STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155242	A. BUILDING 00 B. WING	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00450208, IN00449995, IN00451745, IN00450001, and IN00451569. Complaint IN00450208 - No deficiencies related to the allegations are cited Complaint IN00449995 - No deficiencies related to the allegations are cited Complaint IN00451745 - No deficiencies related to the allegations are cited Complaint IN00450001 - Federal/State deficiencies related to the allegations are cited at F602. Complaint IN00451569 - Federal/State deficiencies related to the allegations are cited at F908. Survey dates: January 15, 16, 17, 21, 22, and 23, 2025. Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 127 Total: 127 Census Payor Type: Medicare: 5 Medicaid: 99	F 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daphne New	Administrator	02/16/2025

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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	Other: 23 Total: 127 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 4, 2025.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure a self-administration assessment was completed for 1 of 1 residents reviewed for self-administration of medication. (Resident 17) Finding includes: During an observation, on 1/15/25 at 11:11 a.m., Resident 17 was in bed with a plastic container on her bedside table. The plastic container held five bottles of eye drops. During an interview, on 1/16/25 at 10:41 a.m., Resident 17 was seated in her wheelchair at the side of her bed. There was a plastic container and a rectangular white box on her bedside table. The plastic container held five bottles of eye drops. The white box contained one bottle of eye drops. Resident 17 indicated she used her eye drops twice a day, was allowed to keep them in her room, and the staff were aware. The plastic container had the following eye drop bottles: 1. Rocklatan (netarsudil and latanoprost) 0.02% drops (a prescription eye drop to reduce eye pressure) without a label or resident identifiers. 2. Systane (an over the counter eye lubricant) night gel 10 grams (g). 1 to 2 drops in affected eye	F 0554	·Resident 17 was not adversely affected by this alleged deficient practice. Resident discharged prior to Administration being made aware. All residents have the potential to be affected. An audit of resident rooms was conducted to ensure no other residents had medications available without the appropriate self-administration assessments in place. No other concerns were noted. Nursing staff have been educated on the self-administration policy and medications being stored in rooms without completed assessment and physician order. Resident rooms will be audited to ensure medications are not available without appropriate self-administration assessment in place. The DON or designee will audit 5 residents, weekly, for 4 weeks, then bi-weekly for 1 month and then monthly for 4 months, for compliance	02/21/2025

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	as needed. The bottle had no resident identifiers. 3. Dorzolamide Ophthalmic 2% drops (a prescription eye drop to treat glaucoma) without a label or resident identifiers. 4. Brimonide Tartrate/Timolol Maleate 0.2/0.5% drops (a prescription eye drop treat glaucoma and ocular hypertension) without a label or resident identifiers. 5. Systane (an over the counter eye lubricant) drops 0.6%. 1 to 2 drops in affected eye as needed. The bottle had no resident identifiers. The white box contained the following eye dropper bottle: Restasis (cyclosporine)(a prescription eye drop to treat dry eyes) 0.05%. 1 drop into each eye twice daily. The box was labeled with resident identifiers. During an interview, on 1/17/25 at 9:55 a.m., Resident 17 was seated at her bedside with a visitor present. The plastic container and white rectangular box was on the bed side table. Resident 17's clinical record was reviewed on 1/17/25 at 10:07 a.m. Diagnoses included dry eye syndrome of unspecified lacrimal gland, other seasonal allergic rhinitis, and essential hypertension. Current physician orders included (12/31/24) dorzolamide-timolol drops; 2-0.5%; give one drop in both eyes for chronic dry eyes, (12/31/24) GenTeal Tears (a lubricant) eye drops, give 1 drop in both eyes for chronic dry eyes, and (1/2/25) cyclosporine drops 0.05 %; give one drop in both eyes for dry eyes. Resident 17's clinical record lacked a physicians orders for Brimonide Tartrate/Timolol Maleate 0.2/0.5% drops, Rocklatan"(netarsudil and		As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits. Compliance date:	

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	latanoprost) 0.02% drops, and for self-administration of eye drop medications. A 1/3/25, Admission, Minimum Date Set (MDS) indicated the resident was moderately cognitively impaired, made poor decisions, and required supervision. Resident 17's clinical record lacked a medication self-administration assessment. During an interview, on 1/21/25 at 12:03 p.m., RN 3 indicated she was aware Resident 17 kept multiple eye drops in her room. RN 3 was told during report when the resident admitted that it was okay for Resident 17 to self administer her eye drops. During an interview, on 1/23/25 at 2:11 p.m., the DON indicated he was not able to locate a self administration assessment for Resident 17. The physician orders had not been written with additional instructions to allow the resident to self administer her eye drop medications. A current facility policy, dated 1/23, titled, "Self-Administration by Resident", provided by the DON on 1/22/25 at 12:39 p.m., indicated the following: "...Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe and the medications are appropriate and safe for self-administration. 1. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process...3. The results of the interdisciplinary team assessment are recorded on the Medication			

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	Self-Administration Assessment, which is placed in the resident's medical record. 4. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted...." 3.1-11(a)			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on record review and interview, the facility failed to prevent the misappropriation of resident funds for 1 of 3 residents reviewed for personal property. (Resident B) Finding includes: A 12/24/24, facility reported incident indicated Resident B reported that he discovered his debit card, grocery card from insurance company and drivers license missing from wallet upon returning from dialysis on 12/24/24. Reported that CNA 31 had assisted him with an online order that night before. The immediate actions taken included reported to the Administrator, local police were called and CNA 31 was suspended pending outcome. The investigation was underway. Preventative measures taken included the suspension of CNA 31 and the police were called. Resident B's clinical record was reviewed on 1/17/25 at 1:31 p.m. Diagnoses included dependence on renal dialysis, end stage renal disease, and need for assistance with personal care. A 11/25/24, Admission, Minimum Data Set (MDS) indicated Resident B was cognitively intact and had reasonably consistent decision making.	F 0602	Resident B was the only resident affected by this alleged deficient practice. The matter was investigated appropriately and reported immediately, by the facility, to authorities and the ISDH. All residents have the potential to be affected. All residents were interviewed and were asked about any concerns related to missing money or debit cards, with no other concerns noted. All staff were in-serviced regarding abuse protocol and misappropriation of resident property and funds. Resident audits will be completed to ensure the safety of resident money/debit cards The Administrator or designee will complete audits on 5 residents, weekly, for 4 weeks, then bi-weekly for 2 months and then monthly for 3 months. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for	02/21/2025

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	Resident B required partial assistance from staff for showering and personal hygiene. During an interview, on 1/17/25 at 3:35 p.m., Resident B was seated in an electric wheelchair at bedside. He indicated, a few weeks ago. he returned to the facility from dialysis and found belongings missing, including his bank card. CNA 31 had recently helped him order a pizza on the night shift and he wondered if she took his stuff. He told another CNA and the Administrator about his missing items and that he had already needed to shut off four debit cards during this month. His financial institution had been extremely helpful in assisting him with three different charges made on his debit card. These issues had not cost him any money out of his own pocket. Someone used his card to buy $300 worth of stuff online and then some shoes that cost around $200. He had spoken with the police and they had not provided him with any documentation or outcome yet. He had spoken with the Office of the Attorney General as well. A review of the facility investigation file, provided by the Administrator on 1/17/25 at 3:47 p.m., indicated the following: A 12/24/24-12/26/24, timeline of events, typed by the Administrator indicated the following: At 4:00 p.m., on 12/24/24 a staff member arrived to notify her of Resident B's missing items. She interviewed the resident and he pointed out his wallet had been moved to the incorrect pocket of his duffel bag. His debit card, grocery card, and driver license was missing. The resident indicated, roughly 3 or 4 weeks ago, he had asked CNA 31 to order him a pizza, during night shift. The CNA took his debit card and was gone for hours. She eventually brought him his pizza, but it was cold		review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits. Compliance Date: 2/21/25	

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	and she returned his card. The resident went to the bank the next day and was told of the charges made online at a major retailer. The total of the charge was roughly $300. The bank assisted him in getting the charges reversed and a new bank card. The facility called the police. Police arrived and spoke with the resident. The resident had to wait until after the Christmas holiday to call his bank for the charge. When he spoke with his bank on 12/26/25, he was made aware of an additional online purchase of $190. The police were called and given this additional information. A 12/30/24 updated timeline of events, authored by the Administrator, indicated the local police asked to have Resident B get a printed statement with all the charges listed. The Administrator was not able to obtain any police records as the case was ongoing, but Resident B could ask for additional information. A 12/24/24 typed statement indicated RN 22 was not aware of anyone assisting Resident B with ordering food. She was aware he went to his bank on a previous day in December, either the 9th or the 16th. A 12/24/24, a hand-written statement from CNA 32 indicated she was working with CNA 31 and Resident B asked them to assist him with ordering items from the online site of a major retailer for his girlfriend. CNA 31 told the resident would come back later and help him place the order. An undated typed statement from CNA 31 indicated her first weekend working in the facility was December 7, 8, and 9, 2024. She was training with a preceptor, CNA 33, when Resident B asked her to assist him in ordering a pizza. The preceptor told her it was fine to order a pizza for this resident			

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	as he asked for assistance a lot. CNA 31 used the facility phone to order the pizza and Resident B gave her his zip code to complete the order. She returned his debit card immediately. She indicated this was the only time she was in contact with his personal belongings and debit card. An undated, typed statement from Unit Manager 16 indicated she was aware of the situation where CNA 31 used the work phone to order Resident B a pizza during her orientation. On the night of 12/22/24, CNA 31 texted her she needed to leave early and was not on site to provide hand off report to the oncoming CNA. A bank statement for the month of December 2024 from Resident B's bank indicated the following: There was no charge documented for pizza dated 12/7/24. On 12/17/24, two charges were made, $210.56 and $118.61 for online purchases at a major retailer. On 12/19/24, the charges were reversed and credited to the account. On 12/23/24, a charge was made for $190.20 at online retailer. On 12/26/24, the charge was reversed and credited to the account. Printed schedules for CNA 31 indicated the employee worked the evening and night shifts on the 800/500 halls on the following dates: 12/14/24, 12/15/24, 12/16/24, and 12/23/24. Review of CNA 31's employee file, provided by the Administrator on 1/21/25 at 10:03 a.m., indicated the following: A 12/27/24, training transcript of completed courses indicated CNA 31 completed the following training: "Safeguarding Resident Rights in Nursing Facilities, Preventing, Recognizing and Reporting Abuse, CNA- New Hire- Day 2-7-			

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	Mandatory Training" and a 12/13/24, "Gift Policy Training Questions" document, completed and signed by CNA 31 indicating stakeholders were not allowed to take money from a resident and use it to shop for the resident, were not allowed to accept money as gift from a resident, and were not allowed to keep a resident's debit/credit card for safekeeping During an interview, on 1/22/25 at 10:15 a.m., RN 22 indicated that Resident B told her he got a message from his bank about the charges, for boots for a female to wear. RN 22 advised him to report this to the Administrator. RN 22 indicated facility policy was that staff was not to take a residents debit/credit card to help them make purchases. During an interview, on 1/22/25 at 10:24 a.m., CNA 33 indicated she was aware of the incident when she was training CNA 31. Resident B asked CNA 31 to order him a pizza. CNA 33 told CNA 31 to ask the RN on staff before agreeing. CNA 31 said "it's okay" and took the resident's debit card. Roughly one hour later, Resident B turned on the call light and asked for his debit card. CNA 31 was seated at the nurse station and had the debit card in her pocket. CNA 31 returned it to Resident B. CNA 33 had not reported the incident to any other staff member. CNA 33 indicated the current facility policy was for staff not to take any money or a debit card from a resident. During an interview, on 1/22/25 at 3:23 p.m., CNA 32 indicated the current facility policy was for staff to direct resident to the social services department or activities department to help them make purchases with money or a debit card. During an interview, on 1/22/25 at 7:44 p.m., Unit			

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	Manager 16 indicated sometime in December, Resident B had unauthorized debit card charges appear on his debit card. The Administrator asked her to assist with an investigation. CNA 31 was in orientation at the time of the incident. She asked CNA 31 what happened and was told she had ordered a pizza, from a restaurant using the 800 Unit telephone, along with CNA 33, for Resident B, per his request, with his debit card. CNA 31 indicated she returned the debit card immediately. Unit Manager 16 reminded CNA 31 of the facility policy to not take money or debit cards from residents, even if it's to assist them with purchases. Unit Manager 16 was not aware of the incident until the Administrator asked for assistance. During an interview, on 1/23/25 at 12:21 p.m., the Activity Director indicated residents brought money to purchase chips, candy, or pop for sale in the activity room. Her department was not to take a residents debit card to assist with online purchases. A resident could go on an outing to a physical store to make purchases with a debit card and the activity staff supervise the outings. During an interview, on 1/23/25 at 12:35 p.m., the Social Services Assistant indicated the social services and the activities departments were allowed to assist residents with purchases online using a debit card. These departments were staffed Monday through Friday from 8:00 a.m. to 5:30 p.m. The weekend manager on duty would be responsible for assisting residents on Saturday and Sunday. There was not an official facility policy for this situation. During an interview, on 1/23/25 at 2:18 p.m., the DON indicated he was made aware of the situation when the investigation was started. The floor staff			

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	was aware they should not be taking money or bank cards from residents, even to assist that resident to make a purchase. The resident was to be advised to talk with the social services or activities departments. However, if the resident requested help after normal business hours, there was not a plan in place to accommodate them. There was not an official facility policy for this type of situation. During an interview, on 1/23/25 at 2:26 p.m., the Administrator indicated there was not an official policy related to residents requesting assistance from staff to make purchases. The social services and activity departments was where residents should be directed if they needed help from staff. If a resident required assistance outside normal business hours, the person in charge on shift was to be contacted. The facility did a gift policy training on 12/13/24. A facility policy, reviewed 1/1/24, titled, " Conduct & Behavior", provided by the Administrator on 12/31/24 at 1:53 p.m., indicated the following: "...It is the policy of the Company that Stakeholder accept certain responsibilities: adhere to acceptable business practices in matters of conduct and behavior and exhibit a high degree of personal integrity at all times...Types of conduct and behaviors that are considered to be inappropriate include, but are not limited to the following:... hh. Borrowing or accepting money from residents, family members, or visitors...." A facility policy, last revised on 11/25/24, titled, "Gifts", provided by the Administrator on 1/21/25 at 12:27 p.m., indicated the following: "..."Gift" means anything of value, including a gift card...If a stakeholder receives a gift or any type of remuneration in violation of this Policy, the			

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	Stakeholder must either return the gift or remuneration or provide it to the Organizations Inspire Foundation...." A facility policy, last revised 9/15/23, titled, " Abuse, Neglect and Misappropriation of Property," provided by the Administrator at the time of entrance conference, indicated the following: "...It is the organizations intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law... Under no circumstances shall any Stakeholder accept any money, property, inheritance, or anything else of value from a resident or resident's family member...." This citation relates to Complaint IN00450001. 3.1-28(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to provide increased monitoring and assessment and interventions for a resident experiencing a worsening change in condition for 1 of 1 resident reviewed for a urinary tract infection. (Resident 76) Finding includes:	F 0684	Resident 76 was affected by this alleged deficient practice. Resident was treated for and has recovered from their acute change in condition. Resident had no further adverse events related to the alleged deficient practice. All residents have the potential to be affected. All	02/21/2025

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	During an interview on 1/15/25 at 10:53 a.m., Resident 76 indicated, in November 2024, she had a really bad urinary tract infection (UTI). She had vomiting and diarrhea, and two nurses would not send her out to the hospital for further evaluation. She begged them to send her out. When she finally was sent out, the hospital gave her a peripherally inserted central catheter (PICC) line and admitted her. She was concerned because the facility was so slow to give antibiotics. The resident's clinical record was reviewed on 1/17/25 at 10:10 a.m. Diagnoses included sepsis, unspecified organism, overactive bladder, dysuria, and post COVID-19. A current physician order, dated 12/14/24, included Macrobid (antibiotic) 100 milligrams (mg) capsule by mouth once daily given for UTI prevention. A physician order, dated 2/8/24, included COVID-19 testing as needed. A physician order, dated 11/27/24, included enhanced barrier precautions every shift. A quarterly Minimum Data Set (MDS) assessment, dated 10/28/24, indicated the resident was cognitively intact. Rejection of care behavior was not exhibited during the assessment period. The resident required partial staff assistance for toileting hygiene and toileting transfers, and she was independent for personal hygiene, footwear, and wheelchair mobility. She had occasional urinary and bowel incontinence. Her diagnoses included sepsis and hematuria. The resident was taking an antibiotic during the assessment period. An annual MDS assessment, dated 12/10/24,		residents were audited to ensure that there were no current changes in condition. No additional concerns were noted. All nurses in-serviced in the change of condition policy and process for when a resident requests to be sent to the hospital. An audit will be completed on residents with changes in condition to ensure assessments have been completed, physician has been notified, and resident requests have been addressed. Audits will be performed by DON or designee week-daily for 4 weeks, then bi-weekly for 2 months, then monthly for 3 months. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits. Compliance date: 2/21/25	

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	indicated the resident was cognitively intact. Rejection of care behavior was not exhibited during the assessment period. The resident required substantial staff assistance for toileting hygiene, partial staff assistance for transfers, and was independent for her personal hygiene. She was dependent on staff for donning and doffing of footwear. She had frequent urinary and bowel incontinence. Her diagnoses included sepsis, and post COVID-19 condition. The resident was taking an antibiotic during the assessment period. A current care plan, initiated 11/20/24, indicated the resident required Enhanced Barrier Precautions (EBP) related to infection control. An intervention indicated to report to the physician any signs and symptoms of infection as needed (11/20/24). A current care plan, initiated 2/8/24, indicated the resident required assistance with activities of daily living including transfers, bed mobility, and toileting. An intervention indicated to report changes in the activity of daily living self-performance to the nurse (2/8/24). A current care plan, initiated 2/8/24, indicated the resident had episodes of urinary incontinence and was at risk for complications. Interventions included the following: Observe the resident for incontinence and change as needed (2/8/24), observe for signs and symptoms of UTI such as fever, change in mental status or function, burning with urination, flank pain, and changes in color and clarity of the urine (2/8/24). The clinical record lacked a care plan for sepsis or being at-risk for sepsis. A Nurse's note, dated 10/18/24 at 2:21 a.m.,			

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	indicated the resident was weak and not feeling well. She had vomiting, incontinence of bowel and bladder, and was cold to touch. The resident had an elevated blood pressure, elevated heart rate, and a low temperature. An order was received to send the resident to the emergency room for further evaluation and treatment. A hospital progress note and "Inpatient Discharge Instructions," for a hospitalization from 10/18/24 to 10/24/24, indicated the resident was being discharged from a hospitalization related to sepsis secondary to a UTI. A Nurse's note, dated 10/31/24 at 1:07 a.m., indicated the resident continued on oral antibiotics for a UTI. A Nurse's note, dated 11/13/24 at 10:28 p.m., indicated the resident requested a urinalysis for pain, burning, and decreased urinary output. The clinical record lacked interventions to support the resident's urinary complaints. A Nurse's note, dated 11/16/24 at 4:58 p.m., indicated the resident's urine culture was received from the lab and was found to have Escherichia coli (bacteria growth) with extended-spectrum beta-lactamases (ESBL- enzymes that are resistant to specific antibiotics). The resident and provider services were notified, and appropriate precautions were initiated. A Nurse's note, dated 11/17/24 at 5:20 p.m., indicated a response was received related to the urine results, and an antibiotic was not needed due to the bacteria count under 100,000 CFU/mL (colony-forming unit per milliliter). The nurse manager and resident were notified.			

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	A Nurse Practitioner's progress note, dated 11/22/24 at 12:00 a.m., indicated the resident denied any worsening urinary incontinence, dysuria, or hematuria. A Nurse's note, dated 11/24/24 at 11:00 p.m., indicated the resident had an unwitnessed fall near her bedside. The clinical record lacked increased frequency of assessments for a resident with a change in condition from 11/26/24. A Nurse's note, dated 11/26/24, at 1:46 p.m. indicated the resident reported she had not felt good since the weekend. On assessment, the resident was clammy, dropping things, poor appetite, thirsty, dry heaves, weak, and shaky. A strong urine smell filled the room. Her vitals were as follows: temperature 97.3 degrees Fahrenheit, pulse 125 beats per minute, blood pressure 161/98 millimeters of mercury (mm Hg), respiratory rate 14 breaths per minute, and oxygen saturation 92 percent on room air. The Medical Director was in the facility and aware of the situation. New orders were received for an electrocardiogram (EKG- a test to look at the electrical activity of the heart), complete blood count (a blood test), and a comprehensive metabolic panel (a blood test). A Change of Condition Form, dated 11/26/24 at 1:52 p.m., indicated the resident had a genitourinary and a cardiac change in condition. Urinary symptoms included amber urine, pain with urination and increased output. Cardiac symptoms included irregular heart tones, increased pulse, and increased blood pressure. An EKG, dated 11/27/24 at 12:26 p.m., was			

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	interpreted as sinus tachycardia (increased heart rate). The result lacked acknowledgement from the physician. A Nurse's note, dated 11/27/24 at 2:26 p.m., indicated, in the morning (there was no indication what time in the morning this occurred), the resident complained of fatigue, weakness, and did not feel well. The resident's blood sugar had increased over the last couple of days. Vitals were as follows: temperature 97.7 degrees Fahrenheit, pulse 117 beats per minute, respirations 16 breaths per minutes, blood pressure 118/85 mm Hg, and oxygen saturation 93 percent on room air. Around 1:00 p.m., the resident was found lying at 10- 15 degrees with vomit in her mouth and falling out of the side. The resident's head was immediately raised to a 90 degree position. The DON was called to the room. The resident vomited after sitting up and was very lethargic. She required assistance from two staff members and was usually independent. The CNA was called to the room. Vitals were as follows: temperature 99.3 degrees Fahrenheit, pulse- 130 to 140 beats per minute, respirations 14 breaths per minutes, and oxygen saturation 82 percent. Oxygen was applied at two liters per minute. The oxygen saturation went up to 95 percent but then desaturated back towards 90 percent on two liters of oxygen per minute. A nebulizer was given, and a STAT chest x-ray was ordered. Management and family were aware. A hospital transfer form, dated 11/27/24, indicated a report was called to the receiving facility at 2:30 p.m. The report indicated the resident's mental status before the acute change in condition was alert and oriented. The resident's functional status before the acute change in condition was independent ambulation.			

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	A Nurse's note, dated 11/28/24 at 8:29 a.m., indicated the resident was admitted to the hospital for a UTI, sepsis, and COVID-19. Review of the Medication Administration Record (MAR) for November 2024 lacked COVID-19 testing performed for the resident in November (an "as needed" order was available). During an interview on 1/22/25 at 12:39 p.m., the DON indicated he was unable to provide any additional urine test results for the resident from 11/14/24 to 11/27/24. Confidential interviews were completed during the survey. During a confidential interview, a staff member indicated Resident 76 had a history of frequently UTIs and had two separate hospitalizations for UTI and sepsis. The resident had known bacteria growth on a urine culture for ESBL approximately two to three weeks before her hospitalization. The resident started having some changes to include a fall and an increased in need for assistance (previously independent). On 11/26/24, the Medical Director was contacted and provided orders for a urinalysis along with the other orders they documented in the clinical record. The urinalysis was not documented because the DON gave instruction to hold off on the urinalysis. On 11/27/24, in the morning, the resident was still having abnormal vital signs and still needing additional assistance from her baseline. They told the resident they were concerned, and thought the resident needed to be sent to the hospital. They returned back to the resident's room at noon. The resident was then lethargic and had vomit coming out of her mouth and her head was			

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	not elevated very much. The DON instructed staff they needed to treat the resident in-house and quit sending the residents out so often. The DON wanted staff to get an order for a chest x-ray. The resident did not get sent out until almost 3:00 p.m. because the DON pushed them off. The DON did not want the residents tested for COVID-19. The resident should have been sent out at noon when the resident was lethargic, vomiting, and had signs of sepsis. The resident was a full code. A resident with urinary symptoms and a history of UTI and sepsis were at higher risk of becoming septic when they were not treated promptly. During a confidential interview, a staff member indicated Resident 76 was sent to the hospital at the end of November 2024. On that day, the nurse was in the resident's room and the DON was on his way in the room. The resident was very lethargic, sick, and required a lot more assistance than normal, so they jumped in to assist. While in the resident's room, the nurse asked the DON to send the resident out to the hospital. The DON told the nurse they were going to try to treat her in house first. During an interview on 1/23/25 at 3:02 p.m., the DON indicated he was aware the resident had a history of UTIs. He indicated the resident had a hospitalization in October 2024 for urosepsis. Signs of potential sepsis included the following: blood pressure irregularity, elevated pulse, abnormal white blood cell count, increased confusion, altered mental status, and decreased physical function. He was aware the resident had some bacterial growth on a urine culture positive for ESBL on 11/16/24. The resident had a fall that could have been potential change. On 11/26/24, the DON was aware the resident was not feeling well. The symptoms were potential signs of			

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	sepsis, but not necessarily urine related. It could have been a standard practice of nursing to request an order for a urine specimen for a resident with a history of UTIs and a strong urine odor. A urine collection order was not obtained and urgent (STAT) orders were not obtained. It was the nurse's duty to advocate for the resident. He was uncertain if he placed eyes on the resident on 11/26/24 or 11/27/24. He was made aware of the resident's status, but it was not presented to him that she was that much worse from the previous day. Labs were drawn on 11/27/24, and the results were not available before the resident was sent to the hospital. The resident did not have any treatment started on 11/26/24, when the resident had potential signs of sepsis. It was unknown if the nurse recommended for him to have the resident sent out to the hospital for further evaluation. The nurse knew that the facility's goal was to treat the residents in house, and this remained the facility's goal. The resident was admitted for a hospitalization from 11/27/24 to 12/4/24 for sepsis. During an interview on 1/23/25 at 4:39 p.m., the Medical Director indicated he was in the facility on 11/26/24, but he did not see Resident 76 that day. He could not recall which orders he had given, but the nurse should have documented all verbal orders. No one contacted him to request to send the resident out to the hospital due to a decline. He had not been asked to change the orders to STAT. A current facility policy, last revised 9/15/23, titled "Notification of Change of Condition," provided by the Administrator on 1/23/25 at 9:35 a.m., indicated the following: "POLICY... To ensure appropriate individuals are notified of changes in condition. Guidelines... 4. If unable to contact the			

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	physician, depending on the significance of the change, the facility may contact the Medical Director, as appropriate. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure resident smoking materials were securely stored for 1 of 4 residents reviewed for accidents. (Resident 86) Finding includes: During an interview on 1/16/25 at 10:31 a.m., Resident 86 was in her room. She indicated she was a smoker and signed herself out to go smoke. She received her cigarettes and lighter from the facility when she signed out on leave of absence early in the day. Then, she kept her smoking paraphernalia for the day, in her purse in bed on her side. She returned the smoking paraphernalia to the facility at the end of the day. Resident 86's clinical record was reviewed on 1/17/25 at 10:26 a.m. Diagnoses included chronic respiratory failure with hypoxia and current tobacco use. A current physician order, dated 8/10/24, indicated the resident used oxygen therapy at 2 liters per minute via nasal cannula. An annual Minimum Data Set (MDS) assessment, dated 7/5/24, indicated the resident was cognitively intact. She used tobacco. A quarterly MDS assessment, dated 11/16/24,	F 0689	Resident 86 was not negatively affected by this alleged deficient practice. Smoking materials were obtained and properly secured according to policy, ~~with~~ Resident was reeducated on the smoking policy —— All other residents that take smoking material LOA with them have the potential to be affected by this deficient practice. All residents who sign out LOA to smoke, have been educated on the process of returning smoking materials to the appropriate staff member to store per policy. All resident rooms were rounded on to ensure no smoking materials were stored in them with no further concerns noted. All staff educated per our policy on collection and storage of resident smoking materials and instructed to ensure new smoking materials sign-out/sign-in log is kept. An audit will be conducted to ensure that smoking materials sign-out/sign-in log is complete and current. The Administrator or designee will complete the audit on 5 residents weekly for 4 weeks,	02/21/2025

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	indicated the resident was cognitively intact. She was independent for eating. The resident was dependent on staff assistance for transfers. She used a manual wheelchair for mobility and required set-up assistance to partial assistance from staff to propel in her wheelchair. A current care plan, last reviewed 11/20/24, indicated the resident wished to smoke. Interventions included the following: Stakeholders will maintain the smoking materials until the designated smoking times or leave of absence (8/21/23). The resident's "Smoking Observation" evaluation, dated 11/11/23, indicated the resident chose to smoke while she was at the facility. The resident was alert and oriented with understanding of the smoking rules, safety, and awareness. During an observation on 1/17/25 at 2:28 p.m., the leave of absence binder indicated Resident 86 signed out for a leave of absence on 1/17/25 at 12:50 p.m. During a review of the leave of absence binder, the leave of absence log indicated Resident 86 signed out for a leave of absence on 1/21/25 at 6:30 p.m. and return on 1/21/25 at 7:50 p.m. During an interview on 1/21/25 at 8:44 p.m., CNA 14 indicated the last resident smoke break was at 6:30 p.m. in the evening. The nurses were the only ones who had access to the residents' smoking materials, which were locked in the medication room. During an interview on 1/21/25 at 9:00 p.m., RN 13 opened the medication room on the 100 unit and looked through the tackle box of smoking		then bi-weekly for 2 months, then monthly for 3 months. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits. Compliance date: 2/21/25	

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	materials for Resident 86's materials. He indicated all of the resident's smoking paraphernalia should have been located in the tackle box in the 100 Unit medication room. Resident 86's smoking materials were not there. During an interview on 1/22/25 at 11:34 a.m., CNA 7 indicated all the residents' smoking materials were required to be managed by the staff. When a resident went on a leave of absence, they were required to return the smoking material upon return from the leave of absence to the staff. They did not have any residents that were permitted to keep the smoking paraphernalia with them in their resident rooms. All smoking materials for the 100 Unit residents were stored in a tackle box locked in the 100 Unit medication room. During an interview on 1/23/25 at 10:49 a.m., the Administrator indicated the resident's smoking paraphernalia was required to be kept in the possession of staff after smoke breaks and immediately upon return from a leave of absence. She was uncertain why the resident's smoking paraphernalia was not in the 100 Unit medication room. Residents, regardless of their cognitive status, were not permitted to keep smoking paraphernalia on them after smoking breaks nor after they returned from a leave of absence. The facility did not track receipt and return of smoking materials. During a continuous observation on 1/23/25 at 11:24 a.m., the Social Services Assistant and another unidentified staff member entered the resident's room with empty hands and shut the door. At 11:25 a.m., the Social Services Assistant exited the resident's room with Resident 86's cigarette pouch (the cigarette box had the			

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	resident's name written on it), in her hand. During an interview, at the time of observation, the Social Services Assistant indicated the resident had the smoking paraphernalia in her room. A current facility policy, last revised 9/15/23, titled "Facility Smoking/Non-Smoking Policy," provided by the Administrator on 1/23/25 at 9:35 a.m., indicated the following: "POLICY STATEMENT... This facility has adopted a smoking policy that will promote safety for residents, visitors, families, and stakeholders. It is not the intent of the facility to prohibit or restrict smoking privileges but to provide for the safety of resident who choose to smoke, as well as the safety of all other facility residents, visitors, and stakeholders. The smoking policy shall be explained to the residents and family upon admission to the facility... GUIDELINE: ... 6. Stakeholders will maintain smoking materials...." 3.1-45(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medications, treatments, and biological products were properly labeled and stored for 2 of 2 medication rooms and 2 of 6 medication carts reviewed for medication storage. (Medication Room East for 100/200/300/400 halls, Medication Room West for the 500/600/700 halls, Medication Cart for the 200 hall, and Treatment Cart for the 500/800 halls) Findings include: 1. During an observation, on 1/21/25 at 10:11 a.m., with the Director of Nursing (DON), the	F 0761	No residents were affected by this alleged deficient practice. All refrigerators and med carts checked with no other open, undated medications ~~vials~~ located. All refrigerator temperatures were immediately reviewed for temperature documentation and appropriate temperature with no concerns noted. All residents had the potential to be affected by this deficient practice. All med room refrigerators and med carts were	02/21/2025

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	refrigerator in the Medication Room East contained an open vial of influenza vaccine and an open vial of tuberculin purified protein derivative (PPD). The vial and box containing the influenza vaccine vial lacked an open date. The vial and plastic package containing the PPD lacked an open date. The temperature log indicated the temperature was taken daily. The DON indicated, at the time of the observation, that the temperature was taken daily on the medication refrigerators and the vials should have open dates. 2. During an observation, on 1/21/25 at 10:31 a.m., with RN 3, the refrigerator in the Medication Room West contained an open vial of influenza vaccine. The vial and box containing the influenza vaccine lacked an open date. The temperature log indicated the temperature was taken daily. RN 3, at the time of the observation, indicated when medication and vaccine vials were opened, an open date should be placed on them, and temperatures were obtained on the medication refrigerator daily. 3. During an observation, on 1/21/25 at 11:21 a.m., with LPN 4, the medication cart for the 200 Hall contained a total of 11 loose, unlabeled medications in the bottom of the drawers. The second drawer contained a blue capsule, a yellow caplet, a white caplet, two half white tablets, and a white tablet. The third drawer contained a white caplet, a white tablet, a reddish-brown tablet and two white tablets. At the time of the observation, LPN 4 indicated the medications should be disposed of immediately. 4. During an medication storage observation of the treatment cart for the 800 and 500 hallways, accompanied by RN 22 at 1/21/25 at 1:54 p.m., the following medications were observed without resident identifiers and		audited to ensure proper labeling/dating. All nurses have been reeducated on recording refrigerator temperatures per policy and proper med storage and labeling per policy. An audit will be completed of medication rooms and medication carts to ensure proper labeling, storage, and refrigerator temperatures are in place. The DON or designee will complete audits 5 times per week for 4 weeks, then 3 times per week bi-weekly for 2 months and then 2 times monthly for 3 months. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits. Compliance date: 2/21/25	

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	directions: Six (6) tubes of miconazole (to treat fungus and yeast) anti-fungal 2% cream, Three (3) tubes of "Medi-honey" (to treat wounds) wound and burn gel, Two (2) tubes of "Hydrogel" (to treat wounds) wound dressing, One tube of lidocaine 4% (to numb and prevent pain) anesthetic cream, One tube of mupririon (to treat bacteria) 2% ointment. During an interview, at the time of the observation, RN 22 indicated the cart was used for the 800 and 500 hall treatments. The Wound team and the nurse assigned to the hall had access. When a staff member used a tube of medication for a resident, they should place it in a plastic bag and put the residents name on it. The anti-fungal cream tubes was for facility stock and kept in the treatment cart. During an interview, on 1/22/25 at 4:07 p.m., the DON indicated the facility did not have a specific policy on vaccine storage. The influenza vaccine manufacturer's package insert information, retrieved on 1/22/25 from https://labeling.seqirus.com/PI/US/Afluria/EN/Afluria-Prescribing-Information.pdf, indicated the following: " ...Once the stopper of the multi-dose vial has been pierced the vial must be discarded within 28 days ...." The article "Vaccine Storage and Handling Toolkit," updated 3/29/24, was retrieved on 1/23/25 from the Centers of Disease Control and Prevention (CDC) website at https://www.cdc.gov/vaccines/hcp/downloads/st			

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	orage-handling-toolkit.pdf. The guidance indicated if the temperature monitoring device did not read maximum/minimum temperatures then the temperature must be checked and recorded a minimum of two times a day as a minimal action to protect the vaccine supply. A pharmacy policy and procedure manual appendix, dated 1/23, titled, "Medications with Shortened Expiration Dates", provided by the DON on 1/22/25 at 12:38 p.m., indicated the following: "... tuberculin PPD, diluted, injection store at 36 degrees to 46 degrees in the dark except when doses are actually being withdrawn from the vial. Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." A facility policy, dated 1/23, titled, "Storage of Medication", provided by the DON on 1/22/25 at 12:38 p.m., indicated the following: "...Medications requiring "refrigeration" or "temperatures between 2°Celsius (C) (36°Fahrenheit (F)) and 8°C (46°F) are kept in a refrigerator with a thermometer to allow temperature monitoring... A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits. The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily... Medication storage should be kept clean, well lit, organized and free of clutter..." A facility policy, dated 1/23, titled, "Medication and Medication Labels", provided by the DON on 1/22/25 at 12:38 p.m., indicated the following: "... Medications are labeled in accordance with currently accepted professional principles including appropriate auxiliary and cautionary instructions to promote safe medication use following state and federal laws... 1. Each			

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	prescription medication will be labeled to include: a. Resident's name, b. Specific directions for use, including route of administration, c. Medication name... d. Strength of medication... e. Prescriber's name, f. Date medication is dispensed, g. Quantity dispensed, h. Expiration or end-of-use date... i. Name, address, and telephone number of dispensing pharmacy, j. Prescription number, k. Accessory/precautionary labels... l. Dispensing pharmacist's initials... 2. Multi- dose vials shall be labeled to assure product integrity, considering the manufactures' specifications. (Example: Modified expiration dates upon opening the multi-dose vial.) Nursing staff should document the date opened on multi-dose vials on the attached auxiliary label... 5. Non-prescription medications not labeled by the pharmacy are kept in the manufacturer's original container. Nursing care center personnel may write the resident's name on the container or label as long as the required information is not covered, if applicable by state regulations... 10. Floor stock medications kept in the original manufactures container must have the expiration date and lot numbers clearly evident. The manufacturer's or pharmacy label shall include the following: a. Medication name, b. Medication strength, c. Quantity, d. Accessory information, e. Lot number, f. Expiration date..." 3.1-25(j) 3.1-25(k)			
F 0802 SS=E Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel Based on observation, interview and record review, the facility failed to provide adequate dietary staff to ensure room tray meals were delivered in a timely manner for 3 of 9 Units. (100 Unit, 300 Unit, and 400 Unit)	F 0802	3 of 9 units were affected. Dining service order adjusted to accommodate mealtimes and current staffing patterns. All residents have the	02/21/2025

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	Findings include: Review of a Meal/Cart Delivery Time schedule, provided by the facility on 1/15/25, indicated the dinner service meal carts were scheduled to arrive at the following times on the specified units: 100 Unit - 5:35 p.m. 300 Unit - 5:55 p.m. 400 Unit - 6:05 p.m. During observations of dinner service meal tray delivery, on 1/21/25, the meal trays were observed delivered at the following times on the specified units: 100 Unit - 6:19 p.m.: This was a 44 minute delay. The last tray was delivered at 6:25 p.m. 300 Unit - 6:52 p.m.: This was a 57 minute delay. The last tray was delivered at 6:59 p.m. 400 Unit - 7:02 p.m.: This was a 57 minute delay. The last tray was delivered at 7:12 p.m. During an observation on 1/21/25 at 7:03 p.m., Resident 76 was seated in her wheelchair in the doorway of her room with the door open and gazed down the unit. The resident indicated she was waiting on her dinner tray. During an observation on 1/21/25 at 7:08 p.m., Resident 53 was seated on her bed and yelled out into the hallway and asked if they have delivered supper yet. Confidential interviews were completed during the survey as follows: Meals were often cold as a result of being the last unit served.		potential to be affected by the same alleged deficiency Adjust dining order to accommodate mealtimes and current staffing patterns. The Dining Services department will employ sufficient staff, with appropriate competencies and skill sets to carry out the functions of food and nutrition services in a manner that is safe and effective. Daily audits to be performed to verify parameters. To ensure compliance, the Dietary Manager or his/her designee will adjust the dining order and mealtimes and provide them to the Administrator. Weekly audits monitoring mealtime delivery will be submitted to the Administrator or designee for review. Any identified issues or concerns will be immediately addressed. Compliance will be maintained by conducting audits weekly for 4 weeks, then bi-weekly for 2 months, then monthly for 3 months, to ensure compliance. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits.	

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	Meals were served cold. Residents on the 400 Unit had complained as recent as the last weekend and reported they usually did not get their dinner meal tray until 6:45 p.m. to 7:00 p.m. This was reported to Unit Manager 16 who said it would be discussed with the dietary manager. They recently started getting a clipboard to sign and time stamp when the meal tray carts arrived on the units. They had been receiving their meals late for quite a long time. The dinner meals had been delivered late, like on 1/21/25, several days each week.. Dinner meal trays had been delivered between 6:45 p.m. and 7:15 p.m. on a daily basis since arrival to the facility. Dinner meals were delivered around 7:00 p.m. for approximately the past year. This had been reported to several staff. They believed there wasn't anything that could be done about it since it had been going on this long. They had so many people to serve meals. No one had responded to let them know if anything was being done to correct the late dinner meals. The kitchen had three dietary staff on duty for dinner, not including a manager, on 1/21/25. Three dietary staff members were the typical amount of staff used on a regular basis. This was not enough staff to serve the residents timely. Dietary management had changed often, and they had notified multiple dietary management team members of the concern that residents were not able to be served in a timely manner. It was reported to the dietary services human resources around June or July of 2024, and it was reported to		·Compliance date: 2/21/25	

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	the supervisor of the Dietary Manager that is not in that position anymore. Each of them said they had to follow the budget. It was also reported to the Administrator of the facility, a few months ago, regarding a lack of enough dietary staff causing the meals to be delayed for dinner. The Administrator said she would do something about it, but nothing happened to correct the problem. Many times, the request for substitutes during meal delivery placed the dietary staff behind and resulted in delayed meals in the evenings. Residents also complained to them about the delay in the dinner meal delivery, but the concern remained a problem. They felt bad because the residents had not received their dinner in a timely manner, and there was no known solution to the problem. Around two out of five days a week, they had observed the dinner meals trays delivered at a late time comparable to the 1/21/25 dinner meal delivery times on the 100 Unit, 300 Unit, and 400 Units. The later meals were usually a hot meal, but the delayed dinner today was even a cold meal. They had reported their concern about late meal tray delivery to a nurse on duty approximately three weeks to a month ago. This was a problem, as it ran into the 8:00 p.m. bed checks when the residents did not get finished with their meals until 7:30 p.m. No one responded to them about a solution to correct the problem, but that was not unusual. There was a lack of enough dietary staff, but she was uncertain if there had been any staff added recently. They had not reported to upper management directly, but late meals had been communicated through a facility group chat. They were uncertain what date it was on the facility group chat. During a telephone interview on 1/22/25 at 7:16			

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	p.m., Unit Manager 16 indicated, two to four weekends in the last four months, she had noticed the meal trays were served late. Staff hadn't really reported it to her, as she was aware. She worked on the weekends, so she was not aware of dinner meal tray delivery times through the week. The kitchen had been short of dietary staff and have even had to bring some staff in from other facilities to assist in the kitchen. The dietary department had problems with staff turnaround. For the delayed meal trays in the last two months, she had spoken with the District Dietary Manager and/or the dietary supervisor on duty, and even offered assistance at the time of the concern if she could assist with pushing a cart for them. In the last two months, she attended morning meetings on Mondays either in person or via the telephone. She brought up the late meal tray concerns during those meetings. She had not personally filled out a grievance form for the concern, but the Administrator was aware due to her discussions in morning meetings. Approximately one year ago, the meal times were so bad that she called the dietary company's corporate office and filed a complaint. She felt the late meal trays were improved since that time, but meals delivered later than a 30 minute delay was an unreasonable delay. During an interview on 1/23/25 at 9:47 a.m., the Dietary Manager indicated the Administrator had mentioned delayed dinner meals to him a little over a month ago. The Dietary Manager and the District Dietary Manager had been staying at the facility for the evening meal pass three times a week. This was an effort to assist with dinner meal service to ensure meals were delivered on time. This was in place since approximately the beginning of December. The District Dietary Manager stayed for the dinner delivery on 1/21/25			

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	and the Dietary Manager stayed for the dinner delivery on 1/22/25. They were still experiencing late dinner meal tray deliveries. They implemented a meal tray delivery tracking audit on 1/16/25, after the annual survey was underway. They also worked with Cook 32 to get more efficient, though he was not on duty on 1/21/25. Cook 32 worked on 1/15/25, 1/17/25, and 1/20/25. They also worked with Cook 10 on his efficiency. The Dietary Manager and District Dietary Manager assisted with cooking, plating food, wrapping the dishware, and helped to keep things moving when they stayed late three days a week. Even though the District Manager stayed for the dinner meal trays on 1/21/25, the dinner meal trays were still excessively delayed. He believed they should have been able to serve the dinner meals timely without additional staff members, even though the dinner meals were still delayed when the Dietary Manager and the District Dietary Managers were there and provided assistance to the three scheduled dietary staff members. Cook 10 must have been "dilly dallying" on 1/21/25. He indicated the staffing schedule required a cook and two dietary aides to serve 120 residents. He had also advocated to have the dietary company hire a Sous Chef in the future. Review of the "Dietary Work Schedule" indicated a Cook and two Dietary Aides were on the schedule for the evening shifts from 1/12/25 through 1/25/25. Evening hours for the Dietary Manager and the District Dietary Manager were not indicated on the schedule. Review of the Cart Delivery Audits, dated 1/16/25 through 1/22/25, indicated the following concerns regarding dinner meal cart delivery dates and times:			

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	100 Unit Meal Cart Delivery Audits 1/16/25: Incomplete 1/17/25: Time received 6:14 p.m. - This was a 39 minute delay. 1/18/25: Time received 6:13 p.m. - This was a 38 minute delay. 1/19/25: Time received 6:19 p.m. - This was a 44 minute delay. 1/20/25: Time received 6:06 p.m. - This was a 31 minute delay. 1/21/25: Time received 6:18 p.m. - This was a 43 minute delay. 1/22/25: Time received 5:07 p.m. - No concerns with delivery on this date. 300 Unit Meal Cart Delivery Audits 1/16/25: Time received 6:31 p.m. - this was a 36 minute delay. 1/17/25: Time received 6:41 p.m. - This was a 46 minute delay. 1/18/25: Time received 6:35 p.m. - This was a 40 minute delay. 1/19/25: Time received 6:47 p.m. - This was a 52 minute delay. 1/20/25: Time received 6:20 p.m. - This was a 25 minute delay. 1/21/25: Time received 6:47 p.m. - This was a 52 minute delay. 1/22/25: Time received 5:34 p.m. - No concerns with delivery on this date. 400 Unit Meal Cart Delivery Audits 1/16/25: Incomplete 1/17/25: Time received 6:51 p.m. - This was a 46 minute delay. 1/18/25: Time received 6:46 p.m. - This was a 41 minute delay. 1/19/25: Time received 6:49 p.m. - This was a 44 minute delay. 1/20/25: Time received 6:35 p.m. - This was a 30			

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	minute delay. 1/21/25: Time received 7:00 p.m. - This was a 55 minute delay. 1/22/25: Time received 5:55 p.m. - No concerns with delivery on this date. During an interview on 1/23/25 at 10:25 a.m., the Administrator indicated delayed supper meal tray delivery had been a periodic issue, though the grievances did not reflect delayed dinner meal concerns. The meal trays for dinner on 1/21/25 were not delivered timely to the units. Any dietary concerns were forwarded to the Dietary Manager immediately. She was unable to recall if they had discussed delayed dinner meal delivery in morning meetings. Delayed dinner meal delivery was brought to the Administrator's attention from a staff member on 1/3/25 via a text that indicated the dinner meal cart arrived on the 100 Unit at 6:23 p.m. She was uncertain which staff member brought it to her attention because she did not put it on a grievance form. She had not followed up with that staff member. She had copied and pasted the staff member's text into another text to the Dietary Manager on 1/3/25. He had responded to her text that he contacted the dietary staff (as he was not in the facility), and they told him everything was going smoothly and on time. In text, he asked if the nursing staff were on break when the tray was delivered. She text him back and let him know the nurse was present on the 100 Unit when the cart arrived at 6:23 p.m. on 1/3/25. There was no further communication after that. She was unaware what was being done to address the problem. She believed the dietary had an in-service, and they started and an audit of the meal cart delivery, after the annual survey was underway. Review of a document, provided by the			

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	Administrator on 1/23/25 at 12:00 p.m., indicated the following: 10 residents were served dinner in their room on the 100 Unit, 10 residents were served dinner in their rooms on the 300 Unit, and 11 residents received dinner in their rooms on the 400 Unit. A current document, dated 2/28/22, titled "DIETARY SERVICES AGREEMENT," provided by the Administrator on 1/22/25 at 10:28 a.m., indicated the following: "... COMPLIANCE WITH LAWS... Both parties agree at all times during the existence of this Agreement to comply with all federal, state, and local laws, rules, ordinances and regulations... shall notify Client within (2) business days of any complaints, concerns, or compliance issues of which... receives notice from any residents, patients, family members, employees, or others...." A current facility policy, last revised 2/2023, titled "Meal Distribution," provided by the Administrator on 1/22/25 at 10:28 a.m., indicated the following: "Policy Statement... Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. Procedures... 4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients...." 3.1-20(h) 3.1-21(c)			
F 0847 SS=E Bldg. 00	483.70(n)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements Based on interview and record review, the facility failed to ensure residents who entered into a	F 0847	All residents have the potential to be affected by this	02/21/2025

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	binding arbitration agreement were granted the right to verbally rescind the agreement within 30 days of signing it and were granted the right to rescind the original agreement for a subsequent stay if discharged and re-admitted to the facility or admitted to another facility owned by the same corporation in the future. This deficiency has the potential to affect 57 of the 127 residents who reside in the facility. Findings include: During an interview, during the entrance conference, on 1/15/25 at 10:10 a.m., the Administrator indicated the facility utilized arbitration agreements. The facility's arbitration agreement provided by the administrator with entrance conference paperwork on 1/15/25, was reviewed on 1/17/25 at 9:15 a.m. The arbitration agreement was included in the residents' admission paperwork and indicated the following: " ...Unless rescinded within thirty (30) days under Paragraph 10 below, this agreement will also remain valid and of full force and effect even if the resident is discharged and then later re-admitted to Facility. It will also apply to all of the Resident's subsequent admissions and stays at any Signature Facility ... [Paragraph 10] The Parties understand and agree that either Party can rescind this agreement by, and only by, providing written notice to the other within thirty (30) days of the date of signing this agreement ...." A list of residents, provided by the Administrator with entrance conference paperwork on 1/15/25, indicated 57 residents currently residing in the facility had signed arbitration agreements.		alleged deficient practice. The existing facility arbitration agreement was revised to include the right to verbally rescind the arbitration agreement within thirty days of signing the agreement and revised to include the right to rescind the original agreement for a subsequent stay if discharged and readmitted to the facility or admitted to another facility owned by the same corporation in the future Residents #21, 40 & 72 were provided the opportunity to sign a newly revised arbitration agreement. All other in-house residents who previously signed the prior arbitration agreement were provided the opportunity to sign a revised arbitration agreement. The staff members responsible for presenting the Arbitration Agreements to the residents were in-serviced by the facility administrator. This in-service included but was not limited to the ability to rescind the arbitration agreement within thirty days of signing the agreement and the ability to rescind the originally signed arbitration agreement for a subsequent stay if a resident is discharged and re-admitted to the facility or admitted to another facility owned by the same corporation. The administrator or designee will audit 3 new admission	

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	During an interview, on 1/23/25 at 12:18 p.m., the DON indicated the Facility Liaison discussed the arbitration agreements with the residents upon admission to the facility. During an interview, on 1/23/25 at 12:19 p.m., the Corporate Nurse indicated she was uncertain if the resident signed the arbitration agreement without rescinding it, then for all subsequent admissions to the facility and other facilities owned by the corporation it would remain in effect for those stays as well. She indicated she would call the legal department for more information. During a phone interview, on 1/23/25 at 3:09 p.m., the Corporate Legal Counsel indicated if the resident admitted to the facility and signed the arbitration agreement, did not rescind it in 30 days, then it would be in effect for the current stay and any other subsequent stays in the facility. If the resident discharged from the facility and readmitted in the future to the facility or another facility owned by the corporation, the agreement remained in effect. She indicated nowhere in the CMS (Centers for Medicaid and Medicare Services) regulations was this not permitted. She indicated the notice to rescind the agreement had to be in writing because from a legal standpoint someone could say at any time, they verbally asked to rescind the agreement. A review, completed on 1/23/25 at 3:39 p.m., of the arbitration agreements signed by Resident 21, 40, and 72, indicated the arbitration agreements were the same as the arbitration agreement sample provided by the Administrator. During a phone interview, on 1/23/25 at 3:43 p.m., the Facility Liaison indicated he and his coworker, the Admission Coordinator discussed the		resident records weekly times four weeks, bimonthly for one month and monthly for one month until 90% compliance is achieved to ensure that the residents who sign an arbitration agreement have signed the updated agreement. Copies of these audits will be provided to the QAPI committee for additional recommendations as indicated. 2/21/25	

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	arbitration agreement with the residents upon admission to the facility. He was uncertain how long the residents had after signing the agreement to change their mind and rescind the agreement. He indicated he had just asked the Admissions Coordinator, and she was uncertain as well. He had never had a resident, or their family, ask to terminate the agreement so he was not sure of the process. During an interview, on 1/23/25 at 4:08 p.m., the Nurse Consultant indicated the facility did not have a policy for the arbitration agreement.			
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies. Finding includes: Review of the Summary Statement of Deficiencies, for the facility's last annual recertification and licensure survey completed on 2/9/24, indicated the facility had deficiencies related to failure to follow infection control guidelines related to isolation procedures and failure to ensure medications were labeled with resident identifiers and directions. During an interview, on 1/23/25 at 4:19 p.m., the Administration indicated the Quality Assessment and Assurance (QAA) committee met quarterly to review current facility concerns. The QAA committee utilized an online program to assist with streamlining the process, assessing trends, and	F 0867	All residents had the potential to be affected by this alleged deficient practice. A QAPI program is established & ongoing, with Infection Control and med storage/labeling concerns added. All nursing staff educated on the types of isolation precautions, EBP, PPE (appropriate PPE, donning and doffing) and hand hygiene. Monthly education for nursing will be ongoing for 6 months. The administrator has been educated on the proper process for implementation and review/completion of the QAPI policy and program and need to continue monitoring when noncompliance remains. The Administrator will ensure ~~problematic~~ areas are included in the QAPI program based on	02/21/2025

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	documentation of these meetings. The current nursing topics were wounds and falls. During a follow-up interview, on 1/23/25 at 4:43 p.m., the Administrator indicated the facility did not have any current QAPI or Performance Improvement Plans (PIP) in place for isolation procedures such as Enhanced Barrier Precautions (EBP) or medication storage and labeling procedures. Repeat concerns regarding infection control and prevents and labeling of drugs and biologicals were cited during the January 23, 2025 survey as follows: The facility failed to ensure medications, treatments, and biological products were properly labeled and stored for 2 of 2 medication rooms and 2 of 6 medication carts reviewed for medication storage. (Medication Room East for 100/200/300/400 halls, Medication Rood West for the 500/600/700 halls, Medication Cart for the 200 hall, and Treatment Cart for the 500/800 halls) The facility failed to develop and implement an infection control program which provided Enhanced Barrier Precautions (EBP) and/or isolation services in order to eliminate or reduce the risk of spread of contagions for 2 of 5 residents reviewed for infection prevention (Residents 66 and 86). A facility policy, revised 9/15/23, titled, "Quality Assurance/Performance Improvement (QAPI) Program Policy", provided by the Administrator on 1/15/25 at 9:50 a.m., indicated the following: "... It is the intent of this facility to conduct an on-going Quality Assurance/Performance Improvement (QAPI) program designed to		facility outcomes and review. A weekly audit by the Administrator or designee, for 6 months, will ensure areas of concern are added, monitored, and reviewed as indicated. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits. Compliance date: 2/21/25	

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	systematically monitor, evaluate, and improve the quality and appropriateness of resident care. QAPI supports the overall goals of the facility and examines both the outcomes and process relevant to these outcomes with the objective of improving the organizations overall performance with addressing care and management systems... The facility will identify areas for QAPI monitoring and tools/resources to be utilized. These monitoring activities should focus on those processes that significantly affect resident outcomes... Criteria for selecting additional aspects of care for performance improvement are based on the following:... Problem areas- the aspect of care has tended in the past to produce problems for staff or residents..." Cross reference F761 Cross reference F880. 3.1-52(b)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to develop and implement an infection control program which provided Enhanced Barrier Precautions (EBP) and/or isolation services in order to eliminate or reduce the risk of spread of contagions for 2 of 5 residents reviewed for infection prevention. (Residents 66 and 86) Findings include: 1. During an observation on 1/15/25 at 11:39 a.m., Resident 66's door had two signs posted. The first sign was a red stop sign posted on pink	F 0880	Residents 66 and 86 were affected by the alleged deficient practice. Both residents were assessed with no adverse effects noted. Appropriate isolation signage was placed and staff were educated on following current isolation guidelines. All residents had the potential to be affected by this deficient practice. All residents in current EBP/isolation precautions were audited to ensure proper signage in place and PPE is available. All	02/21/2025

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	paper. The second sign was instructions regarding how to correctly apply PPE (personal protective equipment). The door signs did not contain direction regarding what type of isolation the resident was under, what was required to enter the room, when a staff or visitor needed to wear P.P.E. During an interview on 1/15/25 at 11:42 a.m., QMA 19 indicated Resident 66 was on some type of precautions, however she was unsure of the type and it might be droplet isolation. She left and quickly returned stating the resident was on Enhanced Barrier Precautions (EBP) or contact isolation due to a rash she used to have. The QMA indicated she thought staff and visitors were supposed to wear P.P.E. when the resident had a rash and the resident did not currently have a rash. During an observation on 1/16/25 at 10:28 a.m., a third sign had been added to Resident 66's door. The third sign indicated the resident was on "Enhanced Barrier Precautions" and offered instructions to staff and visitors. During an observation on 1/17/25 at 10:44 a.m., CNA 21 was speaking to Resident 66 as she assisted her to exit the in room bathroom. CNA 21 removed gloves and threw them away. She then used her bare hands to push the residents wheel chair and assist the residents to don shoes. CNA 21 was not wearing any form of PPE. CNA 21 did not complete hand hygiene. During an interview at this time, CNA 21 indicated she believed she only needed PPE if the resident had a skin rash. She had only used gloves when providing toileting care. CNA 21 reviewed the EBP sign posted on the resident's door and indicated she might be wrong. When the door sign says EBP		residents were audited to ensure current conditions met current precaution requirements, with any corrections made. All nursing staff educated on the types of isolation precautions, EBP, PPE (appropriate PPE, donning and doffing) and hand hygiene. The DON or designee will audit 5 residents in isolation precautions, weekly, for 4 weeks, then bi-weekly for 2 months, then monthly for 3 months, to ensure appropriate signage is in place and proper PPE is available. The DON or designee will interview 5 staff members weekly x4 weeks, then bi-weekly for 2 months, then monthly for 3 months to ensure staff are aware of precautions and appropriate PPE to don when entering isolation rooms. As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits. Compliance date: 2/21/25	

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	employees are supposed to wear full PPE during resident care and she had made an error. The three signs regarding infection control and prevention remained posted on the resident door during the following dates and times: 1/17/27 at 10:03 a.m., 1/17/25 at 10:44 a.m., 1/21/25 at 3:46 p.m., 1/23/25 at 11:47 a.m. During an interview on 1/21/25 at 3:48 p.m. LPN 20, indicated, the resident had contact isolation due to a history of skin rashes. The resident did not have to remain in her room. The resident only had to stay in her room if she had a rash. Staff were to follow the directions on the posted signs. Resident 66's clinical record was reviewed on 1/17/25 at 9:29 a.m. Current diagnoses included candidiasid - unspecified, chronic respiratory failure with hypoxia, and depression. The resident had current physician's orders which included: a. An order which originated, 03/05/2024 for Enhanced Barrier Precautions, b. An order which originated 06/26/2024 for "Resident in room without a roommate for isolation," and c. An order which originated 01/07/2025 for"Resident receives all meals, medications, activities, and therapy in room." The resident had a current, 11/20/24, care plan regarding the need for enhanced barrier precautions for the purpose of infection control. An approach to this problem was "Personal Protective Equipment as indicated." The care plan did not indicate when PPE was indicated. Resident 66 had a 6/25/24 hospital, "Facility			

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	Infection Control Form" which indicated the resident had screened positive for Candida auris on 6/19/24 and had been on enhanced contact precautions while in the hospital. The resident had a 6/25/24 hospital discharge summary which stated the resident had tested positive for Candida auris. She had been on enhanced contact precautions while in the hospital. During an interview on 1/23/25 at 11:50 a.m., the Infection Preventionist (IP) indicated Resident 66 should not have orders for both isolation and EBP. If a resident had an order for isolation the order should be clear as to the type of isolation the resident required. If a resident had an order for EBP a sign regarding the precautions should be posted on the resident's door. She did not believe Resident 66 should be on isolation in her room and she would look into the matter. CNA 21 had informed her she had made an error when she toileted Resident 66. The two had discussed the need for full PPE when caring for the resident. During an interview on 1/23/25 at 2:06 p.m., the IP indicated Resident 66 should not have had orders for isolation or restrictions to remain in her room. The resident required EBP and staff should wear PPE during care. 2. During an interview at the time of observation on 1/16/25 at 10:22 a.m., Resident 86's door and room lacked any signage for specific precautions. Personal protective equipment (PPE) was not observed readily available in or near the resident's room. During an interview with the resident in her room, she indicated she had a pressure ulcer on the middle-right of her buttock. She was resting on her left side in bed and indicated she repositioned herself in bed. Her wound vacuum was on during			

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	the observation. The facility staff changed her wound vacuum every other day. Staff wore gloves when they changed her dressing, but they never wore a gown for her wound care. Resident 86's clinical record was reviewed on 1/17/25 at 10:26 a.m. Diagnoses included pressure ulcer of the sacral region, unspecified stage. The clinical record lacked any orders for enhanced barrier precautions (EBP). A current physician order, dated 12/30/24, included the following: Cleanse the coccyx wound with Hibiclens (antibacterial wound wash) and rinse with normal saline once a day on Mondays, Wednesdays, and Fridays, apply skin preparation to the peri area and black foam to the wound cavity, then cover it with the wound vacuum dressing and set the wound vacuum to run continuously at 150 millimeters of mercury pressure. A quarterly Minimum Data Set (MDS) assessment, dated 11/16/24, indicated the resident was cognitively intact. She required substantial assistance from the staff for toileting, lower body dressing, personal hygiene and donning and doffing of footwear. The resident was dependent on staff assistance for transfers. She had a stage 3 pressure ulcer that was not present on admission. A current care plan, dated 9/2/24, indicated the resident had a pressure ulcer to her sacrum. The care plan lacked any interventions regarding EBP's. During an observation on 1/17/25 at 11:07 a.m., the resident's door to her room was closed. No signage was noted on the resident's door during			

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	the observation. During an observation on 1/17/25 at 11:50 a.m., CNA 15 indicated the resident was ready to get dressed and get up, and she planned to assist her. She knocked on the resident's door and donned a pair of gloves. The resident consented to the observation of her pressure ulcer wound vacuum before she got dressed. Hand hygiene was not observed. CNA 15 leaned in against the resident's bed with her pants directly against the resident's bed linens. She used her gloved hands to pull down the resident's blanket and unsecured the resident's brief. The resident repositioned herself onto her left side. CNA 15 tucked the brief down under the resident for review of the pressure ulcer wound vacuum. The wound vacuum dressing was on the resident's coccyx, clean, dry, and intact with the wound vacuum turned on. The only PPE noted in the room was gloves. No signage for enhanced barrier precautions was in the resident's room. The resident told CNA 15 she was ready to get assistance with her personal hygiene/dressing. The CNA did not don a gown anytime during the observation. Review of a "Care Guide 100 Hall-Last Revision 1/20/2025" document, used as a reference guide for the CNA staff, lacked any indication the resident was in enhanced barrier precautions. During an observation on 1/21/25 at 11:55 a.m., the outside of the resident's door contained an EBP sign that was not present during previous observations. The sign indicated gloves and gowns were required for staff during high contact care activities. During an interview at the time of observation on 1/21/25 at 6:38 p.m., the resident's door had an			

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	EBP sign on the outside. During an interview at the time of observation, the resident indicated staff placed a new sign on her door on this date, as she pointed to the EBP sign. She did not know why it was on her door. She indicated staff had to assist her with dressing. She required assistance from two staff members and a lift to transfer into the wheelchair. Staff wore gloves when they assisted her, but they had not worn gowns during the above-mentioned resident care. During an interview on 1/22/25 at 11:34 a.m., CNA 7 indicated the CNAs were able to identify if a resident had EBP due to a sign on the door labeled enhanced barrier precaution. The CNA activity of daily living (Care Guide) was also used as a reference to ensure they were aware which residents were in EBP. The resident's door did not have an EBP sign prior to 1/21/25 even though the resident had a chronic wound prior to that date. She had received new training on 1/20/25 or 1/21/25 when staff were informed of new things going into effect. This included information that residents with wounds and devices such as colostomies and catheters were required to have EBP implemented. Prior to 1/21/25, the staff were only required to wear gloves in the resident's room during high contact care because EBP were not in place at that time. Since 1/21/25, a gown, gloves, and masks were required to be worn in the resident's room during dressing, bathing, and assistance with wound care. During an interview on 1/23/25 at 9:27 a.m., the Infection Preventionist indicated she explained EBP to the staff when it was initiated on each resident. A sign for EBP was also posted on the door, and gowns and gloves were made readily available when it was implemented as well. Prior to 1/21/25, the staff would not have known they			

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	should have worn a gown and gloves for the resident's high contact care because EBP had not been implemented for her. She had been trying to get clarification from a corporate staff member and was uncertain about which residents should have been in EBP. As a result, the resident's EBP was not implemented until 1/21/25. She had not reached out to the Indiana Department of Health Infection Preventionist for clarification on EBP. The resident's wound developed before 1/21/25. Any resident with wounds required EBP with a gown and gloves worn during any care that involved touching the resident. A current facility infection control door sign titled, "Enhanced Barrier Precautions", which was provided by the DON on 1/23/25 at 9:30 a.m., indicated: "Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and gown for the following High Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care of use: central line, urinary catheter, feeding tube, tracheotomy Wound Care: any skin opening requiring a dressing Do not wear the same gown and gloves for the care of more than one person." A document, which was identified as a resource			

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	used by the facility, Titled "Infection Control Guidance: Candida aurius" was provided by the IP on 1/23/25 at 2:24 p.m., and identified as the CDC (Center for Disease Control) guidance used to direct care for Resident 66 indicated the following: "Ensuring that all healthcare personnel adhere to infection control is critical to preventing transmission of C aurius... Practice good hygiene Use alcohol-based sanitizer as the preferred method of cleaning hands...Wear gowns and gloves using proper donning and doffing techniques..." A current facility policy, last revised 3/25/24, titled "Enhanced Barrier Precautions Policy," provided by the Infection Preventionist on 1/23/25 at 10:20 a.m., indicated the following: "Policy Statement... This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. GUIDELINE: ... 2. Enhanced Barrier Precautions (EBP) are additional measures to attempt to decrease transmission of Multidrug-Resistant Organisms (MDRO)... 3. If a resident is placed on EBP, appropriate signage is placed at the room entrance so that personnel and visitors are aware of the need for and the type of precautions. a. The signage informs the staff of instructions for use of PPE, and/or instructions to see a nurse before entering the room... 5. EBP are indicated for residents who have chronic wounds and or indwelling devices regardless of MDRO status...." 3.1-18(b)(2)			

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	155242	A. BUILDING 00 B. WING	01/23/2025

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F 0908 SS=D Bldg. 00	483.90(d)(2) Essential Equipment, Safe Operating Condition Based on record review, observation, and interview, the facility failed to ensure the automated external defibrillator (AED) was maintained in safe operating condition. (Resident F) Finding includes: Resident F's clinical record was reviewed on 1/21/25 at 2:23 p.m. A progress note, dated 1/18/25 at 11:13 a.m., indicated the resident was observed unresponsive without a pulse. Facility staff had called a "code" (a medical term for cardiac arrest) and begun cardiopulmonary resuscitation (CPR). Emergency services (EMS) were contacted. A progress note, dated 1/18/25 at 12:11 p.m., indicated the facility staff had transferred CPR and rescue breathing to the EMS, who continued without success. CPR was ceased at 11:28 a.m. During an interview, on 1/21/25 at 11:51 a.m., RN 29 indicated when a "code blue (a medical term for cardiac arrest)" was called the staff would get the crash cart from the end of the 700 hall and the AED off the wall, at the junction of the 800 hallway. He indicated the AED was in working order as it was tested just a few months ago. During an interview, on 1/21/25 at 12:03 p.m., RN 3 indicated when a resident required CPR, the staff utilized the crash cart on the 700 hall and obtained the AED from the 800 hallway. She indicated the AED was currently in working order.	F 0908	No residents were affected by this alleged deficient practice. The AED was removed from emergency cart and staff notified of its unavailability, until new battery arrived. All residents had the potential to be affected by this deficient practice. A new AED battery had already been ordered, as was part of a 6-month routine replacement, by Maintenance dept, but had been backordered. Battery obtained from alternate vendor and in place. AED returned to emergency cart and staff notified of availability. All nursing staff educated as while not a requirement to have an AED, we have one available for use in the facility. Staff members have been educated on the location and instruction as to who to notify of any malfunctions have been provided. AED added to quarterly checks in TELS by Maintenance director or designee, to ensure of placement and operational power. An audit will be conducted to ensure that AED is functional and if non-functional is removed from service until repaired or replaced. The audit will be completed by the maintenance director or designee weekly for 1 month, bi-weekly for 2 months, and then monthly for 3 months.	02/21/2025

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	During an observation of the 800 hall junction, on 1/21/25 at 12:30 a.m., the white box attached to the wall contained a red AED device. The outside of the box contained no markings to indicate if the device was in working order. During an observation of the 800 hall junction, on 1/21/25 at 4:15 p.m., the white box attached to the wall was empty. The red AED device was removed from the box. The inside of the box contained no markings or documentation to indicated the device was in working order. During a telephone interview, on 1/22/25 at 2:56 p.m., RN 27 indicated she was working the hallway where Resident F was staying. On 1/18/25, she and Unit Manager 16 entered the residents room and found the resident was not breathing. The Unit Manager immediately started CPR. The AED was brought in at some time during CPR but was unable to be utilized because the battery was dead. During a telephone interview, on 1/22/25 at 7:43 p.m., Unit Manager 16 indicated she was called to help assess Resident F in his room. When she was unable to obtain vital signs, she immediately started CPR. At one point, CNA 28 took over chest compressions, so she retrieved the AED that hung at the 800 hall junction, and called the "Code Blue". EMS was called. When she returned to the residents room she opened the AED, pulled out the cartridges and attached the pads to the residents chest. She pressed the power button and the AED would not turn on. CPR was continued. EMS arrived roughly around 11:10 a.m. and took over CPR. She indicated she was trained in the use of an AED and was under the impression the device had been in working order. After the situation, she contacted the DON		As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits. Compliance date: 2/21/25	

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	and the Maintenance Director to let them know the AED had not worked. She was unaware what staff member was responsible for maintaining the AED in working condition. During an interview, on 1/23/24 at 2:13 p.m., the DON indicated he was aware a battery had been ordered for the AED on 12/6/24, but it had not arrived yet. He was not aware who ordered the battery or the reason why the battery was ordered. He indicated he was not aware of the battery being dead until Unit Manager 16 told him on the night after the "Code Blue". He was not aware of what staff member was responsible for maintaining the AED in working condition. He removed the AED from the box attached to the wall on the 800 hallway on 1/21/25 since it was not in working order. There was not a facility policy related to the AED. The facility did not have a system or practice for routine monitoring and management of the AED. During an interview, on 1/23/25 at 2:22 p.m., the Administrator indicated she was made aware of the AED not working after the "Code Blue". She was aware the Maintenance Director ordered a battery every 6 months as a part of his duties. The battery was ordered on 12/6/24 but had not arrived. The facility did not have a system or practice for routine monitoring and management of the AED. During an interview, on 1/23/25 at 2:43 p.m., the Maintenance Director indicated he requested a battery for the AED every 6 months and had done this since he began working at the facility in 2013. The order is placed through Central Supply and was done on 12/6/24, but the battery had not arrived as it was on back order. He was not aware of which staff member was responsible for			

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	maintaining the AED in working condition. A current AED Owner's Manual, undated, provided by the DON on 1/22/25 at 4:06 p.m., indicated the following: "...The AED performs a self-test every day...As long as the green Ready light is blinking, it is not necessary to test... Checks are recommended after each use and periodic checks are limited to checking the green Ready light...Record each periodic check in your inspection log/maintenance booklet...The green Ready light is your guide to knowing the defibrillator is ready for use...If the Ready light is off and the device is emitting a series of single chirps, and the i-button is flashing: a self test has occurred, there is a problem with the pads or the battery power is low...If the Ready light is off and the device is not chirping and the i-button is not flashing: there is no battery inserted, the battery is depleted, or the device needs repair..." This citation relates to Complaint IN00451569. 3.1-19(bb)			