STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44WP	A. BUILDING: _____ B. WING _____	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR PLACE	81 WINDSOR BOULEVARD COLUMBUS, MS 39702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 10/7/24 through 10/9/24.. During the survey, the SA determined the facility was in compliance with the Minimum Standards of Operations for Alzheimer Disease/Dementia Care Unit. The census for the Alzheimer/Dementia Unit was 20 with a bed capacity of 20 at the time of the survey.	M 000		
M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey at the facility from 10/7/24-10/9/24. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for the Minimum Standards for Institutions for the Aged or Infirm and cited M 610 M 615, M 640, M 705, M 815, and M 1570. The facility had a census of 124 and was licensed for 140 beds at the time of the survey.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and	M 610		11/6/24

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M 610	Continued From page 1 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to shave a resident that was dependent on staff for care for one (1) of three (3) residents reviewed for Activities of Daily Living (ADL). Resident #80 Findings include: Record review of facility policy titled, "Activities of Daily Living Policy", undated, revealed, "It is the policy of the facility to encourage resident choice and participation in activities of daily living (ADL) and provide oversight cuing and assistance as necessary. ADL's included bathing, dressing, grooming, hygiene, toileting, and eating. CNA (Certified Nursing Assistant) will review the resident care card for information on individual care needs and preferences. CNA will provide needed oversight, cuing or assistance to resident. CNA will report any changes in ability or refusals to the nurse". During an observation and interview on 10/07/24 at 12:30 PM, Resident #80 stated he wanted to be shaved and felt that the staff would do this today since it was shower day. He stated he was unsure when he was last shaved and he told his family that if they would bring him a razor, he would shave himself. Observation revealed the resident had an approximate one-third inch scruffy stubble of facial hair on bearded areas of his cheeks, chin, and upper lip. An observation and interview on 10/8/24 at 8:40	M 610	October 8, 2024, Resident #80 was shaved by the Director of Nursing. All residents requiring assistance with Activity of Daily Living, shaving, have the potential to be affected by this practice. October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for nurse and certified nurse assistant staff regarding the importance of providing Activities of Daily Living (ADL), specifically grooming/shaving, to residents. October 28, 2024, in-serviced completed by nurse and certified nurse assistant staff. October 11, 2024, Director of Nursing (Registered Nurse) initiated and completed audit of all residents requiring assistance with grooming/shaving with no negative findings. Beginning October 21, 2024, and going forward indefinitely, certified nurse assistants will report any resident refusing Activities of Daily Living (ADL) care, specifically grooming/shaving, to the resident□s nurse for documentation. Beginning October 21, 2024, the Quality Assurance Nurse (Licensed Practical Nurse) or the Director of Nursing (Registered Nurse) will complete audits of Activities of Daily Living (ADL), specifically grooming/shaving, to residents for five (5) residents weekly for four (4) weeks, three (3) residents weekly for four (4) weeks, and three (3) residents weekly for two (2) months. Findings will be reported to the	

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M 610	Continued From page 2 AM, revealed Resident #80 was still unshaved and stated he preferred to be clean shaven and was not used to being unshaven. Resident #80 was observed on 10/8/24 at 2:30 PM and was still unshaved. He stated the staff had not shaved him and he wanted this to be done. The Director of Nursing (DON) came to the resident and Resident #80 informed her that he wanted to be shaved and had asked staff for this, but it had not been done. The DON informed him that it was the responsibility of the Certified Nursing Assistants (CNAs) to shave him and she assured him she would get this done for him. The DON acknowledged that grooming and shaving was part of the bathing activity of daily living (ADL) care and confirmed the facility failed to shave the facial hair of a resident that preferred to be clean shaven. Record review of an ADL care summary revealed Resident #80 was scheduled for baths on Monday, Wednesday, and Friday. Record review of Resident #80's "Admission Record" revealed the facility admitted the resident on 6/22/22. Diagnoses included Type 2 Diabetes Mellitus and Osteoarthritis. Record review of Resident #80's quarterly "Minimum Data Set" (MDS) with Assessment Reference Date (ARD) of 8/28/24, revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment.	M 610	Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore	M 615		11/6/24

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	44WP	A. BUILDING: _____ B. WING _____	10/09/2024

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M 615	Continued From page 3 shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level III Based on observation, resident and staff interview, record review and facility policy review, the facility failed to provide necessary treatment and services to promote healing and prevent new ulcers from developing for (1) one of five (5) residents with wounds reviewed. Resident #39 Findings include: A review of the facility policy titled, "Overview of Skin and Wound Care Management," revealed, the facility staff strives to prevent/patient skin impairment. ... The Interdisciplinary team works with the resident and family to identify and implement interventions to prevent and treat potential skin integrity issues. ...Components of the skin care and wound management program include, but are not limited to, the following: 2.) Implementation of prevention strategies to minimize the potential for developing pressure ulcers and skin integrity issues. ... An interview with Resident # 39 on 10/07/24 at 11:24 AM, revealed she had a pressure sore on her lower buttocks that she got while in the facility. A record review of the Wound Assessment Report dated 8/23/24 revealed Resident #39 was assessed to have excoriation to the buttocks area with a new treatment order for Calmoseptine	M 615	October 10, 2024, Infection Control Preventionist (Registered Nurse) reviewed Resident #39□s wound assessment report, specifically skin integrity, to ensure all treatment orders are current and being followed through to help prevent and/or heal pressure ulcers with no negative findings. All residents with excoriation or pressure ulcers have the potential to be affected by this practice. October 9, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for nurse staff regarding skin integrity and ensuring that all treatment orders are being followed through to help prevent and/or heal pressure ulcers. October 28, 2024, in-service completed by nurse staff. October 17, 2024, Infection Control Preventionist (ICP, Registered Nurse) and treatment nurses (Licensed Practical Nurses) initiated and then completed on October 18, 2024, audits to ensure treatments have been implemented for admissions between October 9, 2024, and October 18, 2024, that were identified with excoriation(s) and/or pressure ulcer(s). No negative findings. Beginning, October 18, 2024, and going forward indefinitely, the	

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	44WP	A. BUILDING: _____ B. WING _____	10/09/2024

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M 615	Continued From page 4 treatment to the buttocks. A record review of the Order Summary Report for Resident #39 and interview with the Infection Control Nurse on 10/8/24 at 2:05 PM, she stated she was unable to find the physician's order for the Calmoseptine treatment to the excoriation on the buttocks was even entered into the computer system on 8/23/24 and confirmed that the facility failed to implement the physician's order. A record review of the August 2024 Treatment Administration Record (TAR) for Resident #39 and interview with the Infection Control Nurse on 10/8/24 at 2:10 PM she revealed she was unable to find where a treatment was initiated on 8/23/24 for the excoriation to the buttocks and confirmed that not performing the treatment as ordered may have contributed to the acquired pressure ulcer. Record review of the Wound Assessment Report dated 8/27/24 for Resident #39 completed by Registered Nurse (RN) #1 revealed a new stage (2) two pressure ulcer to the right buttock measuring 1 centimeter (CM) in length, 1.5 CM in width, and 0.1 CM in depth. Review of the Order Summary Report for Resident # 39 revealed an order dated 8/27/24 "Cleanse stage 2 to the right buttock with (NS) normal saline, pat dry, apply collagen, and cover with dry dressing every day (QD) and as needed (PRN). Monitor dressing to the right buttock for soilage/dislodgement as needed." Review of the August 2024 TAR for Resident # 39 revealed cleanse stage 2 to the right buttock with NS, pat dry, apply collagen, and cover with dry dressing QD and PRN. Monitor dressing to the right buttock for soilage/dislodgement as needed	M 615	Infection Control Preventionist (Registered Nurse) will review new admissions for treatment orders being implemented for residents identified with excoriation(s) and/or pressure ulcer(s). Beginning October 23, 2024, the Infection Control Preventionist (Registered Nurse) and/or Treatments Nurse (Licensed Practical Nurse) will complete audits of skin integrity for five (5) residents one (1) time per week for four (4) weeks, three (3) residents one (1) time per week for four (4) weeks, then three (3) residents one (1) time per month for two (2) months. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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M 615	Continued From page 5 dated 8/27/24. An interview with Registered Nurse (RN) #1 on 10/8/24 at 3:15 PM, he revealed on 8/27/24 Resident #39 was assessed to have a stage 2 pressure ulcer to the right buttock/ischial area. He revealed that he and the treatment nurse obtained an order for Collagen treatment from the provider and treated the wound. An interview with the Director of Nursing (DON) on 10/08/24 at 3:30 PM, she revealed after reviewing the August 2024 TAR for Resident #39 she was unable to find where the treatment for the excoriation to the buttocks was ever started. An interview with the Assistant Director of Nursing (ADON) on 10/09/24 8:45 at AM she revealed the physician's order for the Calmoseptine treatment on 8/23/24 for Resident #39 was accidentally missed and it could have contributed to the deterioration of the area to the buttocks. Review of the "Admission Record" revealed the facility admitted Resident # 39 on 8/23/24 with a diagnosis of Encounter for orthopedic aftercare following surgical amputation. Record review of Resident # 39's "Section C" of the Admission Minimum Data Set (MDS) revealed on 8/29/24 a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact.	M 615		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate	M 640		11/6/24

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M 640	Continued From page 6 supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, and record review the facility failed to ensure the residents had a environment free of potential hazards as evidenced by cleaning chemicals not being securely locked in a janitors storage closet for two (2) of five (5) units in the building. 400 Hall and Dementia Unit. Findings include: Review of a document provided by the facility,on facility letterhead revealed the facility does not currently have a formal written policy specific to resident accident prevention or monitoring. An observation on 10/7/24 at 11:20 AM on the Dementia Unit revealed a door with a sign that read "Janitor's Closet" was unlocked and held three full bottles of disinfectant. An interview and observation on 10/7/24 at 11:25 AM with Certified Nurse Assistant (CNA) #1 confirmed the "Janitors Closet" has a coded lock that was broke and the room was unlocked. She confirmed there were three full bottles of liquid disinfectant in the closet. She stated that she had not told maintenance and is not sure if they know. She revealed that the closet with the cleaning supplies should always be locked. This observation revealed this unit was an open unit with all resident rooms, day room and janitors closet within view from all areas and the nurses station is directly across from the janitors closet.	M 640	October 8, 2024, Maintenance Director replaced both locks on janitor closets determined to not be working properly. All residents have the potential to be affected by this practice. October 9, 2024, Housekeeping Supervisor initiated in-service for all staff on the importance of janitor closets being always locked and how to report any lock not working properly to the maintenance department. In-service completed by October 16, 2024. October 9, 2024, Housekeeping Supervisor audited all janitor closet□s locks for accurate operation, specifically being lockable, with no negative findings. Beginning October 18, 2024, and going forward indefinitely, housekeepers and janitors will notify Maintenance Director through text and written work orders immediately upon identifying any janitor closet lock not working properly. Beginning October 21, 2024, the Administrator or the Housekeeping Supervisor will audit all janitor closets to ensure they are locked for safety three (3) times per week for four (4) weeks, then two (2) times per week for four (4) weeks, two (2) times per month for one (1) month and one (1) time per month for one (1) month. Findings will be reported to the	

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M 640	Continued From page 7 She confirmed that the janitors closet could always be seen by the staff because it is a small open unit with three (3) CNA's and one nurse in the unit at all times. An observation on 10/7/24 at 11:45 AM of the 400-hall revealed there was a door labeled "Janitors Closet" that had a coded lock that was not locked with four bottles of liquid disinfectant. An interview and observation on 10/7/24 at 11:50 AM with Licensed Practical Nurse (LPN) #1 confirmed that the "Janitors Closet" on the 400 hall was unlocked but should always be locked, because there were chemicals that they would not want the residents to have access to. This observation revealed the janitors closet was directly across from the nurses station and was in view from the 300 and 400 hall. She confirmed that there was a staff member that sat at the nurses desk at all times, answering phone calls and call lights and also the dining area was open and within view of the closet. An interview on 10/7/24 at 11:55 AM with Housekeeping #1 confirmed that the "Janitors Closet" on the 400 hall had a coded lock that had been broken for a few days, but she is not sure if maintenance knows about it. An interview on 10/8/24 at 9:15 AM with Maintenance #2 confirmed that the locks on the "Janitors Closets" on the 400 hall and the "Dementia Unit" were both broken. He stated he put batteries in the lock on the 400-hall last week and thought it was fixed, but he had not been told about the one on the "Dementia Unit". An interview on 10/8/24 at 9:30 AM with the Administrator confirmed the "Janitors Closets"	M 640	Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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M 640	Continued From page 8 should always be locked.	M 640		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following: 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on interview, record review, and facility policy review, the facility failed 1) to ensure a medication order, medication administration record, and narcotic record label were all labeled correctly for one (1) of five (5) medication carts reviewed during medication pass, (100 hall medication cart) and; 2) the facility failed to securely store medications when two medication capsules were found sitting in a clear medication cup in a resident's room for 1 of 124 residents observed on initial tour. (Resident #28). Findings include: 100 Hall Medication Cart Review of the facility policy, "Narcotic Medication Accountability" updated 1/02, revealed 3. As narcotic medication is used/wasted, the nurse	M 705	October 7, 2024, Resident #28, medication discovered in resident□s room was immediately removed by Registered Nurse #1 upon notification by State Agent. October 9, 2024, a direction change sticker was placed on Resident #80□s medication pill card by Licensed Practical Nurse/Medication Nurse to alert nurse staff that there has been a change in the order and to verify the correct order prior to administering the next dose. October 9, 2024, Resident #80□s narcotic was discontinued and removed from the medication chart to be destroyed by the Director of Nursing (Registered Nurse) and Pharmacy Consultant. All residents have the potential to be affected by these practices. October 16, 2024, Staff Development	11/6/24

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M 705	Continued From page 9 responsible should document the usage and any wastage on the accountability record. Observation of Resident #80's Controlled Substance Record revealed instructions for Hydrocodone/APAP (acetaminophen) 10-325MG (milligrams), "Give 1 TABLET by mouth every 4 (four) hours as needed for pain". Review of Resident #80's Physician orders dated 08/01/2024 revealed Hydrocodone/APAP 10-325MG, "Give 1/2 TABLET by mouth every 4 hours as needed for pain". The label on the medication card was not changed to reflect the new order. Interview on 10/09/2024 at 8:10 AM with Licensed Practical Nurse (LPN) #4 on 100 Hall revealed LPN #4 confirmed 09/25/2024, 09/26/2024, 09/28/2024, 09/29/2024, and 10/07/2024 (1) tablet signed out by LPN #7 but 1/2 tablet was not recorded as wasted for Resident #80. LPN #4 also confirmed a missing tablet and stated the card was received from the pharmacy with dose #41 missing. Resident #28 During the initial tour rounds on 10/07/24 at 11:00 AM, an observation of Resident # 28's room from the hallway doorway revealed a clear medication cup with what appeared to medication in the cup sitting next to the television. Upon entrance to the room, the clear medication cup sitting next to the television on the dresser contained two bright yellow and white capsules. An observation of the two yellow and white capsules in Resident # 28 room with Registered Nurse (RN) # 1 on 10/07/24 at 11:05 AM, he	M 705	Coordinator (Registered Nurse) initiated in-service for nurse staff regarding the importance of medications being labeled appropriately in accordance with medication order and ensuring all medications are taken by residents at time of medication pass. October 28, 2024, in-service completed by nurse staff. October 10, 2024, a 100% audit was conducted by Director of Nursing (Registered Nurse) and Assistant Director of Nursing (Registered Nurse) to ensure no medications are left in resident rooms with no negative findings. October 18, 2024, audit initiated and completed October 23, 2024, by Licensed Practical Nurses/Medication Nurses on medication pill cards matching physician orders. Discrepancies were corrected during audit by placement of a direction change sticker on medication pill card. Beginning October 23, 2024, and going forward indefinitely, upon medication pass Medication Nurse (Licensed Practical Nurse/Registered Nurse) will verify that the resident has taken medications. If resident refuses a medication(s), the medication(s) will be removed from resident□s room by Medication Nurse (Licensed Practical Nurse/Registered Nurse). Also beginning October 23, 2024, and going forward indefinitely, upon receipt of medications from pharmacy, the following will be completed by nurse on duty: verify receipt of medications ordered; reconcile medication orders to the labels on the medication pill card/box and if any discrepancies noted a direction change sticker will be applied to the medication pill card/box and pharmacy notified; narcotic	

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M 705	Continued From page 10 confirmed the capsules were on the dresser and should not be in the room and removed the capsules from the room. In a continued observation with RN #1 of Resident#28's medications, he revealed the yellow and white capsules that were found in Resident #28's room were identified as Gabapentin 300 milligrams (mg) and confirmed Resident #28 receives one 300 mg tablet every night at bedtime. He also confirmed the resident did not have an order to self-administer medications and revealed that staff should always ensure each resident has taken their medications before leaving the resident. RN #1 then stated concerns about medications being left in the room is that the resident could have taken the extra pills and had a reaction. Review of the Active Orders for Resident #28 revealed and order for Gabapentin 300 mg capsule give one capsule by mouth at bedtime. In an interview with Resident # 28 on 10/07/24 at 11:10 AM, he revealed that the pills in his room were for his bowels and stated the nurse last night left him an extra pill, and he was saving them until he needed them. He then stated, "I will take them both when I get back to the room." In an interview with LPN # 3 on 10/07/24 at 11:22, she confirmed that Resident #28 cannot self-administer medications and revealed that staff should always watch residents take their medications. She then revealed that with the medications being left in the room, it placed residents at risk for accidentally ingesting the medications, causing possible adverse reactions. In an interview with the Director of Nursing (DON) on 10/08/24 at 11:38 AM, she revealed no	M 705	sheet will be updated and signed; appropriately store all medications received. Beginning October 21, 2024, The Director of Nursing (Registered Nurse) and Assistant Director of Nursing (Registered Nurse) will audit ten (10) controlled substance records and pill count cards to ensure compliance with medication administration three (3) times per week for four (4) weeks, one (1) time per week for four (4) weeks, two (2) times per month for two (2) months. Beginning October 21, 2024, The Director of Nursing (Registered Nurse) and/or Registered Nurse supervisor will perform medication pass audits three (3) times per week for four (4) weeks, one (1) time per week for four (4) weeks, and two (2) per month for two (2) months. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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	44WP	A. BUILDING: _____ B. WING _____	10/09/2024

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M 705	Continued From page 11 medications should ever be left in a resident's room. She stated the resident could have accidentally ingested extra doses, or a wandering resident could have gotten the medication. The DON stated she spoke with Resident #28 on 10/7/24 and stated he was saving the medication to give it back to the nurse, and he stated he paid for it and was not going to waste it. The DON revealed in her professional opinion that the nursing staff could not have observed Resident #28 take his medications because if they did, he would not have been able to save the medications that were found in his room. Review of the "Admission Record" revealed the facility admitted Resident # 28 on 8/20/24 with a diagnosis of Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and Anxiety. Record review of Resident # 28's Section C of the Admission Minimum Data Set (MDS) revealed on 8/26/24 a Brief Interview for Mental Status (BIMS) score was 11, indicating the resident was moderately cognitively impaired.	M 705		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II widespread Based on observation, staff interview, and facility policy review, the facility failed to label and date	M 815	October 7, 2024, Certified Dietary Manager (CDM) removed and discarded all five (5) items identified as open but not	11/6/24

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M 815	Continued From page 12 open items in the pantry, refrigerator, and freezer for one (1) of two (2) kitchen tours during the survey. Findings Include: Review of the facility policy titled "Food Storage" undated, revealed under, "Policy... Foods will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination... 14. Refrigerated food storage... f. All foods should be covered, labeled and dated." Also revealed under, "15. Frozen Foods: c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded." During initial tour of the kitchen on 10/7/24 at 11:20 AM, with the Dietary Manager (DM) #1, an observation of the walk-in refrigerator revealed, a 5-pound (lb.) clear bag of shredded mozzarella cheese that had been opened and had one-fourth (1/4) of the bag remaining, which was unlabeled and undated. Also revealed a 5 lb. container of low-fat cottage cheese that was opened and was undated. An observation of the walk-in pantry revealed a 32-ounce (oz) box of chicken broth, which was open and undated. DM #1 confirmed the box read "refrigerate after opening" and revealed it was not stored properly after opening and must be trashed. An observation of the walk-in freezer revealed a blue bag of six meat-like patties, which the DM confirmed were pork fritters and had not been labeled and dated after opening. Also revealed a blue bag that contained a round breaded food that the DM #1 confirmed was breaded squash and was opened and was also not labeled and dated.	M 815	dated. All residents have the potential to be affected by this practice. October 7, 2024, Certified Dietary Manager and Kitchen Supervisor audited all items in dry storage and in the cooler for being dated once opened with no negative findings. October 8, 2024, Certified Dietary Manager (CDM) initiated and completed in-service for all dietary staff on the importance of dating items when opened. Beginning October 14, 2024, and going forward indefinitely, dietary aides will monitor two (2) times per week for items being dated once opened as dietary aide stocks grocery delivery. Kitchen Supervisor will be notified immediately upon identifying any items not dated correctly. Beginning October 14, 2024, the Certified Dietary Manager and/or Kitchen Supervisor will complete audits of food items for being dated once opened two (2) times per week for four (4) weeks, one (1) time per week for four (4) weeks, two (2) times per month for one (1) month and one (1) time per month for one (1) month. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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M 815	Continued From page 13 An interview with the Dietary Manager #1 on 10/7/24 at 11:55 AM, revealed the kitchen staff had been educated on making sure foods were labeled and dated when they were opened to ensure they use the oldest foods first. She confirmed, if the food was not dated when opened or stored appropriately, it could make someone sick. An interview with the Administrator (ADM) on 10/9/24 at 9:34 AM revealed his expectations were for the kitchen staff to label and date things that were opened and to ensure the foods were not out of date and stored appropriately. He confirmed this should be done so it did not make anybody sick.	M 815		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable	M1570		11/6/24

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M1570	Continued From page 14 diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were initiated for one (1) of five (5) residents reviewed for EBP. Resident #370 Findings include: Review of the facility's "Enhanced Barrier Precautions Policy", dated 04/2024, revealed, "Purpose: "Enhanced Barrier Precautions (EBP) refer to infection control interventions designed to reduce transmission of multidrug-resistant organisms (MDRO) by wearing gown and gloves during high contact resident care activities. The use of EBP does not restrict room placement or out of room activities. 4. High-contact resident care activities include: g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes" On 10/08/24 at 10:40 AM, observation revealed Registered Nurse (RN) #1 performed hand hygiene and used a barrier on overbed table for supplies. Resident #370's RN #1 accessed the Peripheral Inserted Central Catheter (PICC) line using standard precautions. EBP was not done during the administration of the medication.	M1570	October 8, 2024, Director of Nursing (Registered Nurse) in-serviced Registered Nurse #1 immediately upon notification of Registered Nurse #1 not properly donning enhanced barrier precaution personal protective equipment while performing a direct care task, assessing the Peripheral Inserted Central Catheter (PICC) line on Resident #370. All residents requiring the use of enhanced barrier precautions have the potential to be affected by this practice. October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for all direct care staff regarding the importance of properly using the correct personal protective equipment when enhanced barrier precautions are required for providing residents direct care tasks. October 28, 2024, in-service completed by all direct care staff. October 10, 2024, Infection Control Preventionist (Registered Nurse) performed audit of orders for enhanced barrier precautions along with personal protective equipment and signage being in proper placement for all residents requiring these precautions throughout the facility. No negative findings. Beginning October 21, 2024, and going forward indefinitely, Infection Control	

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M1570	Continued From page 15 Observation also revealed no EBP sign posted on the room door for Resident #370. On 10/08/24 at 11:40 AM, an interview with RN #1 revealed she was unaware of the need to implement EBP for a resident with a PICC line. On 10/08/24 at 11:55 AM, an interview with the facility's Training Coordinator and Director of Nurses (DON) revealed the facility policy is for EBP to be used with central lines which would include Resident #370. Record review of Resident #370's Admission Record revealed the facility admitted the resident on 10/07/24.	M1570	Preventionist (Registered Nurse) will audit orders weekly to ensure enhanced barrier precautions have been implemented for residents that meet enhanced barrier precaution criteria. Beginning October 21, 2024, The Infection Control Preventionist (ICP/Registered Nurse) and/or the Assistant Director of Nursing (Registered Nurse) will perform audits for appropriate usage of enhanced barrier precautions personal protective equipment for five (5) residents one (1) time per week for four (4) weeks, three (3) residents one (1) time per week for four (4) weeks, three (3) residents two (2) times per month for one (1) month and three (3) residents one (1) time per month for one (1) month. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	