STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Place Health Campus	2200 N Riley Hwy Shelbyville, IN 46176

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 40287 Based on interview and record review, the facility failed to timely address a grievance for 1 of 1 resident reviewed for dignity (Resident B). Findings include: The clinical record for Resident B was reviewed on 4/25/24 at 12:03 p.m. The Resident's diagnosis included, but were not limited to, hypertension. A Quarterly MDS (Minimum Data Set) Assessment, completed 2/5/24, indicated she was cognitively intact, frequently incontinent of bowel and bladder, and needed maximal assistance of staff for toileting. During an interview on 4/25/24 at 12:03 p.m., FM (Family Member) 20 indicated that approximately a week and a half ago, they had filed a grievance because Resident B had been brought to an appointment on the facility bus after being incontinent of bowel. The facility bus driver had gone back to the facility to get new clothing so that FM 20 could clean Resident B before the appointment. FM 20 was concerned that Resident B had not been toileted prior to leaving the facility. During an interview on 4/30/24 at 2:39 p.m., AS (Activity Assistant) 12 indicated that she had been the bus driver that transported Resident B to her appointment on 4/17/24. Resident B had attended an out of facility activity for approximately 30 minutes prior to her the appointment. AS 12 had taken Resident B from the out of facility activity to the appointment. When AS 12 took Resident B into the building for the appointment AS 12 had heard Resident B tell FM 20 that she had not been cleaned up before she left. FM 20 had taken Resident B into the bathroom and then come back and informed AS 12 that Resident B was a complete mess and asked AS12 to go the facility and get Resident B clean clothes. AS 12 had gone to the facility and informed ED (Executive Director) 1 about the incident and taken clean clothing back to the appointment for Resident B. AS 12 had not noted any odors or visible soiling of Resident B's clothing when she transported her to the appointment. During an interview on 4/30/24 at 3:00 p.m., the SSD (Social Services Director) indicated she had found grievance involving Resident B on the grievance log. The grievance was dated 4/17/24 and did not have a resolved date. SSD was unsure why it was not resolved. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 3:23 p.m., the SSD provided a grievance, dated 4/17/24, that indicated Resident B had arrived at a doctor's appointment on 4/17/24 covered in BM. AS 12 had been sent back to the facility for a change of clothes. FM 20 was concerned that Resident B was not toileted after lunch or before appointments. The resolution was dated 4/30/24 and indicated the SSD had contacted FM 20 and informed them that education had been provided to the staff on the importance of cleanliness and hygiene prior to going to appointments. On 4/30/24 at 3:26 p.m., ED 3 provided the Resident Concern Process Policy, last reviewed 12/31/23, which read .To provide a process for handling, tracking and resolving customer concerns to provide excellence in customer service .5. Enter the concern using the desktop icon labeled 'Resident Concern Form'. All concerns should be entered electronically .6. Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution. 7. Follow up from the department leader will occur within 24-48 [sic] with resolution entered in KeyStats . This Federal Tag relates to complaint IN00430913. 3.1-7(a)(2)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 30344 Based on interview and record review, the facility failed to ensure the required medical and contact information was sent to the hospital for 1 of 1 resident reviewed for discharge. (Resident 54) Findings include: The clinical record for Resident 54 was reviewed on 4/29/24 at 10:28 a.m. Her diagnoses included, but were not limited to, stage 4 chronic kidney disease and stage 4 pressure ulcer of the sacral region. She was discharged from the facility to the hospital on 1/27/24. The 1/27/24, 10:06 p.m. nurse's note read, Res [Resident] has no output in catheter and was flushed x [times] 2. IV [Intravenous] 1L [liter] finished this morning and has drank fluids this shift. Per [name of physician] and spouse send to ed [emergency department] for eval [evaluation.] The 1/28/24 Clinical Discharge Observation, recorded and completed on 2/2/24, indicated a paper-based reconciled medication list was sent to the hospital with Resident 54. There was no information in the clinical record to indicate the contact information of the practitioner responsible for the care of Resident 54, Resident 54's representative information including contact information, advance directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals, and all other necessary information was sent to the hospital to ensure a safe and effective transition of care. An interview was conducted with the DON (Director of Nursing) on 4/29/24 at 11:20 a.m. She indicated when a resident was sent to the hospital, they sent a bed hold policy, continuity of care documentation, and code status with the resident in a packet given to the EMTs (emergency medical technicians.) Most of the time, nursing documented that in a progress note, but not all of the time. The DON reviewed Resident 54's clinical record and indicated she did not see any documentation to verify that information was sent to the hospital for Resident 54. 3.1-12(a)(3)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40287 Based on observation, interview and record review, the facility failed to timely revise a resident's care plans for refusal of showers and depression with individualized interventions for 1 of 5 residents reviewed for unnecessary medications (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 4/26/24 at 9:18 a.m. The Resident's diagnosis included, but were not limited to, depression and anxiety. A care plan, with a start date of 5/5/22 and last reviewed 4/17/24, indicated Resident 20 demonstrates symptoms of depression as evidenced by a score of on the PHQ-9 (depression assessment) sadness and tearfulness. The goal was that the resident will not demonstrate an increase in depressive symptoms. The approaches were GDR (Gradual Dose Reduction) of anti-depressant 4/3/24. Inform psych of an adverse effects noted or any changes in mood/ behavior, initiated 4/8/24, anti-depressant increased 2/5/24 due to failed GDR. Inform psych of any changes in mood/ behavior, initiated 2/5/24, anti-depressant decreased per GDR on 10/20/23 per psych, initiated 10/23/23, assess symptoms of depression with PHQ-9 as needed, initiated 5/5/22, encourage family to visit and participate in the resident's plan of care, initiated 5/5/22, encourage resident to participate in structured group activity and individual leisure activities per choice, initiated 5/5/22, encourage resident to remain actively involved in the plan of care and treatment plan, initiated 5/5/22, meds per order, initiated 5/5/22, observe for overt signs and symptoms of increased depression, initiated 5/5/22, observe mood, affect and behaviors, initiated 5/5/22, provide support and reassurance to resident daily and validate resident's feelings, initiated 5/5/22, provide supportive counseling contacts as needed and refer to psych services as needed, initiated 5/5/22. A care plan, with a start date on 1/17/23 and last reviewed 4/17/24, indicated Resident 20 demonstrated non-compliance with physician orders and/ or plan of care as evidenced by refusing showers at times. The goal was that her preferences will be honored to the extent that non-compliance with physician orders will not result in injury to self or others. The approaches, initiated 1/17/23, were to educate resident regarding physician orders and risk and benefits of compliance, encourage resident to actively participate in care plan and decision making, encourage resident to participate in decision making by offering choices and discussion of advanced directives, observe resident's ability to give informed consent and fluctuations in decision making, and offer alternatives to showers. An Annual MDS (Minimum Data Set) Assessment, completed 1/11/24, indicated she was cognitively intact, needed maximal assistance of staff for showers, and received an anti-depressant daily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Home Psychiatric Subsequent Visit Form, dated 3/22/24, indicated that Resident 20's medication history included a reduction on her Lexapro (anti-depressant) to 10 mg (milligram) on 10/20/23 as a GDR. Lexapro was increased to 20 mg on 1/26/24 because the GDR failed. Current psychotropic medications included Lexapro 20 mg each morning. The presenting problem and patient interview on 3/22/24 indicated Resident 20 denied difficulty with sleep at that time. She reported that her depression was no longer a problem. The treatment plan indicated Resident 20 reported her depression had not been a difficulty for her since her Lexapro was increased. She had no side effects with Lexapro. A gradual dose reduction was contraindicated due to her symptoms improving. The March and April 2024 Medication Administration Record indicated she had taken her Lexapro 20 mg daily, as prescribed by the physician, until 4/3/24. A progress note, dated 4/3/24, read .resident refused Lexapro this am, stating it makes her feel weird and is having weird dreams. Resident does not want to take this med anymore. Notified [psychiatric nurse practitioner] and order to d/c Lexapro. During an interview on 04/26/24 at 9:18 a.m., Resident 20 indicated that she did not get her showers as she should. The staff would say that she refused the shower, but she just wanted them right before bed because the shower helped her relax. She went to bed at different times depending on how she felt and what was on television. She felt bad that she couldn't clean up and was having trouble moving around. She had a counselor when she was at home to talk to but did not have one here. She was observed to be tearful during the interview. She was going to go to bingo later in the day, which she really enjoyed. During an interview on 4/30/24 at 10:02 a.m., the DNS (Director of Nursing Services) indicated Resident 20's Lexapro had been discontinued because she had been refusing the medication and said it made her feel funny in the head. Resident 20 was tearful often, even when taking the Lexapro. Resident 20 had multiple health issues, including a large cyst on her left ovary. She saw multiple specialists. She has good days and bad days and was seen by the psychiatric nurse practitioner. Staff tried to get her out of the room as much as they could to the dining room or to bingo. The care plan for symptoms of depression had not been updated to reflect that Resident 20 had requested the Lexapro to be discontinued, multiple health concerns which may affect her depression, or to encourage Resident 20 to go to bingo and the dining room for meals. During an interview on 4/30/24 at 2:49 p.m., CNA (Certified Nursing Assistant) 13 and COTA (Certified Occupational Therapy Assistant) 14 indicated that Resident 20 preferred her showers in the evening. There were 3 or 4 CNA's who Resident 20 really liked to shower her and she would refuse showers at times if she didn't like the CNA who was assigned to her. If one of the CNA's she preferred was working, then staff would have that CNA shower her. COTA 14 indicated that she would also assist Resident 20 with showers sometimes. The care plan for refusal of showers at times had not been updated to offer alternate care givers which Resident 20 preferred. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 3:45 p.m., the Regional Nurse Consultant provided the Comprehensive Care Plan Guidelines Policy, dated 5/22/18, which read .To ensure appropriateness of services and communication that will meet the resident's needs, severity/ stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines .Care plan interventions should be reflective of risk area[s] or disease processes that impact the individual resident .Should new identified area of concern arise during the resident's stay, they should be addressed on the care plan . 3.1-35(b)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 30344 Based on observation, interview, and record review, the facility failed to administer a resident's medication, as ordered, and to timely address an issue with a physician's order for a new eye medication for a resident whose insurance did not cover the costs of the medication for 2 of 3 residents reviewed for pharmacy services and medication administration. (Resident E and Resident 16) Findings include: 1. The clinical record for Resident E was reviewed on 4/25/24 at 11:55 a.m. Her diagnoses included but were not limited to, type 2 diabetes mellitus and metastatic bone cancer. She was admitted to the facility from the hospital on 4/19/24. An interview was conducted with Resident E on 4/25/24 at 12:00 p.m. She indicated she was discharged from the hospital on a whole list of medications. Because she was admitted to the facility on a Friday, she did not start getting some of the medications until the following Monday. The 4/19/24 hospital discharge medication list indicated to administer one 75 mg capsule of Glucofunction twice daily and one 950 mg Nutrient capsule twice daily. The April, 2024 MAR (medication administration record) indicated the Nutrient capsule was not administered on the following dates due to the drug/item being unavailable: once on 4/20/24, twice on 4/23/24, and once on 4/26/24. The Glucofunction capsule was not administered on the following dates due to the drug/item being unavailable: once on 4/20/24, once on 4/22/24, twice on 4/23/24, and once on 4/26/24. An interview was conducted with the DON (Director of Nursing) on 4/29/24 at 10:59 a.m. She called the pharmacy during this interview to inquire as to why the Nutrient and Glucofunction were unavailable for administration on the above dates. After speaking with the pharmacy, the DON indicated neither the Glucofunction nor the Nutrient was delivered from pharmacy. The only thing she could think of was that since both items were over the counter, they were in the medication cart on the assisted living side of their facility, where Resident E resided prior to her being hospitalized , and staff literally walked over and got them, but not until after the above administrations were missed. The Admissions Checklist was provided by the RNC (Regional Nurse Consultant) on 4/29/24 at 12:07 p.m. There was a column to check yes or no as to whether medications were delivered and a column to check yes or no as to whether a second check of the orders was completed. 41129 2. The clinical record for Resident 16 was reviewed on 4/30/24 at 9:31 a.m. Resident 16's diagnoses included, but not limited to, diabetes type II, gout, chronic kidney disease, anxiety disorder, and retention of urine. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 4/10/24 for Resident 16 indicated to administer 1 drop of 0.1% Nevanac ophthalmic solution (a nonsteroidal anti-inflammatory medication used to treat eye pain, irritation, and inflammation) into eye twice a day. This order was discontinued on 4/19/24. A copy of Resident 16's April 2024 MAR (medication administration record) provided by DON (Director of Nursing) on 4/30/24 @ 4:15 p.m. indicated, on the following dates and times, Resident 16 did not receive the Nevanac eye medication: 4/11/24 - morning and evening doses 4/12/24 - morning dose 4/14/24 - morning and evening doses 4/15/24 - morning dose 4/16/24- morning and evening doses 4/17/24 - morning dose 4/18/24 - morning dose 4/19/24- morning dose A nursing note dated 4/10/2024 at 10:22 p.m. indicated, Resident 16 was seen by the eye doctor that day and a new order for Nevanac eye drops was received and noted. A nursing note dated 4/17/2024 at 2:36 p.m. indicated, the facility had attempted to reach Resident 16's eye doctor due to the new order for Nevanac eye drops was not covered by Resident 16's insurance. The nursing note also indicated a voicemail was left asking for the eye doctor to return the phone call to facility. A nursing note dated 4/18/2024 at 6:14 p.m. indicated, Resident 16's eye doctor had called the facility back regarding the Nevanac not being covered by the resident's insurance and inquired if another eye medication, Xibrom 0.9% would be covered by Resident 16's insurance as a substitution for the Nevanac. The nursing note indicated, facility's pharmacy was called and was to call the facility back regarding coverage and possible other substitutions that would be covered by the resident's insurance. An interview with the facility's pharmacy conducted on 4/30/24 at 9:44 a.m. with Pharm T (Pharmacy Technician) 6 indicated, they had received the physician's order for Resident 16 for the Nevanac on 4/10/24. They further indicated, that on 4/10/24 at 9:42 p.m., they had sent an unable to send medication communication form regarding Resident 16's Nevanac eye drops not being covered by insurance and that it would be an out of pocket cost of over $300. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with DON conducted on 4/30/24 at 10:15 a.m. indicated, when the pharmacy faxes an unable to send medication communication form, it goes to the fax machine at the nursing station and the expectation was for the resident's nurse on duty to contact the physician and get issue with the order addressed. DON indicated, she would have expected the resident's nurse that evening or at least the next day to resolve the pharmacy's unable to fill medication communication. An interview with the facility's pharmacy conducted on 5/1/24 at 10:06 a.m. with Pharm T 7 indicated, Resident 16's eye medication, Nevanac, was never delivered to the facility because of the cost issue. Pharm T 7 indicated, on 4/11/24, they called the facility to inquire about what to do about Resident 16's eye medication, Nevanac, and at that time, the facility indicated, for them (the pharmacy) to place the medication on hold until they speak to the provider. When the pharmacy did not hear back from the facility by 4/16/24, they sent another faxed unable to fill medication communication form to the facility. Pharm T 7 indicated, they still had not heard back from the facility regarding Resident 16's medication issue by 4/19/24 so they faxed another unable to fill medication communication form to the facility. When they hadn't heard back from the facility by 4/24/24, they called the facility and were then notified that the order for Resident 16's eye medication was switched to a medication covered by her insurance. Pharm T 7 verified the Nevanac for Resident 16 was never delivered to the facility. A Guidelines for Medication Orders policy received on 4/30/24 at 4:17 p.m. from ED (Executive Director) 3 indicated, Purpose to establish uniform guidelines in the receiving and recording of medication orders . Telephone/verbal orders .Telephone or verbal orders may be accepted by a licensed nurse only .Telephone or verbal orders shall be recorded in Matrix when received by the nurse receiving the order. 3.1-25(b)(1) 3.1-25(g) 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41129 Based on observation, interview, and record review, the facility failed to ensure: an ophthalmic (eye) medication was labeled with the date it was opened (Resident 24); the timely destruction of medications for an expired resident (Resident 272); and the controlled medication lock box was permanently affixed within the medication refrigerator (Facility) when reviewed for medication storage and labeling. Findings include: A medication storage observation was conducted on 4/30/24 starting at 4:02 p.m. and ending at 4:37 p.m. During the observation, the following was witnessed: 1. In the medication cart on [NAME] hallway with RN (Registered Nurse) 8, inside a drawer was an opened bottle of Timolol eye drops for Resident 24 with an opened date of 3/21. 2. An observation of the medication room on the healthcare side made with RN 9 found inside a cabinet, an opened bottle of Tylenol contained 10 tablets. The Tylenol bottle was labeled for Resident 272 and according to RN 9, Resident 272 was no longer a resident at the facility. Also, inside the medication room, was a medication refrigerator with a metal, locked box which contained controlled medications. The metal locked box was not permanently affixed within the fridge. An observation of the metal lock box for controlled medications inside the refrigerator was made with DON (Director of Nursing) on 4/30/24 at 4:37 p.m. It was observed a metal wire that, according to DON, had been attached to the metal locked medication box was broken and was no longer attached to the metal box. She indicated, she had not been made aware of the controlled medication lock box was no longer tethered to the fridge and was not sure how long it had been like that. A clinical record review for Resident 272 conducted on 5/1/24 at 9:28 a.m. indicated, Resident 272 had expired on 12/24/23. Resident 272's tylenol tablets should have been destroyed/returned in a timely manner. The National Library of Medicine at https://pubmed.ncbi.nlm.nih.gov/Hanssens JM, [NAME]-[NAME] C, [NAME] S, El-Zoghbi N, [NAME] V, [NAME] C, [NAME] JF. Shelf Life and Efficacy of Diagnostic Eye Drops. Optom Vis Sci. 2018 Oct;95(10):947-952. doi: 10.1097/OPX.0000000000001288. PMID: 30234830 last accessed 5/2/24 indicated, pharmaceutical companies recommend discarding ophthalmic drugs 28 days after opening. A Labeling of Medications and Biologicals policy received on 5/1/24 at 11:32 a.m. from RNC (Regional Nurse Consultant) indicated, Facility staff should date the label of any multi-use vial when the vial is first accessed . The staff will check the expiration date of each medication before administering it .No expired medications will be administered to a resident . 3.1-25(k) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-25(n) 3.1-25(o) 3.1-25(r)

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 40287 Based on interview and record review, the facility failed to timely obtain a urinalysis, as ordered by the physician, for 1 of 5 residents reviewed for unnecessary medications (Resident 23). Findings include: The clinical record for Resident 23 was reviewed on 4/29/24 at 10:30 a.m. The Residents diagnosis included, but did were not limited to, diabetes and kidney failure. A Quarterly MDS (Minimum Data Set) Assessment, completed 3/6/24, indicated that she was cognitively intact. A Nurse Practitioner Nursing Home Visit note, dated 4/25/24, indicated that Resident 23 reported urinary frequency, dysuria, and urgency. The plan was to complete a STAT (right away) urinalysis with culture and sensitivity. A physician's order, dated 4/25/24, indicated to obtain a STAT UA with C and S. During an interview on 4/29/24 at 12:44 p.m., the DNS (Director of Nursing Services) indicated that the UA had not been sent to the lab on 4/25/24. It should have been obtained on 4/25/24. On 4/29/24 at 4:01 p.m., the Regional Nurse Consultant provided the current Ordering Lab Test Policy which read . Once the specimen has been collected .Lab Services Customer Care Team to arrange for transport of your STAT specimen[s] to the STAT partner with which we have contracted for you . 3.1-49(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155735	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Place Health Campus	2200 N Riley Hwy Shelbyville, IN 46176

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41129 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control policy by not performing hand hygiene prior to glove use and after dropping a pill onto a medication cart, picking up the pill with bare hands and administering it to the resident for 1 of 3 residents reviewed during the medication administration observation. (Residents 9 and 16) Findings include: 1. A medication administration observation with RN (Registered Nurse) 4 was conducted on 4/30/24 at 8:43 a.m. RN 4 was observed while she prepped and administered Resident 16's oral medications. After administering the oral medications, she turned around back to her medication cart; touched the medication cart and her keys to unlock the cart; opened a drawer and retrieved a pill bottle which contained Resident 16's eye drops bottle. RN 4 had, without performing hand hygiene, donned (put on) gloves and administered the eye drops to Resident 16. An interview with RNC (regional Nurse Consultant) conducted on 4/30/24 at 11:53 a.m. indicated, yes, RN 4 should have performed hand hygiene prior to donning clean gloves and administering Resident 16's eye medication since she had administered medication, touched her keys, unlocked the medication cart, and retrieved the medication out of the cart prior to donning the gloves. 2. A medication administration observation with LPN (Licensed Practical Nurse) 5 was conducted on 4/30/24 at 9:10 a.m. LPN 5 was observed preparing the medications for Resident 9. LPN 5 was opening the pill packets with scissors and then dumping them into a medication cup when one tablet from a pill packet had fell on to the medication carts top. LPN 5, with bare hands, quickly picked up tablet from the top of the medication cart and placed the tablet into the medication cup with Resident 9's other tablets and administered the medications to the resident. She had not performed hand hygiene prior to touching the tablet with her bare hands. An interview with LPN 5 was conducted after the medication administrations and when asked why she picked up the medication off the medication cart with her bare hands, she explained that with the pill packets, she didn't have another tablet (of the same medication) which to replace it. LPN 5 identified the medication she dropped as Resident 9's pantoprazole (acid reducing medication)tablet. LPN 5 indicated, she was unsure if the facility's emergency drug supply carried that medication. An Infection Prevention and Control General Guidelines policy received on 5/1/24 at 2:37 p.m. from ED (Executive Director) 3 indicated, the purpose of the policy was To provide guidelines to prevent the spread of infection from one person to another .Hand washing is the most important method of infection prevention and control .Hands should be washed between direct contact with any resident, after doing cleaning tasks, after using the restroom or any other tasks that provides an opportunity for infection .Gloves should be worn when coming in contact with blood or body secretions . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Diseases and Control website at https://www.cdc.gov/handhygiene/providers/index.html; Last Reviewed: January 8, 2021, Source: Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Healthcare Quality Promotion (DHQP) last accessed 5/1/24, Glove Use When and Where to use Gloves indicated, Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. 3.1-18(b) 3.1-18(l)