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	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BELVEDERE SENIOR HOUSING	343 E 90TH DRIVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00421087. Complaint IN00421087 - No deficiencies related to the allegations are cited. Survey dates: December 4, 5 and 6, 2023. Facility number: 014178 Residential Census: 127 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/11/23.	R 0000	No deficiencies noted, no plan of correction needed	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Westphal	Executive Director	12/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure the fire department was invited to participate in scheduled fire drills at least every six months. This had the potential to affect all 127 residents residing in the facility. Finding includes: The annual fire drills were reviewed on 12/4/23 at 2:13 p.m. The monthly fire drill logs lacked documentation that the fire department was invited or attended any of the drills. Interview with the Maintenance Director on 12/4/23 at 9:19 a.m., indicated the fire department had not been invited to participate in any of the monthly drills.	R 0092	Community will meet with local Fire Chief and coordinate bi-annual fire drills for 2024. This will be completed and community will be in compliance by January 5, 2024. Moving forward, community will contact Fire Chief in December of each consecutive year to coordinate and schedule bi-annual fire drills with the local fire department.	01/05/2024
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility			

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	regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current CPR certification scheduled for 8 of 33 shifts and current first aid certification for 33 of 33 shifts reviewed. Finding includes: Facility staffing schedules for 11/26/23 through 12/6/23 were reviewed on 12/6/23 at 9:45 a.m. The schedules indicated there were no staff members who were CPR or first aid certified on the following dates and shifts: Day Shift: 11/26/23 - 12/6/23 No certified first aide staff available. Evening Shift: 11/26/23 - 12/6/23 No certified first aide staff available Night Shift: 11/26/23 - 12/6/23 No certified first aide staff available. Evening Shift: 11/26/23, 11/27/23, 11/28/23, 12/1/23, 12/2/23, 12/3/23, 12/4/23, and 12/5/23. No certified CPR staff available. Interview with Business Office Manager on 12/6/23 at 12:20 p.m., indicated they were not	R 0117	Community will in-service and coordinate certification in CPR and First Aid of all clinical staff. This will be completed and community will be in compliance by January 5, 2024. Moving forward, the hiring manager, business office manager and ED will follow hiring process and ensure that current and new hires in the nursing department will remain current with required CPR and First Aid Certification. Monthly audits of CPR and First Aid Certifications will be audited during QI meetings. If any deficiencies or expiration of certifications are found, the employee will immediately be pulled off the schedule until the deficiency is rectified.	01/05/2024

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	aware that they had to have coverage for CPR and First Aide for each shift, every day. They are working to fix the issue currently.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants.			

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	(E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure all staff received annual inservice training related to six hour required training not completed by a Qualified Medication Assistant. (QMA 1) Finding includes: The Employee Records were reviewed on 12/6/23 at 9:45 a.m. There was no evidence QMA 1 had received annual inservice training. Interview with the Executive Director on 12/4/23 at 1:50 p.m., indicated none of the QMAs had completed the required training, except one who did hers independently. The Indiana Department of Health document, "QMA Annual Inservice Training", located on INhealth.gov website indicated, "QMA Annual Inservice Training (6 hours) must be completed every year and kept by the QMA. The six (6) hours of QMA Inservice must be obtained annually between January and December..."	R 0120	Community completed in-service and education to all staff on 12/12/2023 on importance and regulatory requirements of annual training/in-service and that the community utilizes Relias to satisfy this regulation. Staff were informed that if mandatory Relias training/in-service is not completed they will be removed from the schedule until completed. Community will complete weekly audits of past due mandatory Relias training/education in-services and discuss every Tuesday at morning meetings. Any employee out of compliance with required Relias training/in-services will be immediately removed from the schedule until it is completed. Community will audit compliance during monthly QI meetings for the next 6 months. QMA required 6 hour training courses were added to 10 QMA's currently employed in the community. Compliance to be met by January 5, 2024.	01/05/2024
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:			

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	(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on observation, record review, and interview, the facility failed to ensure resident service plans were reviewed and signed by the resident or resident's representative for 6 of 8 service plans reviewed. (Residents 2, 3, 6, 4, 7 and 9) The facility also failed to ensure service plans were accurate and/ or complete related to not addressing ostomy and oxygen use, inaccurate for catheter care and not addressing self medication administration. (Residents 4, 8 and 9) Findings include: 1. Resident 2's record was reviewed on 12/4/23 at 9:15 a.m.	R 0217	Community will review all resident service plans for completion and accuracy. DON, ADON and ED will audit for inclusion of ostomy, oxygen, catheter care, self-administration, etc. Community will schedule and obtain signatures on all current service plans. Community will complete and be in compliance by January 5, 2024. Signed resident service plans will be maintained in a binder, in alphabetical order and will be	01/05/2024

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	The Resident Service Plan, dated 12/2/23, was not signed by the resident and/or responsible party. 2. Resident 3's record was reviewed on 12/4/23 at 2:45 p.m. The Resident Service Plan, dated 11/29/23, was not signed by the resident and/or responsible party. 3. The closed record for Resident 6 was reviewed on 12/6/23 at 9:35 a.m. The Resident Service Plan, dated 5/2/23, was not signed by the resident and/or responsible party. Interview with the Assistant Director of Nursing on 12/5/23 at 12:39 p.m., indicated that all Resident Service Plans should have been signed by the resident and/or the responsible party. 4. Resident 4's record was reviewed on 12/4/23 at 1:32 p.m. The Comprehensive Resident Assessment Instrument, dated 11/30/23, indicated the resident was cognitively intact for daily decision making. The resident required oxygen therapy and had an ostomy. The Resident Service Plan, updated on 4/27/23, did not address the resident's ostomy or oxygen use. The Resident Service Plan was not signed by the resident. Interview with the Director of Nursing (DON) on 12/6/23 at 2:30 p.m., indicated the Resident Service Plan should have been signed by the resident and updated to reflect the use of oxygen and the ostomy.		audited at monthly QI meetings for the next 6 months.	

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	5. Resident 7's record was reviewed on 12/5/23 at 2:51 p.m. The Quarterly Assessment, dated 6/21/23, indicated the resident was cognitively intact for daily decision making. The Resident Service Plan, dated 5/3/23, was not signed by the resident and/or responsible party. Interview with the Assistant Director of Nursing on 12/5/23 at 12:39 p.m., indicated that all Resident Service Plans should have been signed by the resident and/or the responsible party. 6. Resident 8's record was reviewed on 12/5/23 at 9:47 a.m. Diagnoses included, but were not limited to, diabetes and congestive heart failure. The Comprehensive Resident Assessment Instrument, dated 11/14/23, indicated the resident had modified independence with some difficulty in new situations only for daily decision making. The Resident Service Plan, updated 11/24/23, indicated the resident had a foley catheter. He required assistance with switching the gravity bag to a leg bag when needed, peri-care daily, and emptying the bag. The services provided included, but were not limited to, monitoring for complications of catheter use, performing peri-care, and monitoring for signs and symptoms of a urinary tract infection (UTI). There was no documentation related to monitoring the catheter, peri-care, or monitoring for signs and symptoms of a UTI. Interview with the Assistant Director of Nursing on 12/6/23 at 2:15 p.m., indicated the facility staff			

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	were not instructed to perform any peri-care for the resident and there was no documentation of peri-care being completed for the resident. The Resident Service Plan needed to be updated. 7. Resident 9's record was reviewed on 12/4/23 at 9:56 a.m. The Comprehensive Resident Assessment Instrument, dated 7/20/23, indicated the resident had modified independence with some difficulty in new situations only for daily decision making. The Resident Service Plan, updated 12/5/23, indicated the resident was able to use medication as directed with set-up and oversight by nursing staff. The Resident Service Plan was not signed by the resident. Interview with Resident 9 on 12/6/23 at 1:15 p.m., indicated the resident self-administered all medications. Interview with the Director of Nursing on 12/6/23 at 2:30 p.m., indicated there were no signed service plans for the resident and the service plan, dated 12/5/23, needed to be corrected as the resident self-administered all medications.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to store, serve, and prepare food under sanitary conditions related to dirty food equipment, food crumbs on clean surfaces,	R 0273	Community has scheduled a deep clean of entire kitchen on December 21, 2023. Community has scheduled an	01/05/2024

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	undated food in the refrigerator and freezer, a food scoop stored improperly, serving dishes and storage containers stored improperly, food stored improperly in the freezer, and improper hand hygiene during food preparation for 1 of 1 kitchen areas observed (the main kitchen). This had the potential to affect the 127 out of 127 total residents who received food from the kitchen. Findings include: 1. During the Initial Kitchen Sanitation Tour with the Dietary Food Manager (DFM) on 12/4/23 at 9:00 a.m., the following was observed: a.. There were food crumbs and debris on a tray on the bottom storage shelf in the kitchen. b. There was a build up of food debris and grease on the side of the oven, top of the stove, and on the griddle. c. The bowls and plates were stored upright on the storage shelving. d. A large scoop was stored in both the flour and sugar bins. e. There were baking dishes stored upright on the storage shelving. f. There were cardboard boxes filled with food items stacked on the shelving in the walk-in freezer that were touching the ceiling. g. There was a container of cooked chicken unlabeled and undated in a Styrofoam to-go container in the salad prep fridge h. There was a plastic bag of unlabeled frozen		in-service with all dietary staff to provide education on proper food storage, proper dating of food and proper hand hygiene on December 21, 2023. Community Dietary Director and ED will complete weekly audits in kitchen of cleanliness, proper storage, proper dating of food and proper hand hygiene. Any and all deficiencies, if found, will be corrected immediately and continued education with dietary staff will continue. Audits and compliance will be reviewed during monthly QI meetings for the next 6 months.	

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	meat in the walk-in freezer. i. There was a package of opened butter with no label in the walk in fridge. Interview with the DFM at the time, indicated the above areas needed cleaned, items needed to be stored properly, and the food all needed proper labels. 2. During the observation of the tray line, on 12/5/23 at 10:56 a.m., Cook 1, was observed touching bread with gloved hands, touching the outside packaging of the bread, and then reaching into the bag and removing a piece of bread with the same gloved hand. She did not perform hand hygiene and don clean gloves before touching the bread. She was observed touching the outside of the salami packaging with gloved hands and then touching the salami with the same gloved hands without performing hand hygiene and donning clean gloves. Interview with the Dietary Food Manager at the time, indicated Cook 1 should have performed hand hygiene and donned clean gloves before touching the food. The Policy titled, "When to Wash Hands," indicated food employees shall lean their hands and exposed portions of their arms immediately before engaging in food preparation, and ...f) during food preparation, as often as is necessary to remove soil and contamination and to prevent cross-contamination when changing tasks ...h) before donning gloves for working with food; and i) after engaging in other activities that contaminate the hands."			

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R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to no Physician notification of lab results, lack of documentation related to home health provided, insulin not given as ordered and not monitoring blood pressures as ordered for 4 of 8 records reviewed. (Residents 3, 4, 8 and 9) Findings include: 1. Resident 3's record was reviewed on 12/4/23 at 2:45 p.m. Diagnoses included, but were not limited to epilepsy, anxiety and radiculopathy. A Progress Note, dated 8/11/23, indicated the Physician had ordered to repeat the lab tests comprehensive metabolic panel, thyroid, Vitamin D level and lipid panel in one month. There was no documentation the labs were repeated in one month in the progress notes or lab results. Interview with the Director of Nursing (DON) on 12/5/23 at 3:35 p.m., indicated the resident had been unavailable on 9/13/23 when the lab personal was in the building to repeat the labs. The resident had been unavailable on multiple	R 0349	DON will complete daily audits of lab results and ensure notification of results provided to ordering Physician. DON will complete audit of current residents on Home Health, Hospice or other Ancillary services and ensure that it is documented in residents chart/service plan. Community will be in compliance with this by January 5, 2024. DON will complete daily audits of insulin administered and ensure all was administered as ordered. DON will complete daily audits of physician orders and ensure that all orders are being followed and documented. All above will be audited and discussed at monthly QI meetings for the next 6 months.	01/05/2024

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	occasions and the labs were not drawn until 10/11/23. The DON contacted the lab and they faxed the results of the labwork from 10/11/23. She indicated there was no documentation the Physician was notified of those results. 2. Resident 4's record was reviewed on 12/4/23 at 1:32 p.m. Diagnoses included, but were not limited to, falls, hemiparesis, and seizures. The Comprehensive Resident Assessment Instrument, dated 11/30/23, indicated the resident was cognitively intact for daily decision making. A Nurses' Note, dated 10/23/23 at 6:16 p.m., indicated the resident had returned from a 9 day hospital stay for a total shoulder arthroplasty surgery for a fracture. The resident informed the facility she would be contacting home health services to receive physical therapy. A Nurses' Note, dated 10/25/23 at 2:22 p.m., indicated the resident had a dry and intact dressing to the right shoulder. There was no documentation related to the resident receiving the home health services, updated Resident Service Plan, Physician's Orders regarding the incision site, or monitoring of the new skin condition. Interview with the Director of Nursing (DON) on 12/6/23 at 2:50 p.m., indicated she spoke with the resident and the incision site was to be addressed by home health care services, however the resident never forwarded that information to the facility. The facility should have been alerted sooner and documented in the chart regarding any Physician's Orders. The Resident Service Plan should have been updated.			

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		A. BUILDING 00 B. WING	12/06/2023

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	3. Resident 8's record was reviewed on 12/5/23 at 9:47 a.m. Diagnoses included, but were not limited to, diabetes and congestive heart failure. The Comprehensive Resident Assessment Instrument, dated 11/14/23, indicated the resident had modified independence with some difficulty in new situations only for daily decision making. A Physician's Order, dated 9/8/23, indicated Novolog (a diabetic insulin medication) 100 units/milliliter flex pen inject per sliding scale: 150-199 = 4 units, 200-299 = 6 units, 300-399 = 8 units three times daily. The Medication Administration Record, dated 11/9/23 at 4:00 p.m., indicated the resident had a blood sugar of 305 and was administered 0 units of Novolog. On 11/30/23 at 4:00 p.m., the resident's blood sugar was 333 and he received 0 units of Novolog. Interview with the Director of Nursing on 12/6/23 at 2:15 p.m., indicated the Physician's Orders should have been followed. 4. Resident 9's record was reviewed on 12/4/23 at 9:56 a.m. Diagnoses included, but were not limited to, anxiety, depression , and hyperlipidemia. The Comprehensive Resident Assessment Instrument, dated 7/20/23, indicated the resident had modified independence with some difficulty in new situations only for daily decision making. A Physician's Order, dated 2/21/23, indicated a daily assessment for blood pressure. The clinical record lacked a blood pressure recorded on 3/1, 3/2, 3/6, 3/8, 3/10, 3/11, 3/12, 3/13,			

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	and 3/14/23. Interview with the Director of Nursing on 12/6/23 at 2:15 p.m., indicated she was unable to find the documentation of blood pressures or refusals for those dates.			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 2 closed records reviewed. (Resident 7) Finding includes: Record review for Resident 7 was completed on 12/5/23 at 2:51 p.m. The resident was admitted to the facility on 4/17/19. The resident discharged from the facility on 10/31/23. A Nurses' Note, dated 7/22/23 at 10:00 a.m., indicated the resident was transitioning out of the	R 0354	Community has scheduled in-service with all nursing staff on December 28, 2023, to educate on transfer/discharge forms. Copies of completed transfer/discharge forms will be stored in a binder in date and alphabetical order. Audit of the completion of transfer/discharge forms will be completed daily by DON/ADON. Compliance of transfer/discharge forms will be reviewed and audited during monthly QI meetings for the	01/05/2024

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	facility to the hospital due to a fall. The last Nurses' Note, dated 10/31/21 at 12:00 p.m., indicated the resident was discharged to the hospital. There was no documentation of a transfer/discharge assessment or instructions completed for the resident. Interview with the Director of Nursing on 12/6/23 at 2:30 p.m., indicated she could not find any documentation related to the resident's transfer/discharge from the facility.		next 6 months.	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure a current emergency information	R 0356	DON, ADON and ED will audit all current residents for accuracy and completeness of all emergency	01/05/2024

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	file was complete for 5 of 6 residents reviewed. (Residents 2, 3, 4, 5 and 9) Findings includes: The emergency file binder was reviewed on 12/5/23 at 10:35 a.m.. The follow items were missing: a. Resident 2 did not have an emergency contact or phone number and hospital preference. b. Resident 3 did not have an emergency contact or phone number and no hospital preference. c. Resident 4 did not have an emergency contact or phone number and no hospital preference. d. Resident 5 did not have any information in the emergency binder. e. Resident 9 did not have an emergency contact or phone number and no hospital preference. Interview with the Director of Nursing on 12/5/23 at 1:30 p.m., indicated she was not aware the above items were missing from the emergency binder.		information. This audit will be completed by January 5, 2024, with compliance met on same date. DON and ADON will ensure that all new admissions moving forward will have complete emergency information and copies of Face Sheets placed in Emergency Evacuation Binder within 24 hours of admission to the community. Continued compliance of this regulation will be monitored and audited at monthly QI meetings for the next 6 months.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents,			

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	including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to not posting signage at the entrance or anywhere in the facility alerting visitors the facility was in outbreak status. The facility also failed to have a system in place for tracking infections. This had the potential to affect all 127 residents residing in the facility. Findings include: 1. Upon entering the facility on 12/4/23 at 8:30 a.m., there was no signage on the front entrance or reception desk that indicated there were COVID-19 positive residents currently in the building. There were isolation rooms throughout the building which had stop signs that indicated visitors should see the nurse prior to entering the room, and had isolation bins outside the doors. Interview with the Executive Director (ED) on 12/4/23 at 8:50 a.m., indicated there were currently 16 residents who were COVID-19 positive. Interview with the Director of Nursing (DON) on 12/6/23 at 10:40 a.m., indicated she was told signs were not necessary, but she would get them put up. The current policy, "COVID-19 Infection Control Policy", received from the ED on 12/5/23, indicated, "...Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV-2 Infection. Post visual alerts (e.g.	R 0407	Effective immediately, ED and DON will ensure the proper signage informing visitors of any infectious outbreaks current in the community. Infection Control program and tracking tool Inservice on December 18, 2023 completed by Regional Director of Clinical Service. DON and/or ADON will audit infection control tracking tool weekly x 4 weeks, monthly times x 5 months. QI will review audits at monthly meetings, this will be ongoing.	01/05/2024

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	signs, posters) at the entrance and in strategic places...." 2. Interview with the DON on 12/5/23 at 1:48 p.m., indicated there were no logs or tracking documented related to infections. She indicated the Interdisciplinary Team would discuss who was on antibiotics during morning meetings. She indicated she knew it should be documented. There was no additional information provided for review.			