STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 21, 22, 23, 24 and 27, 2023. Facility number: 000505 Provider number: 155556 AIM number: 100266350 Census Bed Type: SNF/NF: 67 SNF: 26 Total: 93 Census Payor Type: Medicare: 19 Medicaid: 46 Other: 28 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 6, 2023.	F 0000	March 13, 2023 Brenda Buroker, Director Long term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Survey Event ID: YYZR11 Please accept the following plan of correction as credible evidence of compliance the deficiencies cited during our recent Annual Recertification Survey on February 21, at The Waters of Tipton SNF. Hopefully, you will find that our remedies are both sufficient and thoroughly explained in providing you a clear picture of how we corrected these concerns. With this submission of these remedies, we are requesting paper compliance. after reviewing our	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Juday	Administrator	03/20/2023

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

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			plan of correction, you have any questions, or require further information, please do not hesitate to contact me at your convenience 765-675-8791. Respectfully submitted, Paula Juday, HFA, LMSW Administrator	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the			

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	provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to provide a privacy cover for the urinary catheter drainage bags for 3 of 3 residents reviewed for dignity. (Resident 33, 70 and 84) Findings include: 1. During an observation, on 2/21/23 at 10:15 a.m., Resident 33 had a urine collection bag with dark yellow colored urine hanging on the left side of the bed and visible from the door. The urinary collection drainage bag did not have a privacy cover and could be seen from the hallway. During an observation, on 2/22/23 at 11:00 a.m., Resident 33 had a urine collection bag with dark yellow colored urine hanging on the left side of bed and visible from the door. The urinary collection drainage bag did not have a privacy cover and could be seen from the hallway.	F 0550	p="" paraid="600015358" paraeid="{424f84c2-ad01-4d09-a150-ca2d873e0fb9}{188}">Deficiency ID: F 550 Resident Rights It is the policy of The Waters of Tipton that all residents are provided with Dignity and that Urinary drainage bags will be covered unless residents are in their rooms, at which time the bag will be placed so as not to be visible from the hall if at all possible. (Attachment 1-A). To correct this deficiency: The identified residents (3) were provided with covers for their urinary catheter drainage bags. Completed 2/23/2023. p="" paraid="959448434" paraeid="{424f84c2-ad01-4d09-a150-ca2d873e0fb9}{239}"> All	03/18/2023

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	During an observation, on 02/23/23 at 9:05 a.m., Resident 33 had a urine collection bag with yellow colored urine hanging on the left side of bed and visible from the door. The urinary collection drainage bag did not have a privacy cover and could be seen from the hallway. The record for Resident 33 was reviewed on 02/21/23 at 2:00 p.m. Diagnoses included, but were not limited to, multiple sclerosis, injury at cervical spinal cord, hemiplegia right side dominant, and neuromuscular dysfunction of bladder. A Care Area Assessment (CAA), dated 04/08/22, indicated Resident 33 had a supra-pubic catheter in place and the resident required extensive to total assistance with toileting. Staff were to provide all catheter care per physician's orders. During an interview, on 02/21/23 at 2:15 p.m., Resident 33 indicated his preference would be to not have his catheter bag exposed to others. 2. During an observation, on 02/21/23 at 10:45 a.m., Resident 70 was observed lying in bed and her leg bag was found hung on the exit side of the bed with 150 milliliters of dark yellow colored urine. The urinary collection drainage bag did not have a privacy cover and could be seen by the roommate. During an observation, on 02/22/23 at 9:55 a.m., Resident 70 was observed lying in bed and her leg bag was found hung on the exit side of bed with no cover. She indicated she did not like her urine bag to be visible to others. The record for Resident 70 was reviewed on 02/21/23 at 2:00 p.m. Diagnoses included, but were		residents are at risk affected by this deficient practice. To ensure that resident not affected: *A complete audit of all residents with urinary catheter drainage bags was completed to identify those residents at risk for not having their urinary catheter drainage bags placed in a covered bag. Completed 3/13/2023. *5 residents total were identified with urinary catheter drainage bags and all 5 residents had their catheter drainage bags placed in a covered dignity bag at the time of the audit. Completed 3/13/2023. p="" paraid="1229165284" paraeid="{4ced0e83-dc79-436d-a2d0-9876ef31a498}{34}">To prevent recurrence: *All nursing staff will be educated regarding the dignity policy and procedure (Attachment 1-A). To /18/2023. In-Service will be provided by DON and ADON. *An audit of all residents at risk for dignity related to their urinary catheter drainage bag will be conducted by the DON or designee 5 X a week for 4 weeks; then weekly X 4 weeks, then monthly X 4 months to review dignity related to urinary catheter drainage bags. Any concerns noted through the audit will be immediately corrected and staff will be re-educated. Any trends identified may be further discussed in QAPI and a performance improvement plan may be developed. Any trends	

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	not limited to, bladder cancer, hydronephrosis, chronic kidney disease, and obstructive and reflux uropathy. A Care Area Assessment, dated 06/02/22, indicated she needed extensive assist with toileting, she had a nephrostomy and required staff to assist with emptying her catheter and performing catheter care daily. A Minimum Data Set (MDS) assessment, dated 12/15/22, indicated she was cognitively intact and required extensive assist for activities of daily livening. She had an indwelling catheter. During an observation and interview, on 02/23/23 at 10:30 a.m., Qualified Medication Aide (QMA) 3 indicated Resident 70's urine collection bag was observed not inside the dignity bag and could be observed by her roommate. Any staff member who observed the catheter bag outside of a dignity bag should have put it back inside a dignity bag. 3. During an observation, on 02/22/23 at 10:46 a.m., Resident 84 was observed in her bed with her catheter bag (urinary catheter drainage bag) visible from the hallway. The record for Resident 84 was reviewed. Diagnoses included, but were not limited to, retention of urine. A Minimum Data Set (MDS) assessment, dated 12/11/22, indicated Resident 84 had severely impaired cognition and an indwelling catheter. During an interview, on 02/24/23 at 2:58 p.m., the Director of Nursing indicated catheter bags should be placed inside a dignity bag. The hospice company was working on getting a dignity bag for Resident 70.		identified with specific staff members may result in disciplinary action. (Attachment 1-B). Administrator will monitor completion of audits.	

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	A current policy, titled "Dignity," received from the Executive Director on 02/27/23 at 3:17 p.m., indicated "...Urinary drainage bags will be covered unless residents are in their rooms, at which time the bag w (sic) be placed so as not to be visible from the hall if at all possible...." 3.1-3(t)			
F 0552 SS=E Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Based on interview and record review, the facility failed to ensure residents who received psychotropic medications had the benefits and risks reviewed with them and their representatives for 4 of 5 residents reviewed for psychotropic	F 0552	p="" paraid="600015358" paraeid="{5c526c0c-81de-4a6f-b373-e0a5beeee983}{188}">Deficiency ID: F 552 Right to be Informed / Make Treatment	03/18/2023

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	medications. (Resident 19, 22, 24, and 74) Findings include: 1. The record for Resident 19 was reviewed on 2/27/23 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, psychosis, and Alzheimer's disease. A physician's order, dated 2/2023, indicated to give thioridazine (an antipsychotic medication) twice a day for psychosis, with a start date of 6/28/22. During an interview, on 02/23/23 at 10:25 a.m., Resident 19's Power of Attorney (POA) indicated "No, I don't remember being" informed about the risk or benefits for the use of the antipsychotic medication before the medication was started. During an interview, on 02/24/23 at 2:49 p.m., Social Service Worker (SSW) 6 reviewed Resident 19's medical record for documentation the risks and benefits were discussed prior to the use of the medication and indicated "we (facility) don't have that in place." 2. The record for Resident 22 was reviewed on 2/23/23 at 2:20 p.m. Diagnoses included, but were not limited to, Alzheimer's disease. A physician's order, dated 2/2023, indicated to give olanzapine (Risperdal, an antipsychotic medication) with an original start date of 12/3/21. During an interview, on 02/23/23 at 1:59 p.m., the Director of Nursing (DON) indicated for antipsychotic medications "there are black box warnings" for the use of the medication and "death" was a risk to the resident who took the		Decisions It is the policy of The Waters of Tipton that all residents should always be informed of the meds they are receiving before they receive them (Attachment 2-A). To correct this deficiency: *The identified residents' (4) POA's will be contacted and informed consent or the physician of each resident will be notified of failure to consent. To Be Completed 3/14/2023. p="" paraid="959448434" paraeid="{5c526c0c-81de-4a6f-b373-e0a5beeee983}{251}"> All residents are at risk affected by this deficient practice. To ensure that resident not affected: *A complete audit of all residents with psychotropic medications was completed to identify those residents at risk for not having informed consent for psychotropic medications in place. To be completed 3/14/2023. *Any resident identified for taking a psychotropic medication will have their POA contacted in order to obtain consent for psychotropic medication administration. For those residents whose POA fails to consent, the physician will be notified. To be completed by 3/17/2023. p="" paraid="1229165284" paraeid="{ad518fff-31e6-4f1c-afc9-80ae823473b0}{62}">To prevent recurrence: *All nursing and social	

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	antipsychotic medication. The DON indicated Resident 22's medical record lacked documentation the risks and benefits were discussed for the antipsychotic medication prior to use. 3. The record for Resident 24 was reviewed on 2/27/23 at 2:33 p.m. Diagnoses included, but were not limited to, unspecified dementia. A physician's order, dated 2/2023, indicated to give Risperdal once daily with an original start date of 12/16/22, and to give Zyprexa (an antipsychotic medication) once daily with a start date of 10/7/21. During an interview, on 02/23/23 at 10:17 a.m., Resident 24's spouse indicated I "can't remember" if the facility informed me about the antipsychotic medications before the resident started the medications. During an interview, on 02/23/23 at 2:59 p.m., Social Service Worker (SSW) 5 indicated Resident 24 was on Zyprexa and the antipsychotic medication was changed on 12/16/22 from Zyprexa and added Risperdal which started on 12/17/22. During an interview, on 02/24/23 at 11:14 a.m., SSW 5 reviewed Resident 24's medical record for documentation the risks and benefits related to the antipsychotic medication was discussed and indicated there was no documentation the risks and benefits were discussed before starting the antipsychotic medication. 4. The record for Resident 74 was reviewed on 2/27/23 at 2:47 p.m. Diagnoses included, but were not limited to, Alzheimer's disease.		services staff will be educated regarding the Medication Administration Guidelines policy and procedure (Attachment 2-A). To /18/2023. In-Service will be provided by DON and ADON. *The Psychotropic Medication Assessment and Consent Form will be provided for each resident / resident POA to review and sign prior to administration of psychotropic medications (Attachment 2-B) going forward from this point. This will be completed with each new order for a new psychotropic medication and will continue indefinitely. *An audit of all residents with new psychotropic medications will be conducted by the DON or designee 5 X a week for 4 weeks; then weekly X 4 weeks, then monthly X 4 months to review Informed Consent. Any concerns noted through the audit will be immediately corrected and staff will be re-educated. Any trends identified may be further discussed in QAPI and a performance improvement plan may be developed. Any trends identified with specific staff members may result in disciplinary action. (Attachment 2-C). Completion will be monitored by the Administrator.	

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	A physician's order indicated Resident 74 was to be given Zyprexa with a start date of 6/3/22. During an interview, on 02/24/23 at 11:34 a.m., SSW 5 reviewed Resident 74's medical record for documentation the risks and benefits were discussed prior to starting an antipsychotic medication and indicated there was no documentation found. During an interview, on 02/27/23 at 9:14 a.m., the Assistant Director of Nursing (ADON) indicated antipsychotic medications when used with a diagnosis of dementia had black box warnings and side effects could be "...sudden death." The resident or decision maker should have the understanding of what those risks could be to the resident before starting the antipsychotic medication. A facility policy, titled "Medication Administration Guidelines," undated and provided by the Executive Director (ED) on 2/27/23 at 11:55 a.m., indicated "...Resident should always be informed of the meds (medications) they are receiving before they receive them...." 3.1-3(n)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	to prevent accidents. Based on observation, interview, and record review, the facility failed to implement existing interventions to prevent further falls for 2 of 3 residents reviewed for accidents. (Resident 20 and 21) Findings include: 1. During an interview, on 02/21/23 at 12:46 p.m., Resident 20 indicated he had multiple falls and had fell quite a few times lately. During an observation of Resident 20's room, on 02/21/23 at 11:55 p.m., no Dycem was found on the recliner. His call light was secured to the head of the bed rail. His bed side table was at the other side of the room. No Reacher was observed in his room. During an observation, on 02/22/23 at 8:58 a.m., Resident 20 was lying in his bed. The call light was attached to the left arm of the recliner. His bedside table was across the room near the other bed. During an observation, on 02/23/23 at 8:36 a.m., Resident 20 was seated in the wheelchair with bedside table in front him. His call light was wrapped around the top of the bed rail. No grip strips were found in front of the recliner. A Reacher to reach items on the floor was not found. The record for Resident 20 was reviewed on 02/21/23 at 9:30 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia, chronic kidney disease, diabetes, glaucoma, hypotension, and weakness. A fall risk review, dated 04/02/22, indicated	F 0689	p="" paraid="600015358" paraeid="{f95ab12b-25c2-4430-8903-92dc1c619fd5}{188}">Deficiency ID: F 689 Free of Accident Hazards / Supervision / Devices It is the policy of The Waters of Tipton that each living center implements the falls prevention and intervention program that includes implementing appropriate interventions (Attachment 3-A). To correct this deficiency: *The identified residents' (2) care plans and CNA assignment sheets have been reviewed and updated for fall interventions. Completed 3/13/2023. p="" paraid="959448434" paraeid="{f95ab12b-25c2-4430-8903-92dc1c619fd5}{249}"> All residents are at risk to be affected by this deficient practice. To ensure that other resident are not affected: *A complete audit of all residents with falls was completed to identify those residents at risk for falls and their fall interventions. To be completed 3/14/2023. *A complete audit of all residents with falls was complete to ensure their CNA assignments sheets match their care plans for fall interventions. To be completed by 3/17/2023. p="" paraid="1229165284" paraeid="{91c3b255-2cbc-43ba-a469-60ce94554cbc}{64}">To prevent	03/18/2023

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	Resident 20 was at high risk for falling. A care plan, with a revision date of 05/02/22, indicated the resident was at risk for falls, due to his condition, risk factors, weakness, confusion, forgetfulness, and use of assistive device. Interventions included, but were not limited to, call light in reach and to explain the use of it upon admission and reinforce as needed, encourage resident to use Reacher to pick up items off the floor, encourage or remind the resident to keep his walker within reach, non-skid strips placed at bedside, and Dycem to recliner. A care guide, dated 02/14/23, indicated for staff to ensure Resident 20 had nonskid strips at the bedside, Dycem to the recliner, encourage or remind resident to keep walker within reach, and encourage resident to use a Reacher to pick items up off the floor. During an interview, on 02/22/23 at 9:23 a.m., the Director of Nursing (DON) indicated the staff should ensure interventions were in place as directed in his care plan. During an interview, on 02/24/23 at 10:00 a.m., the Director of Therapy indicated the no-slip grip was at the end of the resident's bed and the resident would have to reposition himself to the left side for his feet to meet the strips which was not ideal to reduce falls. He should have Dycem on the seat of his wheelchair.2. The record for Resident 21 was reviewed on 02/22/2023 at 9:56 a.m. Diagnoses included, but were not limited to, Huntington's disease (a brain disorder which causes involuntary jerking or writhing movements, muscle problems, such as rigidity and impaired gait, posture, and balance), weakness, osteoporosis, epilepsy, lack of coordination, and		recurrence: *All nursing staff will be educated regarding the Falls Management Guidelines policy and procedure (Attachment 3-A). To /18/2023. In-Service will be provided by DON and ADON. *An audit of all residents with fall interventions will be conducted by the DON or designee 5 X a week for 4 weeks; then weekly X 4 weeks, then monthly X 4 months to review Fall Interventions and ensure that interventions are in place. Any concerns noted through the audit will be immediately corrected and staff will be re-educated. Any trends identified may be further discussed in QAPI and a performance improvement plan may be developed. Any trends identified with specific staff members may result in disciplinary action. (Attachment 3-B). This will be monitored by the Administrator.	

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	abnormalities of gait and mobility. A care plan, dated 01/05/2023, indicated the resident was at risk for falls related to condition and risk factors, a history of falls in the past 30 days, impaired balance, pain, poor trunk control when sitting, and unsteady gait. Interventions included, but were not limited to, Dycem (a material to reduce sliding) to the recliner seat dated 01/10/2023. A care guide given to the staff on the unit to describe the resident's needs indicated Dycem to the recliner. Dycem was not observed on the seat of the resident's recliner chair on 02/23/2023 at 10:54 a.m., 02/24/2023 at 8:41 a.m., or 02/27/2023 at 10:51 a.m. During an interview, on 02/27/2023 at 11:03 a.m., the DON (Director of Nursing) indicated she would investigate the missing Dycem to the resident's recliner. On 02/27/2023 at 1:46 p.m., a square of bright red Dycem, measuring approximately 12 by 12 inches was observed lying on the seat of the resident's walker. A current policy, titled " Falls Management," dated as revised on 10/08/16, indicated residents at risk for falls are care planned with individualized interventions. 3.1-45(a)(2)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with			

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure pain assessments were completed to ensure the effectiveness of pain medications for 1 of 1 resident with a history of pain reviewed for pain management. (Resident 33) Finding includes: During an observation and interview, on 2/21/23 at 2:23 p.m., Resident 33 was observed lying in bed, and facial grimacing was noted in his eyebrows. He indicated he was not feeling well, and his pain made him felt uncomfortable. The nursing staff did not always ask him if he was having pain or if he was comfortable. The record for Resident 33 was reviewed on 2/21/23 at 2:00 p.m. Diagnoses included, but were not limited to, multiple sclerosis, injury at cervical spinal cord, hemiplegia right side dominant, neuropathy, and muscle spasm. A care plan, dated 6/1/18, indicated he had a potential for pain/discomfort related to diagnoses of multiple sclerosis, muscle spasm, and peripheral neuropathy. The interventions included, but were not limited to, assess pain using the 0-10 scale, monitor the effectiveness of pain medication, and administer pain medication per physician orders and note the effectiveness. A review of Resident 33's pain level summary, from 7/25/22 to 1/5/23, indicated a pain level was assessed and documented once a week. There was no documentation of the resident's pain level after 1/5/23.	F 0697	p paraid="600015358" paraeid="{dbe287d7-513a-4543-8834-1f06cc9d8891}{188}" >Deficiency ID: F 697 Pain Management It is the policy of The Waters of Tipton that the facility has a standard format for assessing, monitoring, and documenting pain and that as part of a comprehensive approach to pain assessment and management, pain will be considered the “fifth” vital sign at the facility. (Attachment 4-A). To correct this deficiency: The identified resident (1) was immediately assessed for pain and has pain monitoring added to his orders to be completed every shift, weekly, and quarterly going forward. Completed 3/1/2023. p paraid="959448434" paraeid="{dbe287d7-513a-4543-8834-1f06cc9d8891}{253}" > All residents are at risk affected	03/18/2023

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	During an interview, on 2/23/23 at 2:14 p.m., Registered Nurse (RN) 2 indicated Resident 33 did not have a pain assessment completed since 1/5/23. All pain medications scheduled or as needed should be monitored for effectiveness. A current policy, titled "Management of Pain," indicated to monitor treatment efficacy and side effects. 3.1-37(a)		by this deficient practice. To ensure that resident not affected: *A complete audit of all residents with orders for routine pain medications was completed to identify those residents at risk for not having routine pain assessments in place. Completed 3/1/2023. ·*All residents identified with routine pain medications received an order for pain monitoring to be completed each shift. Completed 3/1/2023. ·*All residents identified with routine pain medications have an order to monitor pain weekly with vital signs check. Completed 3/1/2023. ul class="BulletListStyle1 SCXW152607822 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All residents identified with routine pain medications have an order for a quarterly pain assessment to be completed by nursing. Completed 3/1/2023.	

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			To prevent recurrence: *All nursing staff will be educated regarding the Management of Pain policy and procedure (Attachment 4-A). To be completed by 3/18/2023. In-Service will be provided by DON and ADON. ·*An audit of all residents receiving routine pain medications will be conducted by the DON or designee 5 X a week for 4 weeks; then weekly X 4 weeks, then monthly X 4 months to review pain assessments, ensure residents pain is controlled at an acceptable level. Any concerns noted through the audit will be immediately corrected and staff will be re-educated. Any trends identified may be further discussed in QAPI and a performance improvement plan may be developed. (Attachment 4-B). Completion of audits will be monitored by the Administrator.	
F 0812 SS=D 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			

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	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 maintain equipment and kitchen areas in a manner to prevent cross contamination related to 1 of 1 randomly observed ice machine and 1 of 1 randomly observed dietary aid. (First-floor ice machine and dietary aide 1) Findings include: 1. During an observation, on 2/23/23 at 9:27 a.m., the ice machine on the first floor was found to have a white plastic guard located in the ice bin with a black spotted dry substance coated two inches along the entire bottom which was in contact with the ice. During an observation and interview, on 2/23/23 at 9:30 a.m., an unidentified female dietary aide grabbed a clear plastic container and started to scoop the ice into the container from the ice machine. The dietary aide indicated she was going to fill the ice container near the soda machine.	F 0812	p="" paraid="600015358" paraeid="{af978838-1591-429d-a337-cf0d984b73f3}{188}">Deficiency ID: F 812 Food Procurement, Store / Prepare / Serve - Sanitary It is the policy of The Waters of Tipton that the facility will follow sanitary practices in food preparation (Attachment 5-A). To correct this deficiency: The ice in the ice machine was immediately disposed of and the ice machine was immediately cleaned by maintenance. Completed 2/23/2023. ul="" role="list" The dietary aide immediately stopped sweeping the floor when instructed not to sweep during meal preparation. Completed 2/23/2023 All residents are at risk affected	03/18/2023

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	During an observation and interview, on 2/23/23 at 9:30 a.m., the Dietary Manager indicated the white plastic guard inside the ice machine was in contact with the ice and appeared to have a black colored debris, mildew, or mold coating it. Maintenance was responsible for cleaning and maintaining the ice machine. The Dietary Manager directed the dietary aide to not use the ice and dispose of it in the garbage disposal. The ice machine was used throughout the facility for use in beverages, ice packs, and to fill the coolers as needed. 2. During an observation of the meal service prep, on 2/23/23 at 10:30 a.m., the cook was in the kitchen and had items prepped for making the pureed chicken and vegetables. A dietary aide stood on the opposite side of the table to prep the dessert. An unidentified dietary aide (dietary aide 1) grabbed a black bristle boom, walked within five feet from the food prep area and begun to sweep toward the cook and dietary aide who were prepping for lunch. During an interview, on 2/23/23 at 10:35 a.m., the Dietary Manager indicated sweeping should not be completed during food preparation due to the risk for contamination. A facility document, titled "Ice Machine PM Checklist, Semi- Annual Inspection," indicated all ice machines need to be inspected, disinfected, condenser, and evaporator coils cleaned, fan blades inspected, and cleaned. A facility policy, titled "General Preparation and Cooking Practices," dated 4/17, indicated the facility would follow sanitary practices in food preparation and cooking to keep food safe.		by this deficient practice. To ensure that resident not affected: An audit of all ice bins was completed no other ice bin was in need of cleaning. Completed 2/23/2023. All dietary staff were immediately in- not to sweep during meal preparation. /23/2023. p="" paraid="1922036128" paraeid="{5a7fb3d5-a545-4591-b3f4-037f673c4911}{57}"> To prevent recurrence: All dietary and maintenance staff were immediately on the policy General Preparation & Cooking Practices (Attachment 5-A) and included cleaning ice bins and not sweeping during meal preparation. Completed 2/23/2023. An audit of all dietary sanitation will be conducted by the Dietary Manager or designee 5 X a week for 4 weeks; then weekly X 4 weeks, then monthly X 4 months to review Sanitation with the ice bins and ensure that no sweeping is done during meal preparation. Any concerns noted through the audit will be immediately corrected and staff will be re-educated. Any trends identified may be further discussed in QAPI and a performance improvement plan may be developed. Any trends identified with specific staff members may result in disciplinary action. (Attachment 5-B)	

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	3.1-21(i)(3)			
F 0880 SS=D 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			

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	precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure hand hygiene was performed prior to donning Personal Protective Equipment (PPE), prior to entering and upon exiting resident rooms, and failed to ensure a vital sign machine was sanitized after use and	F 0880	p="" paraid="600015358" paraeid="{70181f44-1461-450e-9859-95fc5634d8c3}{188}" **Directed Plan Of Correction** **F880 Specific/Immediate: ·** **The Waters of Tipton failed to**	03/20/2023

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	prior to parking it in the hallway for 3 of 3 staff members randomly observed for infection control practices. (CNA 7, CNA 9, and LPN 8) Findings include: 1. During an observation, on 02/21/23 at 11:13 a.m., CNA 7 removed an isolation gown from the supply hanging on the door of an isolation room for Resident 5. While donning the gown, it was observed to touch the floor. After CNA 7 had tied the gown and slid it over her head, someone yelled for help. CNA 7 removed the gown and put it back into the supply hanging on the door. CNA 7 then entered Resident 194's room, asked the resident if she had yelled for help, was told she did not. She then exited the room, and entered Resident 43's room, spoke with her, and then exited the room. After speaking with another employee in the hall, she then returned to the isolation room for Resident 5, removed the gown she had placed back into the isolation kit, then opened a box of gloves, placed the box into the isolation kit and then grabbed a set of purple gloves and put them on. She was not observed to have performed hand hygiene prior to her initial attempt to don Personal Protective Equipment (PPE), prior to entering Resident 194's room, upon exiting Resident 194's room, prior to entering Resident 43's room, upon exiting Resident 43's room or prior to the second time she donned PPE to enter an isolation room for Resident 5. During an interview, on 02/21/23 at 11:19 a.m., CNA 7 indicated she should have discarded the gown and not put it back into the isolation kit and she should have performed hand hygiene. 2. During an observation, on 02/21/23 at 2:49 p.m., CNA 9 was observed to approach Resident 5's		**follow written policies and procedures for infection control, during the annual review of its IPCP. · This deficient practice has the potential to affect all residents.** The following interventions were immediately implemented following identification by staff of the deficient practices, including, the following corrections: · all staff were educated regarding how and when to don and doff PPE with return demonstration, including, but not limited to performing hand hygiene as the first step following DCD guidance and facility policy; and ensured that hand hygiene items, including soap and water or ABHS is always available (completed 3/17/2023).· vital signs machine was immediately sanitized with EPA appropriate cleaner and identified LPN was provided with education (2/21/2023). **Systemic:1. Conduct a Root Cause Analysis (RCA) with an Infection Preventionist (IP), with input from the facility Medical Director/IP/DON.** **a. Identify the root cause resulting in the facility's failure. This includes the Who, What, Where, When, and Why questions.** · Root Cause Analysis (RCA) was completed with Infection Preventionist (IP)	

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	room, don gloves from the isolation kit, put on a gown, and enter the room. During an interview, on 02/21/23 at 2:54 p.m., CNA 9 indicated she did not perform hand hygiene, she had forgotten. 3. During an observation, on 02/21/23 at 10:53 a.m., LPN 8 was observed to remove a vital sign machine from Resident 194's room. She took the machine to the nursing station in the middle of the hall, sat at the computer and began to enter information. During an interview, on 02/21/23 at 10:57 a.m., LPN 8 indicated she cleans the vital sign machine in the morning before use, then she checks all vital signs of residents not in isolation and then cleans the machine. If she entered an isolation room, she would clean it between residents, but she would really wipe it down after using it on COVID/isolation residents. She then got up and took the vital sign machine down the hall, plugged it in and walked away. She was not observed to have sanitized the machine after she removed it from Resident 194's room, or prior to leaving it charging in the hall. During an interview, on 02/27/23 at 11:46 a.m., the Assistant Director of Nursing indicated the vital sign machine should have been cleaned after it had been used and prior to plugging it in and leaving it in the hall. Hand hygiene should have been performed prior to donning PPE, before entering residents' rooms, and upon exiting the residents' rooms. A facility policy, titled "Personal Protective Equipment (PPE)," undated and provided by the Director of Nursing on 02/21/23 at 1:56 p.m.,		with input from the facility Medical Director, Director of Nursing, facility Administrator, and Maintenance Director (Attachment DPOC 6-A). Completed 3/13/2023 **b. Develop solutions and systemic changes (with the IP) that need to be taken to address the root cause. Return the solutions and systemic changes with the DPOC documentation.** · Addition of stationary hand sanitizers in identified areas within the facility by nursing and maintenance in an IDT meeting (completed 3/20/23).· Follow up after initial training for new staff members on return demonstration of Donning / Doffing PPE and sanitizing equipment (Implemented 3/20/2023 and ongoing with all new staff)· Facility review of policy and procedures including: Infection Control: PPE DONNING AND DOFFING and CLEANING AND DISINFECTING NON-CRITICAL RESIDENT CARE ITEMS policy and procedure (Attachment DPOC 6-B). **2. Review the LTC infection control self-assessment with the consultant IP to determine if it is an accurate reflection of the nursing home. Make changes as needed to make accurate and submit with the DPOC documentation.**· LTC	

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	indicated "...Perform Hand Hygiene...Don Gown....Doffing (removing) PPE...Remove Gown...Discard in waste container...Perform Hand Hygiene...." A facility policy, titled " Isolation-Categories of Transmission-Based Precautions, dated as revised in August 2012 and provided by the Director of Nursing on 02/21/23 at 1:56 p.m., indicated "...If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident...." 3.1-18(b) 3.1-18(l)		infection control self-assessment was reviewed with the IP to be an accurate reflection of the facility (Attachment DPOC 6-C). Completed 3/20/2023 **Training :1. After the RCA and LTC infection control assessment has been completed, implement training to all staff.a. The facility IP will provide training resources and competencies. b. Return the training documents with the DPOC documentation.** Facility IP and ADON educated staff on 3 /17/2023 on policy and procedures including: Infection Control: PPE DONNING AND DOFFING and CLEANING AND DISINFECTING NON-CRITICAL RESIDENT CARE ITEMS policy and procedure (Attachment DPOC 6-B). Education provided (Attachment DPOC 6-D). Return demonstration was included in training. **Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained.1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA, daily or more often as necessary for 6 weeks and until compliance is maintained. 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	02/27/2023

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			ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B1b as above. This will occur for 6 weeks and until compliance is maintained. · QAPI tool titled Infection Prevention and Control – will be completed by IP urse/DON/Designee daily or more often as necessary for 6 weeks and until compliance is maintained. IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA, daily or more often as necessary for 6 weeks and until compliance is maintained (Attachment DPOC 6-E). **Quality Assurance and Performance Improvement (QAPI):1. The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. Findings will be reviewed immediately and corrected upon discovery. Concerns will be logged on the "Quality Performance Facility Plan of Action" (Attachment DPOC 6-F) for review at the monthly QAPI meeting with	

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			systemic changes made as appropriate. p="" paraid="1922036128" paraeid="{8d8e0eb6-d2fc-47c2-9f55-294a452ad52d}{39}">	