STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Muncie Care Center	2701 Lyn-Mar Dr Muncie, IN 47304

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 48146 Based on record review and interview, the facility failed to ensure completion of a Significant Change Minimum Set (MDS) assessment within 14 days of a determined status change for 2 of 5 residents reviewed for timely Significant Change assessments. (Residents 18 and 203) Findings include: 1. Resident 8's clinical record was reviewed on 7/10/24 at 3:12 p.m. Diagnosis included Chronic Obstructive Pulmonary Disorder (COPD), morbid obesity due to excess calories, and dependence on supplemental oxygen. A current physician order, dated 12/8/23, indicated admission to hospice services related to COPD. The annual MDS assessment, dated 12/11/23, indicated the resident utilized oxygen daily and received hospice services. A significant change MDS assessment was not completed. During an interview, on 7/11/24 at 10:58 a.m., the MDS Coordinator indicated she started her current position in April of 2024. She utilized the Resident Assessment Instrument (RAI) manual for overseeing the MDS department. Resident 18 required a Significant Change assessment with the new order for hospice services. The annual assessment completed was not the correct assessment for this status change. 2. Resident 203's clinical record was reviewed on 7/11/24 at 4:00 p.m. Diagnosis included Alzheimer's Disease, protein-calorie malnutrition, and diastolic heart failure. A physicians order, dated 5/31/24, indicated admission to hospice services related to Alzheimer's Disease. The clinical record lacked a Significant Change assessment for new hospice services. (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/11/24 at 10:58 a.m., the MDS Coordinator indicated she utilized the Resident Assessment Instrument (RAI) manual for overseeing the MDS department. Upon reviewing the MDS for resident 203, a Significant Change assessment was needed for the new order for hospice services. Resident 203 had been removed from one hospice provider on 5/8/24 and the appropriate assessment was completed. She was not sure why the appropriate assessment for the additional status change on 5/31/24 was not completed. Review of the current RAI manual, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, on 7/15/24 at 9:05 a.m., indicated the following: .A Significant Change in Status Assessment (SCSA) must be within 14 days from the effective date of the hospice election . and must be performed regardless of whether an assessment was recently conducted on the resident . 3.1-31(d)(1)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 48146 Based on record review and interview, the facility failed to ensure timely completion of Quarterly Minimum Data Set (MDS) assessments every three months for 1 of 5 reviewed for timely assessment. (Residents 65) Findings include: Resident 65's clinical record was reviewed on 7/10/24 at 3:37 p.m. Current diagnosis included heart failure, paranoid schizophrenia, bipolar disorder, and anxiety disorder. The resident had a Quarterly MDS assessment, with the Assessment Reference Date (ARD) of 12/13/23 completed on 1/11/24. The assessment was completed 15 days late. The resident had a Quarterly MDS assessment, with the ARD of 9/12/23 which was completed on 9/27/23. The assessment was completed one day late. During an interview, on 7/11/24 at 10:58 a.m., the MDS Coordinator indicated she started her current role in April 2024 and utilized the Resident Assessment Instrument (RAI) manual for organizing the MDS position. She indicated the above listed assessments were completed late. Review of the current RAI manual, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, on 7/15/24 at 9:05 a.m., indicated the following: . The Quarterly MDS completion date must be no later than 14 days after the assessment reference date (ARD) . 3.1-31(d)(3)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48146 Based on record review and interview, the facility failed to ensure timely submission of Minimum Data Set (MDS) assessments for 1 of 5 resident reviewed for assessment submission. (Resident 65) Findings include: Resident 65's clinical record was reviewed on 7/10/24 at 3:37 p.m. Current diagnoses included heart failure, paranoid schizophrenia, bipolar disorder and anxiety disorder. The resident had a Quarterly MDS assessment with the Assessment Reference Date (ARD) of 5/6/24, completed on 5/13/24. The assessment was completed on time. The record lacked a transmission date. During an interview, on 7/11/24 at 10:58 a.m., the MDS Coordinator indicated she was not aware this assessment had not been transmitted. Upon reviewing the above assessment, she thought this could be an error in the program, as she could see the document was marked as not required for transmission. She would need to reach out to her consultant for direction. Review of the current the RAI manual, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, on 7/15/24 at 9:16 a.m., indicated the following: . The Quarterly MDS submission date must be no later than the completion date plus 14 calendar days .

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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. 40339 Based on observation, interview and record review, the facility failed to monitor the amount of fluids consumed by 1 or 2 residents on fluid restrictions reviewed for dialysis. (Residents 30) Findings include: The clinical record for Resident 30 was reviewed on 7/10/24 at 10:23 a.m. Diagnoses included end stage renal disease (ESRD), heart failure, and dependence on renal dialysis. A quarterly MDS (Minimum Data Set) assessment, dated 3/4/24, indicated the resident had moderate cognitive impairment, and made themselves understood and understood others. A current, 10/23/24 physician's order indicated a 1500 milliliter (ml) fluid restriction, with 960 ml to be provided by dietary and 540 ml provided by nursing. During an observation on 7/11/24 at 9:44 a.m., Resident 30 was asleep in bed. Several Styrofoam cups containing fluid and two cans of soda were observed on the overbed table and bedside table. A current care plan, initiated 1/20/23, indicated the resident was at risk for alteration in hydration related to fluid restriction due to ESRD. Interventions included to maintain fluid restriction per physician order, provide diet and fluids per physician orders, to record intakes, and to see the nurse prior to providing resident fluids related to a fluid restriction order. A current care plan, initiated 12/5/22, indicated the resident had a potential for alteration in kidney function due to ESRD and was dependent on renal dialysis. Interventions included to follow diet and fluid restrictions per physicians order and to encourage resident to follow hydration program interventions A current care plan, initiated 12/8/22, indicated the resident received a therapeutic diet and fluid restriction. Interventions included diet as ordered and monitor meal consumption daily. The eMAR (electronic medical record) for July 2024, contained checkmarks and nursing initials, but lacked measurement amounts of fluids consumed. A resident bedside report, provided by the DON on 7/11/24 at 10:40 a.m., lacked indication the resident had a fluid restriction. The point of care charting for the staff lacked entry of fluid intake amounts. During an interview on 7/11/24 at 9:16 a.m., LPN 5 indicated she was not aware of any documentation or monitoring needed regarding Resident 30's fluid intakes. During an interview on 7/12/24 at 9:03 a.m., the DON indicated the staff were not monitoring Resident 30's fluid intakes. The fluid intakes should have been recorded and monitored per physician's order. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, dated 2022, titled, Fluid Restriction, provided by the DON on 7/12/24 at 9:21 a.m., included the following: .Policy: It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders Compliance Guidelines: 1.and will be recorded on the medication record of other format as per facility protocol 4. Water will not be provided at the bedside unless calculated into the daily total fluid restriction

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42685 Based on observation, interview, and record review, the facility failed to implement and utilize infection prevention and control practices related to contact isolation, enhanced barrier precautions (EBP), and diagnostic testing for 3 of 5 residents reviewed for infection control. (Resident's B, C, and 99) 1.During an observation on 7/10/24 at 11:04 a.m., Resident B's door had an EBP sign on the left side of the door and a contact isolation sign was on the right side of the resident's door. The personal protective equipment canister was just inside the resident's room beside the bathroom door. The contact isolation sign indicated everyone must clean their hands, put on a gown, and put on gloves before entering the room. During an observation on 7/10/24 at 11:32 a.m., LPN 8 performed hand hygiene and put on gloves as she entered the resident's contact isolation room. She walked to the resident's left side of the bed and her clothing brushed up against the bed linens with her unprotected clothing. Then she went around the foot of the bed and used a graduated measuring container to empty the resident's over full expanded urinary drainage bag. An isolation gown was not worn by LPN 8 throughout the observation. During an interview on 7/10/24 at 11:35 a.m., LPN 8 indicated the resident was in contact isolation and she had not worn a gown when she was in his room emptying the urinary drainage bag. During an interview on 7/12/24 at 10:37 a.m., CNA 9 indicated contact isolation was posted on a sign outside the residents' doors when it was required. A gown and gloves should have been worn for care in contact isolation rooms. Resident B's clinical record was reviewed on 7/9/24 at 3:04 p.m. Diagnoses included, paraplegia, obstructive and reflux uropathy, malignant neoplasm of the bladder, and Methicillin-resistant Staphylococcus aureus (MRSA - bacteria resistant to treatment) infection. A current physician order, dated 7/3/24, included Bactrim (antibiotic) Double Strength (DS) - give 1 tablet by mouth twice daily related to a MRSA infection for 10 days. A current physician order, dated 4/8/24, included gown and gloves for all interactions with the resident every shift. A quarterly Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident was cognitively intact. He was dependent on staff assistance for toileting and transfers and used a wheelchair for mobility. He required a urostomy and had frequent bowel incontinence. 2. During an interview at the time of observation on 7/10/24 from 11:18 a.m. to 11:23 a.m., LPN 8 was in the Resident C's EBP room at bedside with gloves on and no gown during the observation. She leaned in towards and against the resident's bed mattress with her scrubs directly against the resident's linens as she disconnected the old urinary drainage bag in her right hand and held the new drainage bag tubing in her left hand. LPN 8 reconnected the new urinary drainage bag to the suprapubic catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24 at 11:35 a.m., LPN 8 indicated the resident was in EBP and she had not worn a gown when she was in his room emptying the urinary drainage bag. Resident C's clinical record was reviewed on 7/9/24 at 3:14 p.m. Diagnoses included obstructive and reflux uropathy and urine retention. A current physician order, dated 4/29/24, included gown and gloves for all interactions with the resident every shift for enhanced precautions. A quarterly MDS assessment, dated 5/3/24, indicated the resident was cognitively intact. The resident was dependent on staff assistance for toileting, lower body dressing, bathing, and transfers. He had an indwelling catheter and was always incontinent of bowel. 3. During an interview on 7/9/24 at 12:15 p.m., Resident 99 was in her room and indicated she was currently suffering from very loose stools, perhaps from antibiotic use. The loose stools impacted her ability to participate in therapy. Resident 99's clinical record was reviewed on 7/9/24 at 4:00 p.m. Diagnoses included the following: unspecified open wound of right foot, subsequent encounter, constipation, and need for assistance with personalized care. A current physician order, dated 7/3/24, included vancomycin hydrochloride (antibiotic used to treat serious infections) administer 10 milliliters (ml) intravenously every 12 hours. A current physician order, dated 7/8/24, included check stool for Clostridium difficile (C. diff- a bacteria that causes an infection of the colon) one time for loose stools. The clinical record lacked any current, completed, or discontinued contact isolation orders from the date loose stools were reported through 7/11/24. An admission Minimum Data Set assessment, dated 6/12/24, indicated the resident was cognitively intact. She required moderate to maximal assistance for toileting, dressing, personal hygiene, and mobility. The resident had occasional urinary incontinence and frequent bowel incontinence. She had a surgical wound and received antibiotic during the assessment period. The clinical record lacked care plans for contact isolation or potential for C. diff. A Nurse's Note, dated 7/7/24 at 1:36 p.m., indicated a bowel movement had not been documented for 3 days, but the resident had experienced loose stools. A Nurse's Note, dated 7/8/24 at 7:20 p.m., indicated the resident voiced concerns related to diarrhea the past few days. Physician orders were received for a stool sample for C. diff and an order for anti-diarrhea medication. Review of the lab results report, dated 7/9/24, indicated the specimen was not collected for C. diff. The nurse was notified. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked indication another specimen was collected, nor the provider notified, that the order was not completed. During an observation on 7/9/24 at 4:15 p.m., the resident's door was closed and had an enhanced barrier precaution (EBP) sign noted on the left side of the door. During an observation on 7/10/24 at 9:44 a.m., the resident's door was closed and had an enhanced barrier precaution sign noted on the left side of the door. During an interview at the time of observation on 7/10/24 at 11:02 a.m., an EBP sign remained on the left of the resident's door. The resident exited her room in her wheelchair and indicated she was headed down to therapy. She was wearing her normal clothing. During an interview, QMA 6 indicated Resident 99 was not in her room. The door was labeled as EBP and lacked indication of any other type of isolation. The clinical record lacked any other isolation orders, active or discontinued, since the resident's ordered stool sample for C. diff testing. A resident with loose stools should have been placed immediately in contact isolation while awaiting the results of the C. diff stool specimen. He was unable to find or provide stool sample laboratory results. During an interview on 7/10/24 at 11:35 a.m., LPN 8 indicated a gown and gloves were required in contact isolation and EBPs. Failure to use a gown in contact isolation and EBPs put other residents at risk for infection because bacteria could have been carried from her clothing into other residents' rooms. During an interview on 7/11/24 at 3:58 p.m., the ADON indicated any resident suspicious for C. diff with loose stools and awaiting results from a C. diff stool sample should have been placed on contact isolation. The contact isolation should not have been removed unless the test result came back negative. Staff should have been educated on the contact isolation and the importance of washing their hands. They did not have any residents in contact isolation for C. diff precautions in the facility. During an interview on 7/11/24 at 5:07 p.m., LPN 7 indicated the resident's clinical record lacked C. diff stool sample results because the specimen was not collected. It should have been collected as ordered. The clinical record lacked indication why the specimen was not obtained. There was no indication of physician notification of the inability to obtain the ordered stool specimen. The resident was not restricted to her room because EBPs were ordered, rather than contact isolation. The resident was at an increased risk for C. diff due to her intravenous antibiotics. Services should have been provided in her room to prevent the potential spread of an infection to other residents. During an interview on 7/11/24 at 5:12 p.m., the ADON indicated the resident should have been placed in contact isolation when she was symptomatic with loose stools and the stool specimen was ordered. The ADON was the Infection Preventionist and should have caught the error, but she had not recognized the the resident was not in contact isolation, nor the stool specimen not collected, due to additional responsibilities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/12/24 at 10:37 a.m., CNA 9 indicated she was responsible for the care of the residents on C- 3 Unit on this date. She had not received information/education regarding any residents on contact isolation for C. diff on her unit. It was posted outside the residents' doors when contact isolation was required. Resident 99's door remained with an EBP sign to the left of the door. The resident was not in contact isolation. During an interview on 7/12/24 at 12:10 p.m., the DON indicated staff were required to wear a gown and gloves upon entering the contact isolation rooms. Staff were required to wear a gown and gloves in EBPs for manipulation of a urinary catheter drainage bag. Three or more loose stools in a day, foul odors, and abdominal cramping were signs of potential C. diff. Residents on intravenous vancomycin were at higher risk for C. diff. She had to look at the entire clinical picture to determine if a resident should have been placed in contact isolation with the above mentioned symptoms of C. diff. During an interview on 7/12/24 at 2:25 p.m., the Administrator indicated the facility followed the Center for Disease Control (CDC) and Indiana Department of Health guidelines regarding infection control practices. During an observation on 7/12/24 at 2:30 p.m., the resident was not in her room. A contact isolation sign was hung to the left of the door, along with the EBP sign. An unknown staff member indicated the resident had gone to the activity room. During an observation on 7/12/24 at 2:33 p.m., Resident 99 was in the activity room in a group activity. Resident 99 had cards in her hand and was in the process of playing a card game where cards were exchanged with the other players. During an interview on 7/12/24 at 2:35 p.m., Resident 99 indicated she last had several loose watery stools on 7/11/24. She had not been educated or encouraged to remain in her room. She was unaware the facility had not received the C. diff stool specimen results. A current facility policy, undated, titled Provision of Physician Ordered Services, provided by the DON on 7/12/24 at 2:43 p.m., indicated the following: .Policy: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality . Policy Explanation and Compliance Guidelines: 1. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders . 2. Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity . 4. Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record . A current facility policy, undated, titled Enhanced Barrier Precautions, provided by the DON on 7/12/24 at 1:50 p.m., indicated the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . Policy Explanation and Compliance Guidelines: .3. Implementation of Enhanced Barrier Precautions: .b. PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities . 4. High-contact resident care activities include: .g. Device care or use: central lines, urinary catheters . 10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current facility policy, undated, titled Isolation Precautions, provided by the DON on 7/12/24 at 1:50 p.m., indicated the following: Policy: It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents. This policy specifies the different types of precautions, including when and how isolation should be used for a resident . Policy Explanation and Compliance Guidelines: .2. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission . 10. The Infection Preventionist will serve as a consultant to facility staff on infectious diseases and the implementation of isolation precautions 3.1-18(a)(2) 3.1-18(b)(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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 40339 Based on record review and interview, the facility failed to implement an antibiotic stewardship program per facility policy. This had the potential to affect 98 or 98 residents residing in the facility. Findings include: A review of the facilities Infection Control Surveillance Binder was completed on 7/12/24 at 10:43 a.m., for the months of May and June 2024, and included the following: For June 2024, the binder contained an Infection Control Report completed by the ADON. It indicated the facility had 19 infections and 19 residents received antibiotics. The binder lacked documentation of resident names and infection types, or supporting documentation of treatment's provided or criteria for determining treatment. For May 2024, the binder contained an Infection Control Report completed by the ADON. It indicated the facility had 18 infections and 18 residents received antibiotics. The binder included 14 Revised McGeer Criteria for Infection Surveillance Checklist forms and three lab or xray results. The checklists lacked documentation regarding symptoms, criteria, or type of infection, or if the criteria for antibiotic treatment was met or not met. During an interview on 7/12/24 at 11:45 a.m., the ADON indicated she was the facility's infection preventionist. The surveillance binder was her record for infection surveillance. The facility's unit managers were to complete the Revised McGeer Criteria for Infection Surveillance Checklist forms when an infection was suspected. These were to be forwarded to her for the monthly report generation. She had not completed the forms herself or reviewed them. She had not received any forms during the month of June. She had not followed up with the unit managers and had not confirmed appropriateness for antibiotic usage. Her responsibility was solely to complete the monthly report. A current, undated facility policy titled Antibiotic Stewardship Program, provided by the DON on 7/12/24 at 12:10 p.m., indicated the following: Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use Policy Explanation and Compliance Guidelines: .2. a. Infection Preventionist - utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms 4. The program includes antibiotic use protocols and a system to monitor antibiotic use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Muncie Care Center	2701 Lyn-Mar Dr Muncie, IN 47304

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 40339 Based on interview and record review, the facility failed to designate one or more individual(s) as the Infection Preventionist with qualifying training or certification. The facility did not have a currently certified Infection Preventionist for 2 of the 5 days of the survey, or prior since 2/5/24. This deficient practice had potential to affect 98 of 98 residents in the facility. Findings include: During an interview on 7/8/24 at 10:35 a.m., the Administrator indicated RN 12 was the Infection Preventionist. A review of the facility's Infection Control Surveillance Binder was completed on 7/12/24 at 10:43 a.m., and documentation indicated the information was completed by the ADON. During an interview on 7/12/24 at 11:45 a.m., the ADON indicated she was the infection preventionist and had been in that roll since January 2024. During an interview 7/12/24 at 12:46 p.m., the Administrator indicated the ADON had been acting Infection Preventionist for the facility. RN 12 had been promoted about two months ago and had not completed her certification as yet. RN 13, who had Infection Preventionist certification, worked at the facility part-time and was to train and consult for the Infection Control Program. A review of a Centers for Disease Control and Prevention Completion for Nursing Home Infection Preventionist Training Course certificate for the ADON, provided by the Administrator on 7/12/24 at 12:42 p. m., indicated the course was completed on 7/10/24. During a telephone interview on 7/12/24 at 1:57 p.m., RN 13 indicated she had not worked as the Infection Preventionist or consulted for the ADON since 2/5/24. She had trained the ADON regarding surveillance issues and how to map infections, how to identify clusters of infections and how to respond, as well as antibiotic stewardship and how to identify and document criteria. She currently worked part-time at the facility and had no involvement with the infection control program. A current facility policy, dated 3/21/23 and titled, Infection Prevention RN Job Description, provided by the DON on 7/12/24 at 1:50 p.m., included the following: .Qualifications .Must also meet state requirements for relevant licensure or certifications Completed specialized training in infection prevention and control through accredited continuing education Cross reference F880. Cross reference F881.