STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155477	A. BUILDING 00 B. WING	02/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LANE HOUSE, THE	1000 LANE AVE CRAWFORDSVILLE, IN 47933

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 13, 14, 15, 16, and 19, 2024 Facility number: 000462 Provider number: 155477 AIM number: 100275380 Census Bed Type: SNF/NF: 46 NF: 36 Total: 46 Census Payor Type: Medicare: 0 Medicaid: 36 Other: 10 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2024.	F 0000	The submission of this POC does not indicate an admission by The Lane house that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of The Lane House. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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			

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

Gloria McGowen | Executive Director | 03/05/2024

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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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident was transferred properly for 1 of 1 resident reviewed for accidents (Resident 14). Findings include: On 2/13/24 at 2:10 p.m., a local police officer was observed entering Resident 14's room with the resident's family member. During an interview, on 2/13/24 at 2:12 p.m., the Executive Director (ED) indicated there had been an allegation of abuse from a resident which indicated a staff had hit her in the right breast during care. The facility had sent in a State reportable incident form and begun an investigation. They also contacted the local police to get statements and investigate. Resident 14's record was reviewed on 2/19/24 at 9:55 a.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems), unspecified dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities without a specific diagnosis), and cognitive communication deficit (difficulty with thinking and how someone uses language which may occur after a stroke, tumor, brain injury, progressive degenerative brain disorder, or other	F 0689	1 Resident 14 had no injury. Additional skin and pain UDA completed as well as OT COTA performed screening with no noted concerns. MD and family were notified on 2/13/2024 of alleged allegation. CNA suspended pending investigation. 2 Other staff members were observed for gait belt use with transfers in the facility that are not mechanical lift transfers. This was completed by nursing management by date of compliance. 3 Education will be provided to nursing staff on the gait belt policy by nursing management members. Gait belt competencies will be completed with nursing by date of compliance by nursing management. No nursing employees will work past date of compliance without this education and competencies being completed. This education/competencies will be offered upon hire, at least annually and as needed. 4 Nursing managers or designee will observe transfers with gait belts 3 x weekly for two month, 2x weekly for two month and 1x weekly for two month.	03/15/2024

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	neurological damage). A quarterly Minimum Data Set (MDS) assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 11/10/23, indicated the resident had moderate cognitive deficit and had no documented behaviors. A care plan, dated 6/4/19, indicated the resident had activities of daily living (ADL-activities related to personal care) self-care performance deficit. Interventions included, but were not limited to, the resident transfers with stand by assistance (SBA-the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury while performing the ADL task in question) of 1 staff assist. A fall risk assessment, dated 1/1/24, indicated the resident was a high risk for falls. A State reportable incident form, dated 2/13/24, was observed. The form indicated the resident had alleged Certified Nursing Assistant (CNA) 8 had been rough with her. The CNA had been suspended pending the facility investigation. The resident was assessed, and no injury was noted. The facility's investigation had been initiated, A typed statement, by Licensed Practical Nurse (LPN) 4, dated 2/13/24, indicated she had often offered assistance to CNA 8, but CNA 8 would get angry when assistance was offered. CNA 8 did not use a gait belt (an assistive device which can be used to help safely transfer a person from a bed to a wheelchair, assist with sitting and standing, and help with walking around) with her transfers.		Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	A typed statement by CNA 8, dated 2/13/24, indicated on 2/12/23 at approximately 6:30 a.m., she had completed morning (am) care with the resident. At times when she assisted the resident to her wheelchair, she would place her arm under the resident's arm to guide her. The resident did not complain during care or exhibit any signs or symptoms of pain or injury during the time of the transfer. The statement lacked documentation that the CNA had used a gait belt when she transferred the resident. During an interview, on 2/19/24 at 11:01 a.m., CNA 7 indicated staff were supposed to use gait belts when transferring residents. Each resident who was assisted with transfer would have a gait belt in their room. At the same time, a gait belt was observed in a bag hanging on the back of Resident 14's door. During an interview, on 2/19/24 at 11:03 a.m., Resident 14 indicated she could not remember if CNA 8 had used the gait belt on her when she was attempting to transfer her on the date of the incident. During an interview, on 2/19/24 at 11:19 a.m., the Assistant Director of Nursing (ADON) indicated during the facility's investigation, it was determined that CNA 8 did not use a gait belt while transferring Resident 14. It was the policy of the facility that staff would use gait belts when transferring residents. At the same time, the ADON provided telephone contact information for CNA 8, and indicated the Director of Nursing (DON) had called CNA 8 and instructed her that someone would be calling her to question her about the alleged incident, and to make sure she answered her phone.			

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	Three attempts were made to contact CNA 8 by telephone on 2/19/24. The first attempt was at 11:30 a.m., with no answer and a message was left informing the CNA that a second call would be forthcoming. The second attempt was made at 11:40 a.m., with no answer. The third attempt was made at 11:50 a.m., with again no answer. During an interview, on 2/19/24 at 12:05 p.m., the DON indicated facility used the Lippincott guidelines (provides evidence-based procedure guidance at the point of care with over 1,700 procedures and skills from a wide variety of nursing specialties) for the gait belt use as the policy for the facility. If CNA 8 was reinstated to her position, the CNA would be educated on the guidelines, and pass the skills check-off, prior to returning to her regular schedule. On 2/19/24 at 12:05 p.m., the DON provided a document, with a revision date of 9/11/23, titled, "Gait Belt Use," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The facility will provide Gait Belt Use in accordance with professional standards of practice, as outlined by Lippincott...Procedure: The facility will utilize Lippincott procedures...." On 2/19/24 at 12:05 p.m., the DON provided a document, dated 9/15/23, titled, "Skills Checklist-Gait Belt Use," and indicated it was the policy currently being used by the facility. The policy indicated, "...Objective: To use a gait belt according to the standard of care...Checklist Step...Wrap gait belt around the patient's waist...Adjust the gait belt so that it fits snugly around the patient's waist...Position yourself close to the patient so that you're facing each other. Grasp both sides of the gait belt with an			

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	underhand grip. While firmly gripping the gait belt...instruct the patient on the count of three, to push off the bed or other surface...Keeping a firm grip on the gait belt, gently lower the patient onto the destination surface...." 3.1-45(a)(1)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure they were free of a medication error of 5% or higher with an error rate of 6.67% for 1 of 5 residents observed for medication administration (Resident 24). Finding includes: During an observation of medication administration, on 2/15/24 at 9:30 a.m., Registered Nurse (RN) 3 proceeded into the main dining room where Resident 24 was standing. RN 3 had a medication cup with the resident's medication in it. Resident 24 was standing by a table with her walker when RN 3 set down the cup of pills on the table. The nurse obtained the resident's blood pressure and indicated to Resident 24 these were her morning pills and that she would be back in a minute because she needed to check on her blood pressure parameters due to her low blood pressure reading. RN 3 walked away from the resident and exited the dining room with 2 pills still in the medication cup minus her blood pressure medication. RN 3 did not observe the resident take her medication before she left the	F 0759	1 Resident #24 had no negative outcomes. RN # 3 was educated immediately. 2 An in house audit random observations of med pass by nursing managers was completed by date of compliance observing medication administration to ensure compliance. No other occurrences were noted. 3 Medication pass competencies were completed by nursing management to ensure nurses were following the med pass policy. No licensed nursing staff will work past date of compliance without education and competency completed. This will be presented on orientation, at least annually and as needed. 4 Nursing managers will audit MARS and TARS 5 times weekly x 2 months, then 3 times weekly x 2 months, then 2 times weekly x 2 months. Audits will be presented	03/15/2024

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	dining room. Resident 24's record was reviewed on 2/15/24 at 11:45 a.m. The profile indicated the resident's diagnoses, included but were not limited to, unspecified dementia (a condition characterized by progressive or persistent loss if intellectual functioning) without behavioral disturbance, essential (primary hypertension) high blood pressure that is not due to another medical condition, and unspecified atrial fibrillation (the heart's upper chambers, called the atria, beat chaotically and irregularly). A quarterly Minimum Data Set (MDS) assessment (a standardized assessment tool that measures health status in nursing home residents), dated 1/17/24, indicated the resident had moderate cognitive impairment. A physician order, dated 2/14/24, indicated Lasix (treat fluid retention) 20 mg (milligram) by mouth one time a day for edema (swelling). A physician order, dated 12/11/23, indicated Venlafaxine (antidepressant) 75 mg by mouth one time a day for depression. During an interview, on 2/15/24 at 1:18 p.m., Licensed Practical Nurse (LPN) 4 indicated the nurse must stay with a resident during medication administration and ensure the resident had taken their medication as ordered. On 2/15/24 at 11:33 a.m., the Regional Director of Clinical Services provided a document, with a revised date of 9/22/21, titled, "Oral Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Stay with the patient until the		to QAPI x 6 months and QAPI will determine the need for further audits.	

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	patient has swallowed the drug ...." 3.1-48(c)(1)			
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 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 hair restraints (hair covering and nets, beard restraints, and clothing that cover body hair) were worn in the kitchen during meal service and preparation during 2 of 2 kitchen observations. Findings include: 1. On 2/13/24 at 11:49 a.m., during observation of	F 0812	1 Staff that were cited in 2567 were immediately educated and put on hair and beard restraints 2 Meal times were randomly observed by Ed or IP for staff having hair/beard restraints on at the proper times. Any concerns were addressed immediately 3 Education will be provided to staff on the hair restraint/beard policy. This education will be	03/15/2024

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	the lunch meal service in the main dining room, an area in the kitchen was observed to be marked with tape, across the floor, which designated the area staff could not go beyond, without a hair restraint. Licensed Practical Nurse (LPN) 4 was observed entering the kitchen area, beyond the designated area, to retrieve meal trays without a hair restraint. At the same time, the Dietary Manager was observed standing in the kitchen, beyond the designated area, with uncovered facial hair. During an interview, on 2/13/24 at 12:01 p.m., the Dietary Manager indicated that both he and LPN 4 were past the designated area of the kitchen and should have been wearing hair restraints. 2. During observation of pureed food (a way to change the texture of solid food so that it is smooth with no lumps and has a texture like pudding) preparation, on 2/16/24 at 10:30 a.m., the Dietary Manager was preparing the pureed food with uncovered facial hair. At the same time, the Dietary Manager acknowledged that he should have his facial hair covered, but failed to put on any hair restraint, and completed the procedure. On 2/14/24 at 10:01 a.m., the Executive Director (ED) provided a document, with a revision date of 3/28/23, titled, "Associate Conduct and Dress Code," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: The facility will ensure all foodservice associates adhere to the company's established code of conduct and dress code...Hair Restraints/Jewelry/Nail Polish-Dietary staff must wear hair restraints (e.g., hairnet...beard restraint)...Procedure: ...1...e. All facial hair including moustaches and beards should be...covered...."		presented upon hire, annually and as needed. No employees will work past date of compliance without this education being completed. 4 An audit for hair restraints/beard by the IP or Designee 3 x weekly x 2 months, 2 times weekly x 2 months, and then 1 time weekly x 2 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative			

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	proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review, the facility failed to ensure the medical record of medication administration was accurately documented for 1 of 5 residents reviewed (Resident 31). Findings Include:	F 0842	1 Resident 31 had no negative outcomes. 2 An in house audit will be completed going back 30 days from date of exit to review MARS and TARS. Any concerns noted will be addressed with appropriate	03/15/2024

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	On 2/15/24 at 10:52 a.m., the medical record of Resident 31was reviewed. The resident was admitted to the facility on 2/22/23. Diagnosis included, but were not limited to, chronic obstruction obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems) COPD, aphasia (a language disorder caused by damage in a specific area of the brain that controls language expression and comprehension) following a cerebral infarction (a stroke which is when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel), anxiety disorder (a feeling of fear, dread, and uneasiness which might cause you to sweat, feel restless and tense, and have a rapid heartbeat), malignant neoplasm of right female breast (cancerous tumor), depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). Physician orders included but were but not limited to, Paroxetine HCl oral tablet 10 mg (milligrams) (Paroxetine HCl) give 20 mg by mouth one time a day for depression, dated 10/20/2023; Lorazepam oral tablet 0.5 mg (Lorazepam) give 1 tablet by mouth at bedtime related to anxiety disorder, dated 11/7/2023; Trazodone HCl oral tablet 50 mg (Trazodone HCl) give 25 mg by mouth at bedtime for anxiety dated 2/13/2024; Hydrocodone-Acetaminophen oral Tablet 10-325 mg (Hydrocodone-Acetaminophen) give 1 tablet by mouth four times a day for pain dated 3/27/2023; Gabapentin Capsule 300 mg give 1 capsule by mouth three times a day for pain - mild dated 4/27/2023; Magnesium Oxide oral tablet 400 mg (Magnesium Oxide) give 1 tablet by mouth		licensed nurse involved and MD will be notified of any omissions encountered. 3 Education and med pass competencies will be provided and completed to licensed nursing staff on med pass policy including appropriate documentation. No licensed nurse will work past date of compliance without this education being completed. This education will be provided upon hire, at least annually, and as needed. Nursing management will have this completed by date of compliance. 4 Nursing management will audit Mars/Tars 3 times weekly for 2 months, then 2 times weekly x 2 months, then 1 time weekly x 2 months. Audits will be presented to QAPI monthly x 6 months and QAPI will determine the need for ongoing audits if indicated.	

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LANE HOUSE, THE	1000 LANE AVE CRAWFORDSVILLE, IN 47933

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	three times a day for leg cramps dated 6/2/2023; and Acetaminophen Tablet 325 mg give 2 tablets every 4 hours as needed (PRN) for pain. A quarterly Minimum Data Set, (MDS) (a standardized assessment tool that measures health status in nursing home residents), dated 12/8/23, indicated the resident had a moderate cognitive impairment. A care plan, dated 5/15/23, included Resident expressed pain & discomfort related to arthritis and cancer. Interventions included but were not limited to, anticipate the resident's need for pain relief and respond immediately to any complaint of pain, evaluate the effectiveness of pain interventions, identify, and record previous pain history and management of pain and impact. Review of medication administration record (MAR) for December 2023 lacked documentation that the following medication were administered. Hydrocodone 1-325 mg (milligrams) on 12/7/23 at 6:00 a.m., 12/22/23 at 6:00 p.m., and 12/23/24 at 6:00 a.m. The Medication administration record for January 2024 lacked documentation that the following medication was administered. Omeprazole 40 mg 1/21/24 a.m. dose. The Medication administration record for February 2024 lacked documentation that the following medication were administered: Docusate Sodium 100 mg 2/10/24 p.m. dose, Gabapentin 300 mg 2/10/24 p.m. dose, and Magnesium oxide 400 mg 2/10/24 p.m. dose. On 2/15/2024 at 11:33 a.m., the Director of Nursing Services (DON) provided a document titled, "Administration of medications," dated 2/13/23,			

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	and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...The facility will ensure medications are administered safely and appropriately per physician order ...B. Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration ...6. Right Documentation ...Make sure to write the time and any remarks on the chart correctly ...Medication administration should be documented timely following the administration to the resident ...Controlled substances should be signed out from the descending count sheet and documented on the MAR for each routine and PRN dose of medication administered ...." 3.1-50(a)			
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			

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	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure proper handling of medication patches during the medication administration pass for 2 of 5 residents reviewed during medication administration (Residents 9 and 26). Findings include: 1. During a medication administration observation, on 2/15/24 at 9:44 a.m., RN 3 placed a Lidocaine (pain relief medicated patch) external patch onto Resident 9's right shoulder. RN 3 did not have gloves on when removing the patch from the packaging or when placing the patch onto the resident's shoulder. Resident 9's record was reviewed, on 2/15/24 at 1:20 p.m. The profile indicated the resident diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe) and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one sided weakness, but without complete paralysis). An annual minimum date set (MDS) assessment (a	F 0880	1 The nurse was immediately educated on the use of gloves with all medication patches. Residents #9 and #26 had no negative outcomes. 2 Random observations were implemented for nurses, to observe for further infection control issues related to medication pass. This was completed by nurse managers by date of compliance. 3 Education was provided to nurses in the building by nursing management and the IP nurse on the medication pass policy related to the use of gloves during a medication patch administration. Medication pass competencies were completed by nursing management to ensure nurses were following the medication pass policy related to infection control. Licensed nurses will not work without this education being completed past date of compliance. This education will be presented in orientation, at least annually and as needed. 4 An audit on medication pass related to Infection Control	03/15/2024

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	standardized assessment tool that measures health status in nursing home residents), dated 12/11/23, indicated the resident had moderate cognitive impairment. A physician order, dated 7/24/23, indicated Lidocaine external patch 5%, apply to right shoulder every morning for pain. 2. During a medication administration observation, on 2/15/24 at 10:35 a.m., RN 3 removed a NicoDerm (smoking sensation medication) patch from the box and used a pair of scissors to cut the patch out of the package with her bare hands. RN 3 proceeded from the medication cart to Resident 26's room with her medications. The nurse removed an old NicoDerm patch from the right side of her chest and placed the new patch on the left side of her chest. The nurse did not wear gloves when removing the old patch and placing a new patch on the resident. Resident 26's record was reviewed, on 2/15/24 at 1:29 p.m. The profile indicated the resident diagnosis included, but were not limited to, COPD and fibromyalgia (a long-term condition that involves widespread body pain and tiredness). An admission MDS assessment, dated 1/22/24, indicated the resident was cognitively intact. A physician order, dated 1/15/24, indicated NicoDerm cq transdermal patch 24-hour 21mg (milligram), apply one transdermal patch once a day for smoking cessation. During an interview, on 2/15/24 at 10:35 a.m., RN 3 indicated she should have worn gloves when removing and or placing medication patches on the residents.		practices 3 x weekly for two month, 2 x weekly for two months, and 1x weekly for two month by nursing management or designee. Audits will be presented to QAPI monthly x 6 months and QAPI will determine the need for further audits.	

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	During an interview, on 2/15/24 at 1:18 p.m., Licensed practical nurse (LPN) 4 indicated nursing staff should always wear gloves when removing or placing medication patches on the residents. On 2/15/24 at 11:33 a.m., the Regional Director of Clinical Services provided a document, with a revised date of 9/23/21, titled, "Transdermal Ointment and Patch Application," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Put on gloves and as needed, other personal protective equipment to comply with standard precautions ...." 3.1-18(b)(1)			
F 0908 SS=D Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview the facility failed to maintain all mechanical equipment was kept in safe operating condition for 2 of 2 observations of the laundry service area. Findings Include: On 2/19/24 at 11:02 a.m., during routine observation of the laundry service area, two large fans were observed. The fan blades and the fan cage covering the blades were coated in a thick layer of grey lint. On the floor behind washers were a large amount of grey lint and debris. Lint traps in two dryers contained a moderate amount of lint on the screens. The cleaning logs indicated	F 0908	1 Fans have been removed from the laundry area and lint was cleaned from the washers/dryers areas. 2 The laundry room has had random observations completed by Housekeeping Supervisor for excessive lint behind washers/dryers. Any concerns noted has been addressed immediately. 3 Education will be provided to laundry and housekeeping staff on routine cleaning of lint in the laundry. This education will include a routine schedule for	03/15/2024

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	the lint traps were cleaned frequently. The lint on the fans and behind the washers created a risk for fire hazard. On 2/19/24 at 1:30 p.m., during an interview with the Administrator indicated the fans and floors of the laundry area must be kept clean and free of lint. On 2/19/2024 at 11:30 a.m., the Assistant Director of Nursing (ADON) provided a document titled, "Laundry Services- General Policy," dated 2/12/20, and indicated it was the policy currently being used by the facility. The policy indicated, "...Separating clean from Dirty in the Laundry...5. All areas should be cleaned on a regular basis ...." 3.1-19(bb)		cleaning behind the washers/dryers as well as accurate, appropriate and timely documentation. No laundry or housekeeping personal will work past date of compliance without this education being completed. This education will be completed upon hire, annually and as needed. 4 An audit for the laundry room lint will be conducted by the laundry/housekeeping manager or designee 3 x weekly for two months, 2 x weekly for two months and 1x weekly for two months. Results will be presented to QAPI monthly and QAPI will determine the need for further audits.	