STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155490	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00422934. Complaint IN00422934 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686. Survey dates: February 13, 14, 15, 16, 19, 20, 2024 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census Bed Type: SNF/NF: 94 Total: 94 Census Payor Type: Medicare: 12 Medicaid: 68 Other: 14 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2024	F 0000	Plan and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of the truth of facts alleged or the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by Federal and State law. This provider maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before 03/19/2024. Ambassador Healthcare respectfully requests that a "desk" review be conducted and accepted. Additional documentation will be sent upon request.	
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on interview and record reviewed, the	F 0638	1 What corrective action(s) will	02/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jared Glaub	Executive Director	03/08/2024

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	facility failed to ensure Minimum Data Set (MDS) Assessments were completed timely, or at least every 92 days, for 3 of 4 residents reviewed for MDS timeliness. (Resident 36, 73, and 79) Findings include: 1 The clinical record for Resident 36 was reviewed on 2/19/2024 at 11:48 a.m. An admission record for Resident 36 indicated she was admitted on 5/27/2021 with a diagnosis of muscle weakness. An Admission MDS Assessment for Resident 36 had an Assessment Reference Date (ARD) of 8/24/2023. No follow up assessment was reflected on the record upon reviewed on 2/19/2024. A discharge assessment for Resident 36 was completed on 2/19/2024 and dated with an ARD date of 9/14/2023. 2. The clinical record for Resident 73 was reviewed on 2/19/2024 at 11:57 a.m. An admission record for Resident 73 indicated she was admitted on 5/1/2023 with a diagnosis of dementia. A Quarterly MDS Assessment for Resident 73 had an ARD date of 9/29/2023. The next MDS assessment had an ARD date of 1/22/2024, a difference of 115 days between assessments. 3. The clinical record for Resident 79 was reviewed on 2/19/2024 at 12:05 p.m. An admission record for Resident 79 indicated she was admitted on 9/21/2022 with a diagnosis of		be accomplished for those residents found to have been affected by the deficient practice? Assessments for residents 36, 73, and 79 were either updated or completed prior to or during the survey process. 2 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 by the alleged deficiency. A facility wide audit will be conducted to ensure all assessments were completed within the federal and state submission timelines. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All MDS staff will be reeducated on the facility policy concerning assessment completion and submission timeframes. Systemic changes include pulling an iQIES report from CMS to ensure no assessments are late as well as logging each residents assessment so that the timeframe does not exceed federal and state submission timelines. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	Alzheimer's disease. A Quarterly MDS Assessment for Resident 79 had an ARD date of 9/29/2023. The next MDS assessment had an ARD date of 1/23/2024, a difference of 116 days between assessments. An interview with the MDS Nurse on 2/19/2024 at 1:45 p.m. indicated that the assessments for Resident 36, 73, and 79 had been missed but completed upon discovery of the oversight. A policy, entitled "MDS Completion and Submission Timeframes", was provided by the DON on 2/19/2024 at 2:20 p.m. The policy indicated, " ...Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes ..." 3.1.-31(d)(3)		program will be put into place? Executive Director, or designee, will audit the following iQIES reports and manual MDS log, Mon- Fri x 4 weeks, then 3 times per week x 8 weeks, weekly x 8 weeks, and monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 02/21/2024	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and observation, the facility failed to accurately code dental status for Resident 82, failed to accurately code Resident 79's urinary status, and failed to accurately code falls for Resident 93. This affected 3 of 34 residents reviewed. Findings include: 1. Resident 82 was observed, on 2/14/24 at 11:08 a.m., to have no teeth. Resident 82's record was reviewed on 2/15/24 at	F 0641	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Assessments for residents 82 (edentulous status), 79 (falls with major injury), and 93 (catheter status) were corrected upon identification during the survey process. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/21/2024

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	10:53 a.m. The record indicated Resident 82 had diagnoses that included, but were not limited to, stroke, difficulty swallowing, and cognitive communication deficit. An Admission Minimum Data Set (MDS) assessment, dated 3/7/23, indicated "no natural teeth or tooth fragment(s) (edentulous) was not marked, which indicated the resident did have teeth. On 2/19/24 at 2:00 p.m., the MDS coordinator, provided paperwork from her admission assessment where the family had said she had her own teeth, and this was documented on the baseline care plan. The MDS coordinator indicated the MDS should have been been marked for the resident being edentulous. 2. The clinical record for Resident 79 was reviewed on 2/19/2024 at 12:05 p.m. An admission record for Resident 79 indicated she was admitted on 9/21/2022 with a diagnosis of Alzheimer's disease. An Annual MDS Assessment for Resident 79, with an Assessment Reference Date (ARD) of 9/29/2023, indicated that they had one fall with no injury and one fall with major injury during the review period. An interdisciplinary note, dated 9/17/2023, indicated that Resident 79 had a fall with injury that did not meet the criteria for a major injury. 3. The clinical record for Resident 93 was reviewed on 2/15/2024 at 1:44 p.m. An MDS Assessment, dated 1/5/2024, indicated		action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Assessments for current residents will be verified according to the documentation that is available in the medical record to ensure it matches assessment coding. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? MDS Coordinator reeducated on following MDS regulations. The facility will complete a validation check and audit results on all further assessments upon completion. 4 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? Executive Director, or designee, will audit the MDS validation reports to ensure accuracy, Mon- Fri x 4 weeks, then 3 times per week x 8 weeks, weekly x 8 weeks, and monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 02/21/2024	

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	Resident 93 had an indwelling catheter. An interview with MDS Nurse on 2/19/2024 at 2:10 p.m. indicated that Resident 93 did not have a catheter and Resident 79 did not have a fall with major injury during the review periods for the aforementioned surveys and that she would enter modifications for those assessments. A policy entitled, "Certifying Accuracy of Resident Assessment", was provided by the DON on 2/19/2024 at 2:20 p.m. The policy indicated, " ...All personnel who complete any portion of the Resident Assessment (MDS) muse sign and certify the accuracy of that portion of the assessment ..."			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care			

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	plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to update Resident 12's care plan after refusal to use a lap buddy, failed to update a care plan after Resident 2 had bruising, and failed to update Resident 93's care plan with fall interventions. This affected 3 of 34 residents reviewed for care plan revisions. Findings include: 1. During an observation, on 2/15/24 at 10:42 a.m., Resident 12 was observed sitting in her wheelchair in her room, watching TV. She did not have a lap buddy (a firm, flat, pillow like device to provide upper body support, help with posture, and reminds residents to ask for help before getting out of their chair) in place. On 2/15/24 at 2:40 p.m., Resident 12 was sitting in her wheelchair in her room, eyes closed, TV on, and had no lap buddy in place. On 2/16/24 at 9:00 a.m., Resident 12 was sitting in her wheelchair in her room, TV on, and had no lap buddy in place. On 2/19/24 at 10:20 a.m., Resident 12 was sitting in her doorway in her wheelchair and had no lap buddy in place. Resident 12's record was reviewed on 2/14/24 at	F 0657	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The care plans for residents 12 (lap buddy refusal), 2 (bruising), and 93 (chair alarm) were each updated to reflect appropriate plan of care. 2 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 by the alleged deficient practice. The facility will audit care plans to ensure that they are updated as needed for an individualized care plan. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The prior days nursing documentation will be reviewed to ensure any changes in plan of care are entered into individualized care plan for each resident. 4 How the corrective action(s)	03/19/2024

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	2:45 p.m. and indicated diagnoses that included, but were not limited to, Parkinson's Disease, lack of coordination, Alzheimer's disease, cognitive communication deficit, history of falling, weakness, abnormal gait and mobility muscle wasting and atrophy. An Annual Minimum Data Set (MDS) assessment, dated 11/17/23, indicated Resident 12 was moderately cognitively impaired and had Alzheimer's disease. Resident 12 had a fall on 10/6/23 and has not had further falls. A current physician's order indicated: "Ensure lap buddy is in place if resident is up in her w/c (wheelchair) every shift". Effective date 9/17/2023 A care plan, with a last revision date of 2/1/2024, indicated Resident 12 was at risk for falls and included an intervention for: "Ensure lap buddy is in place if resident is up in her w/c". The care plan was not updated to indicate Resident 12 refuses to use, and will remove her lap buddy. On 2/20/24, at 12:13 p.m., the Director of Nursing indicated Resident 12 removes her lap buddy and will not wear it a lot of the time, she likes to lean forward and reach things and the lap buddy gets in her way. The documentation is on the Electronic Medication Administration Records for when she refuses to use the lap buddy. 2. The clinical record for Resident 2 was on 2/15/2024 at 1:55 p.m. Resident 2 had a medical diagnosis of Alzheimer's disease.		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director of Nursing, or designee, will audit necessary or required changes to the resident's plan of care, Mon- Fri x 4 weeks, then 3 times per week x 8 weeks, weekly x 8 weeks, and monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting 5 Date of compliance: 03/19/2024	

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	A Quarterly Minimum Data Set (MDS) Assessment, dated 12/3/2023, indicated Resident 2 had a slight cognitive impairment. During an observation and interview on 2/14/2023 at 12:45 p.m. indicated Resident 2 had a bruise to the back of her left hand and wrist that she was unsure of how she had received it. Review of the clinical record indicated that Resident 2 received intravenous (IV) therapy to the left hand/wrist on 2/5/2024. A nursing assessment on 2/6/2024 indicated Resident 2 had a bruise to the back of the left hand/wrist. A bruising care plan for Resident 2 was initiated on 2/15/2024 for the bruise related to her IV therapy. 3. The clinical record for Resident 93 was reviewed on 2/15/2024 at 1:44 p.m. Resident 93 had a medical diagnosis of chronic obstructive pulmonary disease. An Admission Minimum Data Set (MDS) Assessment, dated 1/2/2024, indicated Resident 93 was cognitively intact. A nursing progress note, dated 1/10/2024, indicated that Resident 93 was found after a fall and a chair alarm was placed as intervention. During an interview and observation with Resident 93 on 2/14/2024 at 1:20 p.m., indicated that a chair alarm was placed to his recliner. Resident 93 indicated he had a couple falls since admission and that the alarm was a fall intervention.			

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	Review of the fall care plan for Resident 93 indicated that the intervention of chair alarm was implemented on 1/10/2024, but not created on the care plan until 2/16/2024. A policy entitled, "Care Planning - Interdisciplinary Team", was provided by the Administrator on 2/16/2024 at 3:00 p.m. The policy indicated, "Our facility's Care Planning//Interdisciplinary Team is responsible for the development of an individualized care plan for each resident ..." 3.1-35(b)(2)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide a dependent resident with nail care, and failed to ensure facial hair was to a resident's preference. This affected 2 of 7 residents reviewed for activities of daily living care. (Residents 82 and 93) Findings include: 1. During an observation, on 2/14/24, at 11:07 a.m., Resident 82's nails were observed to be long with a black substance on the nails of both hands. On 2/15/24, at 10:33 a.m., Resident 82 was observed to have a yellow substance under some of the nails on her right hand, and her left hand	F 0677	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Alleged deficient ADL care for the dependent residents 82 (nail care) and 93 (facial hair preferences) was completed upon identification during the survey process. 2 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 by the	03/19/2024

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	had a black substance under 2 of the nails that were observable due to the left hand contracture. On 2/15/24, at 2:38 p.m., Resident 82 sat near the nurse's desk, in a Broda (a specialty chair for comfort and mobility) chair, asleep. The fingernails on her right hand were soiled with a dark substance, her left hand was contracted and unable to view at that time. Resident 82's record was reviewed on 2/15/24, at 10:53 a.m., and indicated diagnoses that included, but were not limited to, stroke, left sided weakness, and cognitive communication deficit. A Quarterly Minimum Data Set assessment, dated 12/2/23, indicated Resident 82 was moderately cognitively impaired, and was dependent on staff for all activities of daily living. A care plan initiated on 3/22/23, indicated a focus for: "Resident is dependent on staff with self care and mobility tasks related to dependent mobility and left sided hemiplegia." The goal was: "Resident will be neat, clean and dressed appropriately daily thru next review." Interventions included, but were not limited to, "Partial bath 5x weekly. Hand resident prepared washcloth and encourage her to wash face. Shower per staff assist 2x weekly with hair and nail care included." On 2/19/24 at 10:42 a.m., CNA 3 indicated Resident 12 gets both showers and bed baths, and gets her fingernails cleaned and trimmed at least once a week. She said Resident 82 had gotten a bed bath today. Resident 82's fingernails were observed and there was a small amount of black substance under her left thumb, and the nails on her right hand had a yellow/brown substance under 3 of		alleged deficient practice. Facility completed facility-wide sweep on nail care and facial hair preferences. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Social Services Coordinator, or designee, will complete a resident preference questionnaire upon admission. Information will be added to each resident's care plan and CNA assignment. Nail care to be reviewed by nurse during med pass. Nursing staff to be reeducated on nail care and facial hair preferences. 4 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? DON, or designee, will verify nail care and facial hair preferences have been satisfied for 20 residents, Mon- Fri x 4 weeks, then 20 residents 3 times per week x 8 weeks, 10 residents weekly x 8 weeks, and 5 residents monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 03/19/2024	

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	the nails. A Policy and Procedure for "Nails - Care Of" was provided by the Administrator on 2/16/24 at 3:00 p.m. The policy included, but was not limited to, "Purpose: To provide cleanliness, manicure, stimulation, and exercise while preventing self-injury and infection. Policy: Nails are cleaned daily as part of a.m. or p.m. care and are trimmed weekly on a set schedule. Responsibility: CNA...." 2. The clinical record for Resident 93 was reviewed on 2/15/2024 at 1:44 p.m. Resident 93 had a medical diagnosis of chronic obstructive pulmonary disease. An Admission Minimum Data Set (MDS) Assessment, dated 1/2/2024, indicated Resident 93 was cognitively intact. During an interview and observation with Resident 93 on 2/14/2024 at 1:20 p.m., indicated that he preferred to have his facial hair shaved except for his mustache. He indicated he had only had his facial hair shaved once since he came to the building and needed some assistance with keeping it shaved and that at home he shaved, or tried to shave, daily. He had long dark facial hair. An observation on 2/15/2024 at 2:05 p.m. indicated Resident 93 continued to have long dark facial hair. An interview with CNA 2 on 2/15/2024 at 2:10 p.m. indicated Resident 93 was not on her shower list and he would get shaved during his shower the next morning. A policy entitled, "SHAVING A RESIDENT - SAFETY RAZOR", was providing by the Administrator on 2/16/2024 at 3:00 p.m. The policy			

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	indicated, " ...Male residents are shaved with showers and upon request ..." 3.1-38(a)(2)(A) 3.1-38(a)(3)(A) 3.1-38(a)(3)(E)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review the facility failed to provide in room activities for 1 of 4 residents reviewed for activities (Resident 59). Finding include: During an observation on 2/13/24 at 11:18 a.m., Resident 59 was sitting in her room with no TV or radio on, no magazine, books or any self initiated activities available. The resident was sitting in her recliner staring at the wall. During an observation on 2/14/24 at 2:35 p.m., Resident 59 was sitting in her room with no TV or radio on, no magazine, books or any self initiated activities available. The resident was sitting in her recliner staring at the wall.	F 0679	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident provided with in-room activities as well as appropriate television/radio entertainment as needed when resident not in common area. 2 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 that require in-room activities have the potential to be affected by the alleged deficient practice. One-on-one documentation was	03/19/2024

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	During an observation on 2/15/24 at 1:48 p.m., Resident 59 was sitting in her room with no TV or radio on, no magazine, books any self initiated activities available. The resident was sitting in her recliner staring at the wall. Review of the record of Resident 59 on 2/19/24 at 1:20 p.m., indicated the resident's diagnoses included, but were not limited, schizoaffective disorder, dementia, vascular dementia, unsteadiness on feet, abnormal gait, bipolar disorder and hypertension. The activity assessment for Resident 59, dated 10/9/23, the resident's current interest in games was words games and puzzles. The resident enjoyed sports basketball. The resident enjoyed talking with friends and family. The resident enjoyed television shows of soap operas, sitcoms, game shows, news, movies and sports. The resident enjoyed music of gospel, country, oldies and listening to the radio. The resident enjoyed spiritual activities of listening to it on the radio and watching it on TV. The resident enjoyed reading the newspaper, magazines and the bible. The Annual Minimum Data (MDS) assessment for Resident 59, dated 10/12/23, indicated the resident was severely impaired for daily decision making. It was very important for the resident to listen to music and to do her favorite activities. The plan of care for Resident 59, dated 10/27/22, indicated the resident was alert with cognitive deficits, she was able to make decisions related to leisure needs and preferred self directed activities of interest in her room. The interventions included, but were not limited to, offer choices, provide word puzzles, puzzles, games, TV and music.		reviewed and Activity Director verified care plan accuracy as well as self-initiated activity supplies were readily available for use. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Facility staff to be trained in person-centered care approaches and strategies for promoting engagement and meaningful activities for residents. Residents with self-initiated in-room activity care plans will be monitored to ensure preferences are fulfilled. 4 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? Activity Director, or designee, will audit one-on-one program completion and that self-initiated activity supplies are readily available, Mon- Fri x 4 weeks, then 3 times per week x 8 weeks, weekly x 8 weeks, and monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 03/19/2024	

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	During an interview with the Director Of Nursing (DON) on 2/19/24 at 12:57 p.m., indicated it was the Activities departments responsibility to ensure Resident 59 had self initiated activities available in her room. The activity policy provided by the DON on 2/19/24 at 2:20 p.m., indicated the program was designed to meet the needs of each resident are available on a daily basis. The activity program was designed to encourage maximum individual participation and are geared to the individual resident's needs. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review the facility failed to date a gastrostomy tube (G-Tube) dressing and failed to date the piston irrigation syringe for 1 of 1 residents reviewed for G-Tube (Resident 49). Finding include: During an observation on 2/13/24 at 11:25 a.m., Resident 49's piston irrigation syringe was sitting	F 0684	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The G-tube dressing and piston syringe for resident 49 were both dated and during the survey process. 2 How other residents having the potential to be affected by the	03/19/2024

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	on her bedside table with no date and the resident's G-tube dressing was not dated. During an observation on 2/14/24 at 2:40 p.m., Resident 49's piston irrigation syringe was sitting on her bedside table with no date and the resident's G-tube dressing was not dated During an observation on 2/15/24 at 1:49 p.m., Resident 49's piston irrigation syringe was sitting on her bedside table dated 2/15/24 and the resident's G-tube dressing was dated 2/15/24. Review of the record of Resident 49 on 2/15/24 at 10:10 a.m., indicated the resident's diagnoses included, but were not limited to, cerebral infarction, vascular dementia, muscle weakness, major depressive disorder, post traumatic stress disorder, apraxia, difficulty walking, unsteadiness on feet, anxiety, hemiplegia/hemiparesis and cerebral infarction affecting left non-dominant side. The February 2024 physician Recapitulation (recap) for Resident 49, indicated the resident was to have silvadene cream (topical antibiotic) to G-tube stoma every day in the evening, apply to G-tube stoma and cover with a dressing. The resident was ordered to have the G-tube flushed with 200 milliliter (ml) 4 times a day. During an interview with the Director Of Nursing (DON) on 2/19/24 at 12:58 p.m., indicated the facilities expectation was that Resident 49's stoma dressing and piston irrigation syringe would be dated. 3.1-37(a)		same deficient practice will be identified and what corrective action(s) will be taken? All residents with G-tubes have the potential to be affected by the alleged deficient practice. Residents with G-tubes were observed to have their dressings and piston syringe dated appropriately. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff to be reeducated on proper G-tube procedures. All nursing staff to be educated upon new hire during orientation. 4 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? DON, or designee, will audit proper G-tube dressing and piston syringe dating, Mon- Fri x 4 weeks, then 3 times per week x 8 weeks, weekly x 8 weeks, and monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 03/19/2024	

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure wound treatments were signed off as administered, conduct weekly would assessments on a pressure ulcer, and ensure there was not multiple treatments for the same pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident B) Findings include: The clinical record for Resident B was reviewed on 2/16/24 at 2:23 p.m. The diagnoses included, but were not limited to, pressure ulcer of sacral region, peripheral vascular disease, acquired absence of left leg below knee, cerebrovascular disease, and chronic pain. An admission nursing assessment, dated 8/17/23, indicated shearing above coccyx and bilateral buttocks.	F 0686	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B has discharged from the facility. 2 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 with the potential for pressure areas have the potential to be affected by the alleged deficient practice. Wound nurse verified all orders for residents on their caseload were accurate and not duplicated as well as weekly assessments were completed. 3 What measures will be put into place and what systemic	03/19/2024

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	A wound assessment, dated 8/29/23, indicated a stage 2 pressure ulcer was present to Resident B's coccyx. The coccyx wound was documented as resolved on 9/19/23. A Quarterly Minimum Data Set (MDS) assessment, dated 11/10/23, indicated a stage 4 pressure ulcer, diabetic foot ulcer, along with infection of the foot. A wound care plan, dated 10/18/23, indicated an unstageable pressure ulcer to Resident B's sacrum with a wound vac treatment initiated on 11/8/23. The interventions included, but were not limited to, perform wound care as ordered. A wound assessment, dated 10/17/23, indicated the pressure ulcer to Resident B's coccyx had reopened and was documented as a stage 3 pressure ulcer. The treatment was to apply medical grade honey to the wound, secure with bordered foam, and change daily at that time. A wound assessment, dated 10/24/23, indicated the pressure ulcer to Resident B's coccyx had worsened but no treatment changes were noted. A wound assessment, dated 10/31/23, indicated the pressure ulcer to Resident B's coccyx was now classified as an unstageable pressure ulcer. A wound center note, dated 11/8/23, indicated to apply negative pressure wound therapy (NPWT) to coccyx at 125 mmHg (millimeters of mercury) with continuous suction and change the dressing on Monday, Wednesday, and Fridays. The electronic treatment administration record (ETAR) for November of 2023 indicated the NPWT to Resident B's coccyx was not signed off,		changes will be made to ensure that the deficient practice does not recur? Nursing staff to be reeducated on wound assessments, wound care, orders, and ETAR documentation. Residents that have pressure, arterial, or vascular wounds will be monitored by treatment nurse to ensure wound care orders are placed appropriately and assessed frequently. 4 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? DON, or designee, will audit the wound assessments, wound treatments, and ETAR documentation for 10 residents, Mon- Fri x 4 weeks, then 10 residents 3 times per week x 8 weeks, 5 residents weekly x 8 weeks, and 5 residents monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 03/19/2024	

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	as administered, on 11/10/23 and 11/14/23. A wound center note, dated 11/15/23, indicated a stage 4 ulcer to Resident B's coccyx and to hold the NPWT for one week. The plan was to cleanse the coccyx with normal saline, apply Santyl and normal saline by wet to moist, cover with Allevyn Life dressing, and change daily. The next wound center appointment was for 11/22/23. The ETAR for November of 2023 indicated the daily treatment with Santyl was signed off from 11/16/23 to 11/25/23. The NPWT treatment was also signed off on 11/22/23. This indicated duplicate treatment to the same pressure ulcer to Resident B's coccyx. Resident B did not go to the wound center on 11/22/23 due to his condition. There were no wound assessments for Resident B's coccyx from 11/20/23 to 11/24/23. Resident B discharged to the local hospital on 11/27/23 and did not return to the facility. An interview conducted with the Director of Nursing (DON), on 2/19/24 at 12:54 p.m., indicated the Wound Nurse is responsible for conducting the weekly wound assessments. If the resident goes to the wound center, then the facility does not conduct weekly wound assessments. The Wound Nurse is responsible for ensuring recommendations for wound treatment are implemented along with the discontinuation and/or holding of previous orders. The DON indicated they receive a missed documentation report 5 days a week and then she sends the missed documentation to the nurses, and they document such.			

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	A policy titled "Pressure Ulcers/Skin Breakdown", revised March 2014, was provided by the Executive Director (ED) on 2/19/24 at 10:00 a.m. The policy indicated the following, " ...Treatment/Management ...1. The physician will authorize pertinent orders related to wound treatments ...Monitoring ...1. During resident visits, the physician will evaluate and document the progress of wound healing - especially for those with complicated, extensive, or non-healing wounds ...2. The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions ...." This Federal Tag relates to Complaint IN00422934. 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence			

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	unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review the facility failed to provide Passive Range Of Motion (PROM) exercises for 1 of 4 residents reviewed for Range Of Motion (ROM) (Resident 49). Finding include: During an observation and interview on 2/13/24 at 11:27 a.m., Resident 49 had a left hand contracture with no splint in place. The resident indicated she did not want to wear a splint. During an observation and interview on 2/15/24 at 1:49 p.m., Resident 49 had a left hand contracture. The resident indicated the staff did not provide her with PROM exercises and she would like to participate in a PROM program. Review of the record of Resident 49 on 2/15/24 at 10:10 a.m., indicated the resident's diagnoses included, but were not limited to, cerebral infarction, vascular dementia, muscle weakness, major depressive disorder, post traumatic stress disorder, apraxia, difficulty walking, unsteadiness on feet, anxiety, hemiplegia/hemiparesis and cerebral infarction affecting left non-dominant side. The plan of care for Resident 49, dated 3/13/23, indicated the resident had left sided hemiplegia. The resident's goal was Resident would perform 15-20 reps of Passive Range Of Motion to arms 1-2x/daily x 90 days. The interventions included, but were not limited to, document amount of reps and time spent with the resident daily. The Quarterly Minimum Data Set (MDS) for	F 0688	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Care plan was updated for resident 49 to reflect discontinuation of restorative program for hand contracture. Resident referred to therapy services for evaluation and treatment of left hand contracture. 2 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? Resident with contractures have the potential to be affected by the alleged deficient practice. Residents with the diagnosis of contracture were audited for appropriate treatments associated with their plan of care and updated as needed. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff to be reeducated on PROM. Residents that have PROM orders will be monitored to ensure orders are updated implemented appropriately and assessed frequently. 4 How the corrective action(s) will be monitored to ensure the	03/19/2024

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	Resident 49, dated 11/25/23, indicated the resident cognitively intact for daily decision making, the resident was consistent and reasonable. The resident had no behaviors of rejecting care. The resident had impairment in her range of motion of the bilateral lower and upper extremities. During an interview with the Administrator on 2/16/24 at 10:26 a.m., indicated the facility did not have any documentation of PROM exercises provided for Resident 49. During an interview with the Director Of Nursing on 2/19/24 at 12:58 p.m.., indicated the CNA's and nurses were responsible to ensure PROM was provided for Resident 49. The ROM policy provided by the Administrator on 2/16/24 at 1:15 p.m., indicated the purpose was to maintain muscle tone, strength and joint function while preventing deformities caused by inactvitiy thus supporting normal physiologic function of all body systems. Document ROM on daily resident care record and document weekly resident participation, toelance level and include any pertinent observations. 3.1-42(a)(2)		deficient practice will not recur, i.e., what quality assurance program will be put into place? DON, or designee, will audit PROM orders and ensure therapy referrals are completed appropriately as indicated, Mon-Fri x 4 weeks, then 3 times per week x 8 weeks, weekly x 8 weeks, and monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 03/19/2024	
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			

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	adequate supervision and assistance devices to prevent accidents. Based observation, interview and record review the facility failed to ensure fall interventions were implemented and failed to transfer a resident in a safe manner for 2 of 5 residents reviewed for accidents (Resident 87 and Resident 72). Finding include: 1.) During an interview with Resident 87 on 2/13/24 at 11:43 a.m., indicated she had a fall in the last six months, she was unsure what caused her to fall. During an observation on 2/14/24 at 2:50 p.m., Resident 87 was lying in bed, there was no fall mat beside her bed. During an observation on 2/15/24 at 1:56 p.m., Resident 87 was lying in bed, there was no fall mat beside her bed. Review of the record of Resident 87 on 2/19/24 at 2:10 p.m., indicated the resident's diagnoses included, but were not limited to, diabetes, dementia, muscle weakness, age related physical debility, hypertension, major depressive disorder and rheumatoid arthritis. The Quarterly Minimum Data (MDS) assessment for Resident 87, dated 12/9/23, indicated the resident was moderately impaired for daily decision making. The fall risk assessment for Resident 87, dated 9/9/23, indicated the resident was at high risk for falls. The progress note for Resident 87, dated 9/17/23	F 0689	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The fall intervention for resident 87 was placed next bed during the survey process by the CNA. The CNA in question with resident 72's transfer was issued an additional gait belt. 2 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 with fall interventions and the need of manual transfers have the potential to be affected by the alleged deficient practice. Fall interventions were audited for correct placement in the facility. Staff in-serviced on proper gait belts. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff to be reeducated on proper use of gait belts and fall interventions. Gait belts will be provided for each resident room to ensure availability. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	03/19/2024

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	at 8:45 p.m., indicated the nurse was called to residents room by CNA's, the resident was lying on the floor face down by the side of the bed. The resident stated she was trying to get out of bed and landed on knees then moved on to her stomach. The Interdisciplinary Team (IDT) progress note for Resident 87, dated 9/18/2023 at 9:12 a.m., indicated the IDT met to discuss resident fall from 9/17/23. Resident was noted to be lying on floor faced down by side of bed. Resident stated she was trying to get out of bed and landed on knees and buttocks then moved on to her stomach. Res assessed for injuries; no apparent injury noted. Staff to ensure fall mat is in place at side of bed whenever resident was in bed. The plan of care for Resident 87, dated 9/11/23, indicated the resident was is risk for falls related to decreased mobility, new surroundings, impaired safety awareness, dementia, delirium, depression, will climb out of bed and onto floor mat and unplug her bed alarm. The interventions included, but were not limited to, ensure fall mat is in place at the side of the bed whenever the resident was in bed (9/11/23). During an observation and interview with Assistant Director of Nursing (ADON) on 2/19/24 at 2:54 p.m., verified Resident 87 was in bed with no fall mat beside her bed. The ADON indicated it was the responsibility of the CNA's to ensure all fall interventions were in place. 2.) Review of the record of Resident 72 on 2/16/24 at 11:40 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease, anxiety, osteoarthritis and		i.e., what quality assurance program will be put into place? DON, or designee, will audit that fall interventions are in place and gait belts being used for manual resident transfers for 10 residents, Mon- Fri x 4 weeks, then 3 times per week for 10 residents x 8 weeks, weekly for 5 residents x 8 weeks, and monthly for 5 residents thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 03/19/2024	

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	155490	A. BUILDING 00 B. WING	02/20/2024

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	pain. The Quarterly Minimum Data (MDS) assessment for Resident 72, dated 11/25/23, indicated the resident required substantial/maximal assistance with transfer from a sitting position to a standing position. The State Optional MDS for Resident 72, dated 11/25/24, indicated the resident required extensive assistance of one person for transfers. The fall risk assessment for Resident 72, dated 11/25/23, indicated the resident was at high risk for falls. During an observation on 2/15/24 at 1:58 p.m., CNA 1 lifted Resident 72 underneath both of her arms and transferred her from the bed to the wheelchair without utilizing a gait belt. The resident required extensive assistance with the transfer. During an interview with the Director Of Nursing on 2/19/24 at 1:00 p.m., indicated the facility expectation was for staff to utilize a gait belt during transfers with Resident 72. The fall policy provided by the Administrator on 2/16/24 at 1:15 p.m., indicated safety interventions would be implemented for each resident identified at risk. The gait belt policy provided by the Administrator on 2/16/24 at 1:15 p.m., indicated the purpose was to prevent injury to staff members and residents while offering security and balance to residents during a transfer. Failure to utilize gait belts on designated residents is a danger to both the resident and staff member.			

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	3.1-45(a)(1) 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review the facility failed to date oxygen tubing and storage bag, failed to store oxygen tubing in a sanitary manner when not in use and failed to have a physician order for oxygen therapy for 2 of 4 residents reviewed for respiratory therapy (Resident 72 and Resident 2). Findings include: 1.) During an observation 2/13/24 on 11:57 a.m., Resident 72 had a portable oxygen on her wheelchair, the resident was receiving oxygen via nasal cannula. The oxygen tubing and the storage bag was not dated. During an observation on 2/14/24 at 2:45 p.m.., Resident 72 had a portable oxygen on her wheelchair, the oxygen tubing and nasal cannula was lying the seat of her wheelchair not stored in the storage bag. The oxygen tubing and the storage bag was not dated.	F 0695	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The oxygen tubing was replaced with new tubing and bag. Both were dated upon changing. Oxygen orders were placed upon identification during the survey process. 2 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 that have oxygen treatments have the potential to be affected by the alleged deficient practice. All residents with oxygen orders were reviewed. 3 What measures will be put	03/19/2024

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	During an observation on 2/15/24 at 1:58 p.m., Resident 72 had a portable oxygen on her wheelchair, the oxygen tubing and nasal cannula was lying the wheelchair wheel not stored in a storage bag. CNA 1 indicated hospice staff must not have put it in the storage bag when they assisted the resident to bed and she would change the oxygen tubing. The oxygen tubing and the storage bag was not dated. Review of the record of Resident 72 on 2/16/24 at 11:40 a.m., indicated the resident's diagnoses included, but were not limited to, respiratory failure with hypoxia and chronic obstructive pulmonary disease. The February 2024 Recapitulation (Recap) for Resident 72, indicated the resident was ordered oxygen between 2 liters to 4 liters to maintain oxygen levels above 90%. During an interview with the Director Of Nursing (DON) on 2/19/24 at 1:00 p.m., indicated it was the responsibility of the staff to store Resident's 72's oxygen tubing in a sanitary manner when not in use. The facilities expectation was Resident 72's oxygen tubing and storage bag should be dated. 2. The clinical record for Resident 2 was on 2/15/2024 at 1:55 p.m. Resident 2 had a medical diagnosis of Alzheimer's disease. A Quarterly Minimum Data Set (MDS) Assessment, dated 12/3/2023, indicated Resident 2 had a slight cognitive impairment. An observation of Resident 2 on 2/14/2024 at 11:36 a.m. indicated she was utilizing oxygen therapy at 2 liters per minute (LPM) via nasal cannula (NC).		into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing to be reeducated on obtaining physician orders for oxygen administration and dating/changing oxygen tubing. Physician order will be placed within 24 hours of implementation of nursing measure. 4 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? DON, or designee, will audit to ensure oxygen tubing and bags are placed appropriately and dated as well as oxygen orders being placed timely for 10 residents, Mon- Fri x 4 weeks, then 3 times per week for 10 residents x 8 weeks, weekly for 5 residents x 8 weeks, and monthly for 5 residents thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 03/19/2024	

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	An observations of Resident 2 on 2/15/2023 at 1:09 p.m. indicated she was utilizing oxygen therapy at 2 LPM via NC. A nursing progress note, dated 1/25/2024, indicated Resident 2 utilized oxygen therapy. A nursing progress note, dated 2/4/2024, indicated Resident 2 utilized oxygen therapy. A physician order for Resident 2 to utilize oxygen therapy was not entered into the medical until 2/15/2024. A policy entitled, "Oxygen Therapy", was provided by the Administrator on 2/16/2024 at 1:15 p.m. The policy indicated, " ...Treatment requires a physician's orders which must include the frequency, method of administration, liters of oxygen, and medical reason ..." Regarding maintenance of oxygen equipment, the policy indicated " ...Change masks, cannulas and tubing weekly or more often as required. These should be dated when put out ...When O2 [oxygen] is not in use, nasal cannulas, or mask and tubing are to be kept in a labeled and dated plastic bag in the resident's bedside table or on oxygen cylinder/machine ..." 3.1-47(a)(6)			
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.			

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	(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 beard restraints were utilized while working with food. This had the potential to affect 89 out of 94 residents who receive food from the kitchen. Findings include: A kitchen tour was conducted on 2/13/24 at 9:45 a.m., with the Dietary Manager (DM). Cook 22 was observed in the food preparation area with the DM and they both were observed with having facial hair and no beard restraint was utilized. Another kitchen tour was conducted on 2/13/24 at 10:47 a.m., with the DM and Cook 22. The food temperatures were obtained and both DM and Cook 22 were standing over the food without wearing a beard restraint. A kitchen observation was conducted on 2/16/24 at 10:43 a.m., with the DM and Cook 22 noted with facial hair and no utilization of a beard restraint.	F 0812	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All dietary staff with facial hair placed beard restraints on when identified by survey team. 2 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 receiving food from the facility kitchen have the potential to be affected by the alleged deficient practice. Dietary staff were educated on the importance of beard restraints in the kitchen. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	03/04/2024

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	A kitchen observation and interview was conducted on 2/16/24 at 1:23 p.m., with the DM indicated Cook 22 has a "clean cut" to his facial hair and would not have to wear a beard restraint. The DM indicated Cook 24 and Dietary Staff 26, who were present in the kitchen during the interview, "could use one" regarding a beard restraint. Cook 24 was called to come out of the kitchen by the DM and Cook 24 had a full beard, and commented "I need to shave", while they proceeded to apply a beard restraint and return to the kitchen at that time. Cook 24 was in the kitchen in the food preparation area before retrieving the beard restraint. A policy titled "Hair Restraints", undated, was provided by the Executive Director (ED), on 2/16/24 at 4:45 p.m. The policy indicated the following, " ...Hair restraints shall be worn by all Dining Services staff when in food production areas, dishwashing areas, or when serving food ...2. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair that is longer than the eyebrow shall require coverage with a beard guard in the production and dishwashing areas ...." 3.1-21(i)(2) 3.1-21(i)(3)		Dietary staff to be reeducated on use of beard restraints. Beard Restraints will be available at the entrance of the kitchen. 4 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? Dietary Manager, or designee, will audit to ensure beard guards are in place while in the kitchen, Mon- Fri x 4 weeks, then 3 times per week x 8 weeks, weekly x 8 weeks, and monthly thereafter for total of 12 months. The results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. 5 Date of compliance: 03/04/2024	