STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 00 B. WING	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00459109. Complaint IN00459109 - Federal/State deficiencies related to the allegations were cited at F602. Survey dates: May 19, 20, 21, 22 and 23, 2025 Facility number: 000509 Provider number: 155412 AIM number: 100266620 Census Bed Type: SNF/NF: 94 Total: 94 Census Payor Type: Medicare: 4 Medicaid: 74 Other: 16 Total: 94 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 3, 2025.	F 0000	The plan of correction is to serve as Greenwood Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Greenwood Health and Living Community is respectfully requesting consideration for desk review.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, interview and record review, the facility failed to provide reasonable accommodation of needs for 1 of 19 reviewed for call light access. (Resident 73)	F 0558	**F 558 Reasonable accommodations Needs/Preferences** **I. The corrective actions to be**	06/17/2025

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

Dorian Mihay | HFA | 06/11/2025

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	Finding includes: On 5/20/25 from 8:35 a.m. to 8:40 a.m., Resident 73 was observed resting in bed while eating breakfast. Resident 73's call light was observed approximately 3 feet to the left of the head of the bed. The call light cord and mechanism were observed hanging from the wall to approximately 3 inches above the floor. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73 indicated he did not know where the call light was located. During an interview on 5/20/25 at 8:43 a.m., Scheduler 7 indicated Resident 73's call light was to be kept within reach of the resident. Resident 73 "sometimes would throw his call light around." On 5/22/25 at 8:45 a.m., Resident 73 was observed sitting in his wheelchair that was positioned at the foot end on the left side of the bed. Resident 73 was facing away from the head of the bed. Against the wall and to the left of the head of the bed was a small bedside table. The call light cord and mechanism were observed hanging from the wall and resting onto the floor to the left of the bedside table. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73 indicated he did not where the call light was located. During an interview on 5/22/25 at 8:47 a.m., Unit Manager 8 indicated call lights were to be kept within reach of the resident. Resident 73 was known to "toss the call light around at times." On 5/20/25 at 1:18 p.m., Resident 73's clinical record was reviewed. The diagnosis included, but		**accomplished for those residents found to have been affected by the practice.** Resident 73s call light was placed within reach. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents were observed to ensure call lights were within reach. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Staff are being educated to keep call lights within reach of residents. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will round and observe residents to ensure call lights are being kept within reach daily for 4 weeks, weekly for 12 weeks and then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee	

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	was not limited to, hemiplegia and hemiparesis (paralysis) following a stroke affecting the dominant right side. The Annual Minimum Data Set (MDS) assessment, dated 4/29/25, indicated Resident 73 was severely cognitively impaired and was at risk for falls. During an interview on 5/22/25 at 8:29 a.m., the Administrator indicated the facility did not have a specific call light policy. The facility practice was that staff were to ensure the call lights were kept within reach of the residents. 3.1-3(v)(1)		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%. **V. Plan of Correction completion date.** Date of Compliance: 6/17/25 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0602 SS=E Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on interview and record review, the facility failed to protect the resident's rights to be free from misappropriation of property for 5 of 5 residents reviewed for misappropriation of property. Narcotic medications were missing. (Resident B, Resident C, Resident D, Resident E, Resident F) Findings include: 1. On 5/20/25 at 12:02 p.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, hypertensive chronic kidney disease and osteomyelitis of vertebra (inflammation of bone caused by infection of a spinal disc). The Annual MDS (Minimum Data Set) assessment, dated 4/7/25, indicated Resident B was cognitively intact.	F 0602	**F 602 Free from Misappropriation/Exploitation** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** There were no negative outcomes related to the incident for residents B, C, D, E, and F and residents were reimbursed if needed. **II. The facility will identify other residents that may potentially be affected by the practice.** Other carts were counted and medications were verified without other discrepancies.	05/29/2025

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	The Physician's Orders included, but were not limited to: - Hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg (milligrams), every six hours a day for pain, initiated 3/27/24. 2. On 5/20/25 at 12:05 p.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, osteomyelitis, pneumonia, and acute respiratory distress. The Admission MDS assessment, dated 5/1/24, indicated Resident C was cognitively intact. The Physician Order Report, dated 4/30/25, indicated the following: - Oxycodone-acetaminophen (narcotic pain medication) 5-325 mg, one tablet every four hours as needed for acute pain. 3. On 5/20/25 at 12:08 p.m., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, atrial fibrillation and personal history of traumatic brain injury. The Quarterly MDS assessment, dated 4/11/25, indicated Resident D was severely cognitively impaired. The Physician Order Report, dated 4/18/25 indicated the following: -Tramadol (narcotic pain medication) 50 mg, three times a day. 4. On 5/20/25 at 12:10 p.m., Resident E's clinical record was reviewed. The diagnoses included, but		**III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** RNs, LPNs, and QMAs are being educated regarding medication storage and misappropriation of property. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will review the sign in/out sheets and controlled drug sheets daily for 4 weeks, weekly x4 weeks, Monthly x3 months, and quarterly x3 months. 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%. The DON, or designee, will review the narcotic master sheet compared to narcotic dispensed report daily for 4 weeks, weekly for 8 weeks, monthly for 3 months, then quarterly ongoing.	

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	were not limited to, cerebral palsy, contracture of right knee, and acute kidney failure. The Quarterly MDS assessment, dated 5/16/25, indicated Resident E was moderately cognitive impaired. The Physician Order Report, dated 3/28/25 indicated the following: - Hydrocodone-acetaminophen 5-325 mg tablet oral tab three times a day. 5. On 5/20/25 at 12:15 p.m., Resident F's clinical record was reviewed. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, physical debility, and type 2 diabetes mellitus. The Admission MDS assessment, dated 4/28/25, indicated Resident F was moderately cognitive impaired. The Physician Order Report, dated 4/21/25 indicated the following: - Hydrocodone-acetaminophen 5-235 mg, one by mouth every six hours as needed. During an interview on 5/21/25 at 2:18 p.m., the Director of Nursing (DON) and Administrator indicated that on 5/7/25 it was brought to their attention that there were a few discrepancies in the narcotic count. During the facility investigation it was discovered that on 5/5/25, LPN 4 took possession of 30 tablets of hydrocodone-acetaminophen 5-325 mg and a card of Ambien prescribed for Resident B. LPN 4 did return the Ambien for destruction but indicated she did not know what happened to Resident B's		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%. **V. Plan of Correction completion date.** Date of Compliance: 5/29/25	

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	30 tablets of hydrocodone-acetaminophen that she had removed for destruction. The DON and Administrator indicated at that time that LPN 4 also signed out an oxycodone-hydrocodone 5-325 mg for Resident C. Resident C was not in facility at that time. It was also noted a Tramadol 50 mg tablet was obtained from the narcotic lock box as an as needed medication for Resident D. Resident D did not have an order for Tramadol as needed, only scheduled times. The DON and Administrator indicated that further investigation revealed hydrocodone-acetaminophen 5-325 mg was missing from the narcotic lock box for Resident E. Resident E was missing 44 hydrocodone-acetaminophen 5-325 mg. LPN 4 was placed on leave pending the investigation and terminated. The DON called LPN 4 who indicated she accidentally took the 44 hydrocodone-acetaminophen 5-325 mg from the facilities lock box and would return them. On 5/22/25 at 9:49 a.m., the facility investigation into the missing narcotic pain medication was reviewed. The investigation indicated the following: - Resident B's Controlled Drug Record indicated the resident should have had 30 hydrocodone-acetaminophen 5-325 mg on the cart. The tablets were missing. - Resident C Oxycodone-acetaminophen 5-325 mg, one tablet every four hours as needed for acute pain. The facility investigation indicated that one medication was missing - Resident D's Tramadol 50 mg three times a day. The facility investigation indicated one Tramadol was missing.			

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	- Resident E's hydrocodone-acetaminophen 5-325 mg tablet, oral tab three times a day. The facility investigation indicated one hydrocodone-acetaminophen was missing. - Resident F's hydrocodone-acetaminophen 5-235 mg, one by mouth, every six hours as needed. The facility investigation indicated that 44 hydrocodone-acetaminophen were missing. During an interview on 5/22/25 at 10:34 a.m., LPN 10 indicated that when narcotics needed to be destroyed the Unit Manager was notified and if a resident refused a narcotic, then two nurses would sign off on the destruction. During an interview on 5/22/25 at 10:55 a.m., RN 12 indicated the DON took care of destruction of narcotics unless it was a single dose refusal then two nurses signed off on the destruction. On 5/22/25 at 8:54 a.m., the Administrator (ADM) provided the facility policy, "Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy," with a revision date of 6/4/19, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...It is the policy of CarDon & Associates, Inc. and its member Communities to provide each resident with an environment that is free from...misappropriation of their property..." On 5/22/25 at 8:42 a.m., the Administrator (ADM) provided the facility policy, "Clinical- Policy and Procedure for Scheduled Drugs," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, ". 2, 2.3, Discontinued schedule II, III, IV and V drugs are to be destroyed in the Community in the presence of the Director of Nursing ("DON") or			

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	designee and a registered nurse employed by Community and their disposal record in accordance with the procedures for destruction of controlled drugs as provided in section 3. ". 4, 4.1, At the beginning of an associate's shift they must be count and account for all scheduled drugs, including refrigerated drugs with the outgoing associate. 4.2, At the end of an associate's shift they must count and account for all scheduled drugs, including refrigerated drugs with the oncoming associate". This citation relates to the Complaint IN00459109. 3.1-28(a)			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to develop care plans for 5 of 19 residents reviewed. Care plans were not developed for skin conditions, use of an electric wheelchair, and non-compliance. (Resident F, Resident 28, Resident 73, Resident 56, Resident 74) Finding includes: 1. On 5/20/25 at 8:30 a.m., observed Resident F in the hallway. Resident F was observed sitting in his manual wheelchair in the hall way. Resident F was wearing short pants. Multiple dried scabs were noted on his bilateral lower extremities. An open area was observed on his left knee and no dressing was observed. During an interview on 5/20/25 at 9:30 a.m., Resident F indicated the facility took his electric wheelchair away from him.	F 0656	**F 656 Develop/Implement Comprehensive Care Plan** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident F, 28,73, 56, and 74's care plans were reviewed and updated as needed. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents care plan's have been audited and updated as needed.	06/17/2025

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	On 5/20/25 at 10:00 a.m., Resident F's clinical record was reviewed. The diagnoses included, but were not limited to, physical debility and muscle weakness. An Admission Assessment, dated 4/21/25, indicated Resident F arrived to the facility with a motorized wheelchair. An Admission Minimum Data Set (MDS) assessment, dated 4/28/25, indicated Resident F was cognitively intact. A Physician's Order, dated 4/13/25 with no end date, indicated clean open scab on left knee every other day with normal saline and cover with a border dressing every evening and every shift as needed for soilage or dislodgement. An Occupational Therapy Note, dated 5/15/25, indicated Resident F had several incidents where he had run into objects with his power wheelchair. The facility would prohibit the use of the electric wheel chair until further assessments and training were completed. The clinical record lacked a comprehensive care plan related to the use of Resident F's electric wheel and skin conditions. During an interview on 5/21/25 at 1:00 p.m., the Administrator indicated the electric wheelchair was taken away for safety issues. Resident F was to be evaluated by Occupational Therapy to determine if the resident was safe to use the electric wheelchair. During an interview on 5/21/25 at 1:33 p.m., the Administrator indicated the clinical record lacked		**III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nurses who intiate care plans and Social Services are being educated regarding implementation of the individual plan of cares. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will review careplans for new residents or residents with changes of condition ensure that care plans have been implemented weekly for 12 weeks and then quarterly ongoing. 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%. **V. Plan of Correction completion date.** Date of Compliance: 6/17/25	

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	a care plan regarding the electric wheelchair. During an interview on 5/24/25 at 2:33 p.m., the Director of Nursing indicated the clinical record lacked a care plan regarding Resident F's skin conditions. 2. On 5/24/25 at 12:00 p.m., the clinical record of Resident 74 was reviewed. The diagnoses included but was not limited to, vascular dementia and type 2 diabetes mellitus. A Skin Assessment, dated 2/26/25, indicated an open area on Resident 74's right heel. A Physician's order, dated 3/29/25, indicated, cleanse right heel with normal saline or wound cleanser. Pat dry and paint with betadine pad with ABD pad and wrap with kerlix. The clinical record lacked a care plan related to the pressure ulcer on Resident 74's right heel. On 5/24/25 the Administrator indicated the facility was unable to locate a current skin care plan that included the pressure ulcer on Resident 74's right heel. 3. On 5/19/25 from 9:40 a.m. to 9:50 a.m., Resident 56 was observed resting in bed. The bed was observed to be in the highest position, approximately 40 inches above the floor. The handheld bed control device was observed on the bed and within reach of the resident. No staff were visible in the area during that time. During an interview at that time, Resident 56 indicated she liked the bed being so high above the floor so she could watch people walking in the hall. On 5/19/25 from 11:25 a.m. to 11:35 a.m., Resident 56 was observed resting in bed. The bed was		The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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	observed to be in the highest position, approximately 40 inches above the floor. The handheld bed control device was observed on the bed and within reach of the resident. No staff were visible in the area during that time. During an interview on 5/19/25 at 11:37 a.m., LPN 5 indicated she did not know the reason for Resident 56's bed to have been left in the highest position. LPN 5 was observed exiting Resident 56's room without lowering the height of the bed. During an interview on 5/19/25 at 11:37 a.m., CNA 6 Indicated Resident 56's bed was not usually kept in the highest position and there were times when Resident 56 would adjust the height of the bed. CNA 6 was observed adjusting the bed into a lower position. On 5/19/25 at 11:45 a.m., Resident 56's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, mood disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/25, indicated Resident 56 was severely cognitively impaired. The clinical record lacked a care plan related to Resident 56's non-compliance with keeping the bed in the low position. During an interview on 5/21/25 at 4:15 p.m., the Administrator indicated Resident 56's care plan should have reflected her non-compliance with keeping the bed in the low position. 4. On 5/20/25 from 8:35 a.m. to 8:40 a.m., Resident 73 was observed resting in bed while eating breakfast. Resident 73's call light was observed			

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	approximately 3 feet to the left of the head of the bed. The call light cord and mechanism were observed hanging from the wall to approximately 3 inches from the floor. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73 indicated he did not know where the call light was located. During an interview on 5/20/25 at 8:43 a.m., Scheduler 7 indicated Resident 73's call light was to be kept within reach of the resident. Resident 73 "sometimes would throw his call light around." On 5/22/25 at 8:45 a.m., Resident 73 was observed sitting in his wheelchair that was positioned at the foot end of the left side of the bed. Resident 73 was facing away from the head of the bed. Against the wall and to the left of the head of the bed was a small bedside table. The call light cord and mechanism were observed hanging from the wall to the floor to the left of the bedside table. The observed call light system was not within reach of the resident. During an interview at that time, Resident 73 indicated he did not where the call light was located. During an interview on 5/22/25 at 8:47 a.m., Unit Manager 8 indicated call lights were to be kept within reach of the resident. Resident 73 was known to "toss the call light around at times." On 5/20/25 at 1:18 p.m., Resident 73's clinical record was reviewed. The diagnosis included, but was not limited to, hemiplegia and hemiparesis (paralysis) following a stroke affecting the dominant right side. The Annual MDS assessment, dated 4/29/25, indicated Resident 73 was severely cognitively			

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GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

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	impaired and at risk for falls. Resident 73's clinical record lacked a care plan to address Resident 73's behavior for throwing the call light beyond his capacity to retrieve the call light. 5. During an observation on 5/21/25 at 11:00 a.m., Resident 28's coccyx and right ankle treatments were observed as ordered by the physician. Unit Manager 8 was observed cleansing the right ankle with normal saline, patting it dry, and applying a collagen sheet with silver and covering the area. Unit Manager 8 was also observed applying a thin layer of triad wound dressing to Resident 28's coccyx area. On 5/21/25 at 9:23 a.m., Resident 28's clinical record was reviewed. The diagnoses included, but were not limited to, sepsis, disorder of the muscle and abnormal posture. Current Physician Orders included, but was not limited to, the following: - Dated 3/19/25 with no end date noted, indicated "Cleanse wound to [right] ankle with [normal saline], pat dry, apply collagen sheet with silver, cover with island dressing...daily..." - Dated 5/15/25 with no end date noted, indicated "triad wound dressing paste, thin amount - topical...apply thin layer to [moisture associated skin damage]...every shift..." The Annual MDS assessment, dated 3/3/25, indicated Resident 28 was moderately cognitively impaired. Section M: Skin Conditions indicated Resident 28 was at risk of developing pressure ulcers and currently had one stage 2 pressure			

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	ulcer and one stage 3 pressure ulcer. On 5/22/25 at 9:22 a.m., the Administrator provided a copy of the current Wound Evaluation and Management Summary document that was completed by the Wound Physician on 5/21/25. A review of the document indicated Resident 28 currently had a stage 2 pressure wound on the coccyx and a stage 3 wound on the right ankle. The wounds had been present for at least 98 days and were considered in the healing process. Resident 28's clinical record lacked a a care plan for the two pressure ulcers. During an interview on 5/21/25 at 4:15 p.m., the Director of Nursing indicated Resident 28's care plan should have reflected the coccyx and right ankle-related skin conditions. On 5/22/25 at 1:21 p.m., the Administrator provided a copy of the Care Pans, Comprehensive Person-Centered policy, dated December 2016, and indicated it was the current policy being used by the facility A review of the document included, "...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...assessments of the residents are ongoing and care plans are revised as information about the residents and the residents' condition change..." 3.1-35(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care			

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	Based on observation, record review, and interview, the facility failed to provide care in accordance with the plan of care for 1 of 1 residents reviewed for skin conditions. Physician's orders were not followed for skin treatments. (Resident F) Finding includes: On 5/20/25 at 8:30 a.m., observed Resident F in the hallway. Resident F was observed sitting in his wheelchair in the hall way. Resident F was wearing short pants. Multiple dried scabs were observed on both of his legs. An open area was observed on his left knee. No dressing was observed. On 5/21/25 at 9:00 a.m., observed Resident F in the hallway wearing short pants. Multiple dried scabs were observed on his both of his legs. An open area was observed on his left knee. No dressing was observed. On 5/22/25 at 9:18 a.m., Resident F was observed sitting in the hallway in his wheelchair wearing shorts. Dried red drainage was observed on his left leg. Open area's on both legs and his left knee were observed to be exposed. On 5/23/25 at 9:48 a.m., Resident F's clinical record was reviewed. The diagnosis included, but was not limited to, type 2 diabetes mellitus with neuropathy. A Physician's Order, initiated 4/13/25, indicated to clean the open scab on the left knee every other day with normal saline and cover with a border dressing every evening and every shift as needed for soilage or dislodgement.	F 0684	**F 684 Quality of care** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident Fs Physician orders were reviewed and updated per physician. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents wound orders were reviewed to ensure treatments were being completed per physician orders. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nursing staff are being educated to follow wound treatments per the physician order. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will review 5 residents with wounds to ensure treatments were done per physician order daily for 4 weeks, weekly for 12 weeks and then	06/17/2025

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	During an interview on 5/22/25 at 1:30 p.m., the Director of Nursing indicated the facility was to follow the physicians orders for the treatment of Resident F's lower extremities and should have had a dressing as ordered by the physician. 3.1-37(a)		quarterly ongoing. 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%. **V. Plan of Correction completion date.** Date of Compliance: 6/17/25 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record review, the facility failed to ensure a resident's enteral feeding (tube feeding) was signed and dated for 1 of 1 resident reviewed for enteral feeding devices. (Resident 253) Finding includes: On 5/19/25 at 11:45 a.m., Resident 253's clinical record was reviewed. The diagnoses included, but were not limited to, atherosclerotic heart disease (a build-up of plaque in artery walls) and unspecified dysphagia (difficulty swallowing). Physician's Orders indicated Resident 253 had an	F 0693	**F 693 Tube Feeding Mgmt/Restore eating skills** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident 253's tube feeding was signed and dated. **II. The facility will identify other residents that may potentially be affected by the practice.**	06/17/2025

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	order for Osmolite 1.2 (a type of enteral tube feeding) to run at 65 mL/hr (milliliters per hour) and H20 (water) at 53 mL/hr bolus (dose) to run continuously on each shift. On 5/19/25 at 12:45 p.m., Resident 253 was observed resting in bed. Next to the bed was an IV pole with an electronic pump device connected to Resident 253. The device was noted to be running at the time of observation. The tube feeding container running into the pump device was labeled as Osmolite 1.2 roughly three fourths full of a tan colored liquid and an unlabeled bag filled with clear liquid also running into the pump device. The feeding container had areas where staff could sign and date it, but they were blank. The clear plastic bag of clear fluid was also unlabeled or dated. The tubing itself was unlabeled or dated. On 5/20/25 at 8:40 a.m., Resident 253 was observed sitting up in his wheelchair. Next to the wheelchair was an electronic pump device connected to Resident 253. The device was noted to be running at the time of observation. The tube feeding container running into the pump device was an Osmolite 1.2 mostly full of a tan colored liquid and an unlabeled bag filled with clear liquid also running into the pump device. The feeding container had areas where staff could sign and date it, but they were blank. The clear plastic bag of clear fluid was also unlabeled or dated and the top of the bag was open. The tubing itself was unlabeled or dated. During an interview on 5/20/25 at 8:58 a.m., LPN 9 indicated that the feeding container and water flush bag should both be labeled, and that the flush bag should not be open. LPN 9 closed the water flush bag and indicated another nurse had		Other residents will be audited to ensure tube feeds are signed and dated. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nursing staff are being educated to sign and date tube feedings. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit residents on tube feeds for signature and date daily for 4 weeks, weekly for 12 weeks and then quarterly ongoing. 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%. **V. Plan of Correction completion date.** Date of Compliance: 6/17/25 The Administrator will be	

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	started Resident 253's tube feeding earlier, but LPN 9 would find out when it was signed out and have it labeled appropriately. During an interview on 5/22/25 at 9:00 a.m., the DON (Director of Nursing) and Administrator indicated that the tube feeding bag should have been signed and dated. 3.1-47(a)(2)		responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on interview and record review, the facility failed to ensure residents were provided a two-step tuberculin skin test upon admission for 1 of 5 resident reviewed for tuberculin skin tests. (Resident 50) Finding includes: On 5/19/25 at 12:45 p.m., Resident 50's clinical record was reviewed. The diagnoses included, but were not limited to, chronic respiratory failure, chronic pulmonary edema (an abnormal build up of fluid in the lungs), and type 2 diabetes mellitus (a chronic condition causes high blood sugar levels). Resident 50 had an admission date of 3/29/25. Resident 50's TB (Tuberculin) test administration history indicated that resident had a first step TB skin test administered on 3/29/25 and a first step TB skin test administered on 4/30/25. The two skin tests were each read with negative results and they were administered 32 days apart. Both tests were labeled in the system as first step TB skin tests and there was no timely second step	F 0880	**F 880 Infection Prevention & Control** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident 50's Second step TB test was completed. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents are being audited to ensure the two step TB tests are completed. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nursing staff are being educated regarding the two step TB tests	06/17/2025

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	associated with either. During an interview on 5/22/25 at 9:00 a.m., the DON (Director of Nursing) indicated that Resident 50's two step TB skin tests were being repeated as the first two were administered too far apart chronologically. On 5/22/25 at 9:22 a.m., the Administrator provided a copy a policy titled "Tuberculosis Infection Control Program", dated October 2017, and indicated it was the policy currently in use by the facility. A review of the policy indicated, "A. Screening Admissions or Readmissions ...4. If the first TST [tuberculin skin test] is negative, a follow-up TST will be administered 1 to 3 weeks after the initial test is read." 3.1-18(f)		and timely administration. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit new admissions TB tests daily for 4 weeks, weekly for 12 weeks and then quarterly ongoing. 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%. **V. Plan of Correction completion date.** Date of Compliance: 6/17/25 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	