STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

(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. Survey dates: January 21, 22, 23, 27, 28, 29, 30, 2025 Facility number: 000451 Provider number: 155508 AIM number: 102266240 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 6 Medicaid: 50 Other: 1 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 13, 2025.	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 the plan of correction be considered our allegation of compliance effective March 1, 2025 to the state findings of the Recertification and State Licensure Survey conducted on January 30, 2025.	
F 0553 SS=E Bldg. 00	483.10(c)(2)(3) Right to Participate in Planning Care Based on interview and record review, the facility failed to facilitate care plan meetings with the resident and/or resident representatives for 5 of 6 random clinical records reviewed for care plan conferences and 1 of 5 residents reviewed for unnecessary medications. A newly admitted resident did not have an initial care plan conference and other residents care plan conferences were not held quarterly. (Resident	F 0553	F - 553 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 260 and/or their representative has now been invited to participate in the resident's care planning process.	03/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin L McCarty	Executive Director	02/27/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	260, Resident 11, Resident 35, Resident 26, Resident 3, Resident 30) Findings include: 1. On 1/28/25 at 8:09 A.M., Resident 260's clinical record was reviewed. Resident 260 was admitted to the facility on 10/10/24. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), schizophrenia, and alcohol dependence with alcohol induced persisting dementia. Resident 260's clinical record lacked a care plan conference since admission. 2. On 1/27/25 at 1:11 P.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, COPD, dementia with behaviors, schizophrenia, Parkinson's disease, and mild intellectual disorder. Resident 11's clinical record indicated the most recent care plan conference was 8/2/24. 3. On 1/27/25 at 8:19 A.M., Resident 35's clinical record was reviewed. Diagnoses included, but were not limited to, COPD, and dementia with behaviors. Resident 35's clinical record indicated the most recent care plan conference was 8/6/24. 4. On 1/27/25 at 11:15 A.M., Resident 3's clinical record was reviewed. Resident 3 was admitted on 2/10/23. Diagnoses included, but were not limited to acute on chronic systolic (congestive) heart failure, fracture of unspecified lumbar vertebra, chronic kidney disease stage 3B, retention of urine, Type 2 diabetes mellitus without complications.		There is documentation in the resident's clinical record to support this invitation to participate in the care planning process. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* there is now documentation in the clinical record to support that the resident identified as resident # 11 has had a recent care plan conference conducted. The resident # 11 and/or their representative was invited to participate in the care plan meeting. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* there is now documentation in the clinical record to support that the resident identified as resident # 35 has had a recent care plan conference conducted. The resident # 35 and/or their representative was invited to participate in the care plan meeting. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* there is now documentation in the clinical record to support that the resident identified as resident # 3 has had a recent care plan conference conducted. The resident # 3 and/or their representative was invited to participate in the care	

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	Resident 3's clinical record indicated the most recent care plan conference was 7/26/24. 5. On 1/22/25 at 1:16 P.M., Resident 26's clinical records were reviewed. Resident 26 was admitted on 10/15/22. Diagnoses included, but were not limited to disorder of bone density and structure, hereditary and idiopathic neuropathy, spinal stenosis, lumbar region with neurogenic claudication, achondroplasia, and neuromuscular dysfunction of bladder. Resident 26's clinical record indicated the most recent care plan conference was 8/2/24. 6. On 1/27/25 at 9:06 A.M., Resident 30's clinical records were reviewed. Resident 30 was admitted on 6/17/22. Diagnoses included, but were not limited to schizophrenia, obstructive sleep apnea, adjustment disorder with mixed anxiety and depressed mood, bipolar disorder, severe, with psychotic features, and dementia, severe, with psychotic disturbance. Resident 30's clinical record indicated the most recent care plan conference was 7/26/24. During an interview on 1/29/25 at 9:01 A.M., the Social Services Director (SSD) indicated she was responsible for scheduling care plan conferences and they should have been done quarterly. On 1/29/25 at 1:10 P.M., the Director of Nursing (DON) provided a current undated Care Plans, Comprehensive Person-Centered policy which indicated "...12. The interdisciplinary team reviews and updates the care plan:...d. at least quarterly, in conjunction with the required quarterly MDS assessment..."		plan meeting. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* there is now documentation in the clinical record to support that the resident identified as resident # 26 has had a recent care plan conference conducted. The resident # 26 and/or their representative was invited to participate in the care plan meeting. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* there is now documentation in the clinical record to support that the resident identified as resident # 30 has had a recent care plan conference conducted. The resident # 30 and/or their representative was invited to participate in the care plan meeting. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all clinical records has now been conducted to ensure that each resident and/or their representative has been invited to participate in the care planning process within the past ninety days. There is now documentation in each clinical record to support that the resident and/or their representative has	

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	3.1-3(n)(3) 3.1-35(d)(2)(B)		been invited to participate in the care planning process as well as the outcome of that participation. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the members of the interdisciplinary team on the facility's policy related to care plan meetings. The social service director was reminded of their responsibility to invite the resident and/or their representative to participate in the care planning process and to document this invitation in the clinical record. All members of the interdisciplinary team were also re-educated on their responsibility of documenting the outcome of the care planning process specific to their individual discipline. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the documentation involving the care planning process. The tool will monitor to ensure there is documentation to support that the resident and/or representative has been invited to participate in the care planning process on admission and at least every ninety days thereafter during the resident's stay at the facility. This tool will be completed by the Director of Nursing and/or their	

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			designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0576 SS=D Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy Based on interview and record review, the facility failed to deliver mail to the residents on Saturdays. Eleven of eleven anonymous residents interviewed indicated they failed to get mail every Saturday. Finding includes: During an interview on 1/27/25 10:53 A.M., eleven residents unanimously indicated they did not receive mail on Saturdays during the resident council meeting. During an interview on 1/27/25 at 11:49 A.M., the Activity Director indicated mail should be delivered everyday. At that time, she indicated she delivered the mail during the week and every other weekend an assistant delivered the mail. She further indicated two weekends a month the mail was not delivered because the office was locked. On 1/28/25 at 11:50 A.M., the Administrator provided a current Mail policy, revised November 2010, that indicated, " ...Mail will be delivered to	F 0576	F – 576 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified in the survey, all residents have the potential to be affected by this deficient practice. All residents are now receiving mail service on Saturdays. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents are now receiving mail service on Saturdays. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has now been conducted for all	03/01/2025

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	the resident within twenty-four (24) hours of delivery on premises ..." 3.1-3(s)(1)		weekend managers on their responsibility to ensure that mail service is delivered to the residents on Saturday in accordance with the regulations and facility policy. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has now been developed and implemented to monitor mail delivery service on Saturdays. The tool will question residents to ensure that they are receiving their mail on Saturdays in accordance with the regulations and facility policy. This tool will be completed by the Social Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, interview, and record review, the facility failed to ensure accuracy of assessments for 6 of 17 resident records reviewed during the survey. Minimum Data Set (MDS) assessments did not accurately reflect resident status. (Resident 31, Resident 20, Resident 6, Resident 23, Resident 30, Resident 40) Findings include:	F 0641	F - 641 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been completed and submitted for the resident identified as resident # 31 with the identified corrections.	03/01/2025

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	1. On 1/23/25 at 9:25 A.M., Resident 31's clinical record was reviewed. Diagnoses included, but were not limited to, depression and anxiety. The most recent Quarterly MDS assessment, dated 12/9/24, indicated no cognitive impairment and diuretic use. The assessment indicated Resident 31 had not received an opioid or an antiplatelet. Current physician orders included, but were not limited to: Aspirin (an antiplatelet) 81mg (milligrams) once a day, dated 8/20/24. Oxycodone-Acetaminophen (an opioid) 7.5-325mg every 12 hours as needed for pain, dated 8/18/24. Resident 31's Medication Administration Record (MAR) for December 2024 indicated during the MDS look back period, a diuretic had not been given, aspirin was administered daily, and oxycodone-acetaminophen was administered once on 12/6/24 at 10:02 A.M. 2. On 1/23/25 at 8:15 A.M., Resident 20's clinical record was reviewed. Diagnosis included but was not limited to, intellectual disability. The most recent Annual MDS assessment, dated 8/7/24, indicated a level 2 Preadmission Screening and Resident Review (PASARR) had not been completed for Resident 20. A level 2 PASARR was completed on 7/25/23. 3. On 1/23/25 at 8:27 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, major neurocognitive due to		*2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been completed and submitted for the resident identified as resident # 20 with the identified corrections. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been completed and submitted for the resident identified as resident # 6 with the identified corrections. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been completed and submitted for the resident identified as resident # 23 with the identified corrections. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been completed and submitted for the resident identified as resident # 30 with the identified corrections. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been completed and submitted for the resident identified as resident # 40 with the identified corrections.	

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	Parkinson's and Bipolar disorder. The most recent Admission MDS assessment, dated 7/8/24, indicated a level 2 Preadmission Screening and Resident Review (PASARR) had not been completed for Resident 6. A level 2 PASARR was completed on 12/20/23. 4. On 1/23/25 at 8:36 A.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limited to, major depression and psychotic disorder. The most recent Annual MDS assessment, dated 1/27/24, indicated a level 2 Preadmission Screening and Resident Review (PASARR) had not been completed for Resident 23. A level 2 PASARR was completed on 9/23/21. 5. On 1/23/25 at 8:42 A.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, Bipolar disorder, Schizophrenic disorder, and adjustment disorder. The most recent Annual MDS assessment, dated 5/28/24, indicated a level 2 Preadmission Screening and Resident Review (PASARR) had not been completed for Resident 30. A level 2 PASARR was completed on 8/22/22. 6. On 1/23/25 at 8:38 A.M., Resident 40's clinical records were reviewed. Diagnoses included, but were not limited to fracture of neck of right femur, and subsequent encounter for closed fracture with routine healing. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 11/16/24, indicated		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all MDSs completed in the past thirty days has now been conducted to ensure the accuracy of each assessment. All information now entered into the individual MDSs is now accurate. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the MDS coordinator to ensure they understand the importance of the accuracy of the MDS and that all entries are to be made in accordance with the RAI manual instructions and guidance. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure the accuracy of the MDS information. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	Resident 40 had moderate cognitive impairment, and had received one injection. Review of the Medical Administration Record (MAR) from 11/10/24 thru 11/16/24 (MDS lookback period) indicated an injection had not been administered during that time. On 1/23/25 at 12:30 P.M., the MDS Coordinator indicated she had "swapped" the antiplatelet and diuretic, marking the wrong one had been given, and missed the opioid on Resident 31's MDS assessment. Residents 20, 6, 23, and 30 should have been marked "yes" for having a level 2 PASARR on their MDS assessments. She further indicated Resident 40 had not received an injection and was unsure why it had been marked but should not have been. At that time, she indicated the Resident Assessment Instrument (RAI) manual was used to enter information into the MDS and was used as a facility policy.			
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 ensure development and implementation of a comprehensive person-centered care plan for each resident for 4 of 17 residents reviewed for care plans. A resident lacked a care plan for antidepressant use, and current care plan interventions were not followed. (Resident 4, Resident 54, Resident 23) Findings include: 1. On 1/22/25 at 1:20 P.M., Resident 4 was observed lying in bed. A call light was observed lying on the floor just under the bed, out of the resident's reach.	F 0656	F - 656 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 4 now has their call light secured within their reach as well as other frequently used items in accordance with their plan of care. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the care plan for the resident identified as resident	03/01/2025

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	On 1/23/25 at 9:13 A.M., Resident 4 was observed lying in bed. A call light was observed lying on the floor beside the bed, out of the resident's reach. On 1/23/25 at 12:19 P.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, depression and schizophrenia. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/12/25, indicated no cognitive impairment and no behaviors. Resident 4 required staff supervision with eating, bed mobility, and transfers. A current risk for falls care plan, dated 10/14/24, indicated an intervention to keep call light and frequently used personal items within reach , last revised 10/14/24. On 1/29/25 at 9:57 A.M., Certified Nurse Aide (CNA) 9 indicated Resident 4's call light should have been in reach at all times as the resident did use it. 2. On 1/27/25 at 1:49 P.M., Resident 54's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, and depression. The most recent Admission Minimum Data Set (MDS), dated 12/9/24, indicated Resident 54's cognition was severely impaired and received an antidepressant. Current physician's orders included, but were not limited to, the following: mirtazapine (antidepressant) 7.5 milligram tablet, take one tablet by mouth at bed time for mood stabilization, ordered 12/25/24		# 54 has now been updated and reflects the use of an antidepressant medication. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 23 now has their bed placed up against the wall and the wheels of the bed have been removed. A fall matt is placed on the floor at the side of the bed in accordance with the current plan of care. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit has been conducted on each resident to ensure that their care plan addresses each of the resident's needs/concerns and that all interventions are currently in place in accordance with their individualized plan of care. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has now been provided for all members of the interdisciplinary team as well as all nursing staff on their responsibility to ensure that a care plan has been developed and implemented to address each resident's current needs/concerns. Each staff	

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	Resident 54's clinical record lacked a care plan related to taking an antidepressant. During an interview on 1/29/25 at 9:21 A.M., the MDS Coordinator indicated she was responsible for developing resident care plans for medications received except for antipsychotics. She indicated if a resident was on a medication they should have a care plan for that medication. 3. On 1/27/25 at 10:53 A.M., Resident 23 was observed to be out of the room, the bed was in the middle of her side of the room, had wheels on it, and no fall mat was observed in the room. On 1/28/25 at 10:01 A.M., Resident 23's bed was not next to the wall, wheels were on bed, and no landing mat was observed in the room. On 1/23/25 at 10:33 A.M., Resident 23's clinical records were reviewed. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, Parkinson's disease with dyskinesia, vascular dementia with other behavioral disturbance, and fracture of right wrist and hand. The most current Quarterly Minimum Data Set (MDS) assessment, dated 11/27/24, indicated Resident 23 had moderate cognitive impairment, required supervision or touching assistance for eating, bed mobility, and transfers, and partial/moderate assistance for toilet use. Current care plans included, but were not limited to: Risk for falls due to medication usage, need for assistance with adls (activities of daily living), variable need for assistive device when ambulating, Parkinson's Disease, she had poor safety awareness and was impulsive, revised		member was also reminded of their individual responsibility to ensure that the care plan was followed. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the residents' care plans to ensure that the care plan addresses each of the resident's needs/concerns and that all interventions are in place in accordance with the current plan of care. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

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	1/23/2025. Interventions included, but were not limited to the following: Keep wheel chair next to bed, initiated 1/14/25 Assistive device rolling walker as needed, initiated 12/24/24 Bed in lowest position, initiated 1/2/25 Encourage to allow staff to assist with toileting needs, initiated 12/24/24 Encouraged to allow staff to assist with clothing and not put it up herself, initiated 12/24/2024 Landing mat at bedside, initiated 1/2/25 Occupational therapy to evaluate for wheelchair positioning. Pommel cushion added, initiated 1/2/25 Remove wheels from bed to lower bed for ease of transfers, initiated 12/24/24 On 1/28/25 at 2:00 P.M., Licensed Practical Nurse (LPN) 5 indicated Resident 23's bed should have been against the wall, the head of the bed should have been against the wall at the top and the left side. She indicated she was unsure if the wheels were supposed to be on the bed, but that when the resident moved rooms, the bed was probably not moved with her. LPN 5 indicated they were supposed to move the fall interventions with the resident when they moved rooms. On 1/29/25 2:10 P.M., the Director of Nursing (DON) provided an undated Care Plans, Comprehensive Person-Centered policy which indicated " 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...2. The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment...11. Assessments			

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	of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..." 3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1) 3.1-35(g)(2)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, interview and record review, the facility failed to revise resident care plans for 1 of 2 residents reviewed for a decline in activities of daily living (ADLs) and 1 of 3 residents reviewed for nutrition. A resident's ADL care plan was not revised with an ADL decline and a resident was receiving a diuretic but the care plan indicated she was not. (Resident 11, Resident 35) Findings include: 1. On 1/27/25 at 11:29 A.M., Resident 11 was observed in a Broda chair brought to the dining room by staff and was being fed her lunch by staff. On 1/27/25 at 1:11 P.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), dementia with behaviors, schizophrenia, edema, Parkinson's disease, and mild intellectual disorder. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 12/28/24, indicated Resident 11's cognition was not able to be assessed, she was totally dependent on staff for	F 0657	F - 657 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 11 has now had their care plan revised related to the use of a diuretic. The physician's orders have also been updated to reflect that nursing administers all medications. The resident's care plan has been reviewed and revised to ensure all appropriate interventions are now in place to meet the resident's current needs. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 35 has been reassessed by the interdisciplinary team. The resident's care plan has now been revised to address all changes in the resident's activities of daily living and nutrition. New interventions have now been	03/01/2025

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	toileting, transfers, bed mobility, eating, and took a diuretic. Current physician's orders included, but were not limited to, the following: Lasix 20 milligram (mg) tablet, give one tablet by mouth one time a day related to edema, unsupervised self-administration, ordered 12/22/24 A current edema care plan, dated 11/13/24 indicated Resident 11 did not take a diuretic. The medication administration record (MAR) for January 2025 was reviewed and indicated Resident 11 self-administered Lasix 20 mg unsupervised daily at 7:00 A.M. from 1/1/24 through 1/27/25. During an interview on 1/29/25 at 2:40 P.M., the MDS Coordinator indicated Resident 11 was not able to self administer medication and she did not self administer her Lasix. She indicated she was unsure why the order and MAR reflected that she did. Resident 11 was not physically or mentally able to do so. At that time, she provided an edema care plan, revised 1/28/25, to indicate Resident 11 was currently taking a diuretic. 2. On 1/27/25 at 10:48 A.M., Resident 35 was observed seated in a wheelchair by himself at a dining room table staring into space. On 1/28/25 at 11:39 A.M., Resident 35 was laying in bed with his eyes closed. On 1/27/25 at 8:19 A.M., Resident 35's clinical record was reviewed. Diagnoses included, but were not limited to, COPD, dementia with behaviors, and stroke.		developed to address each need identified during this assessment of the resident's condition. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all resident's care plans has now been conducted to ensure that each current need/concern of the residents have been identified and appropriate interventions put in place to meet those identified needs. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all members of the interdisciplinary team on the facility's policy related to care planning. The team was re-educated on their responsibility to ensure that each resident's care plan addressed any changes in the resident's condition and/or needs and that appropriate interventions were promptly put in place to address those needs. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident care plans to ensure they are reviewed and revised timely to meet the resident's current needs. This tool will be completed by the Director	

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	A Quarterly MDS assessment, dated 9/5/24, indicated Resident 35's cognition was severely impaired, supervision of staff for eating, substantial to maximum assistance of staff for toileting, bed mobility, bathing, upper and lower body dressing, applying footwear, hygiene, and transfers, walking did not occur, and used a manual wheelchair. The most recent Quarterly MDS assessment, dated 12/6/24, indicated Resident 35's cognition was severely impaired, partial to moderate assistance of staff for eating (decline), substantial to maximum assistance of staff for toileting, bed mobility, and transfers, totally dependent on staff for bathing, hygiene (decline), walking did not occur, and used a manual wheelchair. A current ADL Care Plan, revised 12/9/24, included, but was not limited to the following interventions: bathing/showering: assist of one staff, last revised 12/9/24 bed mobility: supervision to Assist of one staff, last revised 12/9/24 dressing: assist of one staff at times, last revised 12/9/24 eating: extensive assist of one staff, last revised 12/9/24 hygiene: assist of one staff, last revised 12/9/24 toileting: assist of one staff at times, last revised 12/9/24 transfer: supervision, last revised 12/9/24 transfer: resident uses a walker to maximize independence with transferring. Resident often forgets walker and needs reminding often, ast revised 12/9/24 physical therapy/occupational therapy (PT/OT) evaluation and treatment as per Medical Doctor		of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	(MD) orders, last revised 12/9/24 During an interview on 1/29/25 11:13 A.M., Qualified Medication Aide (QMA) 7 indicated she had not noticed a decline in Resident 35. She indicated he had slowed down on eating and some days he would not want to get up out of bed. He was not in therapy and staff didn't do restorative therapy because their restorative aide hadn't worked at the facility for maybe a month. He had a friend at the facility that passed away about a month ago and since then, he sat in the lobby and stared into space because she believed he was bored. During an interview on 1/29/25 at 10:50 A.M., the MDS Coordinator indicated Resident 35 had been the same since she started working at the facility a few months ago. He had not walked with a walker and used a wheelchair. She was out in the dining room everyday and he was not an assist to feed now, but for a while they were trying to get him to eat more. In the last month, he was feeding himself and staff would just go over and cue him. She had noticed he was in bed more. The decline was probably from his dementia. When a resident had a noticed decline, staff would tell her, she would do an assessment, and the directors would discuss it at the ancillary meeting on Wednesday mornings. If there would be a change in functioning, she would expect the care plan to reflect those changes. She indicated they do not have a policy for MDS assessments, but she would use the Resident Assessment Instrument (RAI) manual as the policy. On 1/29/25 at 3:57 P.M., a current non dated current Function Impairment policy was provided by the Administrator and indicated "Upon admission to the facility, whenever a significant			

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	change of condition occurs, and periodically during a resident/patient's stay, the physician and staff will assess the resident/patient's function along with their physical condition ... The staff and physician will identify individuals with potential for significant improvement in function or significant decline in function, including the ability to perform activities of daily living (ADLs) ... " On 1/29/25 at 2:10 P.M., a current non dated Care Plan policy was provided by the Administrator and indicated " ... Assessmetns of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change ... the interdisciplinary team reviews and updates the care plan: ... when there has been a significant change in the resident's condition ... at least quarterly, in conjuction with the required quarterly MDS assessment ... " 3.1-35(d)(2)(B)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities Based on observation, interview and record review, the facility failed to ensure a resident was given the appropriate treatment and services to maintain or improve his ability to carry out the activities of daily living for 1 of 2 residents reviewed for a decline in activities of daily living (ADLs). A resident's functional ability declined, the ADL Care Plan was not revised, and restorative therapy was not provided as recommended. (Resident 35) Findings include: On 1/27/25 at 10:48 A.M., Resident 35 was	F 0676	F - 676 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 35 has now been reassessed by nursing related to their activities of daily living. All current needs have been identified. Additional interventions have now been added to address the resident's current activities of daily living needs including the use of therapy services. The resident	03/01/2025

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	observed seated in a wheelchair by himself at a dining room table. On 1/28/25 at 11:39 A.M., Resident 35 was laying in bed with his eyes closed. On 1/27/25 at 8:19 A.M., Resident 35's clinical record was reviewed. Diagnoses included, but were not limited to, COPD, dementia with behaviors, and stroke. A Quarterly MDS assessment, dated 9/5/24, indicated Resident 35's cognition was severely impaired, supervision of staff for eating, substantial to maximum assistance of staff (more than half effort performed by staff) for toileting, bed mobility, bathing, upper and lower body dressing, applying footwear, hygiene, and transfers, walking did not occur, and used a manual wheelchair. The most recent Quarterly MDS assessment, dated 12/6/24, indicated Resident 35's cognition was severely impaired, partial to moderate assistance (less then half the effort performed by staff) of staff for eating (decline), substantial to maximum assistance of staff (more than half the effort performed by staff) for toileting, upper body dressing, hygiene, bed mobility, transfers, and totally dependent on staff for bathing, lower body dressing, apply footwear (declines), walking did not occur, and used a manual wheelchair. A current ADL Care Plan, revised 12/9/24, included, but was not limited to the following interventions: bathing/showering: assist of one staff, last revised 12/9/24 bed mobility: supervision to Assist of one staff, last revised 12/9/24		will continue to receive the necessary care and services to achieve and maintain their maximum potential in activities of daily living. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents have now been reviewed to ensure that they are receiving all the necessary care and services to reach and maintain their maximum potential in activities of daily living. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing and therapy staff on ensuring that each resident receives the necessary care and services to reach and maintain their maximum potential in activities of daily living. Each staff member was re-educated on their responsibility in providing all services in accordance with each resident's individualized plan of care. The staff was also reminded of their responsibility to report to nursing administration any noted decline in a resident's condition so that appropriate assessment and interventions can be promptly initiated. *The corrective action taken to monitor to ensure the deficient*	

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	dressing: assist of one staff at times, last revised 12/9/24 eating: extensive assist of one staff, last revised 12/9/24 hygiene: assist of one staff, last revised 12/9/24 toileting: assist of one staff at times, last revised 12/9/24 transfer: supervision, last revised 12/9/24 transfer: resident uses a walker to maximize independence with transferring. Resident often forgets walker and needs reminding often, last revised 12/9/24 physical therapy/occupational therapy (PT/OT) evaluation and treatment as per Medical Doctor (MD) orders, last revised 12/9/24 On 1/29/25 at 11:55 A.M., the Director of Therapy Services provided an OT Discharge Summary, dated 10/21/24, and indicated at the time of discharge, the highest practical level of functioning was achieved. The resident was self feeding, completing self hygiene, grooming, and upper body dressing, and performing lower body dressing, bathing, and toileting with supervision or contact guard assistance (CGA). Prognosis: "Good with consistent staff follow-through". Discharge recommendations: Restorative Nursing Program (RNP). During an interview on 1/29/25 11:13 A.M., Qualified Medication Aide (QMA) 7 indicated she had not noticed a decline in Resident 35. She indicated he had slowed down on eating and some days he would not want to get up out of bed. He was not in therapy and staff didn't do restorative therapy because their restorative aide hadn't worked at the facility for maybe a month. He had a friend at the facility that passed away about a month ago and since then, he sat in the lobby and stared into space because she believed		*practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident's activities of daily living to ensure that any change in the resident's condition is promptly identified. The tool will monitor to ensure that any decline in a resident's condition is not only promptly identified but appropriate interventions are implemented in an effort to improve the resident's condition. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	he was bored. During an interview on 1/29/25 at 10:36 A.M., the Director of Therapy Services indicated Resident 35 had been in therapy recently and was discharged on 10/21/24 because he met his goals. He indicated the staff have an ancillary meeting once a week and if someone had a fall or decline, nursing would let them know. A decline on Resident 35 was not discussed. The resident had been in bed a little more. When the MDS Coordinator did her assessment, and noticed a decline, she should let him know about it. The restorative nursing program had been inconsistent in the building because staffing had been an issue and aides were pulled from restorative. He indicated there should be someone working the restorative nursing program six to seven days a week. He also indicated the resident lost a good friend at the facility and maybe that had something to do with his decline. During an interview on 1/29/25 at 10:50 A.M., the MDS Coordinator indicated Resident 35 had been the same since she started working at the facility a few months ago. He did not walk with a walker and was in a wheelchair. She was out in the dining room everyday and he was not an assist to feed now, but for a while they were trying to get him to eat more. Last month, he was feeding himself and staff would just go over and cue him. She had noticed he was in bed more. She indicated the decline was probably from his dementia. When a resident had a noticed decline, staff would tell her, she would do an assessment, and the directors would discuss it at the ancillary meeting on Wednesday mornings. At that time, she indicated they did not have anyone on a restorative nursing program but she thought he would benefit from it. If there would be a change in functioning, she			

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	would expect the care plan to reflect those changes. She indicated she was not sure what constituted as a significant change but the computer program had not triggered him for a significant change so she had not addressed it. She indicated they do not have a policy for MDS assessments, but she would use the Resident Assessment Instrument (RAI) manual as the policy. On 1/29/25 at 3:57 P.M., a current non dated Functional Impairment policy was provided by the Administrator and indicated "Upon admission to the facility, whenever a significant change of condition occurs, and periodically during a resident/patient's stay, the physician and staff will assess the resident/patient's function along with their physical condition ... The staff and physician will identify individuals with potential for significant improvement in function or significant decline in function, including the ability to perform activities of daily living (ADLs) ... The staff and physician will collaborate to identify a rehabilitative or restorative care plan to help improve function and quality of life ..." On 1/29/25 at 3:57 P.M., a current non dated Restorative Nursing Services policy was provided by the Administrator and indicated "Residents will receive restorative nursing care as needed to help promote optimal safety and independence ... " 3.1-38(a)(1)			
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 provide adequate	F 0689	F - 689 *1.) The corrective action taken for*	03/01/2025

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	supervision and an environment free of accident hazards for 1 of 3 residents reviewed for accidents and 2 random observations. Residents were keeping smoking supplies on their person, smoking unsupervised, and in undesignated areas. A dementia resident that was at high risk for falls had an extension cord in his room that was not secured down. (Resident 32, Resident 22, Resident 54) Findings include: 1. On 1/27/25 at 10:48 A.M. Resident 32 was observed punching in the code to exit the door from the dining room to the outside while lunch was being served in the dining room. The resident was observed seated in a chair on that patio, smoking a cigarette, without staff supervision. On 1/28/25 12:01 P.M., Resident 32's clinical record was reviewed. Diagnoses included, but were not limited to, nicotine dependence, diabetes mellitus type II, and polyneuropathy. The most recent Annual Minimum Data Set (MDS) assessment, dated 12/23/24, indicated Resident 32 was cognitively intact, supervision of one staff for bed mobility and transfers, needed partial to moderate staff assistance (less than half the effort was performed by staff) for toileting, substantial to maximum assistance of staff (more than half the effort was performed by staff) for showering, used tobacco and a walker. A current Smoking Care Plan, dated 3/4/24, included, but was not limited to, the following interventions: Notify charge nurse immediately if it is suspected resident has violated facility smoking policy, initiated 3/4/24		*those residents found to have been affected by the deficient practice is that* the resident identified as resident # 32 has again been re-educated on the facility's smoking policy. All smoking materials have been removed from the resident and are stored in a designated secured area. The resident is now smoking at the designated times with staff supervision. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 22 has again been re-educated on the facility's smoking policy. All smoking materials have been removed from the resident and are stored in a designated secured area. The resident is now smoking at the designated times with staff supervision. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the extension cord identified in resident # 54's room has now been removed. Resident # 54's room is now free of any potential trip hazards. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents who smoke have	

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	resident understands the facility policy on smoking: locations, times, and safety concerns, initiated 3/4/24 The most recent Smoking Assessment, dated 3/4/24, indicated "Resident is safe to smoke with staff supervision". The most recent Smoking Safety Assessment, dated 11/26/24, indicated, "Supervision, designated smoking location, and smoking times are determined by facility policy. This evaluation will be utilized for the Resident's smoking care plan on admission and as indicated" ... "Resident follows the facility's policy on location and time of smoking" During an interview on 1/29/25 at 8:45 A.M., Resident 32 indicated he did keep his lighter and cigarettes on him and he did go out of the building by himself to smoke because he preferred smoking by himself. He indicated he "pleads the fifth [amendment]" about the smoking policy being explained to him, and had not had supplies taken from him in the past. 2. On 1/30/25 at 8:15 A.M., Resident 22 was observed seated on the patio furniture in front of the building smoking a cigarette without staff present. On 1/30/25 at 9:19 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, nicotine dependence, mild cognitive impairment of unknown etiology, and delusional disorders. The most recent Quarterly MDS assessment, dated 12/9/24, indicated Resident 22 was cognitively intact, needed supervision of staff for		been re-educated on the facility smoking policy. All smoking materials are now being stored in a designated secured area and resident smokers are now smoking in the designated area at the designated times. A housewide audit of all resident's rooms has also been completed and no additional trip hazards have been identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's smoking policy as well as on the facility incident/accident prevention program. All staff have been reminded of their responsibility to ensure that the resident's environment is free of any accident hazards. The staff was also reminded of their responsibility to ensure that the facility smoking policy is strictly enforced and that any non-compliance is immediately reported to administration. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor for adequate supervision of residents and providing a safe, accident free environment. The tool will monitor to ensure no safety hazards exit in resident areas and that the facility smoking	

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	bed mobility and transfers, and used tobacco. A current Smoking Care Plan, revised 1/8/25, included, but was not limited to, the following interventions: resident's smoking supplies are stored in the social services office, last revised 1/8/25 educate resident on facility smoking policy, last revised 1/8/25 supervise resident while smoking, last revised 1/8/25 The most recent Smoking Assessment, dated 3/4/24, indicated "Resident is safe to smoke with staff supervision". During an interview on 1/30/25 at 8:47 A.M., Qualified Medication Aide (QMA) 7 indicated to her knowledge there shouldn't be anyone smoking unsupervised, they should not have smoking supplies on their person because they should be locked up, and the designated smoking area was outside the dining room doors on the patio. 3. On 1/21/25 at 9:59 AM, Resident 54 was observed roaming in the East Hall and down the hall towards the dining room without eyeglasses. On 1/21/25 at 12:17 P.M., Resident 54 was observed roaming in the West Hall and in the dining room without eyeglasses. On 1/27/25 at 11:16 A.M., Resident 54 was observed roaming down the middle hall, dining room, and then West Hall without his eyeglasses. On 1/28/25 at 11:46 A.M., an orange extension cord was observed laying beside Resident 54's bed by the window in Room 19. The orange extension cord was connected to a white cord that		policy is strictly adhered to by all residents. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	was attached to the air conditioner (AC)/heater unit in the wall. Neither of the cords were secured out of the resident's walking pathway. The orange extension cord went behind the resident's bed and recliner into the corner of his room and was laying loosely on the floor. On 1/29/25 at 3:45 P.M., the same was observed. On 1/27/25 1:49 P.M., Resident 54's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. The most recent Admission MDS assessment, dated 12/9/24, indicated Resident 54's cognition was severely impaired and he did not wear eyeglasses or use any alarms. A current Vision Care Plan, dated 12/2/24, indicated Resident 54 has some difficulty seeing, and staff was to ensure resident was wearing eyeglasses. The most recent Fall Risk Evaluation, dated 12/2/24, indicated the resident had intermittent confusion, decreased muscular coordination, currently took three to four high risk medications, and was a high risk to fall. During an interview on 1/29/25 at 1:04 P.M., Certified Nurse Aide (CNA) 9 indicated that Room 19 was Resident 54's room. At that time, she indicated she did not think Resident 54 was a risk to fall but he was not aware of his own safety. During an interview on 1/29/25 at 10:31 A.M., the Maintenance Supervisor indicated that contractors were replacing the flooring in his room and the hallway for the last week or so. She indicated something happened with the electrical outlet near the AC/heater unit in his room and it			

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	was no longer working. At that time, she indicated they usually do not use extension cords but should make sure it's out of the resident's way. On 1/28/25 at 12:45 P.M., a current non dated current Smoking policy was provided by the Administrator and indicated "This facility has established and maintains safe resident smoking practices. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas ... Smoking is only permitted in designated resident smoking area ... A resident's ability to smoke safely is evaluated on admission (if they are a smoker), and re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff ... and will include the ability to smoke safely with or without supervision ... Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member ... All smoking materials are to be kept at the nurse's station and will be distributed at each designated smoke time ... Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues ... " On 1/30/25 at 9:40 A.M., a current non dated Hazardous Area policy was provided by the Administrator and indicated "All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible ... examples of environmental hazards include but are not limited to the following: ... irregular floor surfaces (cords, buckled carpeting, etc) ... any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable			

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	resident is considered hazardous ... improper or inappropriate use of equipment and devices will be identified as part of the hazards assessment and analysis ... interim safety measures for temporary hazards, such as painting or construction work may be necessary. These may include posting warning signs, redirecting foot traffic, increasing supervision, and if necessary, limiting access to anyone but authorized personnel ... " 3.1-45(a)(2)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure thoroughly completed staffing sheets were posted daily for 7 of 7 days during the survey. Finding includes: The posted nurse staffing sheets indicated total hours worked by nursing staff, but lacked the name of the facility and specific hours for the following days during the survey period: January 21, 2025 January 22, 2025 January 23, 2025 January 27, 2025 January 28, 2025 January 29, 2025 January 30, 2025 During an interview on 1/30/25 at 8:51 A.M., the Director of Nursing (DON) indicated Medical Records posted the nurse staffing sheets and the facility follows state regulation.	F 0732	F - 732 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The facility is now posting the nurse staff information daily with all required components listed on the staffing sheet, including the facility name and the specific hours to be worked. The Medical Records clerk will be responsible for the posting of all required staffing information daily. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice.	03/01/2025

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	On 1/30/25 at 9:20 A.M., the Administrator provided a current undated Posting Direct Care Daily Staffing Numbers policy that indicated, "Our facility will post on a daily basis for each shift nurse staffing data...The name of the facility...The actual time worked during that shift for each category and type of nursing staff..."		The facility is now posting the nurse staff information daily with all required components listed on the staffing sheet, including the facility name and the specific hours to be worked. The Medical Records clerk will be responsible for the posting of all required staffing information daily. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Medical Records staff and the Director of Nursing on the required posting of the nursing staff information. The staff was reminded of each component that must be recorded on the daily nurse staff posting. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the required daily posting of the nursing staff information. The tool will monitor to ensure that each required item is listed on the posting in accordance with the regulation. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is	

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			warranted.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to ensure a resident with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for 1 of 2 residents reviewed for dementia care. A resident didn't have a plan of care for dementia, safety risks were not identified, wandering behavior and interventions were not being documented and evaluated, and a daily routine was not established. (Resident 54) Finding includes: On 1/21/25 at 9:59 AM, Resident 54 was observed roaming in the East Hall and down the hall towards the dining room without eyeglasses. An ankle alarm was not observed. On 1/21/25 at 12:17 P.M., Resident 54 was observed roaming in the West Hall and in the dining room without eyeglasses. An ankle alarm was not observed. On 1/27/25 at 11:11 A.M., Resident 54 was observed walking into Room 51 on the West Hall. He indicated to the Qualified Medication Aide (QMA) who was finishing an accucheck in that room that he didn't have a room to go to. She proceeded to take him back to his room on the East Hall. The resident was not wearing an ankle alarm. On 1/27/25 at 11:16 A.M., Resident 54 was observed roaming down the middle hall, dining	F 0744	F - 744 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 54 has been reviewed by the interdisciplinary team to identify the resident's needs and have implemented the necessary care and services to treat those needs in an effort to attain and maintain the resident's highest practicable physical, mental and psychosocial well-being. A care plan has been developed and implement to address the care needs of a dementia resident. Safety risks have now been identified and appropriate measures put in place to meet those needs. Resident behaviors and wandering events are now being documented and appropriate interventions established to address those needs. A daily routine has now been established in an effort to decrease the resident's behaviors as well as to decrease the resident's wandering. Activities is involved in providing one on one activities as well. The resident has been referred to mental health services as well and their recommendations will be followed	03/01/2025

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	room, and the West Hall without his eyeglasses. An ankle alarm was not observed. On 1/28/25 at 11:46 A.M., an orange extension cord was observed laying beside Resident 54's bed by the window in Room 19. The orange extension cord was connected to a white cord that was attached to the air conditioner (AC)/heater unit in the wall. Neither of the cords were secured out of the resident's walking pathway. The orange extension cord went behind the resident's bed and recliner into the corner of his room and was laying loosely on the floor. On 1/27/25 at 1:49 P.M., Resident 54's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. The most recent Admission Minimum Data Set (MDS) assessment, dated 12/9/24, indicated Resident 54's cognition was severely impaired, needed partial/moderate assistance of staff for transfers, substantial/maximum assistance for bed mobility and toileting, took an antipsychotic, did not have care provided for dementia, wandered daily but wandering did not intrude on others, and was the "same" as the prior assessment. He did not use any alarms, vision was adequate, and did not wear corrective lenses. A current Vision Care Plan, dated 12/2/24, indicated Resident 54 has some difficulty seeing, and staff was to ensure resident was wearing eyeglasses. A current Wandering Care Plan, dated 12/24/24, included, but was not limited to, the following interventions, initiated 12/24/24: distract resident from wandering by offering pleasant diversions, structured activities, food,		and added to the plan of care. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents diagnosed with dementia have the potential to be affected by this deficient practice. Each resident with the diagnosis of dementia has been reviewed by the interdisciplinary team to ensure that they are receiving all of the care and services needed to attain and/or maintain their highest level of functioning. This will be an on-going process with any changes in the resident's condition due to dementia being a progressive illness. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the interdisciplinary team on the facility's dementia protocol policy. The staff will be re-educated on their responsibility to review and revise the resident's plan of care with any changes in the resident's status to ensure appropriate interventions are in place with those changes in an effort to maintain the highest level of functioning for the resident. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to	

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	conversation, television, book. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. A current Elopement Care Plan, dated 12/2/24, included, but was not limited to, the following intervention: wander alert device placed on ankle as preventative measure, initiated 12/2/24 The clinical record lacked a care plan for dementia care. The clinical record lacked documentation of wandering behavior. The most recent Elopement Risk Assessment, dated 12/2/24, indicated the resident was at high risk for elopement. The most recent Fall Risk Evaluation, dated 12/2/24, indicated the resident had intermittent confusion, decreased muscular coordination, currently took three to four high risk medications, and was a high risk to fall. During an interview on 1/29/25 at 1:04 P.M., Certified Nurse Aide (CNA) 9 indicated Resident 54's resided in Room 19 on the East Hall. She thought the reason he walked the halls at the facility was because of boredom, he did not wear a wander guard that she was aware of, and had eyeglasses. At that time, she indicated he did not have a daily routine. She indicated he liked to talk about his dogs and his wife. Resident 54 did refuse care, wouldn't understand when staff explained things to him, and couldn't carry on a conversation with staff. He was not aware of his		monitor the plan of care of the dementia resident to ensure appropriate care and services are being provided to assist the resident in maintaining their highest level of functioning. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	own safety but wasn't a risk to fall or elope. She was not aware of anywhere to document his behavior of wandering or of any specific interventions used for his dementia care. During an interview on 1/29/25 at 1:56 P.M., the Activities Director indicated for dementia residents, they did in person one on one visits. She indicated these were not documented anywhere because she had been enrolled in the computer course for directors since she was hired (10/30/24) but was waiting for the books she needed to complete the course to be able to document in the electronic health record. During an interview on 1/29/25 at 3:57 P.M., the Administrator indicated the diagnosis of Alzheimer's disease as an indication for Resident 54's antipsychotic was not accurate and he took it for major neurocognitive disorder, dementia with behavior disturbance, and agitation psychosis but at the time of the survey, that diagnosis was not included in the clinical record. At that time, she provided a Behavior Care Plan, revised 1/29/25, to include the diagnosis of psychosis. On 1/29/25 at 3:57 P.M., a current non dated Dementia policy was provided by the Administrator and indicated "As part of the initial assessment, the physician will help identify individuals who have been diagnosed as having dementia and those with otherwise impaired cognition ... the interdisciplinary team (IDT) will identify a resident-centered care plan to maximize remaining function and quality of life...the staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician ... the IDT will adjust interventions and the overall plan depending on the individual's responses to those			

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	interventions ... " 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on interview and record review, the facility failed to ensure medications were administered appropriately for 1 of 5 residents reviewed for unnecessary medication use. A blood pressure medication was administered without adequate monitoring as well as given outside of ordered parameters, and an opioid pain medication was administered with excessive use. (Resident 6) Findings include: On 1/23/25 at 1:25 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, hypotension (low blood pressure), and chronic pain. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/8/25, indicated a moderate cognitive impairment, no behaviors, and use of an opioid. Current physician orders included, but were not limited to: Midodrine HCl 5mg (milligrams) three times a day related to orthostatic hypotension. Hold for systolic blood pressure greater than 120, dated 1/19/25. Midodrine HCl 5mg three times a day related to orthostatic hypotension (no parameters), dated 7/3/24 and discontinued 1/18/25. Norco (an opioid pain medication) 5-325mg every	F 0757	F - 757 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 6 is now receiving their medications in accordance with the physician's orders. The medications were reviewed and the physician gave new orders to change the parameters on the blood pressure medication and also discontinued the prn narcotic pain medication since routine pain medication had been ordered. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all MARs has now been conducted to identify any other unnecessary drugs. No other issues have been identified at this time. The consultant pharmacist will continue to monitor the drug regimens during their routine audits. *The measures that have been put into place to ensure that the*	03/01/2025

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	8 hours as needed related to chronic pain, dated 6/26/24. Norco 7.5-325mg three times a day, dated 9/20/24. An order note, dated 9/20/24, indicated the resident felt as if her pain was not well controlled being administered only an as needed dose of pain medication. The physician ordered the Norco to be increased to 7.5mg and made routine three times a day for pain management. The clinical record lacked clarification of this order or clarification to discontinue the as needed medication at that time. Resident 6's Medication Administration Record (MAR) from September 2024 through January 2025 included, but was not limited to, the following administrations of Norco 5mg as needed dose in addition to the 7.5mg given every day at 7:00 A.M., 1:00 P.M., and 7:00 P.M.: 9/17/24 given at 3:30 P.M. and again at 8:47 P.M. 9/23/24 given at 6:41 A.M. 10/19/24 given at 4:30 P.M. 12/1/24 given at 5:00 P.M 1/20/25 given at 4:00 P.M. 1/25/25 given at 4:40 P.M 1/26/25 given at 5:00 P.M. Resident 6's clinical record lacked monitoring for signs and symptoms of excessive opioid administration, and lacked documentation that excessive pain medication had been administered.		*deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility's policy related to unnecessary drugs. The staff was also reminded of the importance of ensuring that medications are to be administered as ordered by the physician and any medication errors must be promptly reported to the physician. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident's drug regimen for any unnecessary drugs. The tool will monitor to ensure medication administration safety and to ensure that the physician's orders are being followed in accordance with any established parameters. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	Resident 6's MAR from August 2024 through January 2025 indicated the following days and times Midodrine HCl was administered without the blood pressure taken prior to administration: 8/7/24 at 7:00 A.M. 8/7/24 at 1:00 P.M. 8/10/24 at 7:00 A.M. 8/20/24 at 1:00 P.M. 9/3/24 at 7:00 A.M. 9/8/24 at 7:00 A.M. (blood pressure recorded as 12/7) 9/8/24 at 1:00 P.M. 9/16/24 at 1:00 P.M. 9/23/24 at 7:00 A.M. 9/23/24 at 1:00 P.M. 9/26/24 at 1:00 P.M. 10/7/24 at 7:00 A.M. 10/10/24 at 7:00 A.M. 10/10/24 at 1:00 P.M. 10/15/24 at 1:00 P.M. 10/21/24 at 7:00 A.M. 10/29/24 at 7:00 A.M. 10/29/24 at 1:00 P.M. 11/4/24 at 1:00 P.M. 12/1/24 at 1:00 P.M. 12/2/24 at 7:00 A.M. 12/2/24 at 1:00 P.M. 12/11/24 at 1:00 P.M. 12/12/24 at 1:00 P.M. 12/16/24 at 7:00 A.M. 12/16/24 at 1:00 P.M. 12/19/24 at 1:00 P.M. 12/23/24 at 1:00 P.M. 12/24/24 at 7:00 A.M. 12/24/24 at 1:00 P.M. 12/29/24 at 1:00 P.M. 12/30/24 at 1:00 P.M. 1/6/25 at 7:00 P.M. 1/9/25 at 7:00 A.M.			

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	1/9/25 at 1:00 P.M. 1/21/25 at 7:00 A.M. 1/26/25 at 7:00 A.M. The clinical record lacked a rationale as to why the blood pressure had not been taken. Resident 6's January 2025 MAR indicated the following days and times Midodrine HCl was administered when the systolic blood pressure was outside of the parameters over 120: 1/19/25 at 7:00 P.M. (128/72) 1/20/25 at 7:00 A.M. (130/76) 1/20/25 at 1:00 P.M. (130/76) 1/21/25 at 1:00 P.M. (134/70) 1/23/25 at 7:00 P.M. (132/68) 1/25/25 at 7:00 A.M. (134/70) 1/25/25 at 1:00 P.M. (126/76) 1/25/25 at 7:00 P.M. (126/76) 1/26/25 at 1:00 P.M. (122/70) 1/27/25 at 7:00 A.M. (126/76) The clinical record lacked a rationale for the blood pressure medication being administered or notification to the physician. On 1/28/25 at 7:39 A.M., Licensed Practical Nurse (LPN) 5 indicated a blood pressure should be taken prior to administering a blood pressure medication. If for any reason the blood pressure could not be taken, the nurse should notify the physician to see whether the medication should be given or not. On 1/29/25 at 8:47 A.M., the Director of Nursing (DON) indicated Resident 6's Midodrine HCl should not have been given when the systolic blood pressure was over 120. She indicated she was unsure why the blood pressure medication had been administered without a blood pressure			

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	reading, but that a blood pressure should have been taken. She further indicated when the Norco order had been changed to three times a day, the as needed order should have been questioned whether is needed to be discontinued or not. On 1/30/25 at 10:06 A.M., Registered Nurse (RN) 23 indicated although she had been the nurse to administer the Midodrine HCl outside of the parameters listed, it should have been held and not given. She indicated they would "typically remove the parameters" and administer regardless because the resident did better when she took the medication. She also indicated she had administered Resident 6's Midodrine HCl without documentation of a blood pressure, but couldn't say why. On 1/29/25 at 3:57 P.M., the Administrator provided a current non-dated Administering Medications policy that indicated "Medications are administered in accordance with prescriber orders, including any required time frame ... If a dosage is believed to be inappropriate or excessive for a resident ... the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns" On 1/30/25 at 9:20 A.M., the Administrator provided a current non-dated Administering Pain Medications policy that indicated "Pain management is a multidisciplinary care process that includes ... Modifying approaches as necessary" 3.1-48(a)			

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to ensure unnecessary use of psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. An antianxiety medication lacked a required gradual dose reduction (GDR) and an antipsychotic medication was given without an appropriate indication. (Resident 31, Resident 54) Findings include: 1. On 1/23/25 at 9:25 A.M., Resident 31's clinical record was reviewed. Diagnoses included, but were not limited to, depression and diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 12/9/24, indicated no cognitive impairment, no behaviors, and use of an antianxiety medication. The MDS indicated a Gradual Dose Reduction (GDR) had not been done due to no antipsychotic medications given. Current physician orders included, but were not limited to: buspirone HCl oral tablet 5mg (milligrams) twice a day for anxiety, dated 8/19/24. A pharmacy review note, dated 7/19/24, indicated there was a recommendation related to buspirone. At that time, there was a current order for buspirone HCl oral tablet 5mg twice a day for anxiety, dated 3/18/24. On 1/27/25 at 1:23 P.M., the Director of Nursing (DON) provided all pharmacy recommendations for Resident 31 completed in the last 12 months.	F 0758	F - 758 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 31 has now been reviewed and a gradual dose reduction for the antianxiety medication has been submitted to the physician for consideration. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 54 has now been reviewed and discussed with the physician. An appropriate diagnosis has now been obtained to support the use of the antipsychotic medication. The diagnosis has been added to the resident's diagnosis list in the clinical record. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents receiving psychotropic medications have the potential to be affected by this deficient practice. A psychotropic medication review meeting has now been conducted to ensure that all residents receiving this type of medication have the appropriate diagnosis to support the need for the medications and	03/01/2025

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	A recommendation related to buspirone was not included. On 1/29/25 at 8:44 A.M., the DON indicated at the time the pharmacy recommendation was done, she was not there and was unsure who would have been reviewing them. She further indicated it was the intent of the facility to do a GDR for buspirone, but the person that put it in did so incorrectly. 2. On 1/27/25 at 1:49 P.M., Resident 54's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, Alzheimer's disease, and depression. The most recent Admission Minimum Data Set (MDS), dated 12/9/24, indicated Resident 54's cognition was severely impaired and receiving antidepressant, opiod (for pain), and an antipyschotic medication. Current Physician's Orders included, but were not limited to, the following: quetiapine (antipyschotic) 50 milligram tablet, take one tablet by mouth three times a day related to Alzheimer's disease, unspecified, ordered 12/2/24 Resident 54's clinical record lacked a clinically indicated diagnosis for receiving an antipyschotic. During an interview on 1/29/25 at 3:57 P.M., the Administrator indicated the diagnosis of Alzheimer's disease as an indication for Resident 54's antipyschotic was not accurate and he took it for major neurocognitive disorder, dementia with behavior disturbance, and agitation psychosis but at the time of the survey, that diagnosis was not included in the clinical record. At that time, she provided a Behavior Care Plan, revised 1/29/25, to		gradual dose reductions are being made in accordance with the regulation. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all members of the behavioral management team to review the facility policy on psychotropic drug use. The team members were reminded that the resident must have supportive diagnoses to justify the need for this type of medication and that gradual dose reductions are conducted timely in accordance with the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that that* a Quality Assurance tool has been developed and implemented to monitor the use of psychotropic medications. The tool will monitor to ensure there is proper supportive diagnosis to warrant the use of this type of medication. The tool will also monitor to ensure that the required gradual dose reductions are being completed in accordance with the regulation. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality	

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	include the diagnosis of pyschosis. On 1/29/25 at 3:57 P.M., a current non dated Antipsychotic Medication Use policy was provided by the Administrator and indicated "Residents will not receive medications that are not clinically indicated to treat a specific condition ... Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective ... " On 1/30/25 at 9:20 A.M., the Administrator provided a current non-dated Tapering Medications and Gradual Drug Dose Reduction policy that indicated "During the first year in which a resident is admitted on a psychotropic medication ... or after the facility has initated such medication, the facility will attempt to taper the medication during at least two separate quarters ... unless contraindicated" 3.1-48(a)(4) 3.1-48(b)(2)		Assurance meetings to determine if any additional action is warranted.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to maintain safe and secure storage of medications for 1 of 1 medication carts observed. A medication cup with loose pills and a narcotic was observed in a medication cart. (Resident 17) Finding includes: During an observation on 1/21/25 at 8:45 A.M., the medication cart on the West Hall had a clear medication cup for Resident 17 with 10 loose pills	F 0761	F - 761 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 17 now has all narcotics stored under a double lock. The QMA identified as QMA #7 has been re-educated on medication administration and storage. The QMA was instructed that when medications have been	03/01/2025

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	in it. The loose pills included, but was not limited to, an oxycodone (narcotic) 10mg (milligram) tablet. At that time, Qualified Medication Aide (QMA) 7 indicated Resident 17 requested his pills and then left the hall. During an interview on 1/21/25 at 12:32 P.M., Registered Nurse (RN) 23 indicated if medications are prepared for a resident, and the resident is unavailable, the medications are placed in the medication cart because you can't put them back in the package. During an interview on 1/30/25 at 10:10 A.M., RN 23 indicated narcotics should be double locked in the medication cart. On 1/27/25 at 11:55 A.M., the Director of Nursing (DON) provided a current, undated Discarding and Destroying Medications policy that indicated, "...All unused controlled substances are retained in a securely locked area with restricted access until disposed of..." On 1/29/25 at 1:42 P.M., the DON provided a current, undated Medication Labeling and Storage policy that indicated, "...Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received..." 3.1-25(r)		pulled for administration and the resident is not readily available to receive those medications that the medications must be labeled with the resident's name and stored in the secured medication chart. If the medications pulled contain a narcotic, then the medication cup must be place in the narcotic drawer so that they are under a double lock security system. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents that receive medications have the potential to be affected by this deficient practice. Medications will not be pulled for administration until the resident is readily available to receive those medications. If the medications are pulled and the resident suddenly becomes unavailable then the medications are being labeled with the resident's name and stored in the secured med cart. If the pulled medications contain any controlled substance, then they are stored under double lock in the narcotic drawer of the med cart. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all license nurses and QMAs on medication labeling and storage policy as well as medication administration	

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			policy. The nurses and QMAs were reminded that if a medication is pulled and the resident is unavailable for administration that the medication must be labeled with the resident's name and stored in the secured med cart. If the pulled medication contains a scheduled drug, then the med cup must be placed in the narcotic drawer so that it is under double lock until the resident is available for administration. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor medication storage to ensure that all medications are stored appropriately and that all controlled substances are stored under a double lock system. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility	F 0880	F - 880	03/01/2025

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	failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 residents observed for wound care and 1 of 2 residents with catheters. Staff did not change gloves after touching multiple items before starting wound care. One resident with a catheter did not have Enhanced Barrier Precautions in place. (Resident 26, Resident 3) Findings include: 1. On 1/22/25 at 1:16 P.M., Resident 26's clinical records were reviewed. Diagnoses included, but were not limited to disorder of bone density and structure, hereditary and idiopathic neuropathy, spinal stenosis, lumbar region with neurogenic claudication, achondroplasia, and neuromuscular dysfunction of bladder. The most recent Quarterly Minimum Data Set (MDS) assessment, date 11/14/24, indicated Resident 26 had severe cognitive impairment, required substantial/maximal assistance where the helper did more than half the effort with bed mobility and transfer, supervision with eating and was dependent for toilet use. Resident 26 had one stage 3 pressure ulcer and had a catheter. Physician orders included, but were not limited to the following: DRESSING CHANGE - Coccyx: Cleanse with wound cleanser, pat dry. Pack with 1/4" packing strip moistened with NaCl (Sodium Chloride). Cover with bordered gauze dressing. Initial and date. every day shift for wound care and as needed for soiled or dislodged dressing, dated 1/14/2025		*1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 26 is now receiving wound care by staff members who are practicing acceptable standards of infection control related to glove usage and hand hygiene. The staff member identified as the wound nurse has been re-educated on proper glove usage and hand hygiene in the process of wound care to ensure proper infection control practices are utilized during wound care. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 3 now has an enhanced barrier precautions signage on their room door and has the appropriate isolation materials readily available at the resident's room door. The resident is now receiving catheter care by staff members who are utilizing all appropriate isolation materials including isolation gowns in an effort to prevent the spread of infection. The nurse identified as RN 23 has been re-educated on the use of personnel protective equipment for those residents in enhanced barrier precautions with catheters, including the wearing of an isolation gown during catheter care due to the potential of	

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	Acetic Acid Irrigation Solution 0.25 % (Acetic Acid) Use 60 cc via irrigation every shift for catheter patency related to spinal stenosis, lumbar region with neurogenic claudication, retention of urine, neuromuscular dysfunction of bladder, dated 12/27/24 CATHETER: May anchor 16Fr (French)/10cc (cubic centimeter) Foley catheter due to urinary retention related to neurogenic bladder. Change every 30 days and prn (as needed) leakage/blockage/dislodgement every 30 days on day shift, dated 12/27/24 WEEKLY SKIN ASSESSMENT one time a day every Friday, dated 4/30/2024 ENHANCED BARRIER PRECAUTIONS: indwelling catheter and wound. No directions specified for order, dated 4/24/2024 On 1/28/25 at 12:47 P.M., the Wound Nurse, who came weekly, was observed doing wound care for Resident 26. She washed her hands in Nutrition Room behind nurse's station due to room bathroom being under construction, put gown on for Enhanced Barrier Precautions (EBP), put gloves on, closed door, pulled curtain around Resident 26, raised bed with remote, unfastened brief, did not change gloves before starting wound care. The dressing was already off of wound when the aides put the resident to bed. Wound Nurse used wound cleanser, sprayed area and wiped area with 4 x 4 gauze, removed gloves, cleaned hands with sanitizer, and put on clean gloves. The wound measured 0.5 x 0.5 centimeters (cm) x 0.6 cm deep. She poured normal saline on 1/4 " packing strip, used swab to push the packing strip into the wound opening, covered		splashing while providing catheter care. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit has been conducted to ensure that any resident requiring enhanced barrier precautions has the appropriate signage posted and isolation supplies readily available for staff usage. All residents who require enhanced barrier precautions are now receiving care and services in accordance with the facility's infection control policy and procedure related to enhanced barrier precautions. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has now been provided for all staff on the facility's infection control policies as it relates to the use of enhanced barrier precautions. The staff members were re-educated on the required isolation materials to be utilized during care as well as the proper use of that equipment, including gowns, gloves and hand hygiene. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to	

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	with border dressing, dated and initialed dressing. Resident 26 rolled to her back and the Wound Nurse fastened the brief, removed gloves, put trash can on other side of bed, pushed curtain back, removed gown, and placed in trash can, cleaned hands with sanitizer, and went to Nutrition Room to wash hands. The Wound Nurse indicated Resident 26 was admitted with the wound, sometimes Resident 26 got yeast in the area and scratched area a lot, but it looked good right now. There was no drainage and the area was not red. There was an EBP sign on wall next to Resident 26's door and a container with EBP supplies next to the wall. During an interview on 1/30/25 at 10:10 A.M., the Infection Preventionist indicated gloves should be changed if they were visibly soiled. If they touched items in the room and were going to do wound care, gloves should be changed and hand hygiene done before proceeding with wound care. Hand hygiene should be with soap and water or hand sanitizer. Hand washing should last almost two minutes. 2. On 1/22/25 at 1:33 P.M., Resident 3 was observed in her room sitting up in wheelchair watching TV, bedside table in front of her with puzzle book on it, Foley catheter hooked under wheelchair. There was no Enhanced Barrier Precaution (EBP) sign outside of door or in room or supplies outside of room or hanging behind door. On 1/29/25 at 10:01 A.M. while walking down the hall it was observed that there was no enhanced barrier precaution sign outside of door or supplies outside of room for Resident 3. On 1/27/25 at 11:15 A.M., Resident 3's clinical		monitor the effectiveness of the facility's infection control practices. This tool will monitor to ensure that appropriate infection control signage is posted on the resident's door when warranted and that all appropriate isolation materials are readily available for staff's use. In addition, the tool will monitor the usage of isolation materials and the staff's proper use of those materials in an effort to prevent the spread of infection. This tool will be completed by the Infection Preventionist and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	records were reviewed. Diagnoses included, but were not limited to acute on chronic systolic (congestive) heart failure, fracture of unspecified lumbar vertebra, chronic kidney disease, stage 3B, retention of urine, Type 2 diabetes mellitus without complications. The most current Quarterly Minimum Data Set (MDS) assessment, dated 11/26/24, indicated Resident 3 was cognitively intact, needed substantial/maximal assistance where helper did more than half the effort for toilet use, bed mobility and transfers, and had an indwelling catheter. Physician orders included, but were not limited to the following: CATHETER: May anchor Foley catheter. 16FR (French), 10cc (cubic centimeters) balloon, Urinary Retention. Change every 30 days and prn (as needed) every day shift starting on the 16th and ending on the 17th every month related to retention of urine, dated 6/16/2024 ENHANCED BARRIER PRECAUTION: Foley catheter, dated 4/24/2024 Care Plan: Resident 3 has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) fatigue, impaired balance, weakness, dated 4/28/2023 Interventions included, but were not limited to Resident 3 has a Foley cath for urinary output needs. Follow catheter policy and procedures in regards to this as Resident 3 will allow. During an interview on 1/30/25 at 10:04 A.M., RN 23 indicated for catheter care she would clean her			

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	hands, tell resident what she was doing, gather supplies, basin, washcloths, towels, peri-cleaner, put on gloves, clean around meatus, catheter tubing, up and away with a soapy washcloth, rinse with clean wash cloths, make sure catheter was patent, put away supplies, remove gloves and clean hands. RN 23 did not indicate she would put on a gown. Due to the resident already being up in her wheelchair, care was not able to be watched. During an interview on 1/30/25 at 10:10 A.M., the Infection Preventionist indicated those residents who had an indwelling medical device or wound should be on EBP. If they were on EBP, she indicated they should have a sign on the door and Personal Protective Equipment (PPE) should be located in the isolation cart or in the closet outside the room. Staff was notified that a resident was on EBP by the sign and cart outside the room and if they didn't know what that meant, they should ask someone. On 1/29/25 at 2:57 P.M., the Administrator provided a current undated Personal Protective Equipment-Using Gloves policy that indicated " Objectives: 1. To prevent the spread of infection, 2. To protect wounds from contamination..." On 1/30/25 at 12:41 P.M., the Administrator provided a current undated Enhanced Barrier Precautions policy that indicated "...2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply...2. a. Gloves and gown are applied prior to performing the high contact resident care activity...3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:..g. device care or use (...urinary catheter...); and h.			

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	wound care (any skin opening requiring a dressing)...5. EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO (Multidrug-Resistant Organisms) colonization...10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 11. PPE is available outside the resident rooms..." 3.1-18(b)(1) 3.1-18(l)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure a sanitary and home-like environment for 2 of 2 halls, 1 of 1 shower rooms reviewed for environment, and 3 of 3 resident personal refrigerator temperature logs reviewed. Temperature logs were not completed for resident personal refrigerators, a call light was out of the wall, brown spots on the wall of resident's room, and cracked tiles along shower front and side wall, paint peeling on ceiling, and vent caked with dust in West Shower Room. (Room 36, Room 31-A, Room 53-A, Room 53-B, Room 39-B, West Shower Room) Findings include: 1. On 1/21/25 at 9:23 A.M., the temperature log for Room 53-A resident refrigerator was observed to be filled out from 1/1/25 through 1/14/25 at 40 degrees. On 1/29/25 at 10:00 A.M., the temperature log for Room 53-A resident refrigerator was observed to be filled out from 1/1/25 through 1/14/25. There	F 0921	F - 921 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the refrigerator located in room 53A has now been cleaned and is free of built- up ice in the freezer. Maintenance has checked the refrigerator and it is maintaining the appropriate temperature. The refrigerator temp log is now being completed by housekeeping daily with the current temperature recorded. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the expired milk and cheese were immediately removed from the refrigerator in room 31-A. The refrigerator has now been cleaned in room 31-A and the temperature log is being completed by housekeeping	03/01/2025

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	were two drink cups sitting in the refrigerator and ice was built up on the freezer. On 1/30/25 8:50 A.M., the Maintenance Assistant looked at the temperature in the resident refrigerator in Room 53-A and indicated it was 28 degrees. 2. On 1/21/25 at 12:07 P.M., the temperature log for Room 31-A resident refrigerator was observed to be filled out from 1/1/25 through 1/3/25 at 40 degrees. On 1/28/25 at 1:45 P.M., the temperature log for Room 31-A resident refrigerator was observed to be filled out from 1/1/25 through 1/3/25. The refrigerator contained milk that expired on 1/25 and cheese. On 1/30/25 8:50 A.M., the Maintenance Assistant looked at the thermometer in Room 31-A resident refrigerator and indicated the temperature was 38 degrees. 3. On 1/22/25 at 8:47 A.M., the temperature log for Room 53-B resident refrigerator was observed to be filled out from 1/1/25 through 1/14/25 at 40 degrees. On 1/29/25 at 10:00 A.M., the temperature log for Room 53-B resident refrigerator was observed to be filled out from 1/1/25 through 1/14/25. There was a container of strawberries and take out box containing food in the refrigerator. The freezer had ice built up in it. On 1/30/25 8:50 A.M., the Maintenance Assistant looked in the resident refrigerator in Room 53-B and indicated there was no thermometer in the refrigerator and the resident must have put it		daily. The accurate temperature is recorded on the log daily by the staff member. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the refrigerator located in 53-B has now been cleaned by housekeeping and a new thermometer has been placed in the refrigerator. Any outdated food items have been removed. Daily temperatures are now being recorded on the temp log by housekeeping. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the wall in room 36-B facing outside from the hallway which had a brown raised substance has now been cleaned and the brown raised substance removed and the wall has been repainted. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the West Hall shower room has now been completely renovated. All cracked tiles have now been replaced. The grout along the front wall of the shower stall has now been thoroughly cleaned. The shower ceiling has been repainted and is now free of any peeling paint. All hand rails in the shower room have now been repaired and are securely adhered to the walls.	

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	somewhere else. During an interview on 1/29/25 at 1:55 P.M. the Housekeeping Supervisor indicated housekeeping was responsible for checking temperatures on the resident's refrigerators and logging it on the form on the front of the refrigerator. This should be done daily, and the form was changed out monthly. The refrigerators were cleaned by housekeeping when someone-resident, Certified Nurse Aide (CNA) or nurse-notified them it needed to be cleaned or freezer needed defrosted. Residents didn't like housekeeping getting into their refrigerators. They were also cleaned when the rooms were deep cleaned. Housekeeping had a deep cleaning schedule. 4. On 1/21/25 at 9:43 A.M., in Room 36-B brown raised areas were observed on the wall facing outside from halfway down the wall to the floor. On 1/30/25 at 8:50 AM, the Maintenance Assistant entered Room 36-B and indicated the brown raised areas were just the texture of the bricks, and the walls were painted to keep them white. He indicated the brown raised areas were of no concern, not from a leak or anything. 5. On 1/21/25 at 9:35 A.M., the following was observed in the West Hall shower room: cracked tiles along the front and side wall of shower stall, brown soiled grout along the front wall of the shower stall, paint peeling from the ceiling in the shower stall, loose circle attachments on 3 handrails, vent fan caked with dust, the caulk around the base of the toilet was brown and flaking off, and the plastic at the bottom on the entrance door was cracked, sticking out from the door, and sharp on the edges.		The vent fan has now been cleaned and is free of any caked dust. The caulking around the base of the toilet has been replaced. The plastic at the bottom on the entrance door has been replaced and is secure and free of any cracks or sharp edges. The toilet paper holder has now been repaired. The resident's clothing was immediately removed and the shower room flooring is clean and free of any debris. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the privacy curtain in room 43 has been cleaned and is now free of any brown smudges. *7.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the entrance door to room 19 has been repaired and no longer rubs along the metal threshold. The door to room 19 now closes securely with no rubbing along the metal threshold. *8.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the call light box in room 39 has now been repaired and is secured to the wall and functions properly. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all	

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	On 1/29/25 at 8:54 A.M., the same was observed in the West Hall shower room along with resident clothing laying on the floor and the toilet paper holder was broken and the uncovered toilet paper was placed on the handrail. 6. On 1/21/25 at 9:23 A.M., the privacy curtain had brown smudges on it in Room 43. On 1/28/25 at 11:39 A.M., the same was observed. 7. On 1/28/25 at 11:46 A.M., the bottom of the entrance door to Room 19 was difficult to open, rubbing along the metal threshold, and would not close. -Door catches on bottom. Can not close On 1/29/25 at 9:16 A.M., the same was observed. 8. On 1/28/25 at 11:42 A.M., the call light box in Room 39 was out of the wall with wires exposed and laying on top of stuffed animals on the dresser. On 1/29/25 at 8:41 A.M., the same was observed. During an interview on 1/21/25 at 9:23 A.M., the Maintenance and Housekeeping Supervisor indicated privacy curtains were changed as needed and when a deep clean was performed on that room. She was unsure when Room 43 had been deep cleaned. She indicated staff was aware of Room 19's door and they need to shave off some of the bottom of the door since the floor was replaced. She was not aware of concerns in the West Hall shower room and indicated the call light box in Room 39 was "always coming out from the wall". If staff noticed things that needed attention, they should fill out and turn in a work order, kept in the copy room, and maintenance checks them daily in the morning.		residents have the potential to be affected by this deficient practice. A housewide audit of all resident rooms and resident common areas has now been conducted to identify any environmental/safety concerns. All identified environmental/safety concerns have now been corrected. All staff members are now reporting any new environmental/safety concerns identified to the maintenance department so that prompt attention can be given to make the necessary repairs/cleaning, etc. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's policy and procedures on environmental services to ensure that a safe, functional, sanitary and comfortable environment is maintained for the residents. The staff was re-educated on the process utilized to report any areas of environmental concern so that any environmental problems can be quickly identified and addressed. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the overall cleanliness, safety and functional environment of the facility. This tool will	

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	On 1/29/25 at 3:57 P.M., a current non dated current Homelike Environment policy was provided by the Administrator and indicated "Residents are provided with a safe, clean, comfortable and homelike environment ... " On 1/30/25 at 9:40 A.M., the Administrator provided a current undated Foods Brought by Family/Visitors policy that indicated "...7. The nursing and /or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates...)" On 1/30/25 at 11:02 A.M., the Administrator provided a current Food Receiving and Storage policy , revised December, 2008, which indicated "...8. Refrigerated foods must be stored at or below 40 degrees Fahrenheit unless otherwise specified by law...Refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines..." 3.1-19(f)		monitor to ensure that all safety hazards are promptly corrected and that all resident areas are clean, comfortable, sanitary and present a comfortable homelike environment. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0926 SS=D Bldg. 00	483.90(i)(5) Smoking Policies Based on observation, interview and record review, the facility failed to ensure the smoking policy was followed for 2 of 2 residents reviewed for smoking. Residents had their smoking supplies on their person, smoking assessments were not completed quarterly, smoking care plans were not revised, residents were smoking without staff supervision, and residents were smoking in undesignated area. (Resident 32, Resident 22)	F 0926	F - 926 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 32 has again been re-educated on the facility's smoking policy. A new smoking assessment has now been completed on this resident.	03/01/2025

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	Findings include: 1. On 1/27/25 at 10:48 A.M. Resident 32 was observed punching in the code to exit the door from the dining room to the outside while lunch was being served in the dining room. The resident was observed seated in a chair on that patio, smoking a cigarette, without staff supervision. On 1/28/25 12:01 P.M., Resident 32's clinical record was reviewed. Diagnoses included, but were not limited to, nicotine dependence, diabetes mellitus type II, and polyneuropathy. The most recent Annual Minimum Data Set (MDS) assessment, dated 12/23/24, indicated Resident 32 was cognitively intact, supervision of one staff for bed mobility and transfers, needed partial to moderate staff assistance for toileting, substantial to maximum assistance of staff for showering, used tobacco and a walker. A current Smoking Care Plan, dated 3/4/24, included, but was not limited to, the following interventions: Notify charge nurse immediately if it is suspected resident has violated facility smoking policy, initiated 3/4/24 resident understands the facility policy on smoking: locations, times, and safety concerns, initiated 3/4/24 The most recent Smoking Assessment, dated 3/4/24, indicated "Resident is safe to smoke with staff supervision". The clinical record lacked any smoking assessments between 6/5/24 and 11/25/24. The most recent Smoking Safety Assessment,		All smoking materials have been removed from the resident and are stored in a designated secured area. The resident is now smoking at the designated times with staff supervision. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident # 22 has again been re-educated on the facility's smoking policy. A new smoking assessment has now been completed on this resident. All smoking materials have been removed from the resident and are stored in a designated secured area. The resident is now smoking at the designated times with staff supervision. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. New smoking assessments have now been completed on all residents who smoke and their care plans updated accordingly. All residents that smoke are now adhering to the facility's smoking policy. On-going education and safety reminders will be provided for the residents when warranted. *The measures that have been put into place to ensure that the deficient practice does not recur is that* all residents that smoke have	

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	dated 11/26/24, indicated, "Supervision, designated smoking location, and smoking times are determined by facility policy. This evaluation will be utilized for the Resident's smoking care plan on admission and as indicated" ... "Resident follows the facility's policy on location and time of smoking" During an interview on 1/29/25 at 8:45 A.M., Resident 32 indicated he did keep his lighter and cigarettes on him and he did go out of the building by himself to smoke because he preferred smoking by himself. He indicated he "pleads the fifth [amendment]" about the smoking policy being explained to him, and had not had supplies taken from him in the past. 2. On 1/30/25 at 8:15 A.M., Resident 22 was observed seated on the patio furniture in front of the building smoking a cigarette without staff present. On 1/30/25 at 9:19 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, nicotine dependence, mild cognitive impairment of unknown etiology, and delusional disorders. The most recent Quarterly MDS assessment, dated 12/9/24, indicated Resident 22 was cognitively intact, needed supervision of staff for bed mobility and transfers, and used tobacco. A current Smoking Care Plan, revised 1/8/25, included, but was not limited to, the following interventions: resident's smoking supplies are stored in the social services office, last revised 1/8/25 educate resident on facility smoking policy, last revised 1/8/25		now been re-educated on the facility's smoking policy. The residents were reminded that the smoking policy will be closely monitored and enforced by all staff members to ensure resident safety. A mandatory in-service has also been conducted for all staff members on the facility's smoking policy as well as their responsibility to ensure that the policy is strictly enforced for the safety of all residents, staff and visitors. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implement to monitor the effectiveness of the facility's smoking policy. The tool will monitor to ensure that all residents are provided with supervision during smoking and all components of the smoking policy are consistently being followed. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	supervise resident while smoking, last revised 1/8/25 The most recent Smoking Assessment, dated 3/4/24, indicated "Resident is safe to smoke with staff supervision". The clinical record lacked smoking assessments from 6/5/24 to present. During an interview on 1/30/25 at 8:47 A.M., Qualified Medication Aide (QMA) 7 indicated to her knowledge there shouldn't be anyone smoking unsupervised, they should not have smoking supplies on their person because they should be locked up, and the designated smoking area was outside the dining room doors on the patio. On 1/28/25 at 12:45 P.M., a current non dated current Smoking policy was provided by the Administrator and indicated "This facility has established and maintains safe resident smoking practices. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas ... Smoking is only permitted in designated resident smoking area ... A resident's ability to smoke safely is evaluated on admission (if they are a smoker), and re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff ... and will include the ability to smoke safely with or without supervision ... Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member ... All smoking materials are to be kept at the nurse's station and will be distributed at each designated smoke time ... Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be			

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	alerted to these issues ... "			