STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION ESTATES PERU, LLC	1200 KITTY HAWK DRIVE PERU, IN 46970

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 21 & 22, 2025 Facility number: 013327 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 4/30/2025.	R 0000	*This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* *The facility respectfully request a desk review for these citations.*	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to timely notify the physician of a low blood pressure for 1 of 8 residents reviewed for physician services. (Resident 8) Finding includes: A record review for Resident 8 was completed on 4/21/2025 at 1:12 P.M. Diagnoses included, but were not limited to: chronic respiratory failure, chronic obstructive pulmonary disease and sleep apnea. A Nursing Progress Note, dated 2/16/2025 at 6:40 A.M., indicated Resident 8 was found on the floor next to her bed. She denied hitting her head, but complained of left shoulder pain. Resident 8	R 0036	I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 8 no longer resides in the facility. II How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents medical records will be reviewed for the last 30 days and any unreported significant changes will be communicated	05/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Attinger	Administrator	05/13/2025

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	refused to go to the hospital. The physician was notified, and Resident 8 would continue to be monitored. A Nursing Progress Note, dated 2/16/2025 at 11:20 A.M., indicated Resident 8 had a blood pressure of 86/53 mmHg (millimeters of mercury) and a pulse of 97 beats per minute. Documentation could not be located within the medical record of physician notification of Resident 8's hypotension (a blood pressure below 90/60 mmHg) and borderline tachycardia (a heart rate greater than 100 beats per minute). A Nursing Progress Note, dated 2/16/2025 at 4:40 P.M., indicated Resident B called for assistance and was found between the toilet, bathroom wall and her electric wheelchair. A Nursing Progress Note, dated 2/16/2025 at 4:51 P.M., indicated an ambulance service was requested and the EMS (emergency medical service) evaluation indicated Resident 8's blood pressure continued to be low. Resident 8 was transported to the emergency room for an evaluation. During an interview, on 4/21/2025 at 1:58 P.M., LPN 3 indicated the physician should be notified if a systolic (top number of a blood pressure reading) blood pressure dropped below 90 mmHg. She indicated the physician should have been notified prior to the resident's transfer to the hospital, however, a physician order was not found for the transfer to the hospital and there was no documentation indicating the physician had been notified of the resident's continued low blood pressure readings.. A policy was provided, on 4/22/2025 at 11:23		with the MD and responsible party if necessary. III What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses will be inserviced on physician/family notification. IV How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **The DON or designee will audit the 24 hour report Tuesday-Friday and the 72 hours report on Mondays to ensure proper md/family notifications are occurring.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	A.M., by the Director of Nursing (DON). The policy titled, "Physician/Family/Responsible Party Notification", indicated, " ...To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner ...The facility will inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative of an interested family member when there is: (B) A significant change in the resident's physical, mental, or psychosocial status ...."			
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance Based on observation, record review and interviews, the facility failed to ensure the most recent State survey results were available for review by residents and visitors. This deficient practice had the potential to affect 22 of 22 residents who resided in the building. Finding includes: During an initial facility tour, on 4/21/2025 at 10:06 A.M., a black binder tilted, "Survey Results", located on the lower shelf of a table in the foyer was reviewed. The binder had survey results from June 8, 2023 and survey results prior to June 2023. The results for the most recent annual survey, conducted, on May 10, 2024, were not available in the binder for review. During an interview, on 4/21/2025 at 2:43 P.M., the Assistant Executive Director indicated the most current and previous three years of surveys should have been available for review. A policy for residents' rights was requested. The	R 0042	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure The survey binder was audited and updated will all surveys from the past 3 years.	05/13/2025

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	Director of Nursing indicated, on 4/22/2025 at 11:23 A.M., a policy was not available for residents' rights, and the facility followed the state regulation.		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator or designee will audit gateway and the survey binder monthly to ensure the most recent survey results are put in the survey binder. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure 2 of 5 staff members reviewed received annual dementia training. (LPN 3 & Housekeeper 4) Finding includes: On 4/22/2025 at 10:02 A.M., a review of the employee records was completed. The employee records for LPN 3 and Housekeeper 4 lacked documentation of yearly dementia training. During an interview, on 4/22/2025 at 10:13 A.M., the Administrator in Training indicated the staff members should have had annual dementia	R 0120	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged	05/13/2025

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	training. On 4/22/2025 at 11:50 A.M., the DON indicated the facility did not have a policy regarding dementia training and they followed the State regulations.		deficient practice III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff will complete the required annual dementia training. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The admin or designee will audit staff inservices monthly to ensure all staff have 6 hours of dementia training in their first 6 months and 3 hours annually thereafter. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on record review and interview, the facility failed to complete a pre-admission assessment for 1 of 7 residents reviewed for pre-admission assessment. (Resident 8)	R 0214	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 8 no residents in the	05/13/2025

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	Finding includes: A record review for Resident 8 was completed on 4/21/2025 at 1:12 P.M. Diagnoses included, but were not limited to: chronic respiratory failure, chronic obstructive pulmonary disease and sleep apnea. Resident 8 was admitted to the facility on August 26, 2024. Documenttion of a pre-admission assessment was not located in the medical record. During an interview, on 4/22/2025 at 11:23 A.M., the Director of Nursing (DON) indicated a pre-admission assessment had not been completed. She indicated the pre-admission assessment should have been completed for Resident 8. A policy was provided, on 4/22/2025 at 11:23 A.M. The policy titled, "Evaluation of Resident's Needs", indicated, " ...An evaluation of Resident's needs will be completed at admission ...."		facility II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility has had no new admission in the last 30 days. All residents charts were reviewed and all resdients have had a functional assessment in the last 6 months. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The nursing staff were inserviced on the preadmission and ongoing assessment requirements. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The administrator will audit all new admissions to ensure a preadmission audit is completed. The DON will audit 5 charts a week for 4 weeks then 5 charts a month to ensure functional assessments are being completed semiannually, upon a known substantial change, or resident request. The results of these audits will be	

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			reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview, the facility failed to obtain an admission and a semi-annual weight for 1 of 7 records reviewed for admission weights. (Resident 8) Finding includes: A record review for Resident 8 was completed on 4/21/2025 at 1:12 P.M. Diagnoses included, but were not limited to: chronic respiratory failure, chronic obstructive pulmonary disease and sleep apnea. An Admission Observation assessment, dated 8/26/2024, indicated an admission weight of 186.2 pounds, obtained on 8/18/2022, was documented.. The 186.2 pounts weight had been documented on 8/18/2022 from the resident's prior admission date. There was no weight from the resident's current admission on 8/26/2024, nor was there a semi-annual weight from the resident's current admission. During an interview, on 4/21/2025 at 9:42 A.M., the Director of Nursing (DON) indicated Resident 8 had been at the facility in 2022 and had returned home for over a year and then was readmitted to	R 0216	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 8 no longer resident in the facility II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility has had no new admissions in the last 30 days. All residents' charts were reviewed and all residents have had a weight taken in the last 6 months. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses were inserviced on the requirement for admission and semi-annual weights for residents.	05/13/2025

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	the facility. She indicated a new admission weight should have been obtained. A policy for resident weights was requested. The Director of Nursing indicated, on 4/22/2025 at 11:23 A.M., a policy was not available for resident weights, and the facility followed the State regulation.		All residents will have a weight taken in April and October to ensure compliance. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON or designee will audit all admissions to ensure a weight was taken. The DON will audit all residents in April and October to ensure a weight is taken semi-annually. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation and interview, the facility failed to ensure food was stored in a sanitary manner related to the potential use of outdated and unlabled foods and food not sealed correctly. This had the potential to affect all 22 residents who received food from the kitchen. Findings include:	R 0273	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having	05/13/2025

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	On 4/21/2025 at 9:45 A.M., during a tour of the kitchen with Cook 2, the following was observed in the fridge: - An opened bag of ham without an open date. - An opened bag of hotdogs without an open date. - An opened container of mayonnaise without an open date. The following was observed in the freezer: - An opened bag of garlic bread not sealed tightly. - An opened bag of egg rolls not sealed tightly. The following was observed in the dry storage: - An opened container of peanut butter with a use by date of 3/19/2025. - An opened bag of lemon gelatin not sealed tightly. During an interview on 4/21/2025, at 10:03 A.M., Cook 2 indicated the bags of food should have been sealed tightly, the expired foods should have been thrown away and the foods missing open dates should have been labeled. On 4/21/2025 at 1:56 P.M., the DON provided a policy titled, "Labeling and Dating Foods" no date and a policy titled, "Food Storage (Dry, Refrigerated, and Frozen) and indicated they were the policies currently being used by the facility. The policies indicated, "....2. Once a case is opened, the individual, refrigerated food items are dated with the date the item was received into the facility and placed in/on the proper storage location utilizing the "first-in- first out" method of rotation. Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturers expiration date. 4. Prepared food or opened food items should be		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. Any unlabeled, potentially outdated, or improperly sealed food was discarded. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff were inserviced on proper food labeling and storage. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The dietary manager or designee will audit the kitchen 5 days a week to ensure food is properly labeled and stored. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	discarded when: the food is older than the expiration date. 1a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. c. Discard food that passes the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration. f. Leftover contents of cans and prepared food will be stored covered, labeled and dated containers in refrigerators and/or freezers...."			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency Based on observation and interview, the facility failed to ensure expired medications were destroyed and failed to ensure over the counter medications were labeled with required information for 1 of 1 medication carts and 1 of 1 medication rooms observed. (Medication cart 1 and Medication Room 1) Findings includes: 1. During a medication storage observation, on 4/22/2025 at 10:07 A.M., with LPN 5, the following was observed: - in the medication room, in the medication refrigerator, there was a glucagon kit (an emergency medication used to treat severe low blood glucose) with an expiration date of 1/2024. During an interview, on 4/22/2025 at 10:10 A.M., LPN 5 indicated the glucagon kit should not have been in the refrigerator. 2. During a medication cart observation, on 4/22/2025 at 10:12 A.M., with LPN 5, the following was observed:	R 0302	Tag number: 302 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The expired medication was discarded and the unlabeled medication was properly labeled. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All med carts were audited and no expired or unlabeled medication were found. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses were inserviced and proper medication storage.	05/13/2025

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	- an opened bottle of Tylenol 500 mg (milligram) was not labeled with the physician's name, resident's name, or the direction for use. - 1 vial of Simbrinza eye drops with an expiration date of 2/2025. - an opened bottle of Prenatal Multivitamins not labeled with the physician's name or the instructions for use. - An unopened bottle of D3 vitamins not labeled with the physician's name, resident's name, or the instructions for use. - An opened bottle of aspirin 81 mg not labeled with the physician's name, resident's name, or the instructions for use. - An opened bottle of D3 vitamins not labeled with the physician's name, resident's name, or the instructions for use. - An opened bottle of Centrum Silver Men's 50 + vitamins not labeled with the physician's name, resident name, or the instructions for use. During an interview, on 4/22/2025 at 10:29 A.M., LPN 5 indicated the over-the-counter medications should have been labeled with the residents name, physician's name, and the instructions for use. On 4/22/2025 at 11:48 A.M., the Director of Nursing provided the policy titled, " Pharmaceutical Services", dated 12/2015, and indicated the policy was the one currently used by the facility. The policy indicated "... 6. Over the counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date... 8. Over the counter medications must be identified with the following: a. Residents name. b. Physician name...."		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON or designee will audit all medication storage areas monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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R 0382 Bldg. 00	410 IAC 16.2-5-11.1(f) Mental Health Screening - Noncompliance Based on record review and interview, the facility failed to complete a comprehensive plan of care for 2 of 2 residents reviewed for mental illness. (Resident 4 and 6) Findings include: 1. A record review for Resident 4 was completed on 4/21/2025 at 2:00 P.M. Diagnoses included, but were not limited to, schizophrenia, dementia, type 2 diabetes and osteomyelitis. Resident 4 was admitted to the facility on 2/8/2021. Current Physician Orders included the following medications: -Aricept 5 mg (milligrams) daily for dementia -Namenda 5 mg twice daily for dementia -Sertraline 25 mg daily for depression The medical record lacked a comprehensive care plan related to Resident 4's diagnosis of schizophrenia. On 4/22/2025 at 11:00 A.M.,the Corporate Nurse indicated there was no comprehensive care plan for mental illness for Resident 4. During an interview on 4/22/2025 at 11:00 A.M., the Corporate Nurse indicated the facility did not have a policy regarding care planning major mental illnesses. 2. The record for Resident 6 was reviewed on 4/21/2025 at 2:45 P.M. Diagnoses included, but were not limited to, major depressive disorder, post-traumatic stress disorder, and morbid obesity. Resident 6 was admitted to the facility on	R 0382	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A comprehensive care plan was developed related to major mental illness for resident 4 and 6 II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents records were audited for major mental illness and all residents with Major mental illness's care plans were updated. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON was inserviced by the social service consultant on Mental health screenings and comprehensive care plans related to mental illness. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON or designee will audit all	05/13/2025

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		A. BUILDING 00 B. WING	04/22/2025

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	11/01/2023. Current Physician Orders included the following medications: -Bupropion ER 150 mg (milligrams) twice daily for major depressive disorder -Trazadone 50 mg at bedtime for insomnia The medical record lacked a comprehensive care plan related to Resident 6's mental health diagnosis. During an interview on 4/22/2025 at 11:00 A.M., the Corporate Nurse indicated rhere was no comprehensive care plan to address Resident 6's mental health diagnosis and tthe facility did not have a policy regarding comprehensive care planning for mental illness.		new admissions for major mental health illnesses to ensure a comprehension care plan is initiated. The DON or designee will audit the dx report weekly to ensure any resident with a newly added dx of major mental illness has a comprehensive care plan added. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure an annual health statement from the physician was obtained yearly for 2 of 8 residents whose clinical records were reviewed. (Resident 4 & 6) Findings includes: 1. The record for Resident 4 was reviewed on 4/21/2025 at 2:00 P.M. Diagnoses in included, but were not limited to, schizophrenia, dementia, type 2 diabetes, and osteomyelitis. Resident 4's record indicated there was no documentation of an annual health statement from the physician for 2024.	R 0409	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 4 and resident 6 have a annual heath statement from the md and the facility completed an annual TB screening. II. How other residents having the potential had be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents charts were audited	05/13/2025

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	During an interview, on 4/22/2025 at 10:45 A.M., the Director of Nursing indicated there was no annual heath statement for Resident 4 completed in 2024. 2. The record for Resident 6 was reviewed on 4/21/2025 at 2:15 P.M. Resident 6's diagnoses included, but were not limited to depression, post-traumatic stress disorder and morbid obesity. Resident 6 was admitted to the facility on 11/1/2023. Resident 6's record lacked the documentation of an annual health statement for 2024. During an interview, on 4/22/2025 at 10:45 A.M. the Director of Nursing indicated the facility followed the State of Indiana guidelines for tuberculosis screening procedures and did not have a policy regarding obtaining annual health statements.		and all other residents are up to date with their annual TB screening and an MD order stating they are free from communicable diseases. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON was inserviced on the regulation pertaining to annual Health screening requirements. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON or designee will audit all residents monthly x 3 months and then 5 residents monthly ongoing. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency			

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	Based on observation, interview and record review, the facility failed to wash hands prior to admistering an insulin injection during 1 of 2 medication administration observations. (LPN 3) Finding includes: During an observation of an insulin injection on 4/21/2025 at 11:14 A.M., LPN 3 entered Resident 4's room and explained to the resident she was going to administer his insulin. LPN 3 applied gloves and wiped the tip of the insulin pen and then wiped Resident 4's upper left arm with another alcohol pad. LPN 3 then administered the insulin, removed her gloves and used hand gel to wash her hands. LPN 3 failed to wash her hands before administering the insulin to Resident 4. During an interview, on 4/20/2025 at 11:16 A.M., LPN 3 indicated she should have washed her hands prior to administering the insulin injection. On 4/22/2025 at 11:48 A.M., the Corporate Nurse provided the policy titled, "Medication Administration General Guidelines", undated, and indicated the policy was the one currently use by the facility. The policy indicated "...7. Hands are washed before putting on examination gloves and upon removal for administration of topical, ophthalmic, injectable ... medications...." On 4/22/2025 at 11:48 A.M., the Corporate Nurse provided the policy titled, "Hand Washing", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...When to Wash Hands (at a minimum): * Before putting on and after taking off gloves...."	R 0414	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; LPN 3 was inserviced on the handwashing policy. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff will be inserviced on infection control policies and procedures. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; The DON or designee will observe 3 insulin injections weekly to ensure proper handwashing is occurring. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90%	05/13/2025

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			compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	