STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Clifty Falls, The	950 Cross Ave Madison, IN 47250

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38769 Based on observation, interview, and record review, the facility failed to identify and follow physician's orders for 3 of 4 residents reviewed for pressure ulcers. (Residents 15, 37, and 38) Findings include: 1. During an observation of Resident 15's pressure wound on 06/21/24 at 12:02 P.M., LPN (Licensed Practical Nurse) 3 obtained the necessary supplies, donned a gown, washed her hands, and donned gloves. The resident was notified of providing treatment to the wound. The old dressing was removed with no odor observed. The wound to the left iliac crest was observed to be a half dollar size. There was no drainage, and the wound bed was pink. The treatment was completed without any concerns. The clinical record for Resident 15 was reviewed on 06/21/24 at 1:35 P.M. An Admission MDS (Minimum Data Set) assessment, dated 09/05/23, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension and heart failure. The resident was at risk for pressure ulcers and admitted with a Stage 3 (Full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss) pressure ulcer to the right hip. She required substantial to maximum staff assistance with rolling from left to the right side and transfers. She required total staff assistance with bathing. A Skin and Wound Noted, dated 10/16/23, indicated the resident had a pressure wound to the right hip. No other skin concerns were documented. The Wound NP (Nurse Practitioner) recommended ongoing reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. The resident was at risk for skin breakdown related to decreased mobility, decreased cognitive function, multiple comorbidities. The staff were to continue to monitor prominent areas and report any non-blanchable redness or open areas. A Weekly Skin Check, dated 10/17/23, indicated the resident had existing wounds with no new loss of skin integrity. A Shower Sheet, dated 10/19/23, indicated the resident had no new skin conditions, there were no other skin conditions listed on the sheet. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note, dated 10/20/23 at 10:37 P.M., indicated upon providing wound care that evening to the right hip wound, it was noted that the resident had yellow drainage and foul odor from her right hip wound and wounds on her buttocks. New orders were received for a wound culture of the wounds to the right hip and buttocks. A SBAR (Situation, Background, Appearance, and Review) Progress Note, dated 10/21/23 at 9:53 A.M., indicated the resident had a new skin wound or ulcer noted. The resident had a pressure ulcer to the left heel that was dark purple in color and soft. The wound measured 1.5 cm (centimeters) X (by) 3 cm with a recommendation for skin prep (a skin protective wipe). A Nursing Progress Note, dated 10/21/23 at 9:53 A.M., indicated the resident was noted to have a dark purple area to the left heel. The area measured 1.5 cm X 3 cm. The area was measured, and skin prep was applied. A new intervention was implemented to float the resident's heels. The physician and DON (Director of Nursing) was notified. A new order was obtained to apply skin prep twice a day. A Nursing Progress Note, dated 10/22/23 at 2:19 A.M., indicated the resident was found to have significant wounds above both her buttocks. The resident was very angry with the nurse and refused to be turned. A Nursing Progress Note, dated 10/22/23 at 2:39 A.M., indicated the resident was found to have two open areas. One above each buttock. The area above the left buttock measured 9 cm X 5.6 cm, and the area above the right buttock measured 5 cm X 4 cm. The wounds were cleansed with normal saline and covered with an island dressing. The physician was notified. A Nursing Progress Note, dated 10/23/23 at 1:43 A.M., indicated wound cultures were obtained to the right hip and sacral wounds. A Skin and Wound Note by the Wound NP, dated 10/23/23 at 5:15 A.M., indicated the resident had new skin issues. The resident was non-complaint with repositioning. The new wounds were as followed: - a deep tissue (Persistent non-blanchable deep red, maroon, or purple discoloration Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) injury to the left heel that measured 3.2 cm X 1.2 cm, - an unstageable (Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer to the left iliac crest that measured 8.7 cm X 7.5 cm X 0.3 cm. There was a moderate amount of serosanguineous (pale red to pink, thin and watery) drainage, the wound was covered in 75-99% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed), and - an unstageable pressure ulcer to the sacrum that measured 5.5 cm X 4.5 cm X 0.3 cm. There was a moderate amount serosanguineous drainage, the wound was covered in 75-99% slough. The resident's sacrum wound was healed on 11/27/23. The resident's left heel wound was healed on 01/29/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Wound Assessment Report, dated 06/17/24, indicated the resident's left iliac crest wound was a Stage 3 pressure ulcer that measured 1.5 cm X 1.5 cm X 0.3 cm. There was a scant amount of serosanguineous drainage with 100% granulation tissue. The clinical record lacked documentation the resident had interventions in place to float heels or a low air loss mattress prior to the new wounds that were identified on 10/23/23 and lacked indication the wounds were identified prior to being unstageable or deep tissue injuries. A Care Plan, titled risk for skin impairment to skin integrity related to history of pressure ulcers and disease process with a start date of 09/08/23. The interventions included, but were not limited to, low air loss mattress with a start date of 12/18/23. A Care Plan, titled an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues with a start date of 10/23/23. The interventions included, but were not limited to the following: -float the resident's bilateral heels as they will allow, with a start date of 10/23/23, -low air loss mattress, with a start date of 12/18/23, -skin will be checked during routine care on a daily basis and during the weekly/Bi-weekly bath or shower schedule with a start date of 10/23/23, -any skin integrity issues/concerns will be conveyed to the Charge Nurse for further evaluation and/or treatment changes/new interventions and the physician will be call as needed, with a start date of 10/23/23, -precautions for prevention of pressure ulcers will be completed. Good pericare and drying of the skin, apply protective barrier cream, reposition resident frequently when in bed/chair/gerichair and or wheelchair, off load heels as needed, CAN shower/skin observations to be reported to the nurse for any unusual findings or changes in the resident's skin integrity, with a start date of 10/23/23, and -pressure reducing/relieving mattress and wheelchair cushion as needed, with a start date of 10/23/23. During an interview on 06/24/24 at 11:00 A.M., LPN 3 indicated the resident came to the facility with a wound. The resident refused to turn and reposition since she admitted to the facility. The resident's skin was checked weekly by the nurse and documented in a weekly skin assessment. If the resident had a new skin concern an SBAR would be filled out and the physician and DON would be notified. There would also be a progress note to document the new skin condition. The nursing staff should be assessing the skin daily and alerting the nurse of any new redness to implement new interventions. Any wounds should be identified before they were open wounds. During an interview on 06/24/24 at 2:41 P.M., the ADON indicated the resident had a pressure area to her hip on admission and was non-compliant with turning and repositioning. She only had the one pressure wound at this time. She did have an accumulation of wounds at one time. The wounds should have been identified before they had drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/24 at 3:11 P.M., QMA (Qualified Medication Aide) 8 indicated she would complete skin checks when providing incontinence care, assisting with changing clothes, and giving showers. She would alert the nurse if she noted anything such as bruising, wounds, scratches, redness, or anything that was abnormal. If she found something during a shower she would document, it on a shower sheet. They didn't document skin concerns anywhere else, they usually just let the nurse know. 34232 2. During an observation and interview on 06/18/24 at 12:40 P.M., Resident 37 was sitting in their room in a chair. The resident had a Band-Aid on the front of their left ankle. They said the Band-Aid was there because of their shoes rubbing on their foot. During an observation on 06/21/24 at 1:55 P.M., the DON pulled the Band-Aid away from the resident's left anterior ankle, there was a 1 mm (millimeter) x 2-3 mm dark scab under the Band-Aid. The surrounding tissue was dry and flaky. The clinical record was reviewed on 06/24/24 at 11:07 A.M. A Quarterly MDS assessment, dated 04/29/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, paranoid schizophrenia, anxiety, and malnutrition. The resident was at risk for pressure ulcers and had one unhealed stage 3 pressure ulcer that was not present on admission or re-entry into the facility. The Weekly Skin Check records for April and May 2024, were provided by the ADON on 06/24/24 at 11:10 A.M., and included, but were not limited to, the following: - A record, dated 04/27/24, indicated the resident had no existing loss of skin integrity and no new loss of skin integrity, and - A record, dated 04/28/24, indicated the resident had no existing loss of skin integrity, had a new loss of skin integrity, and Weekly Wound Evaluations were required. The Weekly Wound Evaluation records for April and May 2024, were provided by the ADON on 06/24/24 at 1:03 P.M., and included, but were not limited to, the following: - A record, dated 04/28/24, indicated the resident had a wound on the top of their left foot, identified on 04/28/24, measuring 1.5 cm x 0.5 cm x 0.5 cm. There was no drainage, and the area was warm to touch. The wound was not staged, - A record, dated 04/29/24, indicated the wound on the top of their left foot measured 1.0 cm x 2.6 cm x 0.3 cm. The wound was not debrided. The area was warm to touch, and the wound was a Stage 3 pressure ulcer, and - A record, dated 05/20/24, indicated the wound was healed. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for April and May 2024 were provided by the ADON on 06/24/24 at 1:03 P.M., and included, but were not limited to, the following physician's orders: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Cleanse top of left foot with wound cleanser, pat dry, apply comfort foam border gauze every three days and as needed for skin integrity, with a start date of 04/28/24, and a discontinued date of 04/29/24, - Cleanse area on the top left foot with wound cleanser, pat dry, apply Medihoney (medical grade honey) and cover with a border gauze dressing daily and as needed for pressure, with a start date of 04/30/24, and a discontinued date of 05/14/24, and - Cleanse left anterior ankle with wound cleanser, pat dry, apply skin prep, and cover with a border gauze dressing everyday shift for pressure, with a start date of 05/15/24, and a discontinued date of 05/21/24. The clinical record lacked indication the wound was identified prior to being a Stage 3 pressure ulcer. During an interview on 06/24/24 at 10:54 A.M., the ADON indicated he made rounds with the wound nurse. The nurses on the floor performed the weekly skin assessments. If they saw something new, they completed a pain assessment, and they should complete the first weekly wound assessment to identify that there was an area. At that point, they would notify the Wound NP and that resident would be added to the weekly rounds. The nurse on the floor also completed an E-Interact assessment at that time as well. Resident 37 had a place on the top of their left foot. It came about from their shoes rubbing on the area. They treated it for a couple of weeks. The last week that they looked at her the Wound NP indicated it was resolved, so they resolved it. The resident liked to keep bandages on the area now. He was unaware there was a scab under the bandage. The Wound NP staged the wounds. The wound had a yellow tint to it at the time the Wound NP assessed it. 50498 3. During an observation on 06/19/24 at 9:59 A.M., Resident 38 was in his room in bed with no pressure reducing boots on his feet and no pressure reducing boots in view. During an observation on 06/21/24 at 9:22 A.M., Resident 38 was in his room in bed with no pressure reducing boots on his feet. During a wound dressing change observation in the resident's room on 06/21/24 at 10:33 A.M., RN 7 stated, Where are your boots at? Your feet should be in boots. Resident 38 replied, I don't know they disappeared. During an observation and interview on 06/21/24 at 2:01 P.M., Resident 38 was in bed with no pressure reducing boots on his feet. The resident indicated his boots had been gone for three weeks. Resident 38's family member indicated the boots were removed from the room when they became soiled with fecal matter, and she had not seen them since. During an observation on 06/24/24 at 9:14 A.M., Resident 38 was asleep in bed with no heel protection on. Their feet were laying directly against the foot of the bed with socks on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/24 at 10:36 A.M., LPN 3 indicated Resident 38 had a wound on his right heel, and there was an order for bilateral heel boots as the resident would allow. LPN 3 requested CNA 4 to verify if the resident had his heel boots on currently. CNA 4 reported back to the nurse saying he did not have any on. LPN 3 proceeded to the storage room to retrieve new boots for the resident. The clinical record was reviewed on 06/20/24 at 10:51 A.M. An Admission MDS assessment, dated 06/04/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, muscle wasting, and muscle weakness. The resident had the following physician orders: An open-ended physician's order, with a start date of 06/01/24 at 6:00 A.M., indicated the staff were to maintain bilateral heel boots as the resident would allow due to a wound on the right heel, completed every shift. A Skin and Wound Note, dated 06/17/24 at 10:07 P.M., indicated Resident 38 had an unstageable pressure ulcer to the right heel that was present on admission the wound measured 1.2 cm x 1.2 cm x 0.2 cm. Preventative measures recommended for ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. The staff were to float heels while in bed with the use of heel boots. A current, undated, facility policy titled Guidelines for Skin Observation/Assessment, was provided by the Regional Nurse Consultant on 06/24/24 at 2:54 P.M. The policy indicated, .During the shower/bath, the care giver will observe the resident's skin. Conditions that will be observed .include but are not limited to what appear to the care giver to be bruises, red areas, open areas, scratches, abrasions, blisters, discoloration, dry flaky skin, pressure ulcers, scars as well as any other conditions of the skin .Only licensed nurses can assess the skin. If the care giver is not a nurse and they observe a change in the resident's skin, the care giver will notify the physician/family as appropriate and also obtain any needed orders for treatment . A current, undated, facility policy titled Guidelines for Preventive Skin Care, was provided by the Regional Nurse Consultant on 06/24/24 at 2:54 P.M. The policy indicated, .It is the intent of the facility to provide residents with preventative skin care .Should a caregiver notice any alteration in a resident's skin to include a scratch, skin tear, bruise or discoloration, redness, rash any broken skin or any other unusual observation ---this will be reported immediately to the charge nurse for assessment and appropriate follow up to include physician and/or resident /POA notification as indicated . A current, undated, facility policy titled Physician Orders, was provided by the Regional Nurse Consultant on 06/24/24 at 2:54 P.M. The policy indicated, .It is the policy of the facility to follow the orders of the physician . 3.1-40 (a)(2)

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	155209	A. Building B. Wing	06/24/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50498 Based on observation, record review, and interview, the facility failed to provide appropriate urinary catheter care for a resident with recent history of UTIs (Urinary Tract Infections) for 1 of 2 residents reviewed for UTIs. (Resident 88) Findings include: During an observation on 06/21/24 at 02:17 P.M., CNA (Certified Nurse Aide) 4 donned gloves and began providing peri-care for Resident 88. CNA 4 assisted the resident onto her right side and began removing her brief. A brown granular substance was observed behind the resident's tailbone. The substance was also visible on the portion of the urinary catheter tubing closest to the resident's body. CNA 4 began wiping away the brown substance behind the resident's tailbone. The CNA did not cleanse the substance off the catheter tubing. CNA 4 then removed the soiled brief and placed a new brief underneath the resident. CNA 4 reached into her own shirt pockets with her gloved hands and removed two black trash bags. CNA 4 put the soiled linens and brief into separate bags and tied them up at the bedside. Then covered the resident with personal blankets. Never cleaning the brown substance from the catheter. The clinical record for the resident was reviewed on 06/21/24 at 11:55 A.M. A Quarterly MDS (Minimum Date Set) assessment, dated 05/10/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, cerebral palsy, pressure ulcer of the sacral region, and urinary tract infections. The resident had the following physician orders: - A physician's order, dated 04/19/24 through 04/22/24, indicated the resident was to take Clindamycin HCl (an antibiotic medication), 300 MG (milligrams), 1 capsule via G-Tube three times a day, for a UTI for three days. - A physician's order, dated 05/10/24 through 05/16/24, indicated the resident was to take Bactrim DS (an antibiotic medication) 800-160 MG, 1 tablet by mouth two times a day, for a UTI for 12 administrations. - A physician's order, dated 05/30/24 through 06/06/24, indicated the resident was to take Macrobid (an antibiotic medication) 100 MG, 1 capsule by mouth two times a day, for a UTI, for 7 days. - An open-ended physician's order with a start date of 03/11/24, indicated the resident required urinary catheter care every shift. During an interview on 06/24/24 at 09:19 A.M., CNA 5 indicated while providing perineal care for a resident with a catheter she would clean from the front to the back starting with the catheter, cleaning from the top (closest to the resident) and moving away down the catheter tubing. If there was a bowel movement, she would provide care from the front to the back starting with the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current, undated, facility policy titled, Indwelling Urinary Catheter care, was provided by the Administrator on 06/24/24 at 1:00 P.M The policy indicated, .To cleanse and maintain hygiene to perineal area and indwelling catheter. To remove mucous from around indwelling catheter to prevent excoriation, inflammation, and discomfort .Cleanse catheter area by washing urethral area first followed by cleansing proximal 1/3 of catheter. Change cloth as necessary . 3.1-41(a)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 34232 Based on observation, interview, and record review, the facility failed to follow the physician's order in regard to the amount of water prescribed for flushing the feeding tube and failed to gently/slowly administer the liquid nourishment without a rapid force for 1 of 2 residents reviewed for feeding tubes. (Resident 33) Findings include: During an observation on Resident 33 was observed on 06/20/24 at 1:16 P.M., while they were receiving their bolus liquid nourishment via their feeding tube administered by RN 2. The resident was sitting up in their wheelchair. The RN washed her hands, donned gloves, and placed a towel under the resident's tube on their stomach. The nurse checked for placement of the tube, checked the residual, then drew up 30 cc (cubic centimeters) of water and flushed the tube by pushing the water in using the plunger on the syringe. The RN poured the carton of liquid nourishment into an open dry container. She then drew up three syringes of the liquid nutritional formula and pushed the formula rapitly with force (over a few seconds, less than one minute), using the plunger and the piston syringe three times, in the feeding tube. The RN flushed the feeding tube using another 30 cc of water, pushing the flush in with the piston syringe. During an interview on 06/20/24 at 3:11 P.M., LPN (Licensed Practical Nurse) 6 indicated for a bolus feed, if there was an order for flushing with an extra amount of water every four hours, she would flush with half of the flush amount before, and half after the administration of the liquid meal. If the physician's order said to flush every four hours, staff were to flush it with the tube feed bolus meals. She always used the gravity method. She held the open syringe without the plunger in it and allowed the flushes and the bolus feedings to go in gradually using the gravity method. During an interview on 06/21/24 at 2:23 P.M., the Nurse Consultant, indicated nurses were trained and observed on performing basic nursing skills upon hire. During an interview on 06/21/24 at 2:28 P.M., the DON (Director of Nursing) indicated when a resident received a bolus feed, the staff checked for placement of the feeding tube, flushed with 30 cc of water or as the order indicated. If a resident was to receive extra water, it would be done with the bolus feeding. She would administer a bolus feed by gravity, pouring the liquid nourishment into the open syringe and allowing it to go in via gravity. Only if there was a problem, would they ever push it through. The clinical record was reviewed on 06/19/24 at 3:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 04/14/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, emphysema, hypertension, and dementia. The resident had a swallowing disorder and had a feeding tube while a resident. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for June 2024, was provided by the ADON (Assistant Director of Nursing) on 06/21/24 at 2:53 P.M., and included, but was not limited to, the following physician's orders: (continued on next page)

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	155209	A. Building B. Wing	06/24/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An open-ended order, with a start date of 06/17/24, for Enteral Feed four times a day of Osmolite, 250 ml (milliliters) per G-tube (gastric tube), - An open-ended order, with a start date of 06/17/24, to flush the G-tube with 160 cc of water every 4 hours for hydration, and - An order, with a start date of 04/24/24, and a discontinued date of 06/17/24, to flush the G-tube with 140 cc of water every 4 hours for hydration. During the observation of the feeding tube process, the nurse failed to follow the physician's order in regard to the amount of water prescribed to flush the feeding tube. The Progress Notes for May and June 2024, were provided by the ADON on 06/21/24 at 2:53 P.M., and included, but were not limited to, the following: - A Nursing Progress Note, dated 05/11/24, indicated the nurse was called to the resident's room. The resident was in bed and had audible (able to hear) crackles (lung sounds). The bolus Osmolite feed had been given per gravity and resident started to cough immediately after administration. The head of the bed was elevated, and it had helped facilitate deep breathing, - A Dietary Progress Note, dated 06/14/24, indicated weight gain was desired and the enteral feed was increased to 250 cc every four hours and the flushes had been increased to 160 cc every four hours, and - A Nursing Progress Note, dated 06/17/24, indicated the resident had new orders to increase the enteral feed to 250 cc every four hours, and increase the flushes to 160 cc every four hours. The current undated PHYSICIAN ORDERS - (FOLLOWING PHYSICIAN ORDERS) policy was provided by the Regional Nurse Consultant on 06/24/24 02:54 P.M. The policy indicated, .It is the policy of the facility to follow the orders of the physician . The current GUIDELINES FOR ENTERAL FEEDING: ADULT, dated 07/03/23, was provided by the Administrator on 06/20/24 at 1:54 P.M. The policy indicated, .Purpose: To provide guidance to qualified licensed clinical staff in hanging and maintaining and managing and administering Tube/Feedings and Enteral Nutrition .OPEN-ENTERAL FEEDING SYSTEM-or use of formula from cans or bottles which is poured into a feeding tube bag or piston syringe . If feeding tube is clogged, gently flush with 30 ml of warm . water . The NIH (National Institute of Health) website Nursing Skills publication, dated 2021, indicated, .Tube feeding can be administered using gravity to provide a bolus feeding or via a pump to provide continuous or intermittent feeding . A HOW TO BOLUS FEED procedure provided by the Regional Nurse Consultant on 06/24/24 at 4:14 P.M., indicated, .Fill the syringe with water as advised by your healthcare professional and flush the water through your feeding tube .Unclamp your feeding tube and gently syringe the feed into your feeding tube by slowly pushing the plunger .This should take at least 15 minutes .) 3.1-47(a)(2)

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	155209	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Clifty Falls, The	950 Cross Ave Madison, IN 47250

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 38239 Based on observation, interview, and record review, the facility failed to adequately monitor a dialysis access site for 1 of 2 residents that received dialysis treatments. (Resident 20) Findings include: Resident 20 was observed in his room on 06/20/24 at 2:20 P.M. A clean dressing was in place on the resident's right forearm. The resident indicated he had an AV (arteriovenous) graft in his right arm for dialysis. They started using it less than a month ago, before that he had an access site in his chest. The nursing home facility staff didn't assess his graft site. The resident's clinical record was reviewed on 06/20/24 at 1:17 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/03/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, renal insufficiency, anxiety, and depression. The resident received dialysis treatment. The resident's current physician's orders were reviewed and lacked an order to monitor the AV graft site. During an interview on 06/20/24 at 3:05 P.M., RN 2 indicated the resident did have an AV graft. She would assess the resident's arm for redness or signs of infection and would change the dressing if it was soiled. She had not ever assessed the AV graft for bruit and thrill, nor did she document any assessment of the AV graft in the resident's record. During an interview on 06/24/24 at 3:01 P.M., the ADON (Assistant Director of Nursing) indicated if a resident had an AV graft that was being used for dialysis, they should have a physician's order for nursing staff to assess it. Nursing should check for bruit and thrill. The resident's AV graft site had been used for dialysis treatment every Monday, Wednesday, and Friday since 06/04/24. The resident's Dialysis Care Plan, with a start date of 05/23/34, included but was not limited to the following interventions: - Monitor shunt for bruit and thrill, and - Observe shunt site after return from dialysis. The current, undated facility policy, titled ASSESSMENT OF ARTERIO VENOUS SHUNTS, FISTULAS, & GRAFTS, was provided by the Administrator on 06/21/24 at 9:20 A.M. The policy indicated, ' .It is the policy of this facility to evaluate arterio venous shunts, fistulas, and grafts by a licensed nurse to facilitate early detection of potential complications .Palpate-place hand over the site for presence of thrill .Auscultate-using the stethoscope, listen for the presence of bruit over the site (swishing sound) . 3.1-37(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 38239 Based on record review and interview, the facility failed to ensure PRN as needed orders for psychotropic medications were limited to 14 days for 1 of 5 residents reviewed for unnecessary medications. (Resident 20) Findings include: Resident 20's clinical record was reviewed on 06/20/24 at 1:17 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 05/03/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, renal insufficiency, anxiety, and depression. The resident's physician's orders included an open-ended order, with a start date of 02/22/24, for Alprazolam (an anti-anxiety medication), 0.5 mg (milligrams) every 8 hours as needed for anxiety. A Note to Attending Physician/Prescriber, dated 03/15/24, indicated the resident was currently receiving Alprazolam 0.5 mg every 8 hours as needed for anxiety from 02/22/24. Per regulatory guidelines, the duration of treatment with such medications on a PRN basis should be limited to 14 days, however, a new order may be written to extend the duration beyond 14 days if the prescriber believed it was appropriate. Please evaluate the continued need for the medication. If it was to be extended, please document the rationale for the extended time period and indicate a specific duration. There was no indication of the physician's response to the pharmacy recommendation. A Note to Attending Physician/Prescriber, dated 04/24/24, indicated the resident was currently receiving Alprazolam 0.5 mg every 8 hours as needed for anxiety from 02/22/24. Per regulatory guidelines, the duration of treatment with such medications on a PRN basis should be limited to 14 days, however, a new order may be written to extend the duration beyond 14 days if the prescriber believed it was appropriate. Please evaluate the continued need for the medication. If it was to be extended, please document the rationale for the extended time period and indicate a specific duration. There was no indication of the physician's response to the pharmacy recommendation. The resident's EMAR (Electronic Medication Administration Record) indicated the resident received the PRN Alprazolam medication in March, April, May, and June. During an interview on 06/24/24 at 10:50 A.M., the ADON (Assistant Director of Nursing) indicated the resident's physician wanted the Psych NP (Psychiatric Nurse Practitioner) to address the pharmacy recommendation. The Psych NP would not address the recommendation because the resident refused to sign the consent to be seen by the Psych NP. The recommendation fell back on the resident's physician to address, and it just didn't get addressed. It should have been addressed. The current, undated facility policy, titled Policy and Procedure--Pharmacy Recommendations, was provided by the Administrator on 06/24/24 at 11:23 A.M. The policy indicated, .ensure residents are receiving medications that are effective and safe .A response as to the action to be taken regarding the . recommendation will be documented within 7 days of the receipt of the recommendation . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-48(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38769 Based on observation and interview, the facility failed to store medications appropriately for 4 of 4 medication carts observed. (1 cart on the In Motion Hallway and 3 carts on the Living Well Hallways) Findings include: 1. During an observation of an In Motion Medication Cart on 06/24/24 at 11:14 A.M., with LPN (Licensed Practical Nurse) 3 the following was observed: - a vial of Humalog insulin for Resident 82 with an open date of 05/15/24, the vial was 3/4 full and - a Humalog insulin pen for Resident 82 with and open date of 05/02/24, that was 3/4 full. LPN 3 indicated the insulin was good for 30 days after it was opened. 2. During an observation of a Living Well Short Medication Cart on 06/24/24 at 11:22 A.M., with LPN 9, the following was observed: - a Fiasp insulin pen for Resident 45 with an open date of 05/22/24 and 50 units left in the pen. The nurse indicated the insulin pen was good for 28 days after it was opened and should have been discarded on 06/20/24. 3. During an observation of a Living Well Short Medication Cart on 06/24/24 at 11:27 A.M., with LPN 9, the following was observed: - a Fiasp insulin pen for Resident 46 with an open date of 05/22/24 that appeared to have not been used. The nurse indicated the pen should have been discarded on 06/20/24, and - a NovoLog insulin pen for Resident 46 with an open date of 05/15/24 and use by date of 06/15/24. The pen contained a little less than 200 units. 4. During an observation of a Living Well Long Medication Cart on 06/24/24 at 3:08 P.M., with QMA (Qualified Medication Aide) 8, the following was observed: - a bottle of lorazepam intensol (liquid antianxiety medication) for Resident 22 with 14 ml (milliliters) in the bottle. The bottle was undated and indicated to keep refrigerated. The current facility policy titled Medication Administration dated [DATE], was provided by the Administrator on 06/24/24 at 1:00 P.M. The policy indicated, .If the medication is discontinued or outdated, remove medication from proper disposal [sic] . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current Humalog Storage policy was provided by the Administrator on 06/24/24 at 1:00 P.M. the policy indicated, .Prior to first use, HUMALOG preparations must be stored in a refrigerator .Cartridges, vials, and prefilled pens that are in current use, should be stored at room temperature .and discarded after 28 days . The current Humulin Storage was provided by the Administrator on 06/24/24 at 1:00 P.M. The policy indicated, .Not In-Use (Unopened) .refrigerated . The current Novolog Storage was provided by the Administrator on 06/24/24 at 1:00 P.M. The policy indicated, .Once a cartridge .is punctured, it should be kept .for up to 28 days . The current Fiasp Storage was provided by the Administrator on 06/24/24 at 1:00 P.M. The policy indicated, . Stored for 28 days . The current Lorazepam Oral Concentrate Label was provided by the ADON (Assistant Director of Nursing) on 06/24/24 at 3:52 P.M. The policy indicated, .Discard open bottle after 90 days . 3.1-25(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34232 Based on observation, interview, and record review, the facility failed to follow infection control guidelines during meal preparation related to the use of hair nets and failed to provide a clean and sanitary kitchen for 93 of 95 residents who received food from the kitchen. Findings include: 1. During the initial kitchen tour with the DM (Dietary Manager) on 06/18/24 at 11:07 A.M., the following was observed in the open kitchen / food prep areas: - The back door to the outside was cracked open about 1/2 inch, - A trash can, near the back door, had a swarm of gnats, greater than 10, flying around it. The DM indicated the trash can was for dirty rags, - A metal rack, that was stationed near the trash can and gnats, contained trays of individual desserts. The top tray was covered, only on the top, with a piece of paper that hung over the edge of the tray and covered 1/2 of the top of second tray on the next lower level. Two and half trays were left uncovered, - The bottom shelves of three food prep tables, one with plastic ware, tubs of cereal, and plate warmers, one with syrups and boxes of thickened liquids, and one with bottles of cooking oil and spices, were littered with crumbs and splattered liquid stains, - Two 3-shelf wheeled carts were littered with crumbs and splatter marks. One cart contained plastic cups and individually wrapped snacks. One cart contained loaves of bread and a large open cup of an iced drink, - A silver wire shelf unit with cardboard boxes that had plastic tubes coming out of them, was caked with gray dust. The dry storage room contained the following: - Two boxes of Spanish rice and a bottle of caramel syrup were lying flat on the floor of the dry storage room, - A 50-pound bag of brown sugar, in a brown paper bag, had the top was rolled down. The bag was 1/4 full and was not sealed or in a tub, - a 25-pound bag of breadcrumbs, in white and red paper bag, had the top rolled down. The bag was 1/3 full and was not sealed or in a tub. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM had a shock of hair, 1 to 1.5 inches wide x (by) 3 inches long hanging out of her hair net on the left side of her head as she worked on reheating the pureed food items on the grill standing over the food. 2. During a second kitchen observation on 06/24/24 at 9:56 A.M., the following was observed: - The DM was wearing a hair net with a one-inch shock of hair hanging down the side of her face as she worked in the food prep areas, - The shelves below the food prep tables were littered with crumbs and food splatters, - A rack, holding trays of clean dishes, was grimy with crumbs and dust clinging to the rack, - Three 3-shelf wheeled carts were littered with crumbs and food splatters. The wheels were caked with black and gray chunks of debris and dust, - A wire metal rack the juice machine sat on was caked with gray dust, - clean baking sheets were caked with black debris around the rims and edges, - [NAME] stains were running down the can opener attachment on the food prep table, and - several gnats were flying about the food prep areas. The DM indicated the cleaning schedules were usually in a binder. They took them out at the end of each month and put a new one in the binder. The binder was observed, and the latest cleaning schedule was from February. The DM indicated there should have been a cleaning schedule in the binder for June. The DM sorted through a pile of papers in the DM office but all she could find was old temperature logs for the refrigerators and freezers. She was unable to locate any cleaning logs for April, May, or June, of 2024. A blank cleaning Schedule for the kitchen was provided by the DM on 06/24/24 at 10:15 A.M. The schedule indicated the can opener, countertops, storage room, and shelves were to be cleaned every morning and every evening. The Cleaning Rotation policy and procedure, dated 2017, was provided by the ADON (Assistant Director of Nursing) on 06/24/24 at 10:38 A.M. The policy indicated, .Items cleaned after each use: . Can opener .Items cleaned daily: .Food carts . The current FOOD SAFETY & SANITATION policy related to Employee Health and Personal Hygiene, with a developed date of 04/2017, was provided by the Regional Nurse Consultant on 06/24/24 at 2:48 P.M. The policy indicated, .Food service employees shall maintain good personal hygiene .Hair restraints will be worn at all times . 3.1-21(i)(3)