STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 00 B. WING	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

(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. This visit included the Investigation of Complaint IN00417201. Complaint IN00417201 - No deficiencies related to the allegations are cited. Survey dates: October 30, 31, & November 1, 2, & 3, 2023 Facility number: 000296 Provider number: 155542 AIM number: 100467820 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 2 Medicaid: 55 Other: 11 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 14, 2023.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Cloverleaf of Knightsville agrees with the allegations and citations listed. Cloverleaf of Knightsville maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review for this plan of correction.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

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

Alexa Abbott | HFA | 12/05/2023

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview, and record review, the facility failed to notify the dialysis center nurse of changes of condition related to low blood pressures for 1 of 1 resident reviewed for dialysis (Resident 53). Findings include: On 11/1/23 at 12:10 p.m., Resident 53 was observed in his room sitting on the side of the bed. The resident indicated he was very dizzy and had been vomiting. The resident indicated he had several episodes of dizziness and nausea. On 11/2/23 at 10:09 a.m., the clinical record of Resident 53 was reviewed. The record indicated the resident had diagnoses included but not limited to, end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, was too high), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs) and dependence on renal dialysis (a treatment for people whose kidneys are failing. Dialysis does the work of your kidneys, removing waste products and excess fluid from the blood). A physician's order, dated 7/9/2023, indicated staff were to clean the Peritoneal Dialysis (PD) exit site, apply Mupirocin (Pea Size) amount to exit site daily, apply a dressing, and secure with paper	F 0580	*F 580* Notify of Changes **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The DON/designee will provide Resident #53's B/P's x's last 60 days. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who receive PD dialysis treatment have the potential to be affected. Licensed nursing staff will be provided with education from the DON/designee on the requirement to communicate low B/P to the PD dialysis nurse. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nursing staff will be provided with education from the DON/designee on the requirement to communicate low B/P to the PD dialysis nurse. Residents receiving PD will have their B/P taken daily and will	12/03/2023

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	tape one time a day. A physician's order, dated 7/9/2023, administer Peritoneal Dialysis solution two 6 Liter (L) bags total, over 12 hours per Baxter Dialysis Machine. Start at 8 p.m., remove when completed one time a day. Call results to PD Nurse at 2 p.m. every day for new orders and set up peritoneal dialysis for night shift. A physician's order, dated 7/9/2023, follow instructions in book one time a day. Monitor PD exit site every shift for signs and symptoms of infection two times a day. Report any swelling or leaking of fluid to PD nurse immediately. A Physician's order, dated 7/27/23, indicated to check clarity of PD (peritoneal dialysis) drain fluid in toilet prior to resident using toilet and flushing in morning. If cloudy inform dialysis every night shift. A quarterly Minimum Data Set (MDS) assessment, dated 8/25/23, indicated the resident was on dialysis during the assessment period. He was cognitively intact during the assessment period. A care plan, dated 4/6/23, indicated resident was at risk for nutritional deficits related to ESRD (end stage renal disease), CHF (congestive heart failure). A care plan, dated 8/2/22 with a revision date of 6/19/23, indicated the resident had a diagnosis of end stage renal disease and was at risk for complications with dialysis treatment. The peritoneal dialysis flow sheet record indicated: on 1/23/23 B/P (blood pressure) reading 98/56, on 2/6/23 B/P reading 94/49,		be communicated to the dialysis nurse. Routine auditing to be completed as noted below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete auditing to ensure B/Ps have been obtained and communicated to the dialysis nurse. Auditing to occur: Residents receiving PD dialysis 5 x's daily x's 30 days, then 5 x's weekly x's30 days, then 5 x's monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance exist. Compliance Date: _12/3/2023_____ . The Administrator at Cloverleaf of Knightsville is responsible for ensuring compliance of this plan of correction.	

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	on 2/22/23 B/P reading 96/54, on 6/5/23 B/P reading 92/61, on 6/12/23 B/P reading 99/56, on 6/16/23 B/P reading 96/61, on 7/13/23 B/P reading 91/53, on 7/25/23 B/P reading 94/53, on 9/30/23 B/P reading 103/57, on 10/2/23 B/P reading 95/49, on 10/17/23 B/P reading 86/58, on 10/2/23 B/P reading 95/49, on 11/1/23 B/P reading 88/57. The medical record lacked documentation of dialysis center nurse notification of the low blood pressure readings of 9 out of 12 documented blood pressure readings. On 11/2/23 at 10:23 a.m., Registered Nurse 16 indicated if the resident has low B/P she would notify the dialysis unit. During a phone interview with the Dialysis Manager, on 11/2/23 at 11:08 a.m., she indicated the facility nurse was to call the dialysis center every day with a report of dialysis administration and information including vital signs. The facility nurse was to notify the dialysis center if a blood pressure was low, this would generate a call from the nurse to give additional orders. On 11/3/23 at 2:28 p.m., the Director of Nursing (DON) provided a document stating it was a record of when they were to call dialysis center for abnormal vital signs or changes in condition. The document titled, "Clinical Education and Training, July PD Patient Lesson." When to call your nurse, dated 2017, indicated, the dialysis document indicated, " ...please call peritoneal dialysis nurse right away, cloudy ... bag ..., abdominal ... pain ..., fever ..., drainage or crust at the exit site ..., redness ..., swelling ..., pain ... contamination ...,			

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	transfer set ... loose ..., transfer set falls off ..., cap falls off ..., tip of transfer set touches anything ...." The facility administrator did not provide a policy for notification of change of condition to dialysis center. 3.1-5(a)			
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, interview, and record review, the facility failed to ensure nail care was provided to dependent residents for 2 of 24 residents reviewed for activities of daily living (ADL) (daily tasks related to resident care and hygiene) (Residents 121 and 46). Findings include: 1. On 10/31/23 10:57 a.m., Resident 121's fingernails were observed untrimmed with chipped nail polish on all the fingernails and dark debris underneath the nails. On 11/1/23 at 2:44 p.m., Resident 121's fingernails were observed untrimmed with chipped nail polish on all the fingernails and dark debris underneath the nails. On 11/2/23 at 8:12 a.m., Resident 121's fingernails were observed untrimmed with chipped nail polish on all the fingernails and dark debris underneath the nails.	F 0677	*F 677 ADL Care Provided for Dependent Residents* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Residents 121 and 46 were given nail care by the licensed nurse. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other dependent residents have the potential to be affected. Dependent residents have been provided nail care by licensed nursing staff **What measures will be put into place or what systemic**	12/03/2023

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	On 11/2/23 at 11:25 a.m., Resident 121's fingernails were observed untrimmed with chipped nail polish on all the fingernails and dark debris underneath the nails. On 11/2/23 at 11:29 a.m., Registered Nurse (RN) 16 observed Resident 121's fingernails and indicated the resident's fingernails were too long and needed to be cleaned, trimmed, and the old nail polish removed. Resident 121's clinical record was reviewed on 11/3/23 at 9:23 a.m. The resident's diagnoses included, but were not limited to, dementia (a 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) and Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement). An admission Minimum Data Set (MDS) assessment, dated 10/3/23, indicated Resident 121 had a severe cognitive impairment and required substantial/maximal assistance for showers and personal hygiene. A care plan, dated 9/26/23, indicated the resident required assistance with ADL's due to the diagnoses of dementia and Parkinson's disease. Interventions on the care plan included, but were not limited to, complete bathing and personal hygiene with staff assistance. Review of Resident 121's clinical record for October 2023 and November 2023 lacked documentation the resident had refused nail care.		**changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed and certified nursing staff on providing nail care on shower days. The DON/designee will ensure residents on the shower schedule have been provided with nail care at least twice weekly. Routine auditing to be completed as noted below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will ensure residents on the shower schedule have been provided with nail care at least twice weekly. Routine auditing to be completed on dependent residents 5 residents weekly x's 30 days, then 5 residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of	

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	2. On 10/31/23 at 11:47 a.m., Resident 46's fingernails were observed untrimmed and jagged, with dark debris underneath the fingernails. On 11/1/23 at 9:31 a.m., Resident 46's fingernails were observed untrimmed and jagged, with dark debris underneath the fingernails. On 11/2/23 at 11:47 a.m., Resident 46's fingernails were observed untrimmed and jagged, with dark debris underneath the fingernails. On 11/2/23 at 12:09 p.m., Registered Nurse (RN) 18 observed Resident 46's fingernails and indicated the resident's fingernails were too long and needed to be cleaned and trimmed. Resident 46's clinical record was reviewed on 11/2/23 at 2:18 p.m. The resident's diagnoses included, but were not limited to, dementia (a 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) and heart failure. A quarterly Minimum Data Set (MDS) assessment, dated 8/9/23, indicated the resident had a moderate cognitive impairment and required substantial/maximal assistance for showers and personal hygiene. Review of Resident 46's clinical record for October 2023 and November 2023 lacked documentation the resident had refused nail care. The Administrator (ADM) provided and identified a document as a current facility policy, titled		reviews will be increased as needed, if areas of noncompliance exist. Compliance Date: _12/3/2023_____ . The Administrator at Riverbend Nursing and Rehabilitation Center is responsible for ensuring compliance of this plan of correction.	

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	"Fingernails/Toenails, Care of," dated February 2018. The policy indicated, " ...Purpose ...The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections ...General Guidelines ...1. Nail care includes daily cleaning and regular trimming ...2. Proper nail care can aid in the prevention of skin problems around the nail bed ...4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin ... Documentation ...The following information should be recorded in the resident's medical record ...1. The date and time that nail care was given ...2. Any difficulties, abnormal conditions, problems or complaints made by the resident with his/her hands or feet or any complaints related to the procedure ...3. If the resident refused the treatment and the intervention taken ...4. The signature and title of the person administering the care and/or recording the data ...." 3.1-38(a)(3)(E)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited			

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	to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record review and interview, the facility failed to ensure pharmacy recommendations were completed for 1 of 5 residents reviewed for unnecessary medications (Resident 11). Finding includes: On 11/1/23 at 11:43 a.m., Resident 11's clinical record was reviewed. The resident's diagnosis included, but were not limited to, osteoarthritis (degeneration of joint cartilage and underlying	F 0756	*F 756 Drug Regimen Review, Report Irregular, Act On* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The DON/designee provided the physician with the pharmacy recommendations for Resident 11. They have been addressed. **How other residents have the**	12/03/2023

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	bone causing pain and stiffness) and pain in the left ankle and joints of the left foot. A current physician's order, dated 2/15/23, indicated Tylenol Tablet (acetaminophen) (pain medication) 325 milligrams (mg), give 650 mg by mouth three times a day related to pain in left ankle and joints of left foot and osteoarthritis. A current physician's order, dated 2/15/23, indicated Tylenol Tablet (acetaminophen) 325 mg, give 2 tablets by mouth every 4 hours as needed for pain/fever. A pharmacy consultation report, dated 4/30/23, indicated Resident 11 had current orders for Acetaminophen recommended the maximum of acetaminophen dose was 4000 mg in 24 hours, but may need to be lower for residents with impaired kidney and/or liver dysfunction. Review and check off if one of the following may be added to all orders containing acetaminophen, maximum dose of 4000 mg in 24 hours of acetaminophen from all sources, maximum dose of 3000 mg in 24 hours of acetaminophen from all sources, or other. The pharmacy consultation report had not been addressed nor signed by the physician. On 11/3/23 at 9:55 a.m., the Director of Nursing (DON) indicated the 4/30/23 pharmacy recommendation was not completed until today,11/3/23. DON indicated she had contacted the physician about the recommendation and wrote on the pharmacy recommendation to change the acetaminophen dose to every 8 hours. Resident 11 had not received acetaminophen more than 4000 mg in 24 hours at any time. All pharmacy medication regimen review (MRR) recommendations should be addressed in a timely manner by the facility and the resident's		**potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who receive recommendations from the pharmacy have the potential to be affected. The DON/designee has provided the physician with current pharmacy recommendations. They have been addressed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Regional Director of Clinical Services will provide education to the DON, who is responsible for the pharmacy recommendations, on the requirement to provide the physician with pharmacy recommendations and to ensure they have been addressed. Routine auditing will be completed as noted below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing to ensure pharmacy recommendations have been addressed by the physician/medical provider.	

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	physician. On 11/3/23 at 12:07 p.m., the DON provided and identified a document as a current facility policy titled, "9.1 Medication Regimen Review," dated 11/28/16. The policy indicated, "...7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon recommendations contained in the MRR...8. Facility should alert the Medical Director when MRRs are not addressed by the attending physician in a timely manner...11. The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation...." 3.1-25(i)		Auditing to occur monthly x's 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance exist.	
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			

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	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 expired insulin medications were disposed of properly for 1 of 1 medication rooms reviewed for medication storage (Resident 9), and the facility failed to ensure medications and biologicals were labeled and stored according to policy for 1 of 1 treatment carts and 1 of 1 medication carts observed for medication and biological storage (Resident 46, 34, 10, 8, and 48). Findings include: During an observation of Hall, A medication storage room, on 11/03/23 at 2:10 p.m., the medication refrigerator had a Lantus Solostar insulin glargine (diabetic insulin injection for blood sugar) 100 units/milliliter (ml), 3 ml prefilled pen for Resident 9. The pen had an opened date of 9/23/23 with an instruction label to discard unused portion after 28 days. During an observation of the medication cart located on A hall, on 11/3/23 at 2:45 p.m., the cart had an opened bottle of Gentamicin (antibiotic eye drops) 0.3% eye drops for Resident 46 with no opened date. A received date of 10/2/23 was on the box with instructions to instill three drops in right eye three times per day for seven days. During an observation of the treatment cart	F 0761	*F 761 Label/Store Drugs and Biologicals* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The DON/designee disposed of the undated insulin pen for Resident 9 and obtained a new pen that she appropriately labeled and dated. The DON/designee labeled and dated the medications for Residents 46,34, 10, 8, and 48. Medications for these residents have been stored properly. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents that are administered medications have the potential to be affected. The DON/designee will complete a facility wide medication storage audit to ensure that medications are stored and labeled/dated appropriately.	12/03/2023

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	located on A hall, on 11/3/23 at 2:55 p.m., to the following was found: a. An opened bottle of Nystatin powder (antifungal powder) 100,000 units/gram for Resident 34 was unbagged with no opened date and stored amongst an opened tube of benzoyl peroxide acne treatment gel 5% (topical skin treatment) for Resident 2 and an opened tube of Biofreeze gel (topical for pain relief) for Resident 2. b. An opened tube of Diclofenac Sodium topical gel 1% (used to treat pain and inflammation) for Resident 10 with no opened date and no lid cap. c. An opened tube of Venelex wound dressing (topical wound treatment) for Resident 10 not inside manufacturer's box with no opened date. A second opened tube of the Venelex for Resident 10 inside manufacturer's box with no opened date. d. An opened bottle of Nystatin powder 100,000 units/gram for Resident 8 with no opened date. e. An opened bottle of Nystatin powder 100,000 units/grams for Resident 48, unbagged with no opened date. f. Opened and unlabeled tube of Medihoney wound and burn dressing (topical wound treatment) with no opened date. During an interview, on 11/03/23 at 2:33 p.m., the Assistant Director of Nursing (ADON) indicated the insulin pen located in the refrigerator was expired and needed to be destroyed. On 11/6/23 at 11:47 a.m., the Administrator (ADM) provided a document, with a revised date of 10/28/19, titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles," and indicated it was the policy currently used by the facility. The policy indicated, " ...4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label ... are		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed nursing staff and QMA on the requirement to store, label, and date medications appropriately. Routine auditing will be completed as noted below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing of medication storage areas to ensure medications are stored, labeled, and dated appropriately. Auditing to occur: 4 med storage areas weekly x's 30 days, then 4 med storage areas monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as	

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	stored separate from other medications until destroyed or returned to the pharmacy or supplier. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened ... When ophthalmic solutions and suspensions are opened the bottle should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened bottle ... 6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels or cautionary instructions ...17. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law ...." 3.1-25(j) 3.1-25(k) 3.1-25(o)		needed, if areas of noncompliance exist. Compliance Date: _12/3/2023_____ . The Administrator at Cloverleaf of Knightsville is responsible for ensuring compliance of this plan of correction	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or			

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	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 was covered when delivered to the units and the facility failed to ensure hand hygiene was completed when assisting residents to eat for 1 of 2 dining observations. Findings include: 1. On 10/30/23 at 11:59 a.m., dietary staff delivered an uncovered meal cart with Residents' trays to the A hall, with uncovered brownies on disposable plates on all of the uncovered meal trays. On 10/30/23 at 12:09 p.m., dietary staff delivered an uncovered meal cart with Residents' trays to the B hall, with uncovered brownies on disposable plates on all of the uncovered meal trays. On 10/30/23 at 12:14 p.m., dietary staff delivered a second uncovered meal cart with Residents' trays to the B hall, with uncovered brownies on disposable plates on all of the uncovered meal trays.	F 0812	*F 812 Food Procurement, Store/Prepare/Serve-Sanitary* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No residents were identified in this statement of deficiencies as having been affected. DON/designee to provide education with dietary, licensed, and certified nursing associates on the requirement to cover meal trays when delivering to the units, and on the requirement to perform hand hygiene when assisting residents with their meals. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. The DON/designee to	12/03/2023

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	On 10/30/23 at 12:36 p.m., dietary staff delivered an uncovered meal cart with Residents' trays to the A hall dining room, with an uncovered plate of food on a meal tray and uncovered brownies on disposable plates on all of the uncovered meal trays. On 11/02/23 at 11:56 a.m., the Dietary Manager (DM) indicated, food was to be covered when being transported to the units. On 11/02/23 at 12:51 p.m., the Administrator (ADM) indicated, all food items on meal trays delivered to outside of the designated meal area should be covered until they are served to the residents. At that time, ADM provided and identified a document as a current facility policy, titled, "Serving of Food (Point of Service)," dated 7/2023. The policy indicated, "...Guidelines...1. All dishware/utensils being transported to point of service areas will be covered to prevent any cross contamination...8. Meals served outside of designated meal areas: ...c. All food items on meal trays delivered to areas outside the designated meal area will be covered until they are served to the resident...." 2a. During a dining observation, on 10/30/23 at 12:40 p.m., Certified Nursing Assistant (CNA) 3 used hand sanitizer in preparation of serving trays in the dining room. The CNA stood at the door in the dining room waiting for a tray to be handed to her, she adjusted the face mask on her face, moved her hair behind her left ear, touched her nose, and crossed her arms in front of her chest. The CNA obtained a tray from the kitchen and picked up the tray card, she then received another tray from the kitchen. The CNA held a tray in each hand and proceeded out of the kitchen down the hallway to take two residents their lunch trays. No hand		provide education with dietary, licensed, and certified nursing associates on the requirement to cover meal trays when delivering to the units, and on the requirement to perform hand hygiene when assisting residents with their meals. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee to provide education with dietary, licensed, and certified nursing associates on the requirement to cover meal trays when delivering to the units, and on the requirement to perform hand hygiene when assisting residents with their meals. Routine auditing will be completed as noted below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator/designee will complete routine auditing to ensure dietary associates cover the hall meal trays before leaving the kitchen. Auditing to occur: 2 meals weekly x's 30 days, then 2 meals monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed. The DON/designee will	

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	hygiene was performed during this observation. 2b. During a dining observation, on 10/30/23 at 12:53 p.m., CNA 3 used hand sanitizer in the dining room and then placed her hands on her hips. The CNA moved a chair closer to a dining room table, adjusted her scrub top, moved a dietary card in front of a resident, and then sat down to assist the resident with her meal. No hand hygiene was performed before assisting the resident with her meal. During an interview, on 10/31/23 at 10:26 a.m., CNA 5 indicated staff should not touch their face, adjust their glasses, or adjust their clothes without performing proper hand hygiene when they are serving in the dining room. During an interview, on 11/1/23 at 1:51 p.m., CNA 21 indicated staff should use hand sanitizer in between residents when passing trays. She indicated if staff had to touch their face or clothing items then they should wash their hands before serving a resident their tray or when they assist a resident to eat. On 11/2/23 at 9:05 a.m., the Administrator provided a document, with a revised date of July 2014, titled, "Preventing Foodborne Illness - Food Handling," and indicated it was the policy currently being used by the facility. The policy indicated, " ...3. All employees who handle, prepare, or serve food will be trained in the practices of safe food handling and preventing foodborne illness...." On 11/2/23 at 9:05 a.m., the Administrator provided a document, with a revised date of January 2019, titled, "Handwashing/Hand Hygiene," and indicated it was the policy		complete auditing to ensure hand hygiene is correctly performed when assisting residents with meals. Auditing to occur: 4 associates weekly x's 30 days, then 4 associates monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance exist. Compliance Date: _12/3/2023_____ . The Administrator at Cloverleaf of Knightsville is responsible for ensuring compliance of this plan of correction.	

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	currently being used by the facility. The policy indicated, " ...6. Use an alcohol-based hand rub alternatively or soap and water for the following situations: ...b. before and after direct contact with residents ...n. before and after eating or handling food... o. before and after assisting a resident with meals ...." 3.1-21(i)(1) 3.1-21(i)(3)			
F 0880 SS=F 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			

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	include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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.			

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	The facility will conduct an annual review of its IPCP and update their program, as necessary. A. Based on observation, interview, and record review, the facility failed to ensure an adequate infection control program was implemented to track the COVID-19 positive and potentially exposed residents which had the potential to effect 68 of 68 residents that reside in the facility. B. Based on observation, interview, and record review, the facility failed to follow infection control precautions, COVID-19 testing protocols, and ensure tracking for a COVID-19 outbreak for 68 of 68 residents reviewed for infection control. Findings include: A. On 11/2/23 at 9:01 a.m., the Infection Prevention Nurse (IP) indicated she was tracking for end dates to remove COVID-19 positive residents from the droplet isolation rooms. Residents would be in isolation for 10 days. She indicated she was given a new policy on 11/1/23 for droplet isolation end dates. Residents who had been exposed to COVID 19, would be in isolation for 10 days as well. The residents would be returning to their rooms once the 10 days of isolation was ended. If the resident was symptomatic after 10 days, they would stay on the designated COVID-19 unit. She was unable to identify or provide the exact number of COVID-19 positive residents at the facility. She would need to obtain the information. The staff were to report when they exhibit symptoms of COVID to a member of the management team. Once she received the notification, she had staff come to the facility and met the employee outside of the building to be tested. If it was after hours a nurse	F 0880	*F 880 Infection Control and Prevention* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The facility Medical Director was notified of the failure to implement Infection Control precautions timely, deficiency in COVID 19 testing protocols, and lack of tracking for the facilities last COVID 19 outbreak for 68 of 68 residents. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected during a COVID-19 Outbreak. The DON/designee will provide education to the facilities Infection Preventionist on the requirement to ensure infection control precautions are implemented timely, testing protocol requirements, and that tracking be completed for COVID-19 outbreaks. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	12/03/2023

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	on the A unit would test the staff. She posted notification signs on the entry door. The notification signs indicated the facility was in an outbreak and should not come into the building if they were exhibiting symptoms. They were not assessing residents for COVID-19 symptoms unless they tested positive for COVID-19. She indicated if she was working on a unit, she would assess any resident who had symptoms such as cough, shortness of breath, fever. The IP nurse was testing the residents every 7 days, testing and testing results were in the medication administration record (MAR), in the tracking log, and or in the nurse's progress notes. Staff must clean all reusable equipment between resident use. If reusable equipment was used within an isolation room, the equipment must be disinfected immediately after it was removed from the isolation room. On 11/3/23 at 9:00 a.m., the IP nurse provided two documents titled, "WEST Outbreak testing," dated 10/25/23 and "Station A outbreak testing day 7," dated 11/1/23. The document identified each resident by name and room number. The IP nurse indicated this was what she used for outbreak tracking and testing. On 11/3/23 at 9:00 a.m., the IP nurse provided a document and indicated it was a tracking log for employees. The log had employee names with collection date, collection time, run time, result, applicator/cartridge lot #, testing employee's name and testing employee signature. Collection dates were from 9/19/23 to 11/1/23. On 11/3/23 at 9:00 a.m., the IP nurse indicated on 10/25/23, the Director of Nursing talked with the corporate office and a decision was made to do an isolation unit instead of just isolating residents in		**practice does not recur?** The DON/designee will provide education to the facilities Infection Preventionist on the requirement to ensure infection control precautions are implemented timely, testing protocol requirements, and that tracking be completed for COVID-19 outbreaks. The DON/designee will complete auditing if/when future COVID-19 outbreak occurs to ensure testing protocols are being followed, infection control precautions and tracking is being done during COVID-19 outbreaks as noted below. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will conduct auditing to ensure testing protocols are being followed, infection control precautions are implemented and tracking is being done during COVID-19 outbreaks upon positive results being confirmed with each new outbreak x's 6 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once	

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	their rooms. Residents who tested COVID positive were moved to the C unit. The IP nurse indicated the first 3 residents were positive on 10/24/23, on 10/25/23, the facility had an overabundance of residents testing positive for COVID. The Medical Director advised he only wanted those residents tested who were symptomatic and she indicated the Medical Director was aware of what the facility policy indicated. On 11/3/23 at 11:27 a.m., the IP nurse provided a copy of the daily nursing schedule and indicated the employees who were highlighted in green were tested on the date they worked at the facility and had tested positive for COVID. On 11/2/23 at 9:05 a.m., a.m., the Administrator provided a document, titled, "Coronavirus Disease (COVID-19)-Testing Residents" dated, May 2023, and indicated it was the policy currently being used by the facility. The policy indicated, Testing Asymptomatic Residents ...a. A symptomatic resident with close contact with someone with SARS0CoV-2 infection should have a series of three viral tests for SARSn-CoV-2 infection ...b. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 ...Testing is not generally recommended for asymptomatic people who have recovered from SARA-CoV-2 infection in the prior 30 days ...Testing residents with Signs or Symptoms of COVID-19 ...1. Any resident (regardless of vaccination status) with even mild symptoms of COVID-19 receives a viral test as soon as possible ...a. Because it may be difficult to tell the difference between influenza, COVID-19, and		full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance exist. Compliance Date: ___12/3/2023___ . The Administrator at Cloverleaf of Knightsville is responsible for ensuring compliance of this plan of correction.	

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	other acute respiratory infections based on symptoms alone, testing for pathogens other than SARS-CoV-2 may be conducted based on recommendations from the infection preventionist and providers ...Additional Measures During Outbreak Investigation ...1. In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration is given to use of empiric (observation) use of transmission-based precautions for residents and work restriction of staff with higher-risk exposures ...3. As part of the broad-based approach, testing will continue on affected unit(s) of facility-wide every 3-7 days until there are no new cases for 14 days ...Documentation ...1. For symptomatic resident testing, the following is documented ...a. The date and time the symptoms were identified ...b, the date and time the test was conducted ...c. the date and time the results were obtained and ...d. actions taken by the facility ...2. For facility outbreak testing, the following is documented ...a. the date the case was identified ...b. the dates that all other residents were tested ...c. the dates that residents who tested negative were retested and ...d. the results of all tests ...." The facility documentation lacked evidence of empiric (observation) of all residents with respiratory symptoms. On 11/2/23 at 9:05 a.m., the Administrator provided a document, titled, "Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures" dated, June 2023, and indicated it was the policy currently being used by the facility. The policy indicated, Policy interpretation and Implementation ...c. identifying and managing ill residents and staff ...e. a process to make everyone entering the facility aware of recommended actions to prevent transmission to			

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	others if they have any of the following three criteria ...(1) A positive viral test for SARS-CoV-2 ...(2) Symptoms of COVID-19 or ...(3) close contact with someone with SARS-CoV2 infection (for residents and visitors) or a higher risk exposure (for healthcare personnel [HCP]) ...f. implementing source control measures ...respiratory assessment of Covid-19 positive residents ...following current environmental infection prevention and control recommendations ...." CDC Viral Respiratory Pathogens Toolkit for Nursing Homes, Last Reviewed September 28, 2023, indicated, "Continue active surveillance to identify others with respiratory viral illness (e.g., daily or every shift review of symptoms among residents and HCP) and manage people who were exposed or infected (e.g., use of source control, work restriction for HCP, use of Transmission-based Precautions)". B1. On 11/2/23 at 9:27 a.m., the IP nurse provided a document titled, "All Staff PPE Refresher Oct.19, 2023". The document indicated to "please read and sign on signature sheet at back of in-service". The document contained information for glove use, wearing masks and gowns. The untitled and undated signature page contained 62 signatures. On 11/3/23 at 9:00 a.m., the IP nurse provided a document titled, "Hand Hygiene Inservice-online". The instructions to the staff indicated ..."to read, sign signature sheet and follow directions on attached sheet. Print out the last page of online which shows you completed it, sign and date that copy and turn in". The untitled and undated signature sheet indicated; 8 employee's signatures. The IP nurse indicated she had not completed a handwashing competency with any of the staff at the time of the training or			

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	since the facility had been in outbreak. On 11/3/23 at 9:00 a.m., the IP nurse indicated she did not have verification of training for staff in correct hand hygiene and donning or doffing PPE. However, she tried to verbally communicate with staff and she had not completed staff competency in donning or doffing PPE. On 11/3/23 at 9:00 a.m., the IP nurse provided a document titled, "Hand Hygiene Inservice Interactive". The document was dated, May 19. The in-service directed the staff to enter a QR code to register for the in-service. She indicated she had not completed handwashing competency of staff. B2. On 10/30/23 at 11:56 a.m., during a routine observation Certified Nurse Aide (CNA) 6 was observed entering into a droplet isolation precaution room (isolation precautions used to prevent the spread of pathogens that are passed through respiratory secretions and do not survive for long in transit) without first donning (to put on) personal protective equipment (PPE). Droplet Transmission based precaution signs were posted on the outside of the door and PPE was in a bin next to the door in the hall. CNA 6 stood in the room and spoke to Registered Nurse 7 regarding PPE equipment. CNA 6 left the isolation room and continued to provide care to other residents on the unit without washing or sanitizing her hands. On 10/30/23 at 12:00 p.m., CNA 3 was observed providing assistance to a resident in a droplet precautions isolation room. The CNA removed her PPE and removed the mechanical lift from inside of the isolation room and placed the lift in the hall against the wall. The CNA left the lift in the hall and failed to sanitize the mechanical lift after use			

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	in an isolation room. The CNA continued to provide assistance to other residents in the unit without first washing or sanitizing her hands after leaving an isolation room. On 10/30/23 at 1:00 p.m., CNA 9 was observed in a droplet isolation room doffing (take off) PPE. CNA 9 was observed placing gloved hands on the inside of her isolation gown and removing the gown from the inside outward. B3. On 10/30/23 at 12:09 p.m., Housekeeper 8 was observed mopping and cleaning rooms while the meal trays were being passed on the unit. The housekeeper entered several droplet isolation rooms and mopped the floors. Housekeeper 8 was not observed to change mop water or cleaning supplies. On 10/30/23 at 12:11 p.m., Housekeeper 8 entered a droplet isolation room. Transmission based precaution signs were posted on the door outside of the room. Housekeeper 8 failed to don PPE prior to entering the droplet isolation room. The housekeeper cleaned and mopped the room and continued to clean other rooms including non-isolation rooms on the unit. On 11/2/23 at 10:29 a.m., Housekeeper 24 indicated she used a housekeeping cart designated for COVID-19 use. She would clean two or more positive rooms, then would change the water and mop head before cleaning other non-isolation rooms. Housekeepers were not allowed to clean rooms when meal trays were being passed. B4. The following observations were observed on the COVID unit where the residents were in Droplet Isolation (when a resident has an infection with germs that can spread to others by speaking, sneezing, or coughing):			

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	On 11/1/23 at 2:09 p.m., the Certified Nursing Assistant (CNA) 22 exited a resident's room and removed her personal protective equipment (PPE). The CNA removed her gloves, gown, shoe covers, and then her face shield. She then went into the staff bathroom. The CNA exited the bathroom and placed on a gown, shoe covers, tied the gown around her neck, grabbed a face shield, and walked over to a resident still holding the face shield in her hand. She leaned down next to the resident holding her Broda (tilt in space position chairs with comfort seating) chair with one hand and face shield in another hand. The CNA pushed the resident while in her chair down the hallway and into her room. The CNA placed on her face shield just prior to entering the resident's room while holding it against the resident's chair down the hallway. On 11/1/23 at 2:21 p.m., CNA 21 went to the linen cart and grabbed washcloths and walked over to the nurse's station and set the washcloths on the counter while she talked to the nurse for a minute at the nurse's station and proceeded back to the linen cart to grab a brief (incontinence item). She obtained the sit to stand (a device to help assist residents from a sitting to a standing position) lift from the hallway and proceeded down the hallway to a resident's room. While the CNA was putting on her PPE she set the washcloths and brief on the sling (offers back support up to shoulder area and under the thighs) to the lift equipment. On 11/1/23 at 2:25 p.m., CNA 22 exited a resident's room and left the Hoyer (an assistive device that allows residents to be transferred between a bed and chair) lift in the hallway. The CNA removed her PPE in the following order: removed gloves, gown, show covers, then her face shield. No			

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	sanitizing of the Hoyer lift was observed. CNA 22 placed on new PPE and no hand hygiene was observed in between placing on new PPE equipment. On 11/1/23 at 2:30 p.m., CNA 22 exited room 51 and went to the linen cart. The CNA grabbed bed linens, washcloths, and towels, the CNA held the bed linens and other supplies against her isolation gown while walking down the hallway and proceeded back into the resident's room to assist the other CNA on the unit. No hand hygiene was performed before entering back into the resident's room. On 11/1/23 at 2:34 p.m., CNA 21 exited room 51 removed her PPE and went to linen cart and grabbed a fitted sheet. The CNA held the fitted sheet against her scrub top and took the sheet to CNA 22 in room 51. On 11/1/23 at 2:39 p.m., CNA 22 exited room 51 with the sit to stand lift. The sit to stand lift and the sling were left in the hallway and no sanitization of the device or sling was observed. The CNA obtained the Hoyer lift from the hallway and placed it in room 53 for use. On 11/1/23 at 2:47 p.m., Licensed Practical Nurse (LPN) 23 entered room 63 with no face shield on. The nurse left the room and grabbed two incontinence briefs from the linen cart. She proceeded back into the room with no face shield on. She provided incontinence care and left the room with dirty trash. On 11/1/23 at 2:52 p.m., CNA 22 exited room 53 with the Hoyer lift and left it in the hallway. No sanitizing of the Hoyer lift was observed.			

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	On 11/1/23 at 2:55 p.m., CNA 22 obtained the Hoyer lift from the hallway and placed it in room 56 for use. On 11/1/23 at 3:06 p.m., CNA 21 brought the Hoyer left out of room 56 and placed in in the hallway. No sanitizing of the Hoyer lift was observed. On 11/1/23 at 3:12 p.m., CNA 21 pushed a female resident in her wheelchair to the shower room to toilet her. No PPE was worn by the CNA except for a face shield and mask. On 11/2/23 at 3:17 p.m., CNA 21 pushed a female resident in her wheelchair to the shower room to toilet her. No PPE was worn by the CNA except for a face shield and mask. During an interview, on 11/2/23 at 9:08 a.m., the infection control nurse indicated the lift equipment should be cleaned between residents. She further indicated bed linens, washcloths, and towels should not be held against the body. The staff should be holding it away from their body to avoid contact. The infection control nurse indicated the staff should be wearing PPE when providing care to a resident who was in isolation, this includes, bathing, toileting, and transferring. During an interview, on 11/2/23 at 9:18 a.m., the IP nurse indicated she had tried to speak with staff in regard to proper donning (placing on) and removing PPE but she did not have any documentation of the education being provided. She provided a policy that demonstrates the proper procedure for donning and removing PPE, she indicated staff should be aware of the procedures. The IP nurse indicated staff should be performing hand hygiene after they removed			

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	their PPE. On 11/2/23 at 9:05 a.m., the Administrator provided a document with a revised date of July 2014, titled, "Cleaning and Disinfection of Resident Care Items and Equipment," and indicated it was the policy currently being used by the facility. The policy indicated, " ...3. Durable medical equipment must be cleaned and disinfected before reuse by another resident ...." On 11/2/23 at 9:05 a.m., the Administrator provided a document with a revised date of January 2019, titled, "Handwashing/Hand Hygiene," and indicated it was the policy currently being used by the facility. The policy indicated, " ...b. before and after direct contact with residents ...l. after removing gloves ...m. before and after entering isolation precaution settings ...." On 11/2/23 at 9:05 a.m., the Administrator provided a document, titled, "Infection guidelines for all nursing procedures" dated, August 2012, and indicated it was the policy currently being used by the facility. The policy indicated, "...General guidelines ...2. Transmission based precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection ...4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations ...5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials ...." On 11/2/23 at 9:40 a.m., the Administrator			

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	provided an undated document, titled, "Example of Safe Donning and Removal of Personal Protective Equipment," and indicated it was the policy currently being used by the facility. The policy indicated," ...remove gloves ...goggles ...gown ...face mask ...perform hand hygiene immediately after removing all PPE ...." On 11/2/23 at 9:40 a.m., the Administrator provided a document with a revised date of February 2018, titled, "Bed, Making an Unoccupied," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1 ... Do not let the sheet touch your clothing or the floor ...." On 11/2/23 at 11:07 a.m., the Administrator provided a document, titled, "Cleaning and Disinfecting Resident rooms" dated, August 2013, and indicated it was the policy currently being used by the facility. The policy indicated, General Guidelines ...6. Floor mopping solution will be replaced every three resident rooms or changed no less often than at 60-minute intervals ...Steps in the procedure ...Resident Room Cleaning ...8. When cleaning rooms of residents in isolation precautions, use personal protective equipment as indicated ...9. When possible, isolation rooms should be cleaned last, and water discarded after cleaning room ...." The CDC guideline for transmission-based droplet precautions indicate, "Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission ... Use personal protective equipment (PPE) appropriately, including gloves			

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	and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens ...Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens". Source: CDC Guideline for Isolation Precautions, January 7, 2016 3.1-18(b)(1) 3.1-18(b)(4)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to review and track facility wide antibiotic stewardship for 4 of 12 months reviewed. Findings include: On 11/2/23 at 9:08 a.m., the Infection Preventionist Nurse (IP) indicated there was no documentation of tracking, facility mapping or antibiotic	F 0881	*F 881 Antibiotic Stewardship Program* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The physician was notified that the facility failed to track antibiotic use for 4 of 12 months.	12/03/2023

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	stewardship for the months of October 2022, November 2022, December 2022, nor October 2023. Review of April and May 2023 antibiotic use and infection tracking documentation indicated an increase in residents with urinary tract infections and upper respiratory infections. The IP nurse on 11/3/23 at 9:00 a.m., provided documentation indicating in-services were completed on 6/22/23 for perineal care and hand hygiene. Training record lacked documentation of education in urinary tract infection prevention, upper respiratory infection, and identification of signs and symptoms of infections. The IP nurse could not provide facility antibiotic stewardship policy and procedure. 3.1-18(b)(1)		The DON/designee will provide education to the Infection Preventionist on the requirement to track antibiotic use within the facility. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who requires antibiotics have the potential to be affected. The DON/designee will provide education to the Infection Preventionist on the requirement to track antibiotic use within the facility. The Infection Preventionist has implemented a new antibiotic tracking process. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to the Infection Preventionist on the requirement to track antibiotic use within the facility. The Infection Preventionist has implemented a new antibiotic tracking process. The DON/designee will complete routine auditing as noted below to ensure that antibiotic tracking is being completed and is current. **How the corrective actions will**	

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			be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON/designee will complete routine auditing to ensure that antibiotic tracking is being completed and is current. Auditing to occur: 4 residents (if orders given) with antibiotic orders weekly x's 30 days, then 4 residents (if orders given) with antibiotic orders monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance exist. Compliance Date: _12/3/2023_____ . The Administrator at Cloverleaf of Knightsville is responsible for ensuring compliance of this plan of correction.	
F 0912 SS=D	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on record review, observation, and interview, the facility failed to provide at least 80 square feet per resident in multiple occupancy resident rooms for 2 of 50 resident rooms observed (Rooms 14 and 15). Findings include: On 11/03/23 at 12:50 p.m., the Administrator provided a copy of a waiver request letter, dated 10/24/22. The letter indicated a waiver had been requested for rooms 14 and 15 of the facility. During a maintenance tour with the Maintenance Director, on 11/03/23 at 12:08 p.m., rooms 14 and 15 were measured. The current measurements of the rooms, were as follows: a. Room 14, licensed for 3 beds, measured 226.2 total square feet. Square footage per resident equaled 75.4 square feet. At the same time, 1 bed was observed in the room. b. Room 15, licensed for 3 beds, measured 226.2 total square feet. Square footage per resident equaled 75.4 square feet. At the same time, 1 bed was observed in the room. During an interview, on 11/03/23 at 12:11 p.m., the Maintenance Director indicated each of the rooms were licensed for 3 beds. Currently, each room had 1 bed in each room. The facility was requesting a waiver for the rooms. 3.1-19(l)(2)	F 0912	*F 912 Bedrooms Measure at Least 80 Sq Ft/Resident* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident rooms 14 and 15 were identified. The facility has submitted a waiver request related to the square footage requirements. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No Other residents or resident's rooms are affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The square footage requirements in no way affect the care that is provided to the residents in rooms 14 and 15. These residents receive the	12/03/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 00 B. WING	11/03/2023

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			highest quality of services. A waiver has been submitted related to the square footage requirements which have been granted annually. Facility will ensure residents in room 14 and 15s needs are being met. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The square footage requirements in no way affect the care that is provided to the residents in rooms 14 and 15. These residents receive the highest quality of services. A waiver has been submitted related to the square footage requirements which have been granted annually. Facility will ensure all needs of residents are being met in room 14 and 15. Compliance Date: _12/3/2023_____ . The Administrator at Cloverleaf of Knightsville is responsible for ensuring compliance of this plan of correction.	