relating to skin issues. How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An auditing tool has been created to monitor all residents skin	08/12/2022

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	plan due to the frequent skin issues. 3.1-35(a)		assessments and ensure approprite careplans are in place. The director of nursing will audit skin assessments/concenrs weekly for 6 months. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly. Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations and wounds for 2 of 5 residents reviewed for non-pressure related skin conditions and not applying a resident's edema sleeve for 1	F 0684	It is the standard of this facility to ensure residents receive the necessary treatment and services related to the monitoring and assessment of skin discolorations and wounds. What corrective action(s) will be	08/12/2022

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	of 1 residents reviewed for edema. (Residents 16 and 2) Findings include: 1. On 7/8/22 at 10:29 a.m., Resident 16 was observed sitting in a wheelchair in her room. She had a dark purple discoloration across the top of her right hand. Her left hand was in a fist and had some swelling observed. The resident indicated she believed the discoloration was from a recent blood draw but not sure because she bruised all the time due to taking a blood thinning medication. She further indicated she can somewhat open her left hand and was supposed to wear a pressure glove on her hand. The glove was somewhere in her room and the staff were to help her put it on everyday. On 7/11/22 at 9:28 a.m., Resident 16 was observed sitting in a wheelchair in her room. The discoloration was still observed to the top of her right hand and her left hand was in a fist with some swelling observed. No sleeve or glove was observed to the resident's left hand. Record review for Resident 16 was completed on 7/11/22 at 9:36 a.m. Diagnoses included, but were not limited to, anemia, heart failure, atrial fibrillation, and generalized edema. The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/22, indicated the resident was cognitively intact. The resident required an extensive 1 person assist for bed mobility, locomotion, dressing and personal hygiene. She required an extensive 2+ assist for transfers, and toilet use. The resident had received an anticoagulant (blood thinning medication) during the assessment period.		accomplished for the residents found to have been affected by the deficient practice: Resident 16 will have glove/sleeve applied as ordered & tolerated. The TAR has had the daily skin inspection added to remind staff to complete. Resident 2 will have weekly skin assessment completed per protocol. The treatment to the Left ankle has been ??? How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents with skin discolorations or wounds have the potential of being affected by this alleged deficient practice. No other resident were affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All nursing staff inserviced on the importance of identifying skin issues and reporting to responible person. Nurses inserviced on the importance of moniotring skin conditions for resident receiving anticoagulants. Skin monitoring orders enterd into PCC Charting for all residents on anticoagulants. All Nursing staff were inserviced on helping residents with adative devices and ensuring are applied	

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	A Care Plan, dated 7/26/19, indicated the resident had potential for complications related to anticoagulant therapy. An intervention included to complete daily skin inspections and to report abnormalities to the nurse. The July 2022 Physician's Order Summary included the following orders: -Coumadin (blood thinning medication) 3 mg (milligrams) in the evening every Tuesday, Thursday, and Saturday -Coumadin 2 mg in the evening every Monday, Wednesday, Friday, and Sunday -Compression sleeve to be placed on left arm upon rising and to be worn 12 hours as resident allows. May keep at bedside and placed by CNA. Nurse to verify placement. The record lacked any documentation the resident's discoloration had been assessed or monitored. Interview with MDS Nurse on 7/11/22 at 10:30 a.m., indicated the resident was supposed to have the compression sleeve applied every day when she woke up and then taken off when she went to sleep. The staff should also have noticed the resident's discoloration with daily resident care. 2. On 7/11/22 at 12:25 p.m., Resident 2 was observed seated in her wheelchair near the Nurse's station. She had a white bandage in place to her left ankle. On 7/12/22 at 11:27 a.m., Resident 2 was observed seated in her wheelchair near the Nurse's station. She had a white bandage in place to her left ankle. Record review for Resident 2 was completed on 7/8/22 at 3:10 p.m. Diagnoses included, but were		as ordered & tolerated. DON/MDSC inserviced on the facility wound care policy, including assessing all wounds at least weekly with accompanying documentation How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An auditing tool was made to ensure residents on anticoagulants are having skin checked and monitored by the nurses. The Director of Nursing/Designee will audit nurses charting on residents order to have skin monitoring 5 times a week for 8 wekks, weekly for 12 weeks, and bi weekly for 4 weeks. An auditing tool was created to monitor resident with adaptive devices. Director of nursing /designee will audit to ensure staff are assisting resident with adaptive devices 5 times a week for 8 weeks, weekly for 12 weeks, and bi weekly for 4 weeks. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly. Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain	

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	not limited to, hypertension, anxiety disorder, and Alzheimer's Disease. The Quarterly MDS assessment, dated 4/12/22, indicated the resident was cognitively impaired. The resident required an extensive 2 + person assist for transfers, dressing, and personal hygiene. A current care plan indicated the resident was at risk for impaired skin integrity. Interventions included, "...daily skin observations by CNAs with daily care and showers...treatments as ordered...weekly skin assessments as indicated..." A Physician's Order, dated 6/26/22, indicated to apply betadine solution to the left ankle every evening for 14 days. The order was discontinued on 7/10/22. There were no further treatment orders for the left ankle. The Physician's Order Summary, dated 7/2022, indicated weekly skin assessments were to be completed on Mondays. The most recent Skin and Wound Total Body Skin Assessment was dated 5/16/22 and indicated the resident did not have any areas of skin impairment. The Skin Binder lacked any documentation of assessment or monitoring of the left ankle wound. The weekly skin assessment sheets, dated 6/2022 and 7/2022, had not been completed for 7/4, 6/27, 6/20, and 6/13. The 6/6/22 skin assessment indicated there were not new skin alterations but there was an existing area. There was no documentation of the existing area. The Quarterly Nursing Assessment, dated 7/2/22,		and maintain continued compliance.	

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	indicated there was a known area to the left ankle with a treatment in place. There was no further assessment or documentation of the wound. Interview with the MDS Nurse on 7/11/22 at 10:33 a.m., indicated the resident had an area to her left ankle for over 3 months. It first appeared to be a like a pimple, and they had tried various treatments to it, the most recent was betadine. She indicated she was not sure what the current treatment was, but the resident had a dressing on it yesterday. She was unsure if there was any skin monitoring sheet completed for the wound, but they were aware of the wound and had been treating it. A facility policy, titled "Skin Management Program," received as current, indicated, "...Residents who receive assistance with bathing and/or peri-care will be observed daily by nursing staff and any observance of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations in skin will be reported to the licensed nurse for further assessment...A resident with a newly identified skin condition will have the appropriate assessment ongoing monitoring form initiated on the basis of the type of skin condition...All flowsheets (both non-pressure and pressure) will be housed in the facility skin binder..." 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including			

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	tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to monitor oxygen saturations as indicated and failed to ensure oxygen was used as ordered for 2 of 2 residents reviewed for respiratory care. (Residents 4 and 24) Findings include: 1. On 7/12/22 at 9:13 a.m., Resident 4 was observed lying in her bed with her oxygen in place. The resident's record was reviewed on 7/12/22 at 10:26 a.m. The resident was admitted to the facility on 4/14/22. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and lung cancer. The resident received hospice services. The Admission Minimum Data Set (MDS) assessment, dated 4/21/22, indicated the resident was cognitively intact, and had not used oxygen within 14 days of admission. A Physician's Order, dated 4/18/22, indicated to use oxygen at 2-3 liters per minute to maintain oxygen saturation above 90%. There were no Physician orders how often to monitor the resident's oxygen saturation. The June and July 2022 Treatment Administration Record lacked documentation that oxygen had been used.	F 0695	It is the standard of this facility to monitor oxygen saturations as indicated and ensure oxygen is ordered as needed What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice: Resident 4 has orders in place that clarfiy how often to check her oxygen saturattion and the results are documented. The TAR has also been updated to reflect the residents oxygen use. Resident 2 will have O2 orders followed properly and saturation checked accordingly. How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents residing in the facility using O2 have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All nursing staff were inserivced on	08/12/2022

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	Interview with the resident on 7/12/22 at 12:43 p.m., indicated she used the oxygen when she felt dizzy or short of breath. Staff did not measure her oxygen saturations very often. Interview with RN 1 on 7/12/22 at 12:46 p.m., indicated the resident used the oxygen sometimes, she had it on this morning but took it off around 9:30 a.m. The nurse indicated she encouraged the resident to wear oxygen all the time. Interview with the MDS Nurse on 7/12/22 at 1:23 p.m., indicated she had contacted the hospice nurse and received clarification on the oxygen orders. She indicated the resident's oxygen levels should have been monitored regularly and they would begin to monitor every shift. 2. On 7/7/22 at 11:36 a.m., Resident 24 was observed lying in bed watching television. Oxygen was in place via nasal cannula. The oxygen concentrator flow rate was set to 1.5 liters. On 7/11/22 at 11:38 a.m., Resident 24 was observed lying in bed watching television. Oxygen was in place via nasal cannula. The oxygen concentrator flow rate was set to 2 liters. On 7/12/22 at 8:50 a.m., Resident 24 was observed sitting in his wheelchair watching television. Oxygen was in place via nasal cannula. The oxygen concentrator flow rate was set to 2 liters. Record review for Resident 24 was completed on 7/11/22 at 2:40 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), emphysema, and hypertension.		following dr orders in regards to O2. All nurses were inserviced on checking O2 saturation accordingly How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An auditing tool was made to monitor O2 orders and ensure saturation checks are being completed correctly. The director of nursing will review O2 orderes and monitor saturation checks 5 times a week for 8 weeks, weekly for 8 weeks and monthly for 2 months. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly. Date of Completion: 8/12/2022 Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/3/22, indicated the resident was cognitively impaired and received oxygen. A current Care Plan indicated the resident had shortness of breath while lying flat. Interventions included oxygen as ordered at 2 liters. The Physician's Order Summary, dated 7/2022, indicated an order to obtain oxygen saturation each shift and place 2 liters oxygen per nasal cannula if less than 90%. The Medication Administration Record and Treatment Administration Record, dated 7/2022, indicated the resident's oxygen saturation had never been under 93%. Interview with the Administrator on 7/12/22 at 10:24 a.m., indicated she would have the staff review the oxygen order. A facility policy, titled, "Oxygen, Moving Resident Within the Facility," received as current, indicated "...10. Adjust flow meter to appropriate liter flow. 11. Place oxygen administration device on resident..." 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of			

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	licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to have the daily nurse staffing postings up to date and available for review. This had the potential to affect all 30 residents residing in the facility. Finding includes: On 7/7/22 at 8:30 a.m., the facility nurse staffing posting was observed outside the Director of	F 0732	It is the standard of this facility to have the daily nurse staffing postings up to date and available for review What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice: No residents were affected by this alleged deficient practice. Nurse	08/12/2022

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	Nursing's (DON) office. It was dated 7/5/22. On 7/7/22 at 11:52 a.m., the facility nurse staffing posting was observed outside the DON's office. It was dated 7/5/22. On 7/7/22, the previous 30 days of nurse staffing postings were requested for review. Nurse staffing postings were provided for the following dates: 7/8, 7/7, 7/6, 7/5, 7/4, 6/19, 6/18, 6/17, 6/15, 6/14, and 6/13. Interview with the Administrator on 7/8/22 at 2:04 p.m., indicated the nurse staffing postings had not been completed daily. She was not aware the information had to be kept for 18 months.		Staffing Postings will be posted daily and kept for 18 months. How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: No residents have the potential to be affected by this alleged deficient practive. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All nurses were inserviced on 8/5/2022 in regards to the nurse staffing postings & requirements. System was put into place for daily completion by the night shift nurse. How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An Audit tool was created to monitor that the Nurse Staffing Posting is being completed and posted accordingy. Administrator/designee will ensure the nurse staffing posting is posted daily on business days for 8 weeks, weekly for 8 weeks, and monthly for 2 months. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly.	

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			Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications, related to laboratory tests not completed as ordered for 1 of 5 residents reviewed for unnecessary medications (Resident	F 0757	It is the standard of this facility to ensure all residents drug regimen is free from unessaesary drugs. What corrective action(s) will be accomplished for the residents	08/12/2022

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	31) Finding includes: Record review for Resident 31 was completed on 7/11/22 at 3:01 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, anxiety, and post traumatic stress disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 6/24/22, indicated the resident was cognitively moderately impaired. The July 2022 Physician's Order Summary included the following order: -CBC (complete blood count) and BMP (basic metabolic panel) laboratory tests to be done every 3 months in April, July, October, and January. The order was dated on 1/28/22. The record lacked any documentation the residents laboratory tests had been completed in April 2022. Interview with Administrator on 7/12/22 at 11:23 a.m., indicated the residents laboratory tests were not completed in April as ordered. She did not find his name in the lab book to be drawn that month. 3.1-48(a)(6)		found to have been affected by the deficient practice: Resident 31 now has laboratory work completed as ordered How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents with orders for laboratory testing have the potental to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All nursing staff were inserviced on importance of following doctors and the completetion of routine/nonroutine labs. How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: A monitoring tool was created to monitor all lab orders. The director of nursing/designee will monitor all lab orders and ensure they were completed as ordered Weekly for 3 months and bi-weekly for 3 months. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly.	

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			Date of Completion: 8/12/2022 Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	
F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food was prepared in form to meet individual needs related to incorrect consistency of the mechanical soft diet. This had the potential to affect 6 residents who received a mechanical soft diet. (Main Kitchen) Finding includes: On 7/11/22 at 12:01 p.m. Cook 1 was observed preparing the mechanical soft meat for lunch service. She placed the meat and gravy in the blender and turned the blender on. She turned the blender off, stirred the blended meat, and placed it in to a serving container. The meat was smooth and had a pudding like consistency, like pureed food. Interview with the Dietary Manager on 7/11/22 at 12:15 p.m., indicated the mechanical meat was not supposed to be pudding like and it appeared the gravy had been blended into it. The Cook should	F 0805	It is the standard of this facility to provide residents food in the form to meet their individual needs. What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice: No resident were affected by this alleged deficient practice. Kitchen staff will prepare mechanical soft meats properly and serve with gravy on top according to facility policy. How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents who receive a mechanical soft diet had the potential to be affected by this alleged deficient practice. No resident were affected by this	08/12/2022

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	have blended the meat without the gravy. Policy titled, "Mechanical Soft," was provided by the Dietary Manager. This current policy indicated, "...1. The purpose of this diet is to modify the texture of foods by chopping or grinding. 2. All meat items will grounded and served with gravy...." 3.1-21(a)(3)		alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All kitchen staff were inserviced on 8/5/2022 in regards to how to prepare and seve mechanical soft foods. How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An audit tool was created to monitor the preperation and serving of mechanical soft foods. Dietary Manager/Designee will monitor the preperation of mechanical soft foods 3 times a week for 8 weeks, Once a week for 8 weeks, and bi-weekly for 8 weeks. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly. Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

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	§483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food and utensils were properly stored under sanitary conditions in the freezers, refrigerators, and dry storage area for the Main Kitchen. This had the potential to affect 30 residents who received meals from the kitchen. (Main Kitchen) Findings include: 1. During the initial tour of the kitchen on 7/7/22 at 9:15 a.m. with the Dietary Manger, the following was observed: a. In the freezer: - Numerous boxes were stacked on the floor. - Numerous boxes and containers were stacked to the ceiling.	F 0812	It is the standard of this facility to ensure food and utinsels are stored properly under sanitary conditions to promote infection control and prevention. What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice: No residents were affected by this alleged deficient practice. The freezer no longer has boxes stacked on the floor or stacked to the ceiling. Expired foods were removed from the refrigerator. The oatmeal was discarded in the dry storage area and the plastic utensils are now contained. Food	08/12/2022

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	b. In the refrigerator: - A clear container labeled Tater Tot Casserole was dated 7/1 and use by 7/4. - A clear container labeled Pepper soup dated 7/3 and use by 7/6. - American cheese, not in its original packaging, was in clear Saran wrap labeled and dated 6/30 with a shelf life of 7/3. c. In the dry storage area: - A large container labeled Oatmeal, undated and was not in its original container. - Three boxes un-contained of plastic forks, spoons and knives. 2. During a lunch service observation on 7/11/22 at 11:22 a.m., Cook 1 had not properly sanitized the food thermometer or her hands with touching food and non food times. Cook 1 was observed taking the temperatures of the prepared foods without first sanitizing the food thermometer, Cook 1 took the temperature of the Swiss Steaks, then pulled out of the oven another tray of Swiss Steaks. She then rinsed the thermometer with water from the faucet and dried it with a paper towel. Next, she took the temperature of the carrots with the same thermometer, and placed the thermometer on the counter top. Cook 1 then went to the Dry storage and retrieved a large can of mushrooms, opened it with can opener, poured the mushrooms into the brown gravy, opened the drawer and retrieved a spoon. While touching the spoon portion, not the handle, with bare unsanitized hands, she stirred the carrots on the stove top. She then took the temperature of the mushroom gravy with the same unsanitized thermometer. She went to the sanitation bucket, wiped down the counter top and cleansed the thermometer with the same cloth. A test strip was		thermometers are now properly sanitized. Dietary staff now hold the utensils properly, use gloves and sanitize their hands. The sanitation bucket now maintains the proper PPM of sanitation. How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents residing in the facility had potential to be affected by this alleged deficient practice. No residents were affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All kitchen staff were inserviced on food storage guidelines, proper storage conitions for the freezer, refrigerator, dry food and utinsels, infection control practices (including handwashing, sanitizing thermometers and sanitation buckets) How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An auditing tool was created to monitor the storage of utinsels and food in the kitchen. The Dietary Manager will audit the kitchen for proper storgae of food/utinsels 2 times a week for 8 weeks, weekly for 12 weeks an monthly for 2 months. Any negative findings will	

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	placed in the sanitation bucket and the strip did not match any of the colors on the bottle to indicate the ppm (parts per million) for the proper sanitation level of 150 ppm. Cook 1 had asked the other staff in the kitchen when the sanitation bucket was last changed and no one had remembered. Cook 1 then used same thermometer that was cleansed with the wash cloth that was used to clean the counter top and from the unregistered sanitation level bucket, and took the temperature of the mashed potatoes. When completed, she used an alcohol prep pad and put the thermometer away. Cook 1 went to the dish storage area and brought a tray of bowls to the preparation counter. With the can opener attached to the counter top, Cook 1 opened a can of diced pears. Without properly sanitizing her bare hands, she opened the utensil drawer and pulled out a spoon touching the spoon portion and not the handle of the spoon. She then scooped out the diced pears with the spoon into 24 bowls. Cook 1 went back to the dry storage area and retrieved another can of dices pears, opened the can with can opener, using the same spoon, scooped out diced pears into 5 more bowls. She washed her hands with soap and water and placed the remaining container of diced pears into the refrigerator. Then without any hand sanitization, opened the utensil drawer, rummaged through the utensils touching the serving part of the utensils and placed certain utensils on a piece of aluminum foil for the plating of the food. Interview with Dietary Manager on 7/11/22 at 11:48 a.m., indicated the stock for storage came in on Tuesday and should have been stored off the floor and eighteen inches from the ceiling, the kitchen alcohol pads to cleanse the thermometer had ran out and had to go to the Nurses station to		be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly Date of Completion: 8/12/2022 Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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	retrieve more. Running water over the thermometer was not the proper way to cleanse the food thermometer between each temperature taken. It was the Cook's responsibility to throw out the used by date leftover foods. The Cook should have washed her hands before touching utensils and retrieved the utensil handle side. Current policies provided by the Dietary Manager, indicated the following: 1. "Storage of Dry Foods,"..3. Working containers holding dry food or ingredients that are removed from heir original packages are identified with the common name of the food...10 . Food should be used within one year of receipt...." 2. "Storage of Foods under Sanitary Conditions,"...3. Leftover foods should be placed in an approved storage container and should be discarded after three days...6. Food is not stored directly on the floor...." 3. "Dish and Utensil Handling,...Fingers should not be places in or at the lip contact surfaces of cups, glasses and flatware...." 4. "Food Temperatures on Service Line,..1. Wash, rinse and sanitize a dial face thermometer with alcohol wipe. RE-sanitize the thermometer after each use...." 5. "Dish and Utensil Handling/Storage,..1. Spoon, knives and forks shall be touched only by their handles. 5. Dishes and utensils shall be handled with clean hands...." 6. "Food Storage,...Section 177...storing of the foods (3) at least six inches above the floor...." 7. "Hand Washing,...Section 129...When to wash hands...(9) Before touching food or food-contact surfaces...(11) After engaging in other activities that contaminate the hands...." 3.1 - 21 (i)(2)(3)			

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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 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;			

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	(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 necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not testing for COVID-19 upon admission, residents not placed in Transmission Based Precautions (TBP) upon admission for 2 of 5 residents reviewed for	F 0880	It is the standard of this facility to ensure infection control guidelines are in place and implemented, including those to prevent and/or contain COVID-19. . What corrective action(s) will be accomplished for the residents found to have been affected by the	08/12/2022

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	infection control, and lack of hand hygiene and masks worn incorrectly in the Kitchen. (Residents 27 and 32, Main Kitchen) Findings include: 1. Resident 27's record was reviewed on 7/8/22 at 10:30 a.m. The resident was admitted to the facility on 6/2/22. The resident had received COVID-19 vaccinations on 2/17/21 and 3/10/21. She had not received any COVID-19 vaccine booster, so was not up to date. There was no evidence a COVID-19 test had been performed at the time of admission and 5 to 7 days later. The resident had not been placed in TBP upon admission. Interview with the Administrator on 7/11/22 at 3:36 p.m., indicated the resident had not been tested upon admission or 5-7 days later. She had not been placed on isolation upon admission because she was fully vaccinated. 2. Resident 32's record was reviewed on 7/8/22 at 10:30 a.m. The resident was admitted to the facility on 6/23/22. The resident had received COVID-19 vaccinations on 1/14/21 and 2/11/21. She had not received any COVID-19 vaccine booster, so was not up to date. There was no evidence a COVID-19 test had been performed at the time of admission and 5 to 7 days later. The resident had not been placed in TBP upon admission. Interview with the Administrator on 7/11/22 at 3:36 p.m., indicated the resident had not been tested upon admission or 5-7 days later. She had not been placed on isolation upon admission because		deficient practice: No residents were affected by this alleged deficient practice. Resident #27 has been COVID free. HAS SHE HAD A BOOSTER YET- IF SO ADD THAT HERE. Resident #32 has been COVID free. HAS SHE HAD A BOOSTER YET- IF SO ADD THAT HERE. Facility staff now wear face masks properly and sanitize their hands accordingly . How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents residing in the facility have the potential to be affected by this alleged deficient practice. No other residents were affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All nursing staff were inseviced on the need for COVID-19 testing for all new admissions and a testing form was added to the admission packet to be completed by the admitting nurse. All staff were inserviced on hand hygiene, infection prevention/control and mask wearing. All dietery staff were inservice on proper sanitation of kitchen devces. How the corrective action(s) will be monitored to ensure the deficient	

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	she was fully vaccinated. The Indiana Department of Health Long-term Care COVID-19 Clinical Guidance, dated 2/8/22, indicated, "Testing : All New admissions and re-admissions regardless of vaccination status, should have a series of two viral tests for COVID-19 infection; immediately and, if negative, again 5-7 days after their admission...Zone placement: New admissions/re-admissions if not up to date on COVID-19 vaccination should be observed in TBP, yellow zone for 10 days..." 3. In the Kitchen, on 7/11/22 at 11:22 a.m., the following was observed: Cook 1 was taking food temperatures and then serving the lunch meal. She was not wearing a face mask during this time. Dietary Aide 1 had her mask under her chin. She poured 6 cups of milk, placed her mask over her mouth without sanitizing or washing her hands, and then continued to pour more drinks. She then moved her mask under her nose and touched multiple surfaces in the kitchen without sanitizing or washing her hands. At 12:01 p.m. she placed her mask back over her nose again without sanitizing or washing her hands. Interview with Dietary Aide 1 on 7/11/22 at 1:09 p.m., indicated the hand sanitizer was outside the kitchen door. She was told she did not have to wear a mask in the kitchen as long as she and the other staff were 6 feet away from each other. Interview with the Dietary Manager on 7/11/22 at 1:11 p.m., indicated she was told they did not have to wear a mask in the kitchen, unless they were interacting with a resident.		pracice will not recur: An auditing tool was created to monitor COVID-19 testing of new admissions. The Director of Nursing/Designee will review all new admissions at least 48 hour post admission and again 5-7 days after for 6 months.An auditing tool was made to monitor infection prevention & control in relation to hand hygiene, proper sanition of kitchen utensils, and mask wearing. The administrator/designee will audit infection control prectices 5 times a week for 8 weeks, 2 times a week for 8 weeks, weekly for 8 weeks, and bi weekly for 8 weeks. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly. Date of Completion: 8/12/2022 Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	

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	Interview with the Infection Preventionist on 7/11/22 at 2:43 p.m., indicated all staff should be wearing a mask, even the kitchen staff. CDC Guidance, dated 2/2/22, indicated, "Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic ... Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission ... " 3.1-18(b)			
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;			

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	(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.			

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	§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on record review and interview, the facility failed to conduct COVID-19 testing for staff per guidelines for 1 of 3 staff records reviewed. (CNA 1) Finding includes: The COVID-19 Staff Vaccination Matrix was reviewed on 7/8/22 at 1:30 p.m. CNA 1 was unvaccinated and had been granted a non-medical exemption. CNA 1 tested positive for COVID-19 on 6/23/22. Previous testing had been completed on 6/16/22 and 6/22/22, which was once per week. The log of county transmission rates was provided by the Administrator on 7/12/22. The county transmission rate for the week of 6/13/22 was high. Interview with the Administrator on 7/12/22 at 10:09 a.m., indicated there were no additional tests for review for CNA 1. Any staff who were not up to date on their COVID vaccine should have been tested twice a week based on high county transmission. The Indiana Department of Health Long-term Care COVID-19 Clinical Guidance, dated 2/8/22, indicated, "...Level of COVID 19 Community Transmission...high (red)...Minimum Testing	F 0886	It is the standard of this facility to conduct COVID-19 testing for staff per guidelines. What corrective action(s) will be accomplished for the residents found to have been affected by the deficient practice: No residents were affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identiied and what corrective action(s) will be taken: All residents had the potential to be affected by this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All Staff were inserviced on COVID-19 Testing Requirments for Vaccinated vs Unvaccinated Staff & Required Frequency based on County Transmission rate. How the corrective action(s) will be monitored to ensure the deficient pracice will not recur: An audit tool was created to monitor the frequency of staff	08/12/2022

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	Frequency of Unvaccinated Staff...twice a week..."		testing. Administrator/Designee will monitor that all staff are testing as required weekly for 12 weeks. Bi weekly for 8 weeks and montly for 2 months. Any negative findings will be corrected immediatley and forwarded to the administrator. A report of progress will be forwarded to the QA Comittee monthly for a minimum of 6 months and plan adjusted accordingly. Date of Completion: 8/12/2022 Wintersong Village would like to request a desk review for compliance with this deficiency as we feel with the new training and processes adapted we will obtain and maintain continued compliance.	