STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 00 B. WING	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: November 21, 22, 25, 26, and 27 2024 Facility number: 003075 Provider number: 155695 AIM number: 200364160 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 1 Medicaid: 43 Other: 27 Total: 71 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 12/12/2024	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after January 8, 2025.**	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on interview and record review, the facility failed to provide the resident and/or the resident's representative with a notice of transfer for 2 of 2 residents reviewed for hospitalization (Residents 21 & 48). 1. During an interview on 11/21/2024 at 10:22 A.M., Resident 21 indicated she had been to the hospital in the last 4 months.	F 0622	F622 – Transfer and Discharge Requirements What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #21 was not negatively affected by this practice. Resident #48 was not negatively affected by this practice	01/08/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tarshia Taylor	Executive Director	12/23/2024

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	On 11/25/2024 at 11:25 A.M., a record review was completed for Resident 21. A Quarterly Minimum Data Set assessment (MDS), dated 10/8/2024 indicated the resident had mild cognitive impairment. A review of Resident 21's census record indicated the resident was hospitalized on 4/19/2024 and returned to the facility on 4/23/2024. A Nursing Progress Note, dated 4/19/2024 at 4:50 P.M., indicated after assessing the resident, the nurse called Emergency Services and the resident was transported to the hospital. During an interview on 11/25/2024 at 1:07 P.M., LPN 12 indicated the process for sending a resident to the hospital included filling out paperwork prior to the resident leaving the facility and completing a transfer/discharge assessment in the resident's chart. During an interview on 11/25/2024 at 1:14 P.M., the Infection Prevention Nurse indicated the transfer/discharge assessment could be found in the observations tab in the resident's chart. She indicated the transfer/discharge paperwork was uploaded to the chart with the resident's discharge paperwork from the hospital. The record lacked the documentation that a transfer/discharge assessment was completed in conjunction with Resident 21's transfer to the hospital on 4/19/2024. During an interview on 11/25/2024 at 1:30 P.M., the Infection Prevention Nurse indicated she was unable to find a transfer/discharge assessment for Resident 21. She indicated one was not completed and should have been.2. A record review was		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. An audit will be completed for any residents transferred to the hospital in the past 30 days to verify the ASC Transfer observation form was completed and accurate. Any deficiencies will be corrected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/designee will in-service all nurses on or before January 8th 2025 on completing the ASC Transfer observation when sending any resident to the hospital. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Transfer/Bed Hold” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be	

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	completed on 11/25/2024 at 9:02 A.M. for Resident 48. Diagnoses included, but was not limited to: unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, and generalized anxiety disorder. A Nursing Progress Note, dated 1/11/2024 at 1:05 P.M., indicated there was an order for Resident 48 to be sent to the psychiatric hospital for an evaluation and treatment related to behaviors. A Nursing Progress Note, dated 1/18/2024 at 12:20 P.M., indicated Resident 48 returned to the facility. A record of hospital transfer forms to the hospital was not found in the electronic medical record. During an interview on 11/25/2024 at 10:51 A.M., LPN 10 indicated that when a resident was sent to the hospital the following papers would be sent with the resident: emergency transfer observation, CCD (Continuity of Care Document), and a bed hold policy. LPN 10 could not locate the transfer paperwork for 1/11/2024 and indicated it should have been filled out. On 11/25/2024 at 2:50 P.M., the Regional Nurse provided a policy titled, "Hospital Discharge/Transfer," revised 2/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...Nursing will complete an Emergency transfer observation and attach copies of the following information from the resident medical record: Face Sheet, H&P Physician Notes, Current orders, CCD, Advance directives, Comprehensive Care Plan, Pertinent labs, Notice of Transfer/Discharge, Bed hold policy, Nursing Notes....."		submitted to the QAPI Committee for review and follow up By what date the systemic changes will be completed: January 8th, 2025	

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F 0625 SS=D Bldg. 00	3.1-12(3) 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure bed hold policies were provided to the resident and/or responsible parties at the time of the hospital transfer for 2 of 3 residents reviewed for hospitalization (Residents 21 & 48). Findings include: 1. During an interview on 11/21/2024 at 10:22 A.M., Resident 21 indicated she had been to the hospital in the last 4 months and did not recall receiving any paperwork prior to leaving the facility. On 11/25/2024 at 11:25 A.M., a record review was completed for Resident 21. A Quarterly Minimum Data Set assessment (MDS), dated 10/8/2024 indicated the resident had mild cognitive impairment. A review of Resident 21's census record indicated the resident was hospitalized on 4/19/2024 and returned to the facility on 4/23/2024. A Nursing Progress Note, dated 4/19/2024 at 4:50 P.M., indicated after assessing the resident, the nurse called Emergency Services and the resident was transported to the hospital. A Nursing Progress Note, dated 4/23/2024 at 4:30 P.M., indicated Resident 21 was readmitted to the facility from the hospital. During an interview on 11/25/2024 1:07 P.M., LPN	F 0625	F625- Notice of Bed Hold Policy Before/Upon Transfer What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #21 was not negatively affected by this practice. Resident #48 was not negatively affected by this practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. An audit will be completed for any residents transferred to the hospital in the past 30 days to verify that the bed hold was provided to the resident and/or responsible party at the time of the transfer. Any deficiencies will be corrected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The DNS/designee will in-service all nurses on or before January 8th 2025 on following the bed hold policy including providing a bed hold to the resident/and or responsible party at the time of a	01/08/2025

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	12 indicated the process for sending a resident to the hospital included filling out paperwork prior to the resident leaving the facility. The paperwork included the bed hold policy and a transfer/discharge assessment. During an interview on 11/25/2024 at 1:14 P.M., the Infection Prevention Nurse indicated the bed hold policies would either be in the miscellaneous tab in the resident's chart or possibly in the paperwork waiting to be scanned into the resident's record. During an interview on 11/25/2024 at 1:30 P.M., the Infection Prevention Nurse indicated she was unable to find a bed hold policy for Resident 21. She indicated a bed hold policy should have been sent with the resident prior to leaving the facility. The record lacked the documentation that a bed hold policy was provided to Resident 21 prior to leaving for the hospital.2. A record review was completed on 11/25/2024 at 9:02 A.M. for Resident 48. Diagnoses included, but was not limited to: unspecified dementia, unspecified severity, with other behavioral disturbance, unspecified psychosis not due to a substance or known physiological condition, and generalized anxiety disorder. A Nursing Progress Note, dated 1/11/2024 at 1:05 P.M., indicated there was an order for Resident 48 to be sent to the psychiatric hospital for an evaluation and treatment related to behaviors. A Nursing Progress Note, dated 1/18/2024 at 12:20 P.M., indicated Resident 48 returned to the facility. A record of hospital transfer forms to the hospital was not found in the electronic medical record.		hospital transfer. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Transfer/Bed Hold” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up By what date the systemic changes will be completed: January 8th, 2025	

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	During an interview on 11/25/2024 at 10:51 A.M., LPN 10 indicated that when a resident was sent to the hospital the following papers would be sent with the resident: emergency transfer observation, CCD (Continuity of Care Document), and a bed hold policy. LPN 10 could not locate the transfer paperwork for 1/11/2024 and indicated it should have been filled out. On 11/25/2024 at 2:50 P.M., the Regional Nurse provided a policy titled, "Hospital Discharge/Transfer," revised 2/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...Nursing will complete an Emergency transfer observation and attach copies of the following information from the resident medical record: Face Sheet, H&P Physician Notes, Current orders, CCD, Advance directives, Comprehensive Care Plan, Pertinent labs, Notice of Transfer/Discharge, Bed hold policy, Nursing Notes....." On 11/26/2024 at 8:40 A.M., the Regional Nurse provided a policy titled, "Bed Hold", revised 1/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...2. The residents will be provided the bed hold policy at the time of the hospital transfer or therapeutic leave....." 3.1-12(25)(A)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review and interview, the facility failed to provide Activities of Daily Living (ADLs) for dependent residents timely related to nail care, shaving, and turning	F 0677	F677- ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those residents	01/08/2025

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	and repositioning for 3 of 5 dependent residents who were reviewed for ADLs. (Residents 15, 38 & 14) Findings include: 1. During an observation on 11/21/2024 at 11:28 A.M., Resident 15 had long fingernails with a brown substance under them on his left hand. During an interview on 11/22/2024 at 2:15 P.M., Resident 15 indicated he had requested his nails be trimmed twice in the last week. He indicated he was unable to trim his own nails because he was blind. Resident 15 had a scab under his left eye and he indicated it was from scratching himself with his long nails. During an observation on 11/22/2024 at 2:15 P.M., Resident 15's fingernails were long and there was a brown substance under most of his nails. Resident 15's record review was completed on 11/25/2024 at 1:50 P.M. Diagnoses included, but were not limited to: Parkinson's disease, congestive heart failure, Type 2 diabetes mellitus, Major depressive disorder, legal blindness, delusional disorder and psychotic disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 11/8/2024, indicated Resident 15 had intact cognition, had not rejected care, had severely impaired vision, was able to understand others and make himself understood and required substantial assistance for showering. A current Care Plan, dated 11/2/2024, indicated Resident 15 required assistance with ADLs. His goal was to have ADL needs met. His interventions included, but were not limited to:		found to have been affected by the deficient practice: Resident #15's fingernails have been cleaned and trimmed. Resident #38 has been shaved and fingernails have been trimmed and cleaned. DNS/designee educated nursing staff on turning and repositioning, including proper positioning of resident #14. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Residents with facial hair will be offered a shave daily with am care. Fingernails will be trimmed and cleaned during their shower and as needed. Dependent residents will be turned and repositioned per plan of care. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DNS/designee will educate all nursing staff on or before January 8th 2025 on care of a dependent resident which includes fingernail care, shaving and turning and repositioning. Shower sheets will be reviewed daily to ensure that shaving and nail care is completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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	AM and PM Care. During an interview on 11/25/2024 at 11:00 A.M., CNA 3 indicated AM Care were the tasks done in the morning when a resident woke up and PM Care were the tasks performed when the resident was getting ready for bed. The tasks for AM and PM Care included face washing, oral care, hair brushing, applying lotion and deodorant, shaving, and nail trimming. During a follow-up interview on 11/25/2024 at 2:00 P.M., Resident 15 indicated his nails had not been trimmed and asked, "Who is going to cut my nails?" During an interview on 11/25/2024 at 2:04 P.M., CNA 11 indicated Resident 15's fingernails were long and dirty and should not be long or dirty. CNA 11 indicated nail care was part of a resident's shower routine or done during AM or PM Care. 2. During an interview on 11/21/2024 at 2:12 P.M., Resident 38 indicated he did not like having facial hair or long fingernails and had requested to be shaved and have his nails trimmed. He indicated he had asked multiple times in the last two weeks and was told someone would do it tomorrow, but staff had not shaved his face or trimmed his nails. During an observation on 11/22/2024 at 11:06 A.M., Resident 38 had long nails and facial hair on his face. During an interview on 11/25/2024 at 9:05 A.M., Resident 38 indicated his roommate had shaved him on 11/22/2024 after he had asked staff twice to shave his facial hair and staff had not shaved him. Resident 38's record review was completed on		quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “ADL Care” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up By what date the systemic changes will be completed: January 8th, 2025	

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	11/25/24 at 1:40 P.M. Diagnoses included, but were not limited to: radiculopathy (pinched nerve), generalized anxiety, hemiparesis/hemiplegia and muscle weakness. A Significant Change MDS assessment, dated 11/14/2024, indicated Resident 38 had intact cognition, had not rejected care, required substantial assistance with showering and supervision for personal hygiene tasks. A current Care Plan, initiated on 5/31/2024, indicated Resident 38 required assistance with ADLs. Resident 38 had a goal to improve his current functional status. Interventions included, but were not limited to: assist with dressing, grooming and hygiene as needed. During an interview on 11/25/2024 at 1:56 P.M., CNA 3 indicated AM and PM Care included partial bedbath, oral care, perineal care, deodorant applied to under arms and shaving was to be offered. During an interview on 11/26/2024 at 9:22 A.M., Resident 38 indicated he had requested his nails trimmed on 11/22/2024 by staff, but they had not been trimmed. He indicated he had not been shaved since his roommate had shaved him on 11/22/2024. During an interview on 11/26/2024 at 9:38 A.M., the Executive Director (ED) indicated she had spoken to staff about shaving Resident 38 on 11/22/2024 and was not aware Resident 38 had not had his face shaved by staff. The ED indicated residents should be shaved and have their nails trimmed when they requested to be shaved or have their nails trimmed.			

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	3. During observations on 11/21/2024 at 10:02 A.M.,11:26 A.M., and 2:09 P.M., Resident 14 was supine in bed with a soft triangular wedge lying next to the left upper body. During observations on 11/22/2024 at 9:27 A.M. and 3:32 P.M. Resident 14 was supine in bed with a soft triangular wedge lying next to the upper body. During observations on 11/25/2024 at 8:36 A.M., 10:14 A.M., 11:21 A.M., 2:31 P.M., Resident 14 was supine in bed with a triangular wedge next to the left upper body. During an observation on 11/25/2024 at 11:47 A.M. CNA 3 entered Resident 14's room and exited with the roommate. During observations on 11/26/2024 at 9:12 A.M., 10:19 A.M., 11:40 A.M., and 2:21 P.M., Resident 14 was supine with a triangular wedge next to his body. During an observation on 11/26/2024 at 10:52 A.M. two staff went into Resident 14's room and exited at 11:36 A.M. with Resident 14's roommate. At 11:40 A.M. Resident 14's bed was in low position, and he was supine with a triangular wedge lying next to the left upper body. A record review was completed on 11/25/2024 at 3:07 P.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following other cerebrovascular diseases affecting right dominant side, other vascular syndromes of brain in cerebrovascular diseases cadasil syndrome, dysphagia following cerebral infarction, aphasia following cerebral infarction.			

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	A Care Plan dated 4/16/2018, for impaired mobility included an intervention to turn and reposition the resident every 2 hours and as needed. A Care Plan dated 8/27/2015, for at risk for skin breakdown included an intervention dated 5/7/2022 indicated to turn and reposition the resident at least every 2 hours. During an interview on 11/25/2024 at 1:23 P.M., CNA 3 indicated she provided care to Resident 14 around 10:15 A.M. with a check and change so far twice during the shift. She indicated she had checked Resident 14 for incontinence and changed him twice during her shift. She indicated he was not on a rotation position schedule, but she was aware there was something wrong with his left side and he could not be left on his left side. She indicated Resident 14 had had a stroke. During an interview on 11/25/2024 at 2:14 P.M., CNA 4 indicated when she took care of a dependent resident, she provided the following care: she washed them, checked and changed them for incontinence every two hours, fed them, applied lotion, cut their nails and combed their hair. During an interview on 11/25/2024 at 2:22 A.M., CNA 6 indicated when she took care of a dependent resident she provided the following care: she did everything for them, checked and changed them for incontinence, assisted them with meals, transferred and emptied Foley catheter if they had one. During an interview on 11/25/2024 at 2:25 P.M., CNA 7 indicated when she took care of a dependent resident, she provided the following care: oral care, if incontinent bed and brief			

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	changed, washed their face and made sure they were comfortable in the right position and safe. During an interview on 11/26/2024 at 10:43 A.M. CNA 2 indicated when she took care of a dependent resident, she provided the following care: oral and nail care, peri- care, toileted, showered, combed hair, transferred, and foot care. During an interview on 11/26/2024 at 1:10 P.M., CNA 2 indicated she had taken care of Resident 14 and provided the following care: before bed bath, oral and nail care, changed his brief three times, and applied lotion. He was turned on his side briefly when she was washed him and provided incontinence care. She indicated his right side was his affected side and the wedge cushion was placed next to his upper body to prevent him from leaning to the left. She indicated he was on his back all the time and was only on his side when he was turned to do peri- care. On 11/25/2024 at 2:30 P.M. the Regional Nurse indicated the facility did not have a policy for providing ADLs to dependent residents. The Regional Nurse provided a checklist, dated 9/2023, and titled, "Fingernail Care", and identified it as the checklist currently by used the facility to provide fingernail care. The checklist did not indicate when fingernail care was to be performed, but listed the steps used by the facility to perform nailcare. The checklist indicated, "...9. Clean under nails with orange stick. 10. Clip fingernails straight across, then file in a curve...." On 11/26/2024 at 11:30 A.M. the ED indicated the facility did not have a policy for providing ADLs to dependent residents. The ED provided a checklist dated, 4/2012, and titled, "AM Care", and identified it as the checklist currently used by			

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	155695	A. BUILDING 00 B. WING	11/27/2024

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	the facility. The checklist indicated, "... 8. Shave resident, if needed or requested...." On 11/26/2024 at 2:13 P.M. the DON indicated they did not have a policy on turning and repositioning but indicated it was the "standard of care." 3.1-38 (a)(1)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to address pharmacy recommendations timely for 1 of 5 residents reviewed for unnecessary medications. (Resident 38) Finding includes: A record review was completed on 11/25/2024 at 1:40 P.M. for Resident 38. Diagnoses included but were not limited to: generalized anxiety, radiculopathy (pinched nerve), hemiparesis/hemiplegia and repeated falls. A Significant Change Minimum Data Set (MDS) assessment, dated 11/14/2024, indicated Resident 38's cognition was intact, he had no behavior issues, had pain and took antianxiety and antidepressant medications daily. Physician Orders for Resident 38 included, but were not limited to: -11/7/2024 buspirone 10 milligrams (mg) by mouth twice a day. -11/8/2024 diazepam 5 mg by mouth twice a day -11/7/2024 trazodone 75 mg by mouth at bedtime -11/14/2024 fluoxetine 20 mg by mouth once a day -11/7/2024 gabapentin 600 mg by mouth three	F 0756	F756- Drug Regimen Review What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #38's pharmacy recommendation has been completed How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. An audit has been completed on pharmacy recommendations. All outstanding recommendations will be addressed by January 8th 2025. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All nurse managers were educated on the completion pharmacy recommendations with 30 days of receiving from the pharmacist and	01/08/2025

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	times a day A Pharmacy Review for Resident 38, completed on August 5, 2024 and September 10, 2024 regarding decreasing the resident's gabapentin dose were not addressed by the physician until after the pharmacist review and recommendations were completed in October 2024. On October 8, 2024 the recommendation was to decrease the gabapentin from 300 mg three times a day to 200 mg three times a day due to the potential for an increased risk for falls. The physician addressed the October recommendation and indicated the gabapentin was unrelated to falls. During an interview on 11/26/24 at 1:44 P.M., the DON indicated Pharmacy recommendations should be addressed when received or at least within 30 days. A current policy provided on 11/26/2024 at 1:56 P.M. by the Regional Nurse, dated October 2018 and titled, "Medication Regimen Reviews and Pharmacy Recommendation," indicated the following, "...Pharmacy recommendations should be reviewed with follow up the the physician within 30 days of the facility receiving...." 3.1-48(3)		scanning into the resident's chart. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Pharmacy Recommendations" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up By what date the systemic changes will be completed: January 8th, 2025	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to store food in a safe and sanitary manner in 1 of 1 kitchen observed. The deficient practice had the potential to affect 70 of 71 residents who consumed food prepared in the kitchen.	F 0812	F-812 Food Procurement, Storage/Prepare/Serve Sanitary What corrective action(s) will be accomplished for found to have been affected by the deficient practice:	01/08/2025

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	Findings include: During an observation of the kitchen conducted on 11/21/2024 at 9:39 A.M. with the Culinary Nutrition Manager the following was observed in the reach-in freezer: -an open, unsealed, bag of frozen peas -an open, unsealed, bag of frozen mixed vegetables were found in the reach in freezer. During an interview on 11/21/2024 at 9:40 A.M., the Culinary Nutrition Manager indicated the bags of opened, frozen food should have been sealed after use. 3.1-21(i)(3)		The Dietary Manager has discarded all the food improperly stored. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions: All open boxes in the freezer and dry storage areas have been inspected. No other open containers were noted. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Dietary Manager will educate all culinary staff on proper food storage. All in-services will be completed on or before January 8, 2025. The Dietary Manager will complete rounds in the food storage areas daily to verify all food is stored properly. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place. Compliance with corrective action will be monitored through Quality Assurance and Performance Improvement Program (QAPI). The Dietary manager will complete a	

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			daily QAPI form titled “Food Storage” for 2 weeks, then weekly for four weeks and monthly for six months. The findings will be submitted to the QAPI committee for review and follow-up. By what date the systematic changes will be completed: 1/8/25	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview and record review, the facility failed to ensure infection control practices were carried out appropriately for 1 of 1 staff observed providing high contact care in an Enhanced Barrier Precautions (EBP) room for 1 of 1 residents observed in isolation (Resident 23). Finding includes: During an observation on 11/22/2024 at 9:10 A.M., Resident 23 had an Enhanced Barrier Precautions sign above her bed and an isolation cart in the room. During an observation on 11/22/2024 at 9:14 A.M., CNA 8 was observed changing the bed linens in Resident 23's room. The CNA did not have on a pair of gloves or a gown while changing the resident's bed linens. During an interview on 11/22/2024 at 9:15 A.M., CNA 8 indicated she was unaware that Resident 23 was on Enhanced Barrier Precautions. She indicated she had not seen the sign on the resident's door.	F 0880	F880- Infection Prevention and Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #23 was not negatively affected by this practice. CNA #8 was educated on the Enhanced Barrier Precautions policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents on Enhanced Barrier Precautions have the potential to be affected. DNS/IP/designee will educate all staff on the Enhanced Barrier Policy on or before January 8th 2025. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: IP/designee will conduct observations on residents in EBP	01/08/2025

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	During an interview on 11/22/2024 at 9:20 A.M., CNA 8 indicated, after checking with the licensed nurse, she was informed Resident 23 was on EBP due to wounds on the bottoms of both of her feet. She indicated she should have been wearing a gown and gloves prior to providing care to Resident 23. On 11/25/2024 at 9:15 A.M., a record review was completed for Resident 23. Diagnoses included, but were not limited to: type 2 diabetes with foot ulcer. A current Care Plan, initiated on 8/16/2024 indicated Resident 23 was at risk for becoming colonized with a Multi-drug Resistant Organism (MDRO) and required enhanced barrier precautions due to chronic wounds. Interventions included, but were not limited to: identify resident as needing EBP through signage and medical record, use standard precautions including hand hygiene in addition to EBP, and wear a gown and gloves prior to high contact resident care activities. On 11/27/2024 at 8:57 A.M., the Regional Nurse provided the policy titled, "Enhanced Barrier Precautions," undated, and indicated it was the policy currently being used by the facility. The policy indicated..."Enhanced barrier precautions are used for: Resident's with chronic wounds and/or indwelling medical devices, regardless of their MDRO status. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Use of personal protective equipment - gown and gloves: During high contact resident care activities and changing linens...."		daily, to ensure staff is following policy. Any concerns will be addressed immediately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Enhanced Barrier Precautions” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up By what date the systemic changes will be completed: January 8th, 2025	

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	3.1-18(a)			