STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00442666, IN00442686, IN00442899, IN00446004, IN00446365, and IN00446377. Complaint IN00442666 - Federal deficiencies related to the allegations are cited at F812 and F921. Complaint IN00442686 - No deficiencies related to the allegations are cited. Complaint IN00442899 - Federal deficiencies related to the allegations are cited at F925. Complaint IN00446004 - Federal deficiencies related to the allegations are cited at F580. Complaint IN00446365 - No deficiencies related to the allegations are cited. Complaint IN00446377 - No deficiencies related to the allegations are cited. Survey dates: November 7, 8, 12, 13 and 14, 2024 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: Medicaid: Other: Total: 68 These deficiencies reflect State Findings cited in	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective December 14, 2024, for the complaint survey completed November14, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Chalman	Interim Administrator	12/13/2024

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	accordance with 410 IAC 16.2-3.1. Quality Review completed on 11/26/2024			
F 0580 SS=E Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify the physician timely of changes for blood glucose readings outside of the ordered parameters for 2 of 3 residents reviewed for insulin usage (Resident 30 & M), for 1 of 2 residents reviewed for death (Resident H) and for 1 of 3 residents reviewed for accidents (Resident 12). Findings include: 1. A record review for Resident 30 was completed on 11/12/2024 at 9:33 A.M. Diagnosis included, but were not limited to Diabetes Type 2, Hepatitis B, depression, anxiety, and dementia. Resident 30's Physician Orders included, but were not limited to: Humalog (a rapid acting) insulin- inject subcutaneous before meals per sliding scale of blood sugar results- if 250 to 500 give 6 units and if over 400 call the MD. Use Freestyle meter for blood sugar levels and call the MD if the result is less than 60 or over 400. Lantus (long acting) insulin pen - inject 20 units subcutaneously two times a day. A current Care Plan, dated 12/3/2024 and revised 5/16/2024, indicated Resident 30 had a diagnosis of Type 2 diabetes with interventions including but not limited to administer my medications as ordered by physician and blood sugar checks as ordered by physician.	F 0580	F 580 Notify of Changes **What corrective action will be accomplished for those residents found to be affected by the deficit practice:**The blood sugars for resident 30 and resident M were printed off to be reviewed by the medical provider and order changes made if indicated. The nurse practitioner was notified of the burn for resident 12 on 9/20/24 and the right arm pain on 11/8/24. Resident H no longer resides in the facility. **How other residents having the potential to be affected by the same deficit practice will be identified and what corrective action will be taken:**All residents who are on insulin with blood sugar parameters ordered or with a change of condition have the potential to be affected by the alleged deficient practice. The progress notes of all residents and the eMar of residents who have orders for blood sugar checks were reviewed to identify condition changes and blood sugar readings outside the established parameters and notification made to the medical provider if indicated. **What measures will be put into**	12/14/2024

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	The Medication Administration Record (MAR) dated October 2024 indicated Resident 30's blood glucose reading's on the following dates were: -10/07/2024 at 11:30 A.M. as 530 -10/07/2024 at 11:30 A.M. as 500 The MAR dated October 2024, lacked the documentation to show Resident 30 had received insulin on the following dates/times: 11:30 A.M. on 10/9/24, and 5:30 P.M. on 10/1, 10/6, 10/18, and 10/28/2024 The MAR dated November 2024 indicated Resident 30 blood glucose reading on 11/12/2024 at 8:00 P.M. was 450. The MAR dated October 2024, lacks the documentation to show Resident 30 had received insulin in the following dates/times: 11:30 A.M. on 11/1, 11/3, 11/4, and 11/10/2024 and at 5:30 P.M. on 11/1, 11/4, and 11/5/2024. During an interview, on 11/13/24 at 12:21 P.M., LPN 19 indicated when residents had a blood glucose out of range, they would notify the physician and make a progress note. If additional units were ordered they would put it in the note, but he would not write it as an order. The chart lacked documentation to show the physician was notified of the blood glucose readings over 400 and no documentation to show physician notification of missed insulin doses.2. A record review for Resident 12 was completed, on 11/12/2024 at 9:20 A.M. Diagnoses included, but were not limited to: hemiplegia affecting right dominant side, aphasia, contracture of right elbow, wrist and hand, dementia, right foot drop and polyneuropathy.		**place and what systematic changes will be made to ensure the deficit practice does not recur.**The policy and procedure for Acute Condition Changes – Clinical protocol was reviewed by the IDT. An in-service was provided to licensed nurses on immediate notification to the medical provider for blood sugar readings outside the established parameters or significant condition changes. Progress notes and charts of residents receiving blood sugar checks will be reviewed in the morning clinical meeting. A quality assurance audit tool has been developed to ensure medical provider notification has been completed for those residents whose blood sugars are outside of established parameters or experience a significant condition change. **How the corrective action will be monitored to ensure the deficit practice will not recur, i.e., what quality assurance program will be put into place.**The Quality Assurance Audit Tool will be completed by the Director of Nursing /Designee on all residents to identify condition changes and those with blood sugar checks for three weeks, then monthly for three months, then quarterly x three. In the event any further concerns are identified, the issue will be immediately corrected, and additional training will be initiated.	

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	A Quarterly Minimum Data Set (MDS) assessment, dated 10/17/2024, indicated Resident 12 was cognitively intact. She had impairment to the upper and lower extremity on one side and required set up or clean up assistance for dining services. A Nursing Progress Note, dated 9/19/2024 at 4:08 P.M., indicated the nurse entered Resident 12's room after a shower was completed where the certified nursing assistant (CNA) observed burns on both of Resident 12's inner thighs. Resident 12 indicated to the nurse that she had wheeled herself in her wheelchair to the nurse's station to get a cup of coffee and the CNA may have filled the cup too full. When Resident 12 placed the cup between her thighs to hold it while self-propelling her wheelchair, the coffee spilled from the opening at the top of the cup and burned her. Resident 12 indicated she did not tell anyone about the burn. A Nursing Progress Note, dated 9/19/2024 at 6:56 P.M., indicated Resident 12 had bilateral redness on both inner upper thighs with no blistering. Resident 12 indicated that the 1st degree burns happened over 48-hours ago and reported symptoms of itching and burning without pain. A Nursing Progress Note, dated 9/20/2024 at 8:06 A.M., indicated Resident 12's left thigh burn had a small scab in the center of the burn from Resident 12 itching the area and her brief rubbing the area. The redness of the bilateral upper thighs continued with the left side being about a fist size and the right side being the size of a quarter. A Nursing Progress Note, dated 9/20/2024 at 11:27 A.M., indicated measurements of the burns were obtained. The left thigh burn measured 3 centimeters by 5 centimeters with a scabbed		Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.Date this deficiency will be corrected: January 6, 2025	

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center of 2 centimeters by 0.25 centimeters. The right thigh burn measured 2 centimeters by 3 centimeters. Resident 12 denied any discomfort.

A Nurse Practitioner Note, dated 9/20/2024 at 11:30 A.M., indicated the Nurse Practitioner was notified of the burns to the bilateral, medial upper thighs. The Nurse Practitioner provided orders including, but not limited to: to gently wash the areas with cool water, pat dry, apply Silvadene cream twice daily and leave open to air for seven days.

During an interview, on 11/14/2024 at 9:16 A.M., the Director of Nursing (DON) indicated the physician and/or nurse practitioner should be notified immediately for any change of condition. The DON indicated he assessed the burns and contacted the nurse practitioner when he was informed on 9/19/2024 of the burns, but did not feel it was an emergency. He indicated there was no documentation in the medical record that this assessment or nurse practitioner contact had occurred timely.

During an interview, on 11/07/2024 at 10:07 A.M., Resident 12 indicated she had fallen and was pointing to her right arm.

During an observation on 11/13/2024 at 9:37 A.M., Resident 12 was observed with a sling to her right arm.

A Nursing Progress Note, dated 11/5/2024 at 3:38 P.M., indicated Resident 12 was observed to have gotten her wheelchair stuck and it started to tip. Resident 12 had her right side wedged between the over the bed table and bed with her weight against her. Resident 12's immobility to the right side, caused her not to be able to free herself and

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	because she struggled to free herself caused the wheelchair to tip and Resident 12 shifted out of the wheelchair. Resident 12 knocked over several personal items and a cup of coffee as she struggled to free herself. Resident 12 indicated she was not in pain, except for the usual pain in her right leg. Resident 12's right leg was observed to have bright red marks from being wedged. Resident 12 indicated she was fine and was more embarrassed than anything. A Nursing Progress Note, dated 11/8/2024 at 2:23 P.M., indicated Resident 12 was complaining of right arm pain. The nurse practitioner was notified, and an order was obtained for a stat (immediately) x-ray. A Nursing Progress Note, dated 11/8/2024 at 7:20 P.M., indicated the x-ray company was in the building to obtain the ordered images. A General Nurse Practitioner Note, dated 11/10/2024 at 8:39 P.M., indicated she had been informed by the DON of Resident 12's x-ray results obtained on 11/8/2024. The x-ray of the right humerus indicated an acute nondisplaced fracture of the proximal humeral metaphysis/nonsurgical humeral neck and severe diffuse osteopenia. A referral to orthopedics was provided. A General Nurse Practitioner Note, dated 11/10/2024 at 8:54 P.M., indicated she had received a call from the facility nurse reporting the results of the x-ray from 11/8/2024. A Nursing Progress Note, dated 11/11/2024 at 8:33 A.M., indicated Resident 12 was informed of the abnormal x-ray results.			

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	During an interview, on 11/14/2024 at 9:16 A.M., the Director of Nursing (DON) indicated the physician and/or nurse practitioner should have been notified immediately for any change of condition. 3. A record review for Resident H was completed on 11/12/2024 at 3:09 P.M. Diagnoses included, but were not limited to: hepatic encephalopathy, alcohol cirrhosis with ascites and severe sepsis with septic shock. An Admission Minimum Data Set (MDS) assessment, dated 10/2/2024, indicated Resident H was cognitively intact. A Nursing Progress Note, dated 10/26/2024 at 3:58 P.M., indicated Resident H was observed sitting on the floor next to the bed with a bowel movement on the floor. A Nursing Progress Note, dated 10/26/2024 at 7:15 P.M., indicated Resident H was found sitting on the floor with his head resting on the bed. Resident H was confused and unsure of his location. Resident H had an oxygen saturation of 64 percent on room air, a blood pressure of 81/40 mmHg (millimeters of mercury), a pulse of 100 beats per minute, and a respiration rate of 24 breaths per minute. The temperature was not able to be obtained. A Nursing Progress Note, dated 10/26/2024 at 7:30 P.M., indicated Resident H's oxygen saturation was 77 percent on three liters of oxygen per minute via nasal cannula. A Nursing Progress Note, dated 10/26/2024 at 8:00 P.M., indicated Resident H had an oxygen saturation of 92 percent on three liters of oxygen			

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	per minute via nasal cannula, a blood pressure of 97/52 mmHg, a pulse rate of 62 beats per minute, and a respiration rate of 24 breaths per minute. A respiratory treatment was completed keeping the mouthpiece close to the mouth, but Resident H would move the mouthpiece away from his mouth. A Nursing Progress Note, dated 10/26/2024 at 8:30 P.M., indicated Resident H had vital signs of the following: oxygen saturation of 95 percent on three liters of oxygen per minute via nasal cannula, a blood pressure of 100/62 mmHg, a pulse of 66 beats per minute, and a respiration rate of 24 breaths per minute. A Nursing Progress Note, dated 10/26/2024 at 9:00 P.M., indicated Resident H continued resting in bed with no problems noted or voiced. A Nursing Progress Note, dated 10/26/2024 at 9:30P.M., indicated Resident H had a temperature of 100.2 F (Fahrenheit) and oxygen saturations of 63 percent on three liters of oxygen per minute via nasal cannula. The oxygen was increased to four liters per minute and his oxygen saturations increased to 70 percent. Resident H was restless, continued not to be able to know his location with the confusion continuing. A Nursing Progress Note, dated 10/26/2024 at 9:44 P.M., indicated Resident H's oxygen saturation was 77 percent on four liters of oxygen per minute via nasal cannula. The oxygen was increased to five liters per minute. A Nursing Progress Note, dated 10/26/2024 at 9:47 P.M., indicated Resident H had an oxygen saturation of 75 percent on five liters of oxygen per minute via nasal cannula and his breath sounds had wheezing anteriorly and posteriorly.			

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	A Nursing Progress Note, dated 10/26/2024 at 9:51 P.M., indicated the nurse practitioner was called. During an interview, on 11/14/2024 at 9:55 A.M., the Director of Nursing indicated the nurse practitioner should have been contacted sooner for the change of condition. 4. A record review for Resident M was completed on 11/12/24 at 11:23 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 and vascular dementia. An Annual Minimum Data Set (MDS) assessment, dated 9/11/2024, indicated Resident M had a severe cognitive deficit and received insulin. A Physician's Order, dated 1/26/2024, indicated glargine solution 100 units per milliliter, inject 18 units subcutaneously at bedtime and notify the physician/nurse practitioner of a blood sugar greater than 500 mg/dL (milligram per deciliter) or less than 60 mg/dL. A Physician's Order, dated 9/30/2024, indicated to obtain a blood sugar daily to notify the medical provider for a blood sugar greater than 400 mg/dL or less than 70 mg/dL. The following blood sugars were documented in the medical record: -11/8/2024 5:24 P.M. 490.0 mg/dL -11/6/2024 8:13 P.M. 452.0 mg/dL -11/2/2024 7:52 P.M. 591.0 mg/dL -10/30/2024 7:46 P.M. 467.0 mg/dL -10/24/2024 10:19 P.M. 435.0 mg/dL -10/20/2024 9:10 P.M. 500.0 mg/dL -10/20/2024 8:11 P.M. 500.0 mg/dL -10/17/2024 4:44 P.M. 438.0 mg/dL			

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	-10/16/2024 7:18 P.M. 478.0 mg/dL -10/16/2024 5:14 P.M. 457.0 mg/dL -10/15/2024 8:41 P.M. 430.0 mg/dL -10/14/2024 8:39 P.M. 432.0 mg/dL -10/13/2024 8:10 P.M. 495.0 mg/dL -10/13/2024 4:38 P.M. 442.0 mg/dL -10/12/2024 11:41 A.M. 448.0 mg/dL -10/11/2024 11:32 A.M. 419.0 mg/dL -10/10/2024 9:23 P.M. 404.0 mg/dL -10/10/2024 5:09 P.M. 466.0 mg/dL -10/9/2024 4:40 P.M. 401.0 mg/dL -10/7/2024 12:13 462.0 mg/dL -10/3/2024 22:58 403.0 mg/dL -10/3/2024 19:40 403.0 mg/dL The medical record did not have documentation of the physician and/or nurse practitioner being notified of the blood sugars out of the ordered range. During an interview, on 11/14/2024 at 9:45 A.M., the Director of Nursing indicated notification of out-of-range blood sugars would be individualized to the resident to when notification of the physician/nurse practitioner would occur. He indicated if parameters were not provided, the general notification parameters were to notify the physician/nurse practitioner when a blood sugar was below 70 mg/dL and above 401 mg/dL. The Director of Nursing indicated the staff should be notifying the physician/nurse practitioner when the blood sugars were outside of the ordered range. A current policy was provided on 11/14/2024 at 10:30 A.M., by the Quality Assurance Administrator. The policy, titled, "Acute Condition Changes-Clinical Protocol", indicated, " ...Assessment and Recognition 8. The nursing staff will contact the physician on urgency of the situation. For emergencies, they will call or page			

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	the physician and request a prompt response [within approximately one-half hour or less] ...." This citation relates to complaint IN00446004. 3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on record review and interview, the facility failed to ensure pertinent transfer and resident clinical information was completed for neccessary hospital transfers for 1 of 4 residents reviewed for hospitalization. (Resident B) Finding includes: A record review for Resident B was completed on 11/08/2024 at 2:32 P.M. Diagnosis included but were not limited to Cerebral Palsy, hydronephrosis, urogenital implants, and obstructive and reflux uropathy. A Nursing Progress Note, dated 6/19/24 at 11:45 A.M., indicated Resident B had returned from the hospital. There was no documentation a physician's order was obtained prior to Resident B's transfer to the hospital. In addition, there was no documentation a transfer/discharge form or bed hold policy was provided to the resident and/or their representative for this transfer. A Nursing Progress Note, dated 8/16/2024 at 12:00 A.M., indicated Resident B was transferred to a local hospital for back and abdominal pain.	F 0622	*F 622 Transfer and Discharge Requirements* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Corrective action is unable to be completed for resident B for previous noncompliance. Resident Bs physician was notified that physicians orders were not put into the electronic medical record for the previous transfers **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who are transferred to the hospital have the potential to be affected. The SSD/designee will complete an audit of residents who were transferred to the hospital in the last 30 days to ensure that the resident and/or	12/14/2024

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	The chart lacked a physician's order to send Resident B to the hospital and there was no documentation that a transfer/discharge form or bed hold policy was provided by the facility to the resident and/or their representative for this transfer. A Nursing Progress Note, dated 11/4/2024 at 09:59 A.M., indicated resident B was on a LOA (Leave of Absence) for surgery. The chart lacked documentation to show a transfer/discharge form and bed hold policy was provided by the facility to the resident and/or their representative for this transfer. During an interview, on 11/13/2024 at 09:31 A.M., LPN 20 indicated they have a checklist of all the things they were to do when they sent someone to the hospital, including but not limited to: sending the transfer/discharge form, a bed hold, and documenting the transfer in a nursing progress note. LPN 20 indicated they do not write a physician's order to send someone to the hospital. During an interview, on 11/13/2024 at 10:00 A.M., LPN 19 indicated the nurses had a checklist of things to do for a transfer that two nurses were supposed to sign once completed. This checklist included the following: transfer/discharge form, bed hold policy, and documenting a nursing progress note. LPN 19 indicated the Nurse's Note should include clinical information, physician notification and a physician's order to send the resident to the hospital had been obtained. During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated		responsible parties have been provided with a notice of transfer/discharge and a bed hold policy. Notices will be sent to those who did not receive these notices. The DON/designee will complete an audit of residents transferred to the hospital x's last 30 days to ensure a physician's order was obtained. The physician will be notified if an order was not obtained. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed nursing staff on the requirement to obtain a physicians order and put the order into the electronic medical record to send to the ER. The DON/designee will provide education to licensed nursing staff and the SSD on the requirement to provide a notice of transfer/discharge and a bed hold policy to the resident and/or responsible party for transfers to the hospital. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing of acute	

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	she could not provide any further transfer/discharge forms for Resident B. 3.1-12(a)(6)(A)		transfers to ensure that a physician's order was obtained and out into the electronic medical record, as well ensuring a notice of transfer/discharge and bed hold policy was provided to the resident and/or responsible party for acute transfers to the hospital. Auditing to occur: with each hospital transfer x's 4 wks, then 4 residents monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure a transfer/discharge form was provided for 4 of 4 residents reviewed for hospitalization. (Residents B, 52, 55, 69) Findings include: 1. A record review for Resident B was completed on 11/08/2024 at 2:32 P.M. Diagnosis included but	F 0623	**F623 Notice Requirements before Transfer/Discharge** ***What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***	12/14/2024

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	were not limited to cerebral palsy, hydronephrosis, urogenital implants, and obstructive and reflux uropathy. A Nursing Progress Note, dated 6/19/24 at 11:45 A.M., indicated Resident B had returned from the hospital. The chart lacked documentation a transfer/discharge form was provided by the facility to the resident and/or the resident's representative for this transfer. In addition, the Ombudsman was not notified of the resident's transfer. A Nursing Progress note, dated 8/16/2024 at 12:00 A.M., indicated that Resident B was transferred to a local hospital for back and abdominal pain. The chart lacked documentation a transfer/discharge form was provided by the facility to the resident and/or the resident's representative for this transfer. In addition, the Ombudsman was not notified of the resident's transfer. A Nursing Progress Note, dated 11/4/2024 at 09:59 A.M., indicated resident B was out for a LOA (Leave of Absence) for surgery. The chart lacked documentation a transfer/discharge form was provided by the facility to the resident and/or the resident's representative for this transfer. In addition, the Ombudsman was not notified of the resident's transfer. During an interview, on 11/13/2024 at 09:31 A.M., LPN 20 indicated they have a checklist of all the things they are to do when they send someone to		Resident's B, 52, 55, 69 had no adverse effects from alleged deficient practice. Resident 69 no longer resides in the facility. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** All residents residing in the health care area have the potential to be affected by this alleged deficiency. DON or designee will review all resident with a discharge from the facility to ensure notification of the Ombudsman was completed on a monthly basis. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** DON or designee will re-educate the Social Services Director on the following campus guideline: SOP Notice of transfer or discharge communication to ombudsman ***How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place?***	

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	the hospital, including but not limited to: sending the transfer/discharge form and documenting a nursing note. During an interview, on 11/13/2024 at 10:00 A.M., LPN 19 indicated the nurses have a checklist of things to do for a transfer that two nurses were supposed to sign once completed, this included but was not limited to: sending the transfer/discharge form and documenting a nursing note. During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated she could not find any further Transfer/discharge forms in the building for Resident B. During an interview, on 11/14/2024 at 1:10 P.M. with the Social Worker, regarding documentation provided for Ombudsman notification of resident transfers for the months of June and August 2024, she indicated Resident B was not on the list provided to the Ombudsman. 2. A record review for Resident 52 was completed on 11/12/2024 at 1:56 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease (COPD), pneumonia and acute respiratory failure. A Quarterly Minimum Data Set (MDS) assessment, dated 9/17/2024, indicated Resident 52 was cognitively intact. A Nursing Progress Note, on 5/27/2024 at 4:05 A.M., indicated at 2:45 A.M. Resident 52 requested her lung sounds to be evaluated. Resident 52's lung sounds had scattered wheezing posteriorly and expiratory wheezing anteriorly. Resident 52 refused a nebulizer treatment or an as needed inhalation medication. Resident 52		The Administrator or designee will complete weekly auditing of ombudsman notification of transfer/discharge x's 1 month, then monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	indicated she felt she had bronchitis and needed an antibiotic. Staff offered for hospice to be called for further instruction. Resident 52 decided to call the Emergency Medical Services for transfer. A Nursing Progress Note, on 7/25/2024 at 8:10 P.M., indicated Resident 52 called emergency services and was transfered to the hospital. The nurse notified hospice services of Resident 52's transfer to the hospital. A Nursing Progress Note, on 9/26/2024 at 11:01 A.M., indicated Resident 52 requested to be sent to the hospital. The medical record lacked any of Resident 52's transfer forms from the facility. During an interview, on 11/13/2024 at 10:29 A.M., the Quality Assurance Administrator produced a stack of un-scanned medical records to review for transfer and discharge forms. After the stack was reviewed, the Quality Assurance Administrator indicated she did not think they had any of the transfer and/or discharge forms. During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated she could not find any further transfer and discharge forms after looking for the forms the prior day. She indicated Resident 52 should have had a transfer and discharge form completed. 3. A record review for Resident 55 was completed on 11/12/2024 at 10:18 A.M. Diagnoses included, but were not limited to: congestive heart failure and pneumonia. A Nursing Progress Note, on 8/17/2024 at 7:12 A.M., indicated Resident 55 was sitting on the			

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	edge of the bed with shortness of breath, diminished lung sounds, a blood pressure of 175/119 mmHg (millimeters of mercury) and a pulse of 133 beats per minute. There was no documentation that Resident 55 was transferred to the hospital. However, a Nursing Progress Note, on 8/20/2024 at 2:40 A.M., indicated Resident 55 was readmitted to the facility after a brief hospital stay for heart failure, shortness of breath and elevated troponin. The medical record lacked documentation a transfer/discharge form was provided by the facility to the resident and/or the resident's representative. During an interview, on 11/13/2024 at 10:29 A.M., the Quality Assurance Administrator produced a stack of un-scanned medical records to review for transfer and discharge forms. After the stack was reviewed, the Quality Assurance Administrator indicated she did not think they had the transfer and discharge forms for Resident 55. During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated she could not find any further transfer and discharge forms after looking for the forms the prior day. She indicated Resident 55 should have had a transfer and discharge form completed. 4. A record review for Resident 69 was completed on 11/12/2024 3:55 P.M. Diagnoses included, but were not limited to: chronic pancreatitis, atrial fibrillation and acute cholecystitis. A Nursing Progress Note, on 9/16/2024 at 6:05 P.M., indicated Resident 69 was observed to be drowsy and disoriented. Resident 69's blood			

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	pressure was 86/54 mmHg, pulse was 130 beats per minute, oxygen saturation was 88 percent and respirations were 18 breaths per minute. Resident 69 was transferred to the hospital via an ambulance. A Nursisng Progress Note, dated 9/16/2024 at 8:57 P.M., indicated Resident 69 returned to the facility. A Nursing Progress Note, on 9/21/2024 at 11:41 A.M., indicated the nurse was notified of Resident 69's skin coloring was not within normal limits. Resident 69 was pale; her demeanor was abnormal, and her oxygen saturations were 82 percent on room air. The nurse practitioner was notified and Resident 69 decided to be transferred to the hospital. A Nursing Progress Note, on 9/24/2024 at 8:22 A.M., indicated Resident 69 would not be returning to the facility. The medical record lacked documentation a transfer/discharge form was provided by the facility to the resident and/or the resident representative. During an interview, on 11/13/2024 at 10:29 A.M., the Quality Assurance Administrator produced a stack of un-scanned medical records to review for transfer and discharge forms. After the stack was reviewed, the Quality Assurance Administrator indicated she did not think they had the transfer and discharge forms for Resident 69. During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated she could not find any further transfer and discharge forms after looking for the forms the			

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	prior day. She indicated Resident 69 should have had a transfer and discharge form completed. A current policy was provided by the Quality Assurance Administrator, on 11/14/2024 at 1:54 P.M. The policy, titled, "Transfer or Discharge, Facility-Initiated", indicated, " ...Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy ...Notice of Transfer or Discharge [Emergent of Therapeutic Leave] 3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: c. An immediate transfer or discharge is required by the resident's urgent medical needs ...." 3.1-12(a)(6)(i)			
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record reviews and interview, the facility failed to provide a bed hold form for 4 of 4 residents reviewed for hospitalizations. (Resident 52, 55, 69 & B) Findings include: 1. A record review for Resident 52 was completed on 11/12/2024 at 1:56 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease (COPD), pneumonia and acute respiratory failure. A Quarterly Minimum Data Set (MDS) assessment, dated 9/17/2024, indicated Resident	F 0625	*F 625 Notice of Bed Hold Policy Before/Upon Transfer* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The SSD/designee will provide bed hold forms to the resident/resident responsible party for Residents 52, 55, 69, and B for the date of transfers listed on this statement of deficiencies. **How other residents have the potential to be affected by the**	12/14/2024

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	52 was cognitively intact. A Nursing Progress Note, on 5/27/2024 at 4:05 A.M., indicated at 2:45 A.M. Resident 52 requested her lung sounds to be evaluated. Resident 52's lung sounds had scattered wheezing posteriorly and expiratory wheezing anteriorly. Resident 52 refused a nebulizer treatment or an as needed inhalation medication. Resident 52 indicated she felt she had bronchitis and needed an antibiotic and was offered for hospice to be called for further instruction. Resident 52 decided to emergency services for transfer and the nurse gathered Resident 52's transfer paperwork. A Nursing Progress Note, on 7/25/2024 at 8:10 P.M., indicated Resident 52 passed the nursing station in her wheelchair, went to her room with several other residents and called emergency services for transportation to the hospital. The nurse completed an assessment and notified hospice services of Resident 52's transfer from the facility. A Nursing Progress Note, on 9/26/2024 at 11:01 A.M., indicated Resident 52 requested to be sent to the hospital for not taking her medications or nourishment for four days. Resident 52 signed the revocation of hospice care. The chart lacked documentation a bed hold policy was provided by the facility. During an interview, on 11/13/2024 at 10:29 A.M., the Quality Assurance Administrator produced a stack of un-scanned medical records to review for bed hold forms. After the stack was reviewed, the Quality Assurance Administrator indicated she did not think the facility had the bed hold forms. During an interview, on 11/14/2024 at 8:55 A.M.,		**same deficient practice will be identified and what corrective actions will be taken?** Other residents who have been transferred to the hospital have the potential to be affected. The DON/designee will complete an audit of the hospital transfers in the last 30 days to ensure bed hold forms were provided to the resident and/or responsible parties. Any findings will be addressed by providing those forms. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed nursing staff on the requirement to provide bed hold forms upon hospital transfers to the resident and/or responsible party and maintain a copy of the bed hold form. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing of residents who are transferred to the hospital to ensure a bed hold form was provided to the resident and/or responsible party with a	

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	the Quality Assurance Administrator indicated she could not find any further forms after looking for bed hold the forms the prior day. She indicated Resident 52 should have had a bed form completed. 2. A record review for Resident 55 was completed on 11/12/2024 at 10:18 A.M. Diagnoses included, but were not limited to: congestive heart failure and pneumonia. An Annual Minimum Data Set (MDS) assessment, dated 8/28/2024, indicated Resident 55 was cognitively intact. A Nursing Progress Note, on 8/17/2024 at 7:12 A.M., indicated Resident 55 was sitting on the edge of the bed with shortness of breath, diminished lung sounds, a blood pressure of 175/119 mmHg (millimeters of mercury) and a pulse of 133 beats per minute. A Nursing Progress Note, on 8/20/2024 at 2:40 A.M., indicated Resident 55 was readmitted to the facility after a brief hospital stay for heart failure, shortness of breath and elevated troponin. The chart lacked documentation a bed hold policy was provided by the facility. During an interview, on 11/13/2024 at 10:29 A.M., the Quality Assurance Administrator produced a stack of un-scanned medical records to review for bed hold forms. After the stack was reviewed, the Quality Assurance Administrator indicated she did not think the facility had the bed hold forms. During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated she could not find any further bed hold forms		copy of the form maintained in the residents medical record. Auditing to occur after each hospital transfer x's 4 wks, then 4 resident hospital transfers wkly x's 4 wks, then 4 resident transfers monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	

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	after looking for the forms the prior day. She indicated Resident 55 should have had a bed hold form completed. 3. A record review for Resident 69 was completed on 11/12/2024 3:55 P.M. Diagnoses included, but were not limited to: chronic pancreatitis, atrial fibrillation and acute cholecystitis. An Admission Minimum Data Set (MDS) assessment, dated 9/9/2024, indicated Resident 69 was cognitively intact. A Nursing Progress Note, on 9/16/2024 at 6:05 P.M., indicated Resident 69 was observed to be drowsy and disoriented. Resident 69's blood pressure was 86/54 mmHg, pulse was 130 beats per minute, oxygen saturation was 88 percent and respirations were 18 breaths per minute. Resident 69 was transferred to the hospital via an ambulance. A Nursing Progress Note, on 9/21/2024 at 11:41 A.M., indicated the nurse was notified of Resident 69's skin coloring was not within normal limits. Resident 69 was pale; her demeanor was abnormal, and her oxygen saturations were 82 percent on room air. The nurse practitioner was notified and Resident 69 decided to be transferred to the hospital. A Nursing Progress Note, on 9/24/2024 at 8:22 A.M., indicated Resident 69 would not be returning to the facility. The chart lacked documentation a bed hold policy was provided by the facility. During an interview, on 11/13/2024 at 10:29 A.M., the Quality Assurance Administrator produced a			

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	stack of un-scanned medical records to review for bed hold forms. After the stack was reviewed, the Quality Assurance Administrator indicated she did not think the facility had the bed hold forms. During an interview, on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated she could not find any further bed hold forms after looking for the forms the prior day. She indicated Resident 69 should have had a bed hold form completed. 4. A record review for Resident B was completed on 11/08/2024 at 2:32 P.M. Diagnosis included but were not limited to cerebral palsy, hydronephrosis, urogenital implants, and obstructive and reflux uropathy. A Nursing Progress Note, dated 6/19/24 at 11:45 A.M., indicated Resident B had returned from the hospital. The chart lacked documentation a bed hold was provided by the facility to the resident and/or resident representative for this transfer. A Nursing Progress Note, dated 8/16/2024 at 12:00 A.M., indicated that Resident B was transferred to a local hospital for back and abdominal pain. The chart lacked documentation a bed hold was provided by the facility to the resident and/or resident representative for this transfer. A Nursing Progress Note, dated 11/4/2024 at 09:59 A.M., indicated resident B was out for a LOA (Leave of Absence) for surgery. The chart lacked documentation a bed hold was provided by the facility to the resident and/or resident representative for this transfer.			

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	During an interview, on 11/13/2024 at 09:31 A.M., LPN 20 indicated they have a checklist of all the things they are to do when they send someone to the hospital, including but not limited to: sending the bed hold and documenting a nursing note. During an interview, on 11/13/2024 at 10:00 A.M., LPN 19 indicated the nurses have a checklist of things to do for a transfer that two nurses were supposed to sign once completed, this included but was not limited to the bed hold and making a nursing progress note. During an interview on 11/14/2024 at 8:55 A.M., the Quality Assurance Administrator indicated she could not provide any further bed hold forms for Residnet B. A policy was provided by the Quality Assurance Administrator, on 11/14/24 at 1:54 P.M. The policy titled, "Bed-Hold Policy", indicated, " ...Before transferring a resident to a hospital, or allowing a Resident to go on therapeutic leave of absence, the Resident, family member, or Resident Representative will be notified in writing of this Resident Bed-Hold Policy ...." 3.1-12(a)(26)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, record review and interviews, the facility failed to develop a comprehensive person-centered care plan for activities (Resident 54) and medication use (Resident 64) for 2 of 27 residents reviewed for care plans (Resident E) .	F 0656	***F 656 Develop/Implement Comprehensive Care Plan*** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	12/14/2024

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	Findings include: 1. During an observation, on 11/8/2024 at 9:45 A.M., Resident 54 was not observed in the morning reading activity. During an observation, on 11/8/2024, at 2:20 P.M., Resident 54 was observed walking in the activity room of the Dementia Unit and was non-responsive to questions from facility staff. Resident 54 was resistant to sit in the activity room despite staff encouragement and walked out of activity room. During an observation, on 11/12/2024, at 10:21 A.M., Resident 54 walked by the nursing station but was able to be re-directed to sit in a chair located in front of the nursing station intermittently. The record review for Resident 54 was completed on 11/12/2024 at 11:19 A.M. Diagnosis included, but were not limited to: Alzheimer's disease, dementia, anxiety, depression, unsteadiness on feet, hallucinations and hypertension. A Quarterly Minimum Data Set (MDS) assessment, dated 10/1/2024, indicated the resident had short and long-term memory issues. The MDS indicated Resident 54 had no indicators of hallucinations or delusions but had had physical behaviors towards others and other behavioral symptoms not directed towards others. Resident 54 required supervision with eating, footwear and upper body dressing, partial assistance with oral hygiene, lower body dressing, personal hygiene and showering/bathing and required substantial assistance with toileting. The MDS indicated the resident received hospice services. A Significant		The Activity Director/designee will contact the family of Resident 54 to determine known activity references and the plan of care will be updated to reflect those preferences. The SSD/designee will update Resident Es care plan to include psychotropic drug use Resident 64 is not in the findings. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who want to participate in activities have the potential to be affected Residents who have orders for psychotropic medications have the potential to be affected The Activity Director will complete resident interviews to ensure that their activity preferences are included in their plan of care. The SSD/designee will audit current residents who have orders for psychotropic medications have a plan of care in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee will provide education to the Activity Director on the requirement that residents have activity preferences in their	

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	Change MDS, dated 7/10/2024, indicated Resident 54 was non-responsive and gave no responses to activity preference questions. The record lacked a person-centered care plan for Resident 54's activity preferences. During an interview, on 11/14/2024, at 9:10 A.M., the Activities Director (AD) indicated the activity care plans were completed by the AD upon admission and quarterly. The AD indicated all the residents should have an activity care plan. During an interview, on 11/14/2024, at 9:12 A.M., the Social Services Director (SSD) indicated the initial care plans were completed by the admitting resident's nurse but otherwise most care plans sections were updated and created by the Minimum Data Set (MDS) nurse. 2. A record review for Resident E was completed on 11/12/2024 at 10:59 A.M. Diagnoses included, but were not limited to: encephalopathy, diabetes, anxiety, and depression. An Admission Minimum Data Set (MDS) assessment, dated 9/20/2024, indicated the resident received antipsychotic and antidepressant medications. Current Physician's Orders included: Risperdal (antipsychotic medication) 2 mg (milligram) give 2 mg by mouth two times a day. Sertraline (antidepressant medication) 50 mg give 1 tablet by mouth one time a day related to depression. There were no care plans for Residenty E regarding the use of the antipsychotic and antidepressant medications. During an interview, on 11/13/2024 at 9:43 A.M.,		care plan. DON/designee will provide education to the SSD on the requirement that residents who have orders for psychotropic medications have a care plan in place. The Activity Director/designee will be responsible for ensuring newly admitted residents have been interviewed for activity preferences and that their plan of care reflect those preferences. Care plans will be reviewed quarterly during the quarterly care plan meeting and any changes in preferences will be updated in the plan of care. The SSD/designee will be responsible for ensuring newly admitted residents who have orders for psychotropic medications as well as new orders for psychotropics have a care plan in place to reflect residents needs and concerns. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing to ensure activity preference care plans are in place and remain current. Auditing to occur: 4 random residents wkly x's 4 wks, 4 random residents monthly x's 5 months for a total of 6 months of	

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	the Social Service Director indicated the resident should have care plans for the use of the antipsychotic and antidepressant medications. On 11/14/2024 at 9:10 A.M., the Corporate Assurance Administrator provided the policy titled, "Care Plans, Comprehensive Person-Centered", with a revision date of 9/2022, and indicated the policy was the one currently used by the facility. The policy indicated"... 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident...8. The comprehensive, person-centered care plan will... c. Describes services that would otherwise be provided for the above... h. Incorporate identified problem areas; i. Incorporate risk factors associated with identified problems... m. Identify the professional services that are responsible for each element of care...." 3.1-35(a)		monitoring. Any findings will be addressed. The DON/designee will complete routine auditing to ensure that residents who have orders for psychotropics have updated care plans in place. Auditing to occur: 4 random residents wkly x's 4 wks, 4 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Any findings of non-compliance identified through the auditing process will be addressed re-education, increase of frequency and/or duration of auditing until full compliance achieved.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on interview, record review and interview, the facility failed to ensure showers were provided for 3 of 7 residents reviewed for ADL's (Activities of Daily Living). (Residents 53, E & F) Findings include: 1. During an interview, on 11/7/2024 at 10:54 A.M., Resident 53 indicated "Sometimes I don't get any	F 0677	*F 677 ADL Care Provided for Dependent Residents* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 53 was offered a shower by certified nursing staff	12/14/2024

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	showers for 2 weeks." A record review for Resident 53 was completed on 11/12/2024 at 10:26 A.M. Diagnoses included, but were not limited to: chronic kidney disease, obesity, lymphedema, depression, and diarrhea. An Annual Minimum Date Set (MDS) assessment, dated 10/23/2024, indicated Resident 53 required substantial to maximum assistance for transfers, bathing and showering, was occasionally incontinent of bladder and frequently incontinent of bowels. A current Care Plan, initiated on 12/19/2023, indicated: The resident has an ADL Self Care performance deficit related to impaired mobility and recent hospital stay. BATHING: The resident is totally dependent on staff to provide a bath/Shower weekly and as necessary. ADL-Bathing shower/bed bath on Wednesday and Saturday after breakfast. A Skin/Wound note, dated 9/11/2024 at 5:20 P.M., indicated the physician saw the resident. The resident was to take showers via a shower bed. The Wound Nurse was to wash the resident's legs while the aide gave him a bath, on Wednesday morning after breakfast. The September shower Documentation Survey Report sheet indicated the resident had received the following: -a bed bath on 9/7. -a shower on 9/18. -a bed bath on 9/21. The October shower Documentation Survey Report sheet indicated the residents had received the following:		during the survey process on 11/7/24 and declined. He has a care plan in place for refusals to take showers and a preference for bed baths. The DON/designee will review resident bathing preferences to ensure the schedule reflects those preferences and are scheduled in the electronic medical record accordingly to ensure Resident E & F preferences are being met. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected The DON/designee will review current residents bathing preferences to ensure the schedule reflects those preferences and are scheduled in the electronic medical record accordingly **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to nursing associates on the requirements that bathing type and frequency be completed according to resident preference as per the bathing schedule. Refusals are to be documented.	

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	- a shower on 10/1 - a bed bath on 10/6 - a bed bath on 10/12 - a bed bath on 10/20 - a bed bath on 10/24/24. The November shower Documentation Survey Report sheet, indicated no showers/bed baths had been documented from 11/1 through 11/14/2024. During an interview, on 11/13/2024 at 10:06 A.M., CNA 16 indicated the resident should have had his showers every 2 days after breakfast. During an interview, on 11/13/2024 at 1:58 P.M., the Director of Nursing indicated the staff do not write out shower sheets anymore, all the showers were logged in the computer. 2. During an interview, on 11/8/2024 at 11:05 A.M., Resident E indicated she only received an occasional shower. A record review for Resident E was completed on 11/12/2024 at 10:59 A.M. Diagnoses included, but were not limited to encephalopathy, diabetes, anxiety, and depression. An Admission Minimum Data Set (MDS) assessment, dated 9/20/2024, indicated the resident was always incontinent of bladder and bowels, required partial to moderate assistance with showing and substantial assistance for transfers. The November shower Documentation Survey Report sheet indicated Resident E was to receive a shower/bed bath on Mondays and Thursdays.		Newly admitted residents will be interviewed to determine bathing preference as to type and frequency. The bathing schedule will be updated to reflect those preferences **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing to ensure that bathing is being completed and documented per the bathing schedule. Auditing to occur: 4 random residents daily x's 4 wks, then 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	

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	Resident E received the following: -a shower on 10/4/2024. During an interview, on 11/13/2024 at 10:39 A.M., CNA 17 indicated she should have had showers twice a week. During an interview, on 11/13/2024 at 1:58 P.M., the Director of Nursing indicated the staff do not write out shower sheets anymore, all the showers were to be logged in the computer. During an interview, on 11/13/2024 at 2:49 P.M. the Unit manager indicated the resident was not listed on the shower schedule and should have been. 3. During an interview, on 11/07/2024 at 10:19 A.M., Resident G indicated he was "supposed to get 2 showers a week at 5:00 A.M." A record review was completed for Resident G on 11/12/2024 at 9:21 A.M. Diagnoses included, but were not limited to diabetes, osteoarthritis of the left hip, and obesity. A Quarterly Minimum Data Set (MDS) assessment, dated 10/16/2024, indicated the resident was able to make his own decisions and required supervision of one staff for showering. A current Care Plan, initiated on 3/15/2021, indicated Resident G required assistance with adl's due to pain and arthritis of the left hip. Interventions included, but were not limited to, extensive assistance of one staff. Resident G's preference was to have showers at 5:00 A.M., on his scheduled day with help from staff. The September shower Documentation Survey			

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	Report sheet indicated Resident G had received the following: -a shower on 9/5/2024. The October shower Documentation Survey Report sheet indicated Resident G had received the following: -a shower on 10/1. -a shower on 10/7. -a shower on 10/18. -a bed bath on 10/20/2024 The November shower Documentation Survey Report sheet indicated Resident G had received the following: -a shower on 11/5 -a shower on 11/12/2024 A current Physician's Order, dated 11/25/2023, indicated showers were to be done at 5:00 A.M. on Tuesday and Friday mornings per the resident's choice. During an interview, on 11/13/2024 at 10:15 A.M., CNA 17 indicated the resident should get his showers twice a week per the shower schedule. During an interview, on 11/13/24 at 1:58 PM the Director of Nursing indicated the staff do not complete shower sheets anymore, all the showers were logged in the computer. During an interview, on 11/13/2024 at 2:49 P.M. the Unit manager indicated the resident was not listed on the shower schedule and should have been. On 11/14 2024 at 9:10 A.M., the Corporate Assurance Administrator provided the policy titled, "Shower/Bathing Policy", with a revised			

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	date of 8/2018, and indicated the policy was the one currently use by the facility. The policy indicated "...Resident preferences will be considered, and shower/bath/bed bath shell be provided at least weekly...If the resident refuses a shower, a bed bath will be offered and provided as per the residents' preference...." 3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview and record review, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well-being for 1 of 4 residents reviewed for activities (Resident 54). Finding includes: During an observation, on 11/8/2024 at 9:45 A.M., Resident 54 was not observed in the morning reading activity. During an observation, on 11/8/2024, at 2:20 P.M., Resident 54 was observed walking in the activity room of the Dementia Unit and was non-responsive to questions from facility staff. Resident 54 was resistant to sit down in the activity room despite staff encouragement and walked out of activity room. During an observation, on 11/12/2024, at 10:21 A.M., Resident 54 walked by the nursing station but was able to be re-directed to sit down intermittently. The record review for Resident 54 was completed	F 0679	*F 679 Activities Meet Interests/Needs of Residents* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A new activity assessment was completed for Resident 54. Activities will be offered based on that assessment. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected An updated activity assessment will be completed for all residents on Unit 400 to assure activities of interest are offered **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	12/14/2024

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	on 11/12/2024 at 11:19 A.M. Diagnosis included, but were not limited to: Alzheimer's disease, dementia, anxiety, depression, unsteadiness on feet, hallucinations and hypertension. A Quarterly Minimum Data Set (MDS)assessment , dated 10/1/2024, indicated the resident had short and long-term memory issues, had no indicators of hallucinations or delusions but had had physical behaviors towards others and other behavioral symptoms not directed towards others. The resident also required supervision with eating, footwear and upper body dressing, partial assistance with oral hygiene, lower body dressing, personal hygiene and showering/bathing and substantial assistance with toileting. A Significant Change MDS, dated 7/10/2024, indicated Resident 54 was non-responsive and gave no responses to activity preference questions. There was no care plan to address Resident 54's activity preferences and needs. In addition, there was no documentation Resident 54 had attended any group or individual activities from October 30 through November 9. During an interview, on 11/14/2024, at 9:38 A.M., the AD indicated all activity attendance and participation by each resident was documented in the electronic medical record (EMR). During an interview, on 11/14/2024, at 10:55 A.M., CNA 7 indicated unit activities were scheduled from early morning through early evening when the activity assistant went home. She indicated staff tried to get all residents to attend activities, if the residents were willing. On 11/14/2024 at 1:35 P.M., the DON provided a		**practice does not recur?** Memory Care Director/Activity Director will review interests of residents quarterly and schedule activities according to those interests. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Admin/designee will complete routine auditing to ensure activities of interest are being offered to residents. Auditing to occur: 4 random residents daily x's 4 wks, then 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	

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	policy titled, "Activity Evaluation," dated May 2013 and indicated the policy was the one currently used by the facility. The policyt indicated "...allow the resident to participate in activities of his/her choice and interest..." There was no policy to indicate an comprehensive activity assessment of each resident's past and current activity interests and an individualized care plan for activities were completed in regards to providing an individualized activity program. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to ensure physician orders for extra fluids were discontinued timely. This deficient practice resulted in the resident developing bilateral lower extremity edema requiring the use of diuretic medication. (Resident M) Finding includes: A record review for Resident M was completed on 11/12/24 at 11:23 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, congestive heart failure and vascular dementia. An Annual Minimum Data Set (MDS) assessment, dated 9/11/2024, indicated Resident M had a severe cognitive deficit and received insulin and diuretic medication. Current Physician's Orders, dated 7/19/2024, indicated to encourage Resident M to consume an additional 240 milliliters of fluids every shift for 72 hours.	F 0684	*F 684 Quality of Care* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The DON/designee notified Resident M's physician that the order to give additional fluids were not discontinued timely and resident M experienced BLE edema. The BLE edema was treated appropriately by physician. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who have orders for additional fluids have the potential to be affected The DON/designee has reviewed physician orders of current residents who have orders	12/14/2024

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	The Medication Administration Record (MAR), from 7/19/2024 through October 2024, indicated Resident M continued to receive 240 milliliters of additional fluids three times a day. A Physician's Progress Note, dated 7/16/2024 at 1:53 P.M., indicated Resident M did not have edema. A Physician's Progress Note, dated 7/19/2024 at 11:28 A.M., indicated to encourage an additional 240 milliliters of fluids every shift for 72 hours. A Physician's Progress Note, dated 7/30/2024 at 4:38 P.M., indicated Resident M was complaining of occasional shortness of breath with moderate activity, random BNP (B-Type Natriuretic Peptide, measures the level of BNP protein in the blood to diagnoses heat failure, range for a person over 75 years of age should be less than 450pg/mL) laboratory blood test was performed on 7/20/2024 with a result of 3,134 pg/mL (picogram per milliliter) and Resident M was not on any diuretic. Resident M's assessment indicated he had one plus edema to bilateral lower extremities. The Physician indicated to start Lasix (diuretic) daily for 7 days, to repeat laboratory tests on 8/8/2024 and monitor Resident M's weight. A Physician's Progress Note, dated 8/13/2024 at 2:24 P.M., indicated BNP was 1,481pg/mL. The physician indicated to continue the Lasix treatment, to repeat laboratory tests on 8/28/2024 and monitor Resident M's weight. A Physician's Progress Note, dated 8/21/2024 at 8:42 P.M., indicated Resident M had a chest x-ray on 8/16/2024 that indicated mild congestive heart failure or volume overload. The Physician indicated to administer an additional dose of Lasix		to give additional fluids to ensure orders are current. No findings were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed nursing associates on the requirement to discontinue orders for additional fluids upon receiving the order to discontinue. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will review medical providers progress notes in the morning meeting to ensure orders to discontinue additional fluids were discontinued timely. Auditing to occur: M-F x's 4 wks, then wkly x's 4 weeks, then monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education,	

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	20 milligrams and to start Lasix 20 milligrams daily. "Heart Failure" (May 15, 2024) was retrieved on 11/14/2024 from the Centers of Disease Control (CDC) website. The guidance for heart failure treatment indicated, but was not limited to, to drink less liquids During an interview, on 11/14/2024 at 9:45 A.M., the Director of Nursing indicated Resident M should not have been receiving additional fluids due to congestive heart failure, and this may have contributed to his need for diuretic therapy. A current policy was provided by the Quality Assurance Administrator, on 11/14/2024 at 1:54 P.M. The policy, titled, "Heart Failure-Clinical Protocol", indicated, "...The physician will help identify or clarify causes of congestive heart failure ...Treatment/Management 4. The physician will prescribe treatments for residents with heart failure that are consistent with relevant guidelines and protocols; for example, those of the American Heart Association ...." 3.1-25(a)(2)		frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision Based on record review and interview, the facility failed to ensure a resident with impaired vision received the appropriate follow-up care for 1 of 1 residents reviewed for communication (Resident 35). Finding includes: A record review for Resident 35 was completed on 11/12/2024 at 3:21 P.M. Resident was admitted on	F 0685	F 685*F 685 Treatment/Devices to Main Hearing/Vision*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident 35 is scheduled to see the optometrist during the next scheduled visit.How other residents have the potential to be	12/14/2024

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	3/24/2021. Diagnoses included but were not limited to: multiple sclerosis, depression, chronic obstructive pulmonary disease, dementia, anxiety, abnormal weight loss, mood disorder, muscle weakness and hypertension. A Quarterly Minimum Data Set (MDS), dated 9/12/2024, indicated Resident 35 had moderate cognitive impairment, had impaired vision and required corrective lens. A Physician's order, dated 11/21/2022, indicated the resident could be seen by an optometrist as needed. Resident 35's current Care Plan, reviewed on 9/12/2024, indicated the resident had impaired visual function. Interventions included but were not limited to: the resident will wear his glasses and adjust the tone of voice when communicating with the resident. During an interview, on 11/13/2024 at 11:19 A.M., the Social Services Director (SSD) indicated the optometry service was last at the facility on 9/7/2024 but Resident 35 was not seen at that time. The SSD indicated that she could not locate any notes indicating resident has seen optometry since their admission to the facility. The SSD spoke with facility scheduler on the phone and the SSD indicated the scheduler did not have any notes of the resident being seen outside of the facility by optometry. The SSD indicated the facility should make sure residents with glasses were seen by optometry every other year due to Medicare regulations. During an interview, on 11/14/2024 at 10:00 A.M., the SSD indicated she still had not determined when Resident 35 was last seen by an eye doctor.		affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected Social Service will offer vision services to each resident if indicated. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Social Service will complete consent forms for vision services upon admission and document response in resident records. A vision assessment will be completed quarterly with the MDS. Vision services will be offered as needed if a change in vision is noted in the assessment and for routine exams at least annually. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Admin/designee will complete routine auditing to ensure vision services are offered to residents. Auditing to occur: 4 random residents daily x's 4 wks, then 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will	

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	On 11/14/2024 at 11:55 A.M., the Regional Quality Assurance Administrator provided a policy titled, "Sensory Impairments - Clinical Protocol," dated March 2018 and indicated the policy was the one currently used by the facility. The policy indicated, " ...physician will identify and order appropriate consultations to help manage ...sensory impairments ..." 3.1-39(a)(b)		be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process. Date of compliance: December 14, 2024	
F 0689 SS=E 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 the environment was free from potential hazards for 1 of 4 halls. In addition, the facility failed to ensure interventions were in place to prevent burns for 1 of 3 residents reviewed for accidents. (Resident 12) Findings include: 1. During an observation of room 111 on 11/14/2024 at 10:00 A.M., Resident R's bed was pushed against the packaged terminal air conditioner (PTAC) (ductless, self-contained air conditioning unit for heating and cooling small areas). The top and front of the PTAC was warped and melted. The PTAC unit was plugged in but was turned off. Resident R was not in his room. An interview with Resident S, Resident R's roommate, was completed on 11/14/2024 at 10:02	F 0689	***F 689 Accidents*** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The PTAC unit in Room 111 was replaced November 14, 2024 Resident 12 was effectively treated for the burn she sustained. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. All units in the facility were checked and in proper working order.	12/14/2024

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	A.M. Resident S indicated the PTAC melted at least five months prior. He indicated his roommate's comforter had been in front of the PTAC unit and due to excessive heat, melted the PTAC unit. He indicated the current Maintenance Director (MD) had checked the unit after it melted and was not able to say if the unit would be replaced. Resident S indicated the melted PTAC was still being used to heat the room when it was cold outside. During an interview on 11/14/2024 at 11:28 A.M., Resident R indicated his comforter was in front of the PTAC and caused the top and front of the PTAC to melt about five months prior. He indicated the MD had inspected the PTAC and told him it would be replaced, but the PTAC was not replaced. Resident R indicated staff had never offered to move his bed away from the PTAC and the melted PTAC was still being used to heat the room. During an interview on 11/14/2024 at 1:07 P.M., CNA 21 indicated she was unable to remember how long ago the PTAC unit had melted, but it was more than one month. She indicated the maintenance department was aware and was supposed to take care of it. During an interview on 11/14/2024 at 1:09 P.M., the Unit Manger (UM) indicated she had reported the melted PTAC unit to maintenance over a week ago and was told maintenance already knew about it. During an interview on 11/14/2024 at 1:20 P.M., Housekeeper 23 indicated the PTAC unit had been melted for weeks, if not months, but she had not reported it to anyone because Residents R and S had told her the maintenance department		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An audit was completed for each PTAC unit in the facility and any malfunction was addressed. Staff are to enter equipment needing repair in the TELS system and were educated on the use of the system. TELS is to be monitored by maintenance to ensure repairs are completed timely. Residents who have difficulty holding cups or glasses will be offered a lid for hot beverages. A hot liquid assessment will be completed on admission and at least quarterly. Measures will be put into place as indicated and therapy if determined to be at safety risk. The safety measures will be put on the care plan to be sent to the kardex and a communication form sent to dietary for placement of information on the meal ticket. Staff will be educated on the assessment and communication of measures based on the results. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what	

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	was already taking care of it. During an interview on 10/14/2024 at 10:30 A.M., the Executive Director (ED) indicated the facility was unaware of the melted PTAC and the MD had been in the room two days prior and the PTAC was not melted at that time. During an interview on 11/14/2024 at 1:30 P.M., the MD indicated he was not aware the PTAC unit was melted and he had been in the room two days prior, changing remote batteries, and would have noticed a melted PTAC unit. The MD indicated the facility used TELS (a web-based platform designed for managing building operations, including maintenance, asset management, and life safety compliance, specifically tailored for senior living communities) to submit and prioritize work orders. However, the MD was unable to provide a list from the facility's TELS system regarding work orders that had been submitted or a list of work orders he was currently working on in the facility. 2. A record review for Resident 12 was completed, on 11/12/2024 at 9:20 A.M. Diagnoses included, but were not limited to: hemiplegia affecting right dominant side, aphasia, contracture of right elbow, wrist and hand, dementia and polyneuropathy. An Annual MDS assessment, compelted on 9/10/2024 and a Quarterly Minimum Data Set (MDS) assessment, completed on 10/17/2024, indicated Resident 12 was cognitively intact, had impairment to the upper and lower extremity on one side and required set up or clean up assistance for dining services. A Nursing Progress Note, dated 9/19/2024 at 4:08		quality assurance program will be put into place? The Admin/designee will complete routine audits of rooms with PTACS. DON/designee will review 24 hour report to note resident difficulty holding liquids. Auditing to occur: 4 random rooms daily x's 4 wks, then 4 random rooms wkly x's 4 wks, then 4 random rooms monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The DON/designee will complete routine audits of residents who may have difficulty holding cups. Auditing to occur: 4 random residents daily x's 4 wks, then 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as	

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	P.M., indicated the nurse entered Resident 12's room after a shower was completed where the certified nursing assistant (CNA) observed burns on both of Resident 12's inner thighs. Resident 12 indicated to the nurse she had wheeled herself in her wheelchair to the nurse's station to get a cup of coffee and the CNA may have filled the cup too full. When Resident 12 placed the cup between her thighs to hold while self-propelling her wheelchair, the coffee spilled from the opening at the top and she had burned herself. Resident 12 indicated she did not tell anyone about the burn. A Hot Liquid Safety Evaluation, dated 9/20/2024, indicated Resident 12 had altered muscle strength of her arms, hands and fingers with altered range of motion or contracture of the joints to the hand and fingers and had a history of spills. The evaluation recommended providing Resident 12 with a cup with a lid or other adaptive equipment and staff assistance. There was no Hot Liquid Safety Evaluation completed for Resident 12 prior to 9/20/2024. The Administrator reported to the Indiana Department of Health, on 9/20/2024 at 11:44 A.M., of Resident 12's burn. On 9/27/2024, the Administrator indicated in a follow-up statement, "Resident seen by the wound doctor with treatment in place .....resident referred to therapy for recommendations. Hot liquids to be served in a cup with a lid and a cup holder is being purchased ...." A Care Plan, dated 9/26/2024, indicated Resident 12 was at risk for spilling hot liquids and foods related to muscle weakness and deficits due to effects from a previous stroke. The Care Plan goals included, Resident 12 will not have any hot food or liquids transported by herself and will not		needed, if areas of noncompliance are identified through the interview process.	

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	suffer any burns from food or liquids. Interventions included, but were not limited to: Resident 12 will allow staff to transport her hot food and liquids for her and utilize cups/mugs with handles and lids for all liquids. There was no care plan regarding hot liquid needs/safety for Resident 12 prior to 9/26/2024. During an observation, on 11/13/2024 at 9:37 A.M., Resident 12 was observed in her bed. She had 2 unhandled tumbler cups with lids with unknown substances. Resident 12 indicated she drinks hot liquids without a lid. During an interview, on 11/13/24 at 9:18 A.M., the Director of Rehabilitation indicated Resident 12 had not been recently evaluated for therapy services During an interview, on 11/14/2024 at 9:08 A.M., Dietary Aide 27 indicated special equipment for cup ware would be listed on the meal ticket. The meal ticket was observed, and Dietary Aide 27 indicated Resident 12's hot liquids would be served in a regular cup. Dietary Aide 27 was unaware of the care plan intervention to serve Resident 12's hot liquids in a cup/mug with a handle and lid. During an interview, on 11/14/2024 at 9:16 A.M., the Director of Nursing (DON) indicated the admission nursing assessment specifically asks about cognitive abilities and functional limb abilities to determine risk for burns. On 11/14/2024 at 11:00 A.M., the ED provided an undated document titled, "Physical Plant Standards" and indicated the facility did not have a policy related to providing a safe environment, but used that document. The document indicated,			

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	"...The facility shall have adequate plumbing, heating, and ventilating systems as governed by applicable rules of the fire prevention and building safety commission... Each facility shall have an adequate air conditioning system, as governed by applicable rules of the fire prevention and building safety commission...." On 11/14/2024 at 1:05 P.M., the Quality Assurance Administrator provided a policy titled, "First Aid Treatment". The policy indicated, "...Residents and employees who experience minor injuries shall be treated at the facility. IF the injuries cannot be treated with basic Red Cross first aid intervention, the emergency medical system [EMS] will be activated...." 3.1-45(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review, interview and observation, the facility failed to ensure physician ordered medications were available for 3 of 24 residents whose medications were reviewed. (Residents E, L and M) Findings include: 1. A record review for Resident E was completed on 11/12/2024 at 10:59 A.M. Diagnoses included, but were not limited to: encephalopathy, diabetes, anxiety, and depression. Resident E's current Physician Order's included the following: Atorvastatin Calcium 20 mg (milligram) give 1 tablet at bedtime for high cholesterol. Esomeprazole Magnesium 20 mg give 2 tablets	F 0755	*F 755 Pharmacy Srvs/Procedures/Pharmacist/ Records* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The DON/designee contacted the pharmacy to reorder Resident E, L, M and verified delivery o **The physician for Resident E, L, and M was notified of medications not administered for dates listed in this statement of deficiencies.**	12/14/2024

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	before breakfast (to decrease stomach acids). Ezetimibe 10 mg give 1 tablet one time a day (lower cholesterol). Metformin 500 mg 2 tablets two times a day (anti diabetic). Risperdal (antipsychotic) 2 mg give 1 tablet two times a day for psychosis. Sitagliptin 100 mg (anti-diabetic) 1 tablet every day for diabetes. Veozah 45 mg every day (to reduce moderate to severe vasomotor symptoms due to menopause). The September Medication Administration Record (MAR) indicated Resident E had not received the following medications on these dates: Atorvastatin 20 mg on 9/14, 9/15 and 9/16/2024. Esomeprazole 40 mg on 9/16, 9/18, 9/19, and 9/28/2024. Ezetimibe 10 mg on 9/15, and 9/16/2024. Sitagliptin 100 mg on 9/16, 9/24, 9/26, 9/27, 9/29, and 9/30/2024. Veozah 45 mg on 9/15, 9/16, 9/17, 9/19, 9/21, 9/22, 9/24, 9/25, 9/27, 9/29 and 9/30/2024. Metformin 1000 mg on 9/15 and 9/16/2024. Risperdal 4 mg on 9/16, 9/24, 9/27, 9/29 and 9/30/2024. Resident E's October MAR indicated she had not received the following medications on these dates: Ezetimibe 10 mg on 10/19, 10/20, 10/22, and 10/23/2024. Sitagliptin 100 mg on 10/1 through 10/6, 10/8 through 10/15, 10/17, 10/19, 10/20, 10/22, 10/23, 10/25, and 10/28 through 10/31/2024. Veozah 45 mg on 10/1 through 10/6, 10/8 through 10/23, and 10/25, and 10/28 through 10/31/2024. The November Medication Administration Record (MAR) indicated Resident E had not received the		**How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who have medications ordered and administered by facility associates have the potential to be affected. The DON/designee will complete a facility wide medication audit to ensure that medications are available as per physician's orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed nursing staff on timely reordering of medications. Education will also be provided to nursing associated who administer medications on utilizing the EDK for medications when necessary for medications not yet dispensed to resident. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will routinely audit medication carts to ensure medications are available for administration. Auditing to occur: 4 residents daily M-F x's 4 wks, then 4 residents wkly x's 4	

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	following medications on these dates: Sitagliptin 100 mg on 11/1 through 11/3, 11/5 through 11/8, 11/11, and 11/2024. Metformin 1000 mg on 11/2/2024. Veozah 45 mg on 11/1 through 11/3, 11/5 through 11/8, and 11/11 through 11/13/2024. The clinical record lacked documentation to indicate the reasons why the medications were not administered. During an interview, on 11/14/2024 at 10:40 A.M., the Director of Nursing indicated the nurse should have called the pharmacy, then looked to see if the medications were in-house, looked in the EDK (emergency drug kit) and called the provider for an alternate medication order and the physician should be called after 3 days if the medication was not administered. 2. During an interview, on 11/7/2024 at 1:54 P.M., Resident L indicated she had not received her pain medication for a month. A record review for Resident L was completed on 11/12/2024 at 3:22 P.M. Diagnoses included, but were not limited to kidney failure, diabetes, osteoarthritis, anxiety, and diabetic polyneuropathy. Current Physician Orders included Lidoderm Patch 5% (Lidocaine) pain reliever apply to bilateral hip/thighs in the morning for chronic pain and remove Lidocaine patches from bilateral hips and bilateral thighs at bedtime every night. The October Medication Administration Record (MAR), indicated the Lidoderm pain patch was not applied on the following dates: 10/6, 10/10, 10/11 and 10/18/204.		wks, then 4 residents monthly x's 4 months for a total of 6 months of monitoring. The DON/designee will review the Medication Admin Audit Report to ensure that residents have received their medications as ordered. Any findings will be addressed. Auditing to occur: Daily M-F x's 4 weeks, then weekly x's 4 weeks, then monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	

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	155086	A. BUILDING 00 B. WING	11/14/2024

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	The October MAR indicated the Lidoderm pain patch was not removed on the following dates: 10/11, 10/18 through 11/24, 11/27, 11/29 and 11/30/2024. The November MAR indicated the Lidoderm pain patch was not applied on the following dates: 11/5, 11/6, and 11/8 through 11/12/2024. The November MAR indicated the Lidoderm pain patch was not removed on the following dates: 11/6, and 11/11 through 11/13/2024 A Medication Administration Note, dated 9/14/2024 at 8:07 P.M. indicated no patch was available to remove. A Medication Administration Note, dated 10/6/2024 at 10:18 A.M., indicated the Lidoderm patch was not available. A Medication Administration Note, dated 10/10/2024 at 9:59 A.M., indicated the Lidoderm patch was on order from the pharmacy. A Medication Administration Note, dated 10/112024 at 10:56 A.M., indicated the Lidoderm patch was on order from the pharmacy. A Medication Administration Note, dated 10/11/2024 at 7:28 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/18/2024 at 8:30 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/19/2024 at 10:46 P.M., indicated the Lidoderm			

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	patch was not available for removal. A Medication Administration Note, dated 10/20/2024 at 10:38 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/21/2024 at 10:38 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/22/2024 at 10:38 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/23/2024 at 9:57 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/24/2024 at 9:51 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/25/2024 at 9:54 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/26/2024 at 9:17 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/27/2024 at 9:33 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/29/2024 at 9:43 P.M., indicated the Lidoderm patch was not available for removal. A Medication Administration Note, dated 10/30/2024 at 9:37 P.M., indicated the Lidoderm			

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	patch was not available for removal. A Medication Administration Note, dated 11/5/2024 at 9:53 A.M., indicated the Lidoderm patch was on order from the pharmacy. A Medication Administration Note, dated 11/6/2024 at 7:48 A.M., indicated the Lidoderm patch was on order from the pharmacy. A Medication Administration Note, dated 11/8/2024 at 9:49 A.M., indicated the Lidoderm patch was on order from the pharmacy. A Medication Administration Note, dated 11/9/2024 at 11:33 A.M., indicated the Lidoderm patch was unavailable. A Medication Administration Note, dated 11/11/2024 at 9:03 A.M., indicated the Lidoderm patch was on order from the pharmacy. A Medication Administration Note, dated 11/12/2024 at 7:40 A.M., indicated the Lidoderm patch was on order from the pharmacy. During an interview, on 11/13/2024 at 2:17 P.M., LPN 20 indicated if the medication was not in the cart, he would let the unit manager know. He would then look in the EDK, and if it was not available in the EDK, he would order the medication unless it was already ordered. If it was ordered, it would show on the MAR. During an interview, on 11/14/2024 at 10:40 A.M., the Director of Nursing indicated the nurse should have called the pharmacy, looked see if the medication was in-house, looked in the EDK (emergency drug kit) and called the provider for an alternative medication order. The DON			

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	indicated the physician should be notified after 3 days if the medication was not administered. During a medication storage observation on 11/13/2024 at 11:10 A.M., on the 100 hall with QMA 18 there were no Lidocaine pain patches in the medication cart for Resident L. During an interview, on 11/13/2024 at 11:22 A.M., QMA 18 indicated if the medication was not in the medication cart, she would look in the EDK, and if the medication was not in the EDK, she would reorder it and put a note in the chart indicating: "reordered awaiting arrival from pharmacy".3. A record review for Resident M was completed on 11/12/24 at 11:23 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, congestive heart failure and vascular dementia. An Annual Minimum Data Set (MDS) assessment, dated 9/11/2024, indicated Resident M had a severe cognitive deficit received insulin and diuretic medications. Current Physician's Orders, included, but were not limited to: - Jardiance 10 milligrams in the morning initiated on 4/2/2022 The Medication Administration Record, dated November 2024, indicated Resident M missed doses of Jardiance 10 milligrams on 11/1/2024, 11/5/2024, 11/9/2024, 11/10/2024, and 11/12/2024. During an interview, on 11/14/2024 at 9:45 A.M., the Director of Nursing indicated if a medication was unavailable, the nursing staff should have contacted the pharmacy and then the physician to determine if alternate orders were necessary.			

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	On 11/14/2024 at 9:10 A.M., the Quality Assurance Administrator provided the policy titled, "Emergency Pharmacy Service and Emergency Kits", dated 5/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated "...Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved medication supply or by a special order from the pharmacy. An emergency supply of medications, including emergency drugs, antibiotics, controlled substances... If the medication is not available, call/faxes the pharmacy, using the pharmacy or appropriate after-hours emergency number(s) if necessary. ...5. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency box or from the pharmacy...." A current policy was provided by the Quality Assurance Administrator, on 11/14/2024 at 1:54 P.M. The policy titled, "Adverse Consequences and Medication Errors", indicated 5. A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principals of the professional[s] providing services. 6. Examples of medication errors include: a. Omission-a drug is ordered but not administered...c. Wrong dose ...." 3.1-48(a)(1) 3.1-48(c)(2) 3.1-25(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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	Based on observation, interview and record review, the facility failed to adequately label an over the counter medication stored in a medication cart for 1 of 1 medication cart reviewed (400 Unit). The facility also failed to monitor and maintain proper temperatures of a refrigerator where medications were stored for 1 of 1 medication refrigerators reviewed (Nurses Station 1). Findings include: 1. During an observation of the medication cart on the 400 Unit on 11/8/2024 at 11:45 A.M., an opened bottle of Tylenol and an open bottle of melatonin did not have any resident identifying information on the bottles. During an interview on 11/08/2024 at 11:48 A.M., LPN 24 indicated she was not able to identify whose Tylenol and melatonin were observed. She indicated over the counter medications should be labeled with the resident's name and room number. During an interview on 11/8/2024 at 11:51 A.M., the Director of Nursing (DON) indicated all medications should be labeled with the resident's name, prescriber name and dosage information. 2. During an observation of the nursing station 1 medication refrigerator on 11/12/2024 at 9:30 A.M. with LPN 20, the medication refrigerator thermometer indicated the temperature was 32 degrees Fahrenheit (F). The refrigerator had the following medications stored: -A locked Emergency Drug Kit with 1 vial of Humalog (insulin), 1 vial Humulin N (insulin), 1 vial of Humulin R (insulin), 1 vial of Humulin 70/30 (insulin), 1 vial of Novolog (insulin), 1 vial of lorazepam 20 milligrams (mg) (antianxiety), 1 vial of	F 0761	***F 761 Label/Store Drugs and Biologicals*** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No resident was identified in this statement no deficiency as being affected r/t to the OTC Tylenol and Melatonin not having appropriate labels. The DON/designee removed the opened bottle of Tylenol and melatonin from the 400-unit medication cart and audited resident orders who resident on that unit to ensure residents that have orders for Tylenol and melatonin have a supply on hand designated for each resident. DON/designee verified appropriate labels are in place for those medications. Medications that were stored in the Nurses' station 1 refrigerator as listed in this statement of deficiencies were removed, disposed of, and reordered by the DON/designee. The refrigerated EDK was removed and picked up by pharmacy. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who have OTC medications not dispensed from	12/14/2024

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	lorazepam 2 mg, 1 vial of Lantus (insulin), 1 vial of Leviemir (insulin), 1 promethazine (relieve or prevent some types of allergy or allergic reactions) 25 mg suppositories. -3 boxes of Tubersol (aid in the diagnosis of tuberculosis) -4 boxes of Aplisol (aid in the diagnosis of tuberculosis) -3 Lantus Solostar (insulin) pens for Resident 30 -4 Gargine (insulin) pens for Resident 26 The temperature log hanging on the front of the Medication Refrigerator had out of range temperatures logged for the following dates: -11/1/2024 33 degrees F -11/2/2024 33 degrees F -11/3/2024 30 degrees F -11/4/2024 30 degrees F -11/5/2024 33 degrees F -11/6/2024 33 degrees F -11/7/2024 33 degrees F -11/8/2024 33 degrees F -11/9/2024 33 degrees F -11/10/2024 32 degrees F -11/11/2024 33 degrees F -11/12/2024 33 degrees F During an interview on 11/12/2024 at 9:33 A.M., LPN 20 indicated the nurses were responsible for checking and recording the medication refrigerator's temperatures. He indicated the temperature of refrigerator was 32 F and believed it was an appropriate temperature. After looking at the acceptable temperature parameters printed on the temperature log, LPN 20 indicated the refrigerator temperature was out of range and he would notify maintenance. On 11/12/2024 at 10:00 A.M., the Executive		the pharmacy have the potential to be affected. The DON/designee will complete a cart audit to ensure that residents who have OTC medication orders not dispensed by the pharmacy have appropriate labels in place. Any findings will be addressed. The DON/designee will complete a refrigerated medication audit to ensure that the temps logs are current and within range. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to nursing associates that administer medications on the requirement to ensure the temp logs kept on refrigerated medications must be obtained, current, and within range, and the process of addressing any temps that are out of range. The DON/designee will provide education to nursing associates who administer medications on the requirement to ensure OTC medications have appropriate labels. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	Director (ED) provided an undated policy titled, "Medication Storage in the Facility", and identified it as the policy currently used by the facility. The policy indicated, "... K. Medications requiring "refrigeration" or "temperatures between 36 degrees F and 46 degrees F" are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage "in a cool place" are refrigerated unless otherwise directed on the label...." On 11/12/2024 at 2:14 P.M., the DON provided a policy dated, 4/2007, and titled, "Labeling of Medication Containers" and identified it as the policy currently used by the facility. The policy indicated, "... 3. Labels for individual drug containers shall include all necessary information, such as: a. The resident's name; b. The prescribing physician's name;... d. The name, strength, and quantity of the drug;... i. Directions for use...." 3.1-25 (j) 3.1-25 (m)		DON/designee to complete routine auditing of medication carts to ensure that OTC medications being administered have appropriate labels. Auditing to occur: all med carts 4 x's wkly x's 4 wks, then monthly x's 5 months for a total of 6 months of monitoring. DON designee to to complete routine auditing of refrigerators that contain medications. Auditing to occur: all refrigerated med storage areas 4 x's wkly x's 4 wks, then monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Any findings of non-compliance identified through the auditing process will be addressed re-education, increase of frequency and/or duration of auditing until full compliance achieved.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review and interview, the facility failed to ensure 1 of 2 unit pantries was maintained in a sanitary manner. This had the potential to affect 18 of 18 residents on the 400 unit.	F 0812	***F 812 Food Procurement, Store/Prepare/Serve-Sanitary*** What corrective actions will be accomplished for those residents found to have been affected by the	12/14/2024

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	Finding includes: An observation of the 400 unit pantry was completed with the Dietary Director (DD) and the Executive Director on 11/13/2024 at 9:13 A.M. The following was observed: - A microwave with dried food splatter on the inside. - A wet white blanket with black and brown stains on the bottom of the cabinet underneath the sink. During an interview on 11/13/2024 at 9:15 A.M., the DD indicated the microwave was dirty and needed to be cleaned. She indicated the blanket was used to catch the dripping water from the leaking plumbing, but was not able to recall the last time the blanket had been changed. The ED indicated the blanket should not be used to absorb the leaking water and she had already notified maintenance about the leaking sink prior to the survey starting. A policy for maintaining the pantry and any cleaning checklists related to the pantry were requested but not provided prior to the survey exit. On 11/13/2024 at 9:16 A.M., the ED indicated the facility did not have a policy for maintaining the pantries, but used an undated document titled, "Physical Plant Standards". The three page "Physical Plant Standards" document did not include information pertaining to the sanitation or upkeep of equipment in pantries or the kitchen. This citation relates to complaint IN00442666. 3.1-21(i)(3)		deficient practice? The pantry on Unit 400 was cleaned November 13, 2024. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A cleaning schedule has been created for the pantry. Nursing will be responsible for maintaining the cleanliness of the pantry and have been educated on the cleaning schedule. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON/designee will complete routine auditing of each pantry. Auditing to occur: 4 random days x's 4 wks, then 4 random days x's 4 wks, then 4 random days x's 4 months for a	

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			total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	
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 ensure infection control practices were followed related to glove use and handwashing during perineal and catheter care for 1 of 2 residents observed for catheter care. (Resident 50) Finding includes: During an observation, on 11/14/2024 at 11:02 A.M., Certified Nursing Assistant (CNA) 23 was observed to provide incontinence/catheter care to Resident 50. She used a washcloth and cleaned the urinary catheter and tubing. CNA 25, with the assistance of LPN 19, then turned the resident	F 0880	*F 880 Infection Prevention & Control* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 50 did not experience a negative outcome from deficient practice. CNA 23 and LPN 19 was educated by the DON/designee on glove use and handwashing during peri care, catheter care. These associates will perform a return	01/06/2025

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	over to his right side. CNA 23 cleansed the smear of feces from her buttocks and LPN 19 applied a barrier cream to his buttocks. Without changing her gloves, or washing her hands, CNA 23 obtained a clean bed pad and clean brief and placed them under the resident and pulled the resident's shirt down in back. The resident was then rolled over and his brief was fastened in the front. CNA 23 moved Resident 50's arms and pillows, then repositioned the resident up in bed. She placed a clean sheet over the resident, and lastley CNA 23 put all the dirty linens in a bag and then removed her contaminated gloves. During an interview, on 11/14/2024 at 11:15 A.M., CNA 23 indicated she should have changed her gloves and washed her hands. On 11/14/2024 at 12:56 P.M., the Quality Assurance Administrator provided the policy titled, "Perineal Care," with a revision date of 2/2018, and indicated the policy was the one currently used by the facility. The policy indicated "...m. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. n. Dry area thoroughly... 10. Remove gloves and discard into designated container. 11. Wash and dry your hand thoroughly...." 3.1-18(a)		demonstration with the DON/designee of best practices in these areas. Any findings will be addressed. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who receive peri care and catheter care have the potential to be affected The DON/designee will provide education to licensed and certified nursing associates on glove usage during peri care and catheter care. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed and certified nursing associates on glove usage during peri care and catheter care. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine observations of glove use and hand washing during peri care to ensure best practices are being performed. Observations to occur: 4 random	

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			associates performing peri care wkly x's 4 wks, then 4 random associates performing peri care monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on record review and interview, the facility failed to provide a resident with a pneumococcal vaccination timely for 1 of 5 residents reviewed for vaccinations. (Resident 11) Finding includes: Resident 11's record review was completed on 11/12/2024 at 11:01 A.M. Diagnoses included but were not limited to: multiple sclerosis, anxiety disorder, cerebral infarction, bipolar disorder, hemiplegia and hemiparesis of left side and cerebral aneurysm. Resident 11 had received the Prevnar 13 (pneumococcal vaccine) on 3/15/2023.	F 0883	*F 883 Influenza and Pneumococcal Immunizations* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident 11 received the PNE20 vaccine on November 15, 2024. Vaccine clinic was held November 15, 2024 and all residents who gave consent received influenza and pneumonia vaccines. **How other residents have the**	01/06/2025

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	A document titled, "Influenza/pneumococcal/Covid Vaccine/Booster Immunization Consent or Refusal" indicated the resident wanted to be given the pneumococcal vaccine(s). Resident 11 signed the document on 10/30/2023. A document titled, "Influenza/pneumococcal/Covid Vaccine/Booster Immunization Consent or Refusal" indicated the resident wanted to be given the pneumococcal vaccine(s). Resident 11's Power of Attorney/Guardian gave verbal consent for the pneumococcal vaccine on 10/24/2024. During an interview on 11/13/2024 at 10:20 A.M., the Clinical Nurse (CN) indicated the facility followed the recommendations of the Centers for Disease Control and Prevention (CDC) for pneumococcal vaccinations. The CN indicated based on the CDC recommendations, Resident 11 should receive a pneumococcal vaccine at least one year after she had received the Prevnar 13 vaccine. On 11/12/2024 at 2:14 P.M., the Director of Nursing (DON) provided a policy dated, 7/22/2022, and titled, "Infection Control". The DON indicated it was the policy currently used by the facility. The policy indicated, "...K. Influenza and pneumococcal immunizations... 2. Pneumococcal disease... Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized...." 3.1-13(a)		**potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Facility will review vaccine status of each new admission to the facility, obtain consents and schedule vaccines upon consent. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing of new admissions. Auditing to occur: 4 random admits daily x's 4 wks, then 4 random admits wkly x's 4 wks, then 4 random admits monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved	

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			for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview and record review, the facility failed to maintain a sanitary environment related to urine odors, dirty ceilings and walls and unpainted spackle in resident's rooms and related to gouges and unpainted spackle on the 400 unit hall walls. Findings include: 1. During an observation on 11/8/2024 at 11:06 A.M., a strong smell of urine was detected in room 112. During an Environmental tour with the Maintenance Director (MD), Executive Director (ED) and the Director of Housekeeping (DH) on 11/14/2024 at 9:05 A.M., a strong smell of urine was detected in room 112. During an interview on 11/14/2024 at 9:07 A.M., the DH indicated Room 112 smelled of urine due to a urine soaked mattress. The DH indicated the resident brought his own mattress on admission and it was not cleanable. The DH indicated there had been conversations with the resident about replacing the mattress, but the resident refused. The DH indicated she did not have any documentation to indicate the resident had been offered a new mattress.	F 0921	***F 921 Safe/Comfortable Environment*** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Room 222 and Room 229 have had repairs made. Bed and mattress in Room 112 has been replaced and room has been deep cleaned. Unit 400 hallway repairs have been completed. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. An audit of all rooms has been completed which detail work needing to be done.	12/14/2024

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	On 11/14/2024 at 10:45 A.M., the DH provided cleaning checklists that did not include cleaning resident's mattresses. On 11/14/2024 at 1:00 P.M., the DH provided an undated document indicating the resident wanted to keep his mattress and refused the opportunity to receive a new mattress. The DH indicated the resident had signed the document on 11/14/2024. 2. During an observation of room 229 on 11/07/2024 at 2:06 P.M., there were gouges along the wall next to the bed by the door, unpainted spackle on the wall by the ceiling with room decor hanging from the unpainted spackle, and a dark spot on the ceiling near the window. During an Environmental tour with the Maintenance Director (MD), Executive Director (ED) and the Director of Housekeeping (DH) on 11/14/2024 at 9:08 A.M., the following was observed in Room 229: gouges along the wall next to the bed by the door, unpainted spackle on the wall by the ceiling with room decor hanging from the unpainted spackle, and a dark spot on the ceiling near the window. During an interview with the MD and DH on 11/14/2024 at 9:10 A.M., the MD indicated he was not aware of the gouges in the wall along the bed. He indicated he had spackled the wall a week prior and had not painted it yet. The MD indicated the ceiling did not leak and it was dirt on the ceiling. The DH indicated it was dirt on the ceiling and it was housekeeping's responsibility to clean the ceiling and Housekeeping should have been dusting from ceiling to floor daily. On 11/14/2024 at 10:45 A.M., the DH provided		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A maintenance/environmental policy has been written and will serve as the guideline for environmental conditions of the building. The TELs system will be utilized by staff to communicate needs facility repairs. Staff have been educated on the TELS system and the new policy and guidelines for the facility environment. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Admin/designee will complete routine auditing of the environment. Auditing to occur: 4 random rooms daily x's 4 wks, then 4 random rooms wkly x's 4 wks, then 4 random rooms monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be	

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	cleaning checklists. The cleaning check lists did not include dusting the ceiling or walls. 3. During an observation of Room 222 on 11/07/2024 at 11:04 A.M., there were two holes in the wall next to bed by the door. During an Environmental tour with the Maintenance Director (MD), Executive Director (ED) and the Director of Housekeeping (DH) on 11/14/2024 at 9:12 A.M., Room 222 had two holes in the wall above the bed closest to the door. During an interview on 11/14/2024 at 9:13 A.M., the MD indicated he was not aware of the holes in the wall in Room 222. During an interview on 11/14/2024 at 9:14 A.M., Resident J indicated he admitted to the facility six months prior and the holes had been in the wall since his admission. 4. During an Environmental tour with the Maintenance Director (MD), Executive Director (ED) and the Director of Housekeeping (DH) on 11/14/2024 at 9:16 A.M., the 400 Hall had four large areas along the hallway wall that had been spackled but had not been painted. During an interview on 11/14/2024 at 9:22 A.M., the MD indicated that his assistant had spackled the wall one week prior. The MD indicated the facility used TELS (a web-based platform designed for managing building operations, including maintenance, asset management, and life safety compliance, specifically tailored for senior living communities) to submit work orders for building repairs. He indicated staff submitted work orders and he prioritized work orders based on safety concerns. The MD indicated he		discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	

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	completed a daily walk through of the facility's halls and common areas to identify any possible maintenance concerns. He indicated he visited several rooms a day and was in every room at least every two weeks to identify possible maintenance concerns. During an interview on 11/14/2024 at 9:30 A.M., the ED indicated the facility did not have a policy for maintaining the building and environment, but used the document titled, "Physical Plant Standards." During an interview on 11/14/2024 at 1:30 P.M., the MD indicated he was not able to provide a list of tasks that had been submitted through TELS or a list of the current tasks he was working on in the facility. On 11/14/2024 at 11:00 A.M., the ED provided an undated document titled, "Physical Plant Standards" and indicated the facility did not have a policy related to maintaining the facility's environment, but used that document. The document indicated, "...(2) Provide each resident with the following items upon request at the time of admission: (A) A bed:... (ii) with a clean and comfortable mattress...." This citation relates to complaint IN00442666. 3.1-19 (f)			
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program Based on observation, interview and record review, the facility failed to maintain an effective Pest Control Program related to an infestation of fruit flies. This had the potential to affect 68 of the	F 0925	***F 925 Maintain Effective Pest Control Program*** What corrective actions will be accomplished for those residents	12/14/2024

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	68 residents who reside in the facility. Finding includes: During an observation of room 229 on 11/7/2024 at 2:06 P.M., fruit flies were seen in the resident's room. During an observation of room 112 on 11/8/2024 at 11:06 A.M., fruit flies were seen in the resident's room. During an observation of room 110 on 11/8/2024 at 11:11 A.M., fruit flies were seen in the resident's room. During the Resident Council Meeting on 11/08/24 at 1:17 P.M., 5 out of 8 residents indicated fruit flies had been a problem for three months or longer. During a record review of the Pest Control binder on 11/8/2024 at 2:00 P.M., no documentation was located to indicate the facility had received any Pest Control visits/treatments related to fruit flies in the last three months. On 11/14/2024 at 8:45 A.M., the ED provided an invoice from a Pest Control company dated, 11/13/2024. The invoice indicated the 100 Hall was inspected for fruit flies. Fruit flies were located in room 110, 111, 112, 114, 118, 120 and in a clean utility room behind Nurse's Station 1. The invoice did not include treatment to any other halls besides the 100 Hall. During an Environmental tour with the Maintenance Director (MD), Executive Director (ED) and the Director of Housekeeping (DH) on 11/14/2024 at 9:05 A.M., fruit flies were observed		found to have been affected by the deficient practice? Aardvark Pest Control was here November 13, 2024 and sprayed foam in drains How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. All rooms throughout the facility were sprayed for gnats and will be treated weekly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Pest control services specific to gnats are scheduled weekly beginning December 6, 2024.Staff are to enter into the TELS system the location of pests if seen in the facility with maintenance to monitor. All staff will be in-serviced on the use of the TELS system. A performance improvement tool has been developed to audit areas of the facility to ensure it is free of gnats and pest control has effectively sprayed as scheduled. How the corrective actions will be monitored to ensure the deficient	

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	in the following rooms: -402 -406 -110 -112 -229 During an interview on 11/14/2024 at 9:22 A.M., the MD indicated the facility was receiving regular treatments for fruit flies but did not have any invoices to show a Pest Control company had treated the facility other than the invoice on 11/13/2024. During an interview on 11/14/2024 at 9:30 A.M., the ED indicated the facility used a Pest Control company to treat for fruit flies. The ED indicated the facility was having difficulties with the Pest Control company providing invoices after treatments and provided the phone number of the Pest Control company the facility was using. A copy of the Pest Control Policy was requested and the ED indicated she believed she had already submitted the Pest Control Policy but would double check. A policy was not received before the exit of the survey. During an interview on 11/14/2024 at 9:50 A.M., a representative from the Pest Control company indicated any invoices from the last six months would be emailed to the facility immediately. No invoices were received before the exit of the survey. On 11/14/2024 at 1:05 P.M., the ED provided three documents and identified the documents as invoices for Pest Control services. The documents were dated 9/24, 11/12 and 11/14/2024 and did not list a Pest Control company or what services were received.		practice will not recur, i.e., what quality assurance program will be put into place? The Admin/designee will complete routine auditing of the environment. Auditing to occur: 4 random rooms/areas daily x's 4 wks, then 4 random rooms/areas wkly x's 4 wks, then 4 random rooms/areas monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process. Compliance date: December 14, 2024	

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F 9999 Bldg. 00	This citation relates to complaint IN00442889. 3.1-19 (f)(4) 3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure employees complete yearly education and training on residents' rights for 4 of 10 employees whose files were reviewed. (CNA 3, Dietary Assistant 5, Cook 7, and LPN 11) Finding includes: During a review of employee records, on 11/8/2024 at 10:00 A.M., CNA 3, Dietary Assistant 5, Cook 7 and LPN 11's files did not contain documentation to indicate they had completed annual training on resident rights. During an interview on 11/8/2024 at 1:38 P.M., the Administrator indicated the training was not completed for resident rights. On 11/8/2024 at 2:25 P.M., the Administrator provided a policy dated June 2023 and titled, "Resident Rights." The policy indicated, "...4.	F 9999	*F 9999* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this deficient practice. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents were not affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** A new HR Director was hired and started December 2, 2024. A system will be developed to track TB tests and annual training to assure all employees are compliant. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	12/14/2024

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	Orientation and in-service training programs are conducted quarterly to assist our employees in understanding our residents' rights...." 3.1-14 Personnel (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to have employees complete 3 hours of annual dementia training for 4 of 10 employees whose files were reviewed. (CNA 3, Dietary Assistant 5, Cook 7, and LPN 11) Finding includes: During a review of employee records on 11/8/2024 at 10:00 A.M., CNA 3, Dietary Assistant 5, Cook 7, and LPN 11's files did not contain documentation to indicate they had completed the three hours of annual dementia training. During an interview on 11/8/2024 at 1:38 P.M., the Administrator indicated the training was not completed for dementia. On 11/8/2024 at 2:25 P.M., the Administrator provided a policy dated October 2017 and titled,		**into place?** The Admin/designee will complete routine auditing of employee files. Auditing to occur: 3 files daily x's 4 wks, then 3 files weekly x's 4 wks, then 3 files monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the interview process.	

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	"In-Service Training Program, Nurse Aide." The policy indicated, "...f. Include training in dementia management...." 3.1-14 Personnel (vi) Promoting residents' right to be free from abuse, mistreatment, and neglect, and the need to report any instances of such treatment to appropriate facility staff. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure employees complete yearly education and training on abuse for 4 of 10 employees whose files were reviewed. (CNA 3, Dietary Assistant 5, Cook 7, and LPN 11) Finding includes: During a review of employee records on 11/8/2024 at 10:00 A.M., CNA 3, Dietary Assistant 5, Cook 7, and LPN 11's files did not contain documentation to indicate they had completed annual training on abuse. During an interview on 11/8/2024 at 1:38 P.M., the Administrator indicated the training was not completed for abuse. On 11/8/2024 at 2:25 P.M., the Administrator provided a policy dated January 2020 and titled, "Abuse Policy." The policy did not include information regarding annual training for employees. 3.1-14 Personnel			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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	(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to screen employees for tuberculosis within one month prior to employment and at least annually thereafter for 10 of 10 employees whose records were reviewed. (QMA 2, CNA 3, CNA 4, Dietary Assistant 5, Dietary Assistant 6, Cook 7, CNA 8, Maintenance Assistant 9, RN 10, and LPN 11) Finding includes: During a review of employee records on 11/8/2024 at 10:00 A.M., QMA 2, CNA 3, CNA 4, Dietary Assistant 5, Dietary Assistant 6, Cook 7, CNA 8, Maintenance Assistant 9, RN 10, and LPN 11's files did not contain documentation to indicate they had been screened for tuberculosis upon hire and annually thereafter. During an interview on 11/8/2024 at 1:38 P.M., the Administrator indicated tuberculosis screening had not been completed for these employees.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	On 11/8/2024 at 2:25 P.M., the Administrator provided a policy dated 5/24/2022 and titled, "Tuberculosis Skin Testing Procedure." The policy indicted, "...1. All associates (and volunteers) are screened and tested for tuberculosis at the time of hire (baseline testing)...." and "...4. The frequency of TB screening after baseline is determined by the facility's risk classification...."			