STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155506	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOLY CROSS REHABILITATION AND WELLNESS	17475 DUGDALE DR SOUTH BEND, IN 46635

(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 IN00454362. Complaint IN00454362 - Federal/State deficiencies related to the allegations are cited at F565. Survey dates: April 21, 22, 23, 24, 25 & 28, 2025 Facility number: 001201 Provider number: 155506 AIM number: 100380860 Census Bed Type: SNF: 21 SNF/NF: 45 Total: 66 Census Payor Type: Medicare: 21 Medicaid: 38 Other: 7 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 5/6/2025	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Based on interview and record review, the facility failed to effectively act and resolve Resident Council's concerns related to long call light response times. This failure affected 2 of 7	F 0565	The facility requests paper compliance • what corrective action(s) will be accomplished for those residents	06/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roger Garmendia	Administrator	05/30/2025

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	residents attending the Resident/Surveyor group meeting. Findings Include: During a Resident/surveyor meeting on 4/22/25 at 12:59 P.M., seven of seven residents indicated the Resident Council had complained about long wait times for their call lights to be answered. Two of seven residents reported they were experiencing continued delays, and Resident B stated he had waited as long as an hour within the past couple of weeks. A review of Resident Council meeting minutes revealed repeated concerns over the past year about delayed call light responses on the following months: - 1/27/2025 - 10/16/2024 - 7/8/2024 During an interview on 4/24/2025 at 10:00 A.M., the Executive Director (ED) acknowledged he had been made aware of the Resident Council concerns regarding long call light response times. He indicated he had identified two potential causes for the issue related to long call light response times: the call light system required a 2-3 second hold to properly reset and some staff ignored call light alarms assuming they had already been answered and care had been provided. The ED indicated the call light concerns and system had been addressed in the facility's QAPI (Quality Assurance and Performance Improvement) meetings and a Performance Improvement Project (PIP) had been implemented for both October 2024 and January 2025. However, the long call light response/wait times		found to have been affected by the deficient practice: A call light satisfaction survey was completed with all long term interviewable residents including Resident Council Members on 5/28/25. Concerns found are being addressed as individual grievances. • 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; o A call light satisfaction survey was completed with all long term interviewable residents. Concerns found are being addressed as individual grievances. All concerns voiced in monthly resident council will be taken through the grievance process to assure all concerns are addressed. Concerns will be tracked/trended and discussed in QAPI for proper follow-up and process improvement. o All care staff will be re-educated on the proper use of the call light system and prompt response to activated call lights. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:	

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	had persisted. The ED indicated call light response times had been added to QAPI as a PIP in October 2024 and the plan had been closed out after two months because he was not receiving complaints from residents anymore. The ED indicated the staff had been educated on the call light system and the need to hold the reset buttons on the call lights but he was unable to provide the documentation of the education prior to the exit of the survey. In January 2025, call lights were again added to QAPI as a Performance Improvement Plan (PIP) after several complaints. One intervention was the facility had implemented was running daily reports for call light times and discussing the reports at the morning meetings. Another intervention was to have an Administrator hold a call light pager while they were in the building and the on-call manager held the call light pager while in the building on the weekends. The ED indicated after the Administrators left for the day, there was no one to monitor the call lights during the evening and night shifts. In addition, the ED indicated staff had not followed up with the residents that had experienced long call light wait times based on the call light response reports. He indicated the maintenance department was aware of the problem and had worked on the system several times. Although the facility had implemented PIP plans, the ED indicated he had based the call light wait times on resident feedback, but again indicated no one had followed up with the residents who had experienced long call light wait/response times from the call light report.. A review of the call light report was completed on 4/24/2025 at 11:00 A.M. The following dates and times had a call light response time of 30 minutes or longer. When asked what the facility considered a reasonable maximum call light wait/response time, the ED indicated he was not		All care staff will be re-educated by the compliance date on the proper use of the call light system and prompt response to activated call lights. The Activities Director will be re-educated on taking all concerns voiced in Resident Council through the grievance process. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The IDT will complete random call light satisfaction surveys twice a week for 4 weeks, weekly for 4 weeks, and then monthly x4. Concerns mentioned during the surveys will be addressed as individual grievances. The Administrator or designee will review the Resident Council minutes x6 months to assure concerns brought forward are taken through the grievance process. Results of the surveys and review of Resident Council Minutes will be taken to QAPI for review/revision/tracking and trending as appropriate.	

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	able to give a timeframe regarding when the call light should have been answered because the answer would have been different based on what the staff were working on at the time the call light went alarmed. -4/10/2025 at 12:12 A.M. call light from room 24 took 45 minutes to be turned off. -4/10/2025 at 12:23 A.M. call light from room 1224 took 1 hour 15 minutes to be turned off. -4/10/2025 at 12:46 A.M. call light from room 1214 took 51 minutes to be turned off. -4/10/2025 at 2:08 A.M. call light from room 1220 took 59 minutes to be turned off. -4/10/2025 at 4:05 A.M. call light from room 7 took 44 minutes to be turned off. -4/10/2025 at 5:07 A.M. call light from room 1218 took 34 minutes to be turned off. -4/10/2025 at 8:19 A.M. call light from room 11 took 44 minutes to be turned off. -4/10/2025 at 8:37 A.M. call light from room 31 took 1 hour and 36 minutes to be turned off. -4/10/2025 at 8:41 A.M. call light from room 22 took 1 hour and 45 minutes to be turned off. -4/10/2025 at 12:23 A.M. call light from room 1220 took 59 minutes to be turned off. -4/10/2025 at 9:48 A.M. call light from room 14 took 35 minutes to be turned off. -4/10/2025 at 10:45 A.M. call light from room 5 took 56 minutes to be turned off. -4/10/2025 at 10:57 A.M. call light from room 19 took 1 hour and 37 minutes to be turned off. -4/10/2025 at 11:07 A.M. call light from room 3 took 34 minutes to be turned off. -4/10/2025 at 1:52 P.M. call light from room 11 took 37 minutes to be turned off. -4/10/2025 at 1:59 P.M. call light from room 16 took 34 minutes to be turned off. -4/10/2025 at 2:10 P.M. call light from room 27 took 1 hour and 33 minutes to be turned off.			

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	-4/10/2025 at 2:28 P.M. call light from room 30 took 53 minutes to be turned off. -4/10/2025 at 2:53 P.M. call light from room 1122 took 44 minutes to be turned off. -4/10/2025 at 3:14 P.M. call light from room 28 took 1 hour and 46 minutes to be turned off. -4/10/2025 at 4:30 P.M. call light from room 1209 took 32 minutes to be turned off. -4/10/2025 at 5:28 P.M. call light from room 16 took 41 minutes to be turned off. -4/10/2025 at 6:05 P.M. call light from room 1202 took 30 minutes to be turned off. -4/10/2025 at 6:44 P.M. call light from room 1122 took 1 hour and 57 minutes to be turned off. -4/10/2025 at 7:10 P.M. call light from room 15 took 40 minutes to be turned off. -4/10/2025 at 7:58 P.M. call light from room 28 took 60 minutes to be turned off. -4/10/2025 at 8:42 P.M. call light from room 11 took 38 minutes to be turned off. -4/10/2025 at 9:58 P.M. call light from room 30 took 45 minutes to be turned off. -4/10/2025 at 10:01 P.M. call light from room took 2 hours and 26 minutes to be turned off. -4/10/2025 at 10:03 P.M. call light from room 27 took 51 minutes to be turned off. -4/10/2025 at 10:13 P.M. call light from room 3 took 44 minutes to be turned off. -4/10/2025 at 10:15 P.M. call light from room 11 Bed A took 30 minutes to be turned off. -4/10/2025 at 10:43 P.M. call light from room 11 Bed B took 2 hours and 1 minute to be turned off. -4/10/2025 at 11:35 P.M. call light from room 11 Bed A took 32 minutes to be turned off. -4/11/2025 at 1:08 A.M. call light from room 11 Bed B took 1 hour and 40 minutes to be turned off. -4/11/2025 at 1:27 A.M. call light from room 1217 took 36 minutes to be turned off. -4/11/2025 at 1:29 A.M. call light from room 19 took 1 hour and 44 minutes to be turned off.			

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	-4/11/2025 at 4:15 A.M. call light from room 16 took 1 hour and 9 minutes to be turned off. -4/11/2025 at 5:07 A.M. call light from room 5 took 2 hours and 45 minutes to be turned off. -4/11/2025 at 5:20 A.M. call light from room 21 took 1 hour and 5 minutes to be turned off. -4/11/2025 at 6:35 A.M. call light from room 16 took 2 hours and 7 minutes to be turned off. -4/11/2025 at 8:59 A.M. call light from room 3 took 1 hour and 2 minutes to be turned off. -4/11/2025 at 10:20 A.M. call light from room 27 took 38 minutes to be turned off. -4/11/2025 at 10:35 A.M. call light from room 5 took 1 hour and 40 minutes to be turned off. -4/11/2025 at 11:57 A.M. call light from room 14 took 53 minutes to be turned off. -4/11/2025 at 12:15 P.M. call light from room 6 took 2 hours to be turned off. -4/11/2025 at 1:10 P.M. call light from room 8 took 1 hour and 8 minutes to be turned off. -4/11/2025 at 1:39 P.M. call light from room 20 took 2 hours and 48 minutes to be turned off. -4/11/2025 at 3:01 P.M. call light from room 11 took 1 hour and 28 minutes to be turned off. -4/11/2025 at 3:20 P.M. call light from room 20 took 1 hour and 10 minutes to be turned off. -4/11/2025 at 3:36 P.M. call light from room 3 took 1 hour to be turned off. -4/11/2025 at 4:30 P.M. call light from room 16 took 30 minutes to be turned off. -4/11/2025 at 6:41 P.M. call light from room 27 took 59 minutes to be turned off. -4/11/2025 at 6:46 P.M. call light from room 11 Bed A took 43 minutes to be turned off. -4/11/2025 at 8:08 P.M. call light from room 11 Bed B took 54 minutes to be turned off. -4/11/2025 at 8:21 P.M. call light from room 28 took 48 minutes to be turned off. -4/11/2025 at 8:38 P.M. call light from room 27 took 40 minutes to be turned off.			

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	-4/11/2025 at 9:15 P.M. call light from room 13 took 41 minutes to be turned off. -4/11/2025 at 9:44 P.M. call light from room 5 took 35 minutes to be turned off. -4/11/2025 at 10:39 P.M. call light from room 16 took 1 hour and 29 minutes to be turned off. -4/11/2025 at 11:14 P.M. call light from room 1217 took 40 minutes to be turned off. This citation relates to Complaint IN00454362. 3.1-19(u)			
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility failed to ensure the Discharge Minimum Data Set (MDS) assessment was completed and submitted in a timely manner for 1 of 4 residents who were reviewed for discharge assessments. (Resident 29) Findings include: Resident 29's record review was completed on 04/23/2025 at 10:47 AM. Diagnoses included, but were not limited to: hypertension, atrial fibrillation, and arthritis. Resident 29 was discharged on 12/22/2024. Resident 29's Discharge MDS assessment was completed and submitted on 4/23/2025, 122 days after discharge. During an interview on 04/28/25 at 11:15 AM, the Director of Nursing (DON) indicated the MDS assessment had not been completed or submitted timely. The DON also indicated the facility did not have a policy related to MDS assessment completion and followed the Resident	F 0640	The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Discharge assessment for Resident 29 was completed, transmitted, and accepted on 4/23/25. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The MDS nurse/ designee will review the current open MDS assessments to ensure timely completion and transmittal according to the RAI manual. Any outstanding assessments will be completed and transmitted as	06/06/2025

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	Assessment Instrument (RAI) manual as their guidance. According to the RAI User's Manual, Chapter 2, Page 2-17, a Discharge assessment must be completed (i.e., signed and dated as complete) within 14 days after the resident had been discharged from the facility, and submitted within 14 days of completion.		required. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The MDS nurse will be re-educated on timely completion and transmission of MDS assessments according to the RAI manual. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The MDS nurse/ designee will monitor the MDS tracker for open assessments weekly for 4 weeks, then monthly for 5 months to assure timely completion and transmission of assessments. Results of audits will be taken to QAPI for review/revision as appropriate.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 2 of 17 residents reviewed for care planning (Resident 22-bowel	F 0656	The facility requests paper compliance • what corrective action(s) will be accomplished for those residents	06/06/2025

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	issues) and (Resident 27-skin issues). Findings include: 1. A record review was completed on 4/23/2025 at 9:01 A.M. for Resident 22. Diagnoses included, but were not limited to, Parkinson's disease and chronic kidney disease. A Significant Change Minimum Data Set (MDS) assessment, dated 1/29/2025, indicated Resident 22's cognition was moderately impaired and he was occasionally incontinent of bowels. Physician Orders included, but were not limited to: -3/20/2025 Linzess 145 micrograms (mcg) by mouth daily for constipation. -3/13/2025 polyethylene glycol 17 grams by mouth daily mixed with 4-8 ounces of water for constipation. -12/10/2024 docusate sodium 100 milligrams (mg) by mouth twice a day for constipation. The record lacked a care plan that addressed bowel issues, including constipation, and the use of bowel medications. During an interview on 4/25/2025 at 1:40 P.M., the ADON confirmed although Resident 22 received three different medications for his bowels, there was no care plan addressing the bowel issues or medication use. 2. During an observation of a medication administration on 04/23/2025 at 8:51 A.M., Resident 27 had a dime-sized blister located directly below the G-tube site on his abdomen. LPN 4 indicated the blister was new and attributed it to friction caused by the G-tube tubing being too long. LPN 4 pointed to a band-aid located toward the center of Resident 27's abdomen and		found to have been affected by the deficient practice: 1. Resident 22's care plan was revised to reflect current order BM issues and use of bowel medication. 2. Resident 27's care plan was revised to address the abdominal blister. • 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 care plans for LTC residents will be reviewed by the IDT to assure the care plans are comprehensive. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur The Interdisciplinary team will be re-educated on the process for developing, updating and reviewing comprehensive care plans. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will	

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	indicated the resident had developed a similar blister several days earlier due to friction from the tubing rubbing on the resident's skin. LPN 4 indicated the resident did not have an order for the treatment of the second blister and she did not know if the facility had created a Care Plan to address further blister formation from the G-tube. Resident 27's record review was completed on 04/23/2025 at 10:51 AM. Diagnoses included, but were not limited to: cerebral infarction, rhabdomyolysis, dysphagia, and chronic kidney disease. An Admission Minimum Data Set (MDS) assessment, dated 1/28/2025, indicated the had a G-tube. There was no care plan for Resident 27 to address the skin issues caused by his gastostomy tube. A Nurse's Progress Note, dated 04/21/2025, indicated, "Blister noted to belly near G-Tube holder, red, unopened, possibly due to friction and rubbing of G-tube and clamp. Repositioned tubing, secured with paper tape and blister covered with band aid for protection. Clinical Care Coordinator (CCC) was aware." During an interview with the Director of Nursing (DON) on 4/25/2025 at 10:59 A.M., the DON indicated Resident 27 should have had a G-tube care plan created after admission. On 4/25/2025 at 1:18 P.M., the Director of Nursing (DON) indicated the facility did not have a policy related to creating care plans and the facility used the Nursing Standards of Practice for creating care plans.		complete a random audit of care plans that have been reviewed by the Care Conference team weekly for 4 weeks, then monthly for 5 months to assure care plans are comprehensive. Results of audits will be taken to QAPI for review/revision as appropriate.	

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	American Nurses Association (ANA), Nursing: Scope and Standards of Practice, 4th Edition, 2021, included, "The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes. The plan reflects current evidence, is derived from the assessment, and is modified as needed in response to the patient's condition or situation...." 3.1-35 (d)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview and record review, the facility failed to ensure the skin of a resident with a Gastronomy tube (G-tube) did not develop blisters caused by the friction from the G-tube for of 1 of 6 residents who were reviewed for skin problems. (Resident 27) Finding includes: During an observation of a medication administration on 04/23/2025 at 8:51 A.M., Resident 27 had a dime-sized blister directly located below the G-tube site on his abdomen. LPN 4 indicated the blister was new and attributed it to friction caused by the G-tube tubing being too long. LPN 4 pointed to a band-aid located toward the center of Resident 27's abdomen and indicated the resident had developed a similar blister several days earlier due to friction from the tubing rubbing on the resident's skin. LPN 4 indicated the resident did not have an order for the treatment of the second blister and she did not know if the facility had created a Care Plan to address further blister formation from the G-tube. Resident 27's record review was completed on	F 0684	The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 27's care plan was revised to ensure interventions are in place for blister prevention. The family and physician were notified, and a treatment order was obtained. • 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 with a G-Tube will be reviewed to ensure proper positioning of catheter and prevention measures are in place to prevent friction. All current wounds were reviewed to assure proper notifications, treatment	06/06/2025

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	155506	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOLY CROSS REHABILITATION AND WELLNESS	17475 DUGDALE DR SOUTH BEND, IN 46635

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	04/23/2025 at 10:51 AM. Diagnoses included, but were not limited to: cerebral infarction, rhabdomyolysis, dysphagia, and chronic kidney disease. A Nurse's Progress Note, dated 04/21/2025, indicated, "Blister noted to belly near G-Tube holder, red, unopen, possibly due to friction and rubbing of G-tube and clamp. Repositioned tubing, secured with paper tape and blister covered with band aid for protection. Clinical Care Coordinator (CCC) was aware." Resident 27's record lacked the documentation that the provider had been notified of the new blister, orders for treatment of the new blister had been obtained, or a Care Plan had been created after either blister developed. During an interview with the CCC and the Director of Nursing (DON) on 4/25/2025 at 10:59 A.M., the CCC indicated she had been notified verbally about the blister but because the notification was verbal, she had forgotten to follow up. The CCC indicated the provider and family had not been notified but should have been and the resident's plan of care should have been updated. The CCC indicated, in addition, physician orders should have been obtained regarding treatment of the blister and preventative treatments for the G-tube site. The DON indicated Resident 27 should have had a care plan created for a G-tube after the first blister had formed On 4/25/2025 at 1:18 P.M., the Director of Nursing (DON) indicated the facility did not have a policy for contacting the provider for a change in the resident's condition or a policy related to creating care plans. The DON indicated the facility used the Nursing Standards of Practice for contacting		orders and care plans are in place. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All active clinical staff will be re-educated on proper positioning of G-Tube to avoid friction injuries. All active nurses will be re-educated on the processes to follow if a wound is noted. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will complete a random audit to ensure proper positioning of G-tubes; The DON or designee will complete a random audit of new wound documentation to assure proper notifications, care plan interventions and treatment orders are in place weekly for 4 weeks, then monthly for 5 months. Results of audits will be taken to QAPI for review/revision as appropriate.	

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	the provider and creating a care plan. American Nurses Association (ANA), Nursing: Scope and Standards of Practice, 4th Edition, 2021, included, "The registered nurse communicates effectively in all areas of practice. This includes timely and appropriate communication with healthcare providers regarding changes in patient condition....The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes. The plan reflects current evidence, is derived from the assessment, and is modified as needed in response to the patient's condition or situation." 3.1-37 (a)			
F 0757 Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interviews, the facility failed to ensure there was adequate monitoring of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 25) Findings include: A record review for Resident 25 was completed on 4/23/2025 at 4:01 P.M. The resident's diagnoses included, but were no limited to: hypertension, diabetes mellitus, anxiety, depression, bipolar disorder and hereditary and idiopathic neuropathy. A Quarterly Minimum Data Set (MDS) assessment, dated 4/15/2025, indicated Resident 25 was cognitively intact. The MDS assessment indicated the resident had no potential indicators	F 0757	The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 25 had an AIMS assessment completed on 4/16/25 • 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 LTC residents with orders for antipsychotic medications were reviewed to assure an AIMS	06/06/2025

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	of psychosis, no behavioral symptoms, had not demonstrated any rejection of care and had no wandering behaviors. In addition, the MDS assessment indicated the resident was receiving an antipsychotic, an antidepressant, an anticoagulant and a diuretic medication. A Physician Order, dated 2/20/2025, indicated the resident was to receive Aripiprazole (anti-psychotic) 2 mg (milligrams) tablet oral six times weekly for bipolar disorder. A Pharmacy Consultation Report, dated 8/8/2024, recommended an AIMS (Abnormal Involuntary Movement Scale) or similar assessment be completed for Resident 25, as one had not been completed in the previous 6 months. A Pharmacy Consultation Report, dated 9/17/2024, indicated a second request for an AIMS assessment, or similar assessment, be completed for Resident 25. The recommendation was signed by the medical provider. However, an AIMS assessment was not completed for Resident 25 until 1/19/2025. A current Care Plan, revised 1/19/2025, indicated Resident 25 had a diagnosis of bipolar disorder and was treated with an antipsychotic medication. Interventions included, but were not limited to: perform an AIMS test quarterly and as needed. During an interview, on 4/24/2025 at 3:22 P.M., the Assistant Director of Nursing (ADON) indicated Resident 25 has been on an antipsychotic and had an AIMS assessment completed in January and April of 2025. The ADON indicated the facility's policy was for nursing to complete AIMS assessments for residents taking antipsychotic medications every quarter or with any new dosage		assessment has been completed according to Standard of Practice. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The clinical leadership team will be re-educated on the standard of practice for AIMS assessments. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will complete random audits of LTC residents with orders for antipsychotic medications to assure an AIMS assessment completed according to standard of practice weekly for 4 weeks, then monthly x 5 months. Results of audits will be taken to QAPI for review/revision as appropriate.	

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	changes. During an interview, on 4/25/2025 at 10:02 A.M., the Social Services Worker (SSW) indicated she created the care plans for the residents in conjunction with the Unit Manager. SSW indicated the interventions in the care plan were monitored for completion by herself and the Unit Manager or other nursing management. SSW indicated she was unsure how the completion of AIMS assessments were being monitored. During an interview, on 4/25/2025 at 2:52 P.M., the ADON indicated there was no written facility policy regarding AIMS but that the facility standard was to perform an AIMS assessment every 6 months on any resident taking an antipsychotic. 3.1-25(i)			
F 0812 Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure the kitchen equipment was in working order for 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 66 of 66 residents who received meals from the kitchen. Finding includes: On 4/21/2025 at 9:26 A.M., an observation included the northernmost sink of the cooking area of the kitchen. This sink was leaking underneath into the drainage area from the drain pipe in addition to the faucet slowly running and unable to be turned off. During an interview, on 4/21/2025 at 10:15 A.M.,	F 0812	The facility requests paper compliance • What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The leaking faucet and drain will be repaired be the compliance date. • How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	06/06/2025

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	the Dietary Manager indicated Maintenance was aware of the broken sink and she indicated maintenance was waiting for a part to fix the sink. During an interview, on 4/24/2025 at 1:44 P.M., the Maintenance Director indicated he had never received a work order for the kitchen sink and was unaware of any broken sink in the kitchen. During an interview, on 4/24/2025 at 1:51 P.M., Registered Dietician 1 indicated she was unaware of any leaking sink in the kitchen and stated, " I usually just go through there and haven't noticed anything." On 4/24/2025 at 3:15 P.M., the Director of Nursing (DON) provided a policy titled, "Director of Dining Services", undated and indicated the policy was the one currently used by the facility. The policy indicated, "...the Director of Dining Services...directs and conducts safety, sanitation, and maintenance programs..." On 4/24/2025 at 3:15 P.M., the DON provided a policy titled, "Registered Dietitian", undated and indicated the policy was the one currently used by the facility. The policy indicated, "...The Registered Dietitian...set and communicate objectives, communicate, and reinforce high standard in all areas, monitor performance and addresses issues..." 3.1-19(bb)		action(s) will be taken: All sinks and drains in the kitchen were inspected for proper functionality. Repairs are being completed as needed. • What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All active dietary staff will be re-educated on submitting a work order to Maintenance. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The IDT will complete random audits of sinks and drains in the kitchen weekly for 4 weeks, then monthly x 5 to ensure proper functionality. Results of audits will be taken to QAPI for review/revision as appropriate.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure enhanced	F 0880	The facility requests paper compliance • what corrective action(s) will be	06/06/2025

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	barrier precautions were followed for 2 of 5 residents reviewed for isolation needs. (Resident 27 and 35) Findings include: 1. The clinical record of Resident 35 was reviewed on 4/24/2025 at 10:26 A.M. The resident's diagnoses included, but were no limited to: diabetes mellitus, septicemia, obstructive uropathy, hypertension, anxiety and depression. An Annual Minimum Data Set (MDS) assessment, dated 2/24/2025, indicated Resident 35 was moderately cognitively impaired, was taking an antibiotic and had an indwelling catheter. A Physician Order, dated 10/19/2024, indicated Resident 35 was to be in enhanced barrier precautions; with instructions noted to maintain enhanced barrier precautions during high-contact resident care activities. A current Care Plan, created 5/31/2024, indicated Resident 35 required enhanced barrier precaution isolation. During an observation and interview on 4/24/2025 at 11:08 A.M., CNA 3 entered Resident 35's room without any PPE (personal protective equipment or gear worn to minimize exposure to workplace hazards that could cause serious injuries or illnesses, such as chemical, radiological, physical, electrical, or mechanical hazards) in place. The PPE cart was located outside of the resident's room door. CNA 3 then performed hand hygiene with hand sanitizer and donned clean gloves once inside Resident 35's room but she did not don a gown or a mask. CNA 3 then transferred Resident 35 from her bed to her wheelchair. CNA 3 exited		accomplished for those residents found to have been affected by the deficient practice: CNA 3 and LPN 4 have been educated on enhanced barrier precautions protocol and Transmission Precaution signage. • 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 on enhanced barrier precautions have the potential to be affected. All direct care staff will be re-educated on enhanced barrier precautions protocols and Transmission Precaution signage. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All direct care staff will be re-educated on enhanced barrier precautions protocols and Transmission Precaution Signage. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Infection Preventionist/designee will	

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	Resident 35's room after removing her gloves and performed hand hygiene. CNA 3 indicated she was unaware the resident was on "contact precautions" as CNA 3 indicated the nurse had not instructed her regarding the need for enhanced barrier precautions. CNA indicated if the resident was on enhanced barrier precautions, she should have been following the policy and worn a gown and mask. 2. During an observation of a medication administration on 04/23/2025 at 8:51 AM, LPN 4 administered a 200 milliliter (mL) water flush to Resident 27 Gastrostomy tube while only wearing gloves. LPN 4 was not wearing a gown when she administered the flush. An Enhanced Barrier Precautions (EBP) sign was hanging on Resident 27's to room door. During an interview on 04/23/2025 at 8:58 AM, LPN 4 indicated Resident 27 was in EBP and she should have worn a gown while administering the flush. Resident 27's record review was completed on 04/23/2025 at 10:51 AM. Diagnoses included, but were not limited to: cerebral infarction, rhabdomyolysis, dysphagia, and chronic kidney disease. A current Physician's order, dated 02/04/2025, indicated Resident 27 was on EBP. A current Care Plan, initiated on 01/28/2025, indicated Resident 27 was on EBP related to a Gastrostomy Tube (G-tube). On 04/23/2025, the Assistant Director of Nursing (ADON) provided a policy, dated 11/12/2024, and titled "Infection Prevention." The ADON		complete a random audit of residents on EBP to ensure staff follow proper enhanced barrier precaution procedures 2x/week for 4 weeks, then weekly for 4 weeks, then monthly x4. Results of audits will be taken to QAPI for review/revision as appropriate.	

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	indicated it was the policy currently used by the facility. The policy indicated: "...2. Enhanced Barrier Precautions...The use of gown and gloves for high-contact resident care activities may be indicated, when Contact Precautions do not otherwise apply, for nursing home residents with chronic wounds and/or indwelling medical devices regardless of MDRO colonization...." 3.1-18(a)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview the facility failed to ensure water faucets were functional in 4 of 30 rooms in the long term care unit. (Rooms W7, W12, W15 and W24) Findings include: 1. During an observation on 4/25/2025 at 2:00 P.M., the faucet in Room W7 was running and could not be turned off. During an interview on 4/25/2025 at 2:00 P.M., Resident 57 indicated it had been running for quite awhile but did not know how long. She had reported it to the facility but it had not been fixed yet. She indicated she turned her television volume up louder so she forgot about it and was able to sleep. 2. During an observation of Room W24 on 4/22/2025 at 11:12 A.M., the faucet was missing and water was continuously dripping down the back of the sink. 3. During an observation of W15 on 4/22/2025 at 9:44 A.M., the faucet was dripping continuously.	F 0921	The facility requests paper compliance • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The faucets in rooms W7, W12, W15, and W24 have been repaired. • 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 sinks in long term care were inspected for functionality. Sinks to be found malfunctioning have been scheduled for repair. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:	06/06/2025

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	4. During an observation of Room W12 on 4/22/2025 at 9:45 A.M., the faucet was dripping continuously. During a tour and an interview on 4/25/2025 at 2:35 P.M., the Maintenance Director indicated he had tried to fix the faucets but they needed to be replaced and he was not sure how many leaking sinks the facility had but admitted there were several. He indicated he had ordered new parts several months ago, and the parts had come in, but he was now waiting on a new tool that he had ordered. When asked when the tool was ordered he returned with the tool indicating it had just been delivered, and he would begin fixing the leaking faucets. On 4/25/2025 at 2:35 P.M. dates of work orders for leaking faucets and invoices, or purchase orders for parts and tools were requested, but none were provided prior to the exit of the survey. During an interview on 4/28/2025 at 11:00 A.M., the ED. indicated the facility did not have a policy for maintenance of the building. 3.1-19(f)		All active staff will be re-educated on the process of submitting work orders to Maintenance. In addition, the Maintenance Director will be re-educated on prompt response to work orders. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The IDT will do a random audit of sinks in resident rooms weekly for 4 weeks, then monthly x 5 to ensure proper functionality. Results of audits will be taken to QAPI for review/revision as appropriate.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:	F 9999	The facility requests paper compliance • What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	06/06/2025

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	(7) Documentation of orientation to the facility and to the specific job skills. This state rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure employees received a job specific orientation for 3 of 10 employees whose personnel records were reviewed. (Employees 10, 11 and 12) Findings include: During a review of employee personnel records on 4/23/2025 at 10:45 A.M., Employee 10's record lacked a signed job specific orientation. During a review of employee personnel records on 4/23/2025 at 10:50 A.M., Employee 11's record lacked a signed job specific orientation. During a review of employee personnel records on 4/23/2025 at 10:55 A.M., Employee 12's record lacked a signed job specific orientation. During an interview on 4/23/2025 at 9:00 A.M., the ED indicated the job specific orientations for Employees 10, 11 and 12 were missing from the employee personnel records. A policy regarding personnel records was requested on 4/23/2025 at 11:30 A.M. and again on 4/28/2025 at 1:15 P.M. but none was provided prior to the time of exit of the survey. 3.1-14 (t)(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		No residents were affected by this practice. Employees 10, 11 and 12 had a job specific orientation validation completed on 5/29/25. Employee 8 and Employee 9 will had a TB screening put in place on 5/29/25. • 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: Employee files will be audited by the Human Resources Manager/Designee to ensure job specific orientation and TB screens are 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: The Human Resources manager will be re-educated on assuring job specific orientation and TB screening are completed upon hire and kept in the employee file. • How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Human Resources manager/designee will complete a	

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	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 ensure, at the time of employment, 2 of 10 employees reviewed were screened for tuberculosis, utilizing the two-step Mantoux tuberculin skin testing method. (Employees 8 and 9) Findings include: During a review of Employee 8's personnel record, on 4/23/2025 at 11:00 A.M., there was no documentation of a first and second step tuberculosis (TB) test. Employee 8 had a hire date of 10/14/2024. During a review of Employee 9's personnel record, on 4/23/2025 at 11:05 A.M., there was no documentation of a first and second step TB test. Employee 9 had a hire date of 8/26/2024. On 4/28/2025 at 12:00 P.M. the ADON provided a policy titled, "TB Transmission Reduction Program" and dated 4/1/2014. The policy indicated, "...Colleagues receive baseline tuberculosis screening upon hire and annual testing or screening based on the THSC Community's risk classification or state specific requirements...."		random audit of new employee files to ensure job specific orientation and TB screenings are in place weekly for 4 weeks, then monthly x5. Results of audits will be taken to QAPI for review/revision as appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING 00 B. WING	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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