STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PILGRIM MANOR	222 PARKVIEW ST PLYMOUTH, IN 46563

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00447285, IN00442585, IN00442243 and IN00442061. Complaint IN00447285 - Federal deficiencies related to the allegations are cited at F684 and F689. Complaint IN00442585 - No deficiencies related to the allegation are cited. Complaint IN00442243 - No deficiencies related to the allegation are cited. Complaint IN00442061 - Federal deficiencies related to the allegations are cited at F755. Survey dates: November 21, 22, 25, 26, and 27, 2024. Facility number: 000030 Provider number: 155703 AIM number: 100275260 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 6 Medicaid: 47 Other: 20 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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 December 27, 2024, for the annual survey completed November 27, 2024.	

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

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	Quality Review completed on 12/12/2024.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to allow residents to exercise their rights when choosing where to eat for 3 of 3 resident reviewed for resident rights. (Resident C, D and N) Findings include: 1. During an interview on 11/22/2024 at 10:27 A.M., Resident C indicated she was not allowed to eat in her room and all meals were to be eaten in the dining room. A record review for Resident C was completed on 11/25/2024 at 8:27 A.M. Diagnosis included, but were not limited to: schizoaffective disorder (bi-polar type), depression, anxiety, extrapyramidal and movement disorder. The current diet order for Resident C indicated she was on a regular diet with thin consistency. A Quarterly Minimum Data Set (MDS) Assessment. dated 11/01/2024, indicated Resident C was cognitively intact and only required set-up assistance for eating. During an interview, on 11/26/2024 at 1:35 P.M., Resident C indicated that if you were feeling bad or just did not want to eat in the dining room, staff would not bring a tray to your room. If you were hungry, you would have to go to the dining room. She indicated she was allowed to eat in her room once, but only because staff felt she was too sick to go to the dining room.	F 0550	It is the practice of this facility that the residents live a dignified existence, self-determined with communication and access to persons and services inside and outside the facility, including those specified in F 550. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: All residents on North Hall were interviewed for preferences on where they wish to be served their meal and care plans updated. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken: All residents on North Hall were at potential risk for not eating according to their preferences. All were interviewed as to their preferences and care plans were updated.	12/27/2024

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	During an interview on 11/26/24 at 03:28 P.M., RN #14 indicated that the North Hall residents were more independent and could go down to the dining room and they were not allowed to get their meals in their rooms. He indicated that was the way he understood the facility's policy. RN #14 indicated he had been instructed to encourage the residents to go down to the dining room for meals, otherwise the resident would not receive a meal. During an interview on 11/27/24 at 10:58 A.M. CNA #13 indicated residents could not eat in their rooms because they were able to get up and go to the dining room. CNA #13 indicated staff were to encourage residents to go to the dining room and if they still did not want to eat in the dining room, they were not to receive a meal. 2. A record review for Resident N was completed on 11/25/2024 at 3:15 P.M. Diagnosis included, but were not limited to: vascular dementia without disturbances, depression, fibromyalgia, and anxiety. The current diet order for Resident C indicated she was on a regular diet with thin consistency. A Quarterly Minimum Data Set (MDS) Assessment, dated 11/08/2024, indicated Resident N was cognitively intact and required set-up assistance for eating. A current Care Plan, dated 7/28/2024, indicated the resident needed help with self-care related to: lack of motivation. Interventions included but were not limited to: -Eats meals in west dining room, had food in her room if she chose not to eat in the dining room. Independent with transfer, bed mobility, toileting, toileting hygiene, eating.		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policy on Resident Rights was reviewed by the IDT. An in-service was conducted with all facility staff on the policy and residents' right for self-determination on 12/12/2024 by Administrator/designee. A performance improvement tool has been developed to monitor residents are being served during mealtimes according to their preferences. How the corrective actions will be monitored to ensure the deficient practice does not recur; The Administrator/designee will complete routine auditing to ensure residents are receiving their meal during mealtimes according to their area of preference. Auditing to occur; 5 random residents weekly x's 30 days, 5 random residents monthly x's 5 months for a total of 6 months of monitoring. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the	

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	During an interview, on 11/26/2024 at 2:50 P.M., Resident N indicated that North Hall were independent and if they did not go down to the dining room they were on their own for that meal. The resident indicated she kept food in the fridge in her room in case she did not feel like going down to the dining room because staff would not bring a tray to her room. 3. During an interview on 11/26/24 2:40 P.M., Resident D indicated that if she was not feeling good, she would have to go to the dining room for meals. She also indicated there were a couple times she did not want to go down but had to go because staff would not bring any food to her room. She indicated she was allowed to eat in her room once, but only because staff felt she was too sick to go to the dining room. A record review for Resident D was completed on 11/27/2024 at 11:20 A.M. Diagnosis included, but were not limited to: depression, anxiety, CKD, unspecified dementia without disturbances. A current care plan dated 8/9/2024 indicated the resident needed little help with self care Interventions included but were not limited to: independent in eating, eats all meals in the west dining room. The current diet order for Resident D indicated she was on a regular diet with thin consistency. A Quarterly Minimum Data Set (MDS) Assessment dated 10/02/2024, indicated Resident C was cognitively intact and only required set-up assistance for eating. During an interview on 11/27/24 at 1:22 PM., the		Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	

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	Dietary Manager indicated she did not recall anyone on North Hall ever receiving a room tray and she did not know if resdients were allowed to eat in their rooms. She indicated she would expect staff to have asked for a room tray if a resident stayed in their room for the meal. A current policy was provided on 11/27/2024 at 3:20 P.M. by the DON, titled, "Quality of Life-Residents Self Determination and Participation." The policy included the following: "Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments and plans of care, including: daily routine, such as sleeping and waking, eating ..." 3.1-3(u)(1) 3.1-3(u)(3)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on record review and interview, the facility failed to provide quarterly statements for 2 of 2 residents reviewed for personal funds. (Residents 5 & E) Findings include: 1. During an interview, on 11/22/2024 at 10:46 A.M., Resident 5 indicated she had not received quarterly statements for her personal funds account at the facility. She indicated if she needed to know her account's balance, the Business Office Manager (BOM) would verbally tell her the balance of the account. A record review for Resident 5 was completed on 11/25/2024 at 9:32 A.M. Diagnoses included, but	F 0558	It is the practice of this facility that residents reside and receive services in the facility with reasonable accommodation of their needs and preferences except when to do so would endanger the health or safety of the resident or other residents. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Residents 5 and E were provided with their quarterly statements. How are other residents having the	12/27/2024

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	were not limited to: dementia with psychotic disturbance, psychotic disorder with delusions, bipolar disorder, generalized anxiety disorder and depressive disorder. An Annual Minimum Data Set (MDS) assessment, dated 11/13/2024, indicated Resident 5 was cognitively intact. 2. During an interview, on 11/21/2024 at 2:38 P.M., Resident E indicated he had only received one quarterly statement since his admission to the facility, on 7/28/2023. A record review for Resident E was completed on 11/25/2024 at 10:53 A.M. Diagnoses included, but were not limited to: heart failure, atrial fibrillation, and hypertensive heart with heart failure. A Quarterly Minimum Data Set (MDS) assessment, dated 11/6/2024, indicated Resident E was cognitively intact. During an interview, on 11/27/2024 at 12:59 P.M., the BOM indicated the residents received personal fund statements whenever they asked for a statement. She indicated she tried to give the residents a statement anytime they withdrew money. The statement included the beginning and ending balances of their account. She indicated there were no specific time frames for personal fund statements to be provided to the residents. The Business Office Manager was unable to provide any documentation the residents and/or their representatives had received quarterly resident fund account statements. A policy was provided on 11/27/2024 at 3:30 P.M. by the Director of Nursing. The policy titled,		potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents have the potential to be affected. The residents did not experience any negative consequences related to the deficient practice. All residents who have accounts with the facility were sent a quarterly statement for the current quarter through 12/19/2024. All residents with accounts with the facility will receive quarterly statements going forward. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policy on quarterly statements was reviewed by the IDT. Administrator in-serviced Business Office Manager on 12/19/2024 on the policy for providing quarterly statements. A performance improvement tool has been developed to monitor that residents who have an account with the facility receive their quarterly statements. How the corrective actions will be monitored to ensure the deficient practice does not recur; The Administrator/designee will complete routine auditing to ensure residents who have an account with the facility receive	

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	"Accounting and Records", indicated, " ...2. The individual financial record will be available through quarterly statements and on request to the resident or his or her legal representative ...." 3.1-6(g)		their quarterly statements. Auditing to occur: quarterly ongoing. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to complete a self administration of medication assessment timely for 1 of 1 resident reviewed for self administration of medications. (Resident N) Finding includes: During an interview, on 11/26/2024 at 9:11 A.M., Resident N indicated the nurse left her medications in her room and she took her medications herself. During an interview, on 11/26/2024 at 9:13 A.M., QMA 16 indicted it was okay to leave Resident N's medications in her room because she was alert and oriented.	F 0641	It is the practice of this facility that the resident's assessments accurately reflect the resident's status. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: New self-administration assessment was completed on Resident N on 11/26/2024 and care plan updated. How are other residents having the potential to be affected by the same deficient practice identified	12/27/2024

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	A current Care Plan, initiated on 7/28/2024, indicated the resident had requested to administer his/her own medications. Interventions included: The nurse was to bring medications to her room, all medications may be left with resident to take without assistance except for narcotics. A current physician order, dated 8/18/2024, indicated the following: may leave medications at bedside every shift. A Self Administration of Medications Assessment, dated 5/28/2024, was provided by the Director of Nursing and indicated Resident N was able to self administer medications. The Director of Nursing indicated the last Self Administration of Medication Assessment was completed on 5/2024 and she was unable to provide more recent assessments for August or November. On 11/27/2024 at 12:41 P.M.,the Director of Nursing provided the policy titled, "Self Administration of Medications", dated 5/20/2020, and indicated the policy was the one currently use by the facility. The policy indicated "... 3. The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis...." 3.1-50(a)(1)		and what corrective action(s) will be taken; All residents who self-administer have the potential to be affected. All residents who self-administer were audited by DON on 2/19/2024 to ensure they had up to date assessments completed and were care planned. Any concerns were addressed at the time of audit. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policy on self-administration of medications was reviewed by the IDT. An in-service was conducted with all facility staff on the policy on or before 12/27/2024. A performance improvement tool has been developed to monitor residents who self-administer due upon admission, readmission, change of condition, and quarterly. How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/designee will complete routine auditing to ensure all residents who self-administer have an updated assessment and are care planned for self-administration. Auditing to	

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			occur: 5 random residents weekly x's 30 days, 5 ransom residents monthly x's 5 months for a total of 6 months of monitoring. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to ensure a comprehensive plan of care was created for a resident with medical conditions of antiplatelet use, seizure disorder, gastroesophageal reflux disease (GERD) and glaucoma (Resident 39), a resident with splints to the wrist and fifth finger (Resident 22), and a resident with a pacemaker (Resident 29) for 3 of 19 residents reviewed for comprehensive care plans. Findings include: 1. A record review for Resident 39 was completed on 11/25/2024 at 10:19 A.M. Diagnoses included, but were not limited to: hemiplegia, seizure disorder, GERD and glaucoma.	F 0656	It is the practice of this facility that the residents have comprehensive care plans that are developed in a person-centered manner and meet all other regulatory requirements. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Resident 29 no longer resides in the facility. Resident 39 care plan was updated to reflect current diagnosis. Resident 22 x-ray was redone on 12/14/2024 and showed no acute fracture or dislocation	12/27/2024

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	A Quarterly Minimum Data Set (MDS) assessment indicated Resident 39 received an antiplatelet medication, had range of motion limitations to one upper and lower extremity and had moderate impairment of her vision. A Physician's Order, dated 8/20/3034, indicated Resident 39 received clopidogrel (antiplatelet medication) 75 milligrams daily related to hemiplegia, levetiracetam (antiseizure medication) 750 milligrams twice daily for seizures, carbamazepine (antiseizure medication) 200 milligrams twice daily for seizures, pantoprazole (proton pump inhibitor) 40 milligrams daily for GERD and dorzolamide-timolol (topical beta blocker) 2 percent one drop in both eyes twice daily for glaucoma. A review of Resident 39's comprehensive plan of care indicated Resident 39 did not have a plan of care for antiplatelet use, seizure disorder, GERD or glaucoma. During an interview, on 11/27/2024 at 1:15 P.M., the Director of Nursing indicated Resident 39 should have had a plan of care for antiplatelet use, seizure disorder, GERD and glaucoma. 2. During an observation, on 11/21/2024 at 11:39 A.M., Resident 22 had her right pinky finger splinted with two flat, wooden sticks and secured with paper tape. During an observation, on 11/25/2024 at 12:26 P.M., Resident 22 wore a firm black, cloth splint on her right wrist and 5th digit. The medical record for Resident 22 was reviewed on 11/25/2024 at 8:41 A.M. Diagnoses included, but were not limited to: resistant hypertension,		care plan was updated. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents that had Antiplatelet use, GERD, Seizures, Glaucoma, or Braces/Splints/Pacemakers have the potential to be affected. An audit was conducted by DON/Designee on those residents' and care plans updated as needed. An audit was completed on all current admissions for the last three months to ensure all had Comprehensive Care Plans created and used by staff. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policy on Comprehensive Care Plans was reviewed by the IDT. An in-service was conducted with all nursing facility staff, Social Services Staff, MDS, and Leadership on the policy. A performance improvement tool has been developed to monitor that residents are evaluated on admission, readmission, change of condition, and quarterly to ensure comprehensive care plan is correct and being followed. How the corrective actions will be	

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	Alzheimer's disease, depression, diabetes mellitus, chronic obstructive pulmonary disease, heart failure, dementia, chronic fatigue syndrome and unsteadiness on feet. A Quarterly Minimum Data Set (MDS) assessment, dated 10/24/2024, indicated the resident was mildly cognitively impaired with no hallucinations or delusions. The MDS indicated the resident had no falls since the last assessment. The current Physician's Orders included an order for an x-ray of the right wrist one time only for pain, dated and completed on 11/16/2024. An Occupational Therapy Evaluation, dated 11/21/2024, indicated Resident 22's recommendations included wearing a splint full-time with skin checks and hygiene after every meal and prior to bedtime. There was no care plan for Resident 22 regarding the use of splints. During an interview, on 11/26/2024 at 11:31 A.M., the Director of Nursing (DON) was unable to provide Resident 22's care plan for the splint use and verbalized there was not a care plan for the splint.3. The record for Resident 29 was reviewed on 11/27/2024 at 9:47 A.M. Diagnoses included, but were not limited to: obesity, chronic ischemic heart disease, pacemaker, spinal stenosis, chronic pain syndrome,and hypertension. An Admission Nursing Assessment, dated 10/31/2024, indicated the resident had a pacemaker. Under the comments section was documented: "resident stated that she hasn't had her pacemaker checked since last year."		monitored to ensure the deficient practice does not recur; The DON/designee will complete routine auditing to ensure Comprehensive Care Plans are up to date and accurate. Auditing to occur: 5 random residents weekly x's 30 days, 5 random residents monthly x's 5 months for a total of 6 months of monitoring. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	

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	The History and Physical form from the hospital dated, 10/31/2024, indicated under surgical history was documented as Pacemaker/Defibrillator 2020. The clinical record lacked a care plan for the use and care of the pacemaker. During an interview, on 11/27/2024 at 10:39 A.M., the Director of Nursing indicated there should have been a care plan for the pacemaker on the chart. On 11/27/2024 at 12:42 P.M., the Director of Nursing provided the policy titled, "Care Plans, Comprehensive Person -Centered", dated 9/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develop and implements a comprehensive, person-centered care plan for each resident... Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change...." 3.1-35(a)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to follow bowel movement protocols. This resulted in the resident obtaining an ileus (a painful obstruction of the ileum or other part of the intestine) for 1 of 3 residents reviewed for quality of care. (Resident K) Finding includes:	F 0684	It is the practice of this facility that the residents receive quality care that is based on the assessment of each resident, that the care received is provided within professional standards of practice and is done so in conjunction with their person-centered care plan	12/27/2024

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	155073	A. BUILDING 00 B. WING	11/27/2024

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	A record review for Resident K was completed on 11/26/2024 at 10:16 A.M. Diagnoses included, but were not limited to: Alzheimer's disease and constipation. The Quarterly Minimum Data Set (MDS) assessment, completed on 6/25/24 indicated the resident was severely cogntively impaired, was incontinent of her bladder and continent of her bowels and required some partial staff assistance for personal hygiene needs. A current Care Plan, initiated on 7/30/2024, indicated Resident K had the potential for constipation related to decreased mobility. The goal was for the resident to have a soft formed bowel movement at least every 3 days. Interventions included, but were not limited to: administer medications as ordered, check how often bowel movements occur, encourage fluid intake, give routine medications as ordered, check for bowel sounds, abdominal pain or swelling as needed, three times per week and report complaints of bowel problems to the nurse. The August 2024 physician's order recapitulation did not include orders for any as needed medications to soften stools and/or promote regular bowel movements (laxatives). The August 2024 bowel record forms indicated Resident K had a large bowel movement on 8/16/2024 during the day shift. There was no documentation of any bowel movements for Resident K in the nurse's notes or in the daily nursing bowel record form on 8/17/2024 and 8/18/2024. There was no documentation in assessments or nursing progress notes that the resident was assessed due to having gone two		and their personal choices. *An informal dispute resolution for F 684 has been requested as the facility disagrees with the conclusion that the ileus was caused by not following the facility bowel and bladder protocol. Please see attached document detailing supportive reasoning.* The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Resident K ileus resolved with regimen at facility. Hospital intervention was not required. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents with diagnosis of constipation have the potential to be affected. An audit of all residents' bowel movements was conducted with no concerns noted. An audit on all residents Bowel Regimen Medications was also conducted with no concerns noted. Resident care plans updated. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policy on Bowel	

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	days without a bowel movement per the facility bowel protocol policy. On 8/19/2024 the bowel record form indicated Resident K had a small bowel movement on the evening shift. There was no documentation of any bowel movements for Resident K in the nurse's notes or in the daily nursing bowel record form from 8/20/2024 through 8/25/2024. There was no documentation in assessments or nursing progress notes that the resident was assessed due to having gone 5 days without a bowel movement. The physician was not notified and there were no PRN (as needed) medications to promote bowel movements administered to Resident K per the facility's bowel protocol policy. On 8/26/2024 during the night shift, the resident was documented as having a small bowel movement. A Physician's Progress Note, on 8/26/2024 at 10:17 P.M., indicated the family was concerned about Resident K due to abdominal swelling. An order was obtained for a 2-view abdominal x-ray. Physician Orders for Resident K, dated 8/26/2024, indicated the following medications were ordered: bisacodyl (medication to treat constipation) 5 milligrams daily, bisacodyl 10 milligram suppository (medication to treat constipation) as needed, docusate sodium (stool softener) 100 milligrams twice daily for 3 days and Milk of Magnesia (laxative) 30 milliliters as needed. A Nursing Progress Note, on 8/27/2024 at 12:29 P.M., indicated the results of the abdominal x-ray were received. The results indicated, " ...5.4 centimeter dilated air-filled large bowel loops within the abdomen and pelvis in keeping with ileus in the appropriate clinical setting ...." A Nursing Progress Note, on 8/28/2024 at 12:35		Protocol was reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policy on or before 12/27/2024. A bowel movement record report will be run every night from the EMR and the bowel protocol initiated if indicated. A performance improvement tool has been developed to monitor residents who are on bowel movement regimen medications and the bowel movement report will be reviewed five times a week during daily clinical meeting. How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/designee will complete routine auditing to ensure there are no concerns with the bowel movement report or residents who are on bowel regimen medications. Auditing to occur: 5 random residents weekly x's 30 days, 5 random residents monthly x's 5 months for a total of 6 months of monitoring. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process.	

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	A.M., indicated Resident K had no regular bowel movements after 8/16/2024. An order was received from the nurse practitioner for a bisacodyl suppository if no bowel movement after 4 hours. A Nursing Progress Note, on 8/28/2024 at 2:39 P.M., indicated new orders were obtained from the physician including: absolutely no enema, 2 doses of MiraLAX 2-3 hours apart then continue as needed for constipation, Senna Plus 50 milligrams/8.6 milligrams 2 tablets a day for 7 days then 2 tablets at night, and if no bowel movement give another suppository tonight at bedtime. The August 2024 Medication Administration Record indicated although biscodyl 5 milligram tab was ordered on 8/26/2024 to be administered twice daily until 8/29/2024, the resident did not receive any tablets until 8/29/24. Resident K was also not administered the bisacodyl suppository, docusate sodium or Milk of Magnesia from 8/26/2024 through 8/29/2024. The August bowel record indicated the resident had a small bowel movement on the evening shift of 8/26/2024 and 8/28/2024. There was no bowel movement documented on 8/27/2024 for Resident K. A Nursing Progress Note, on 8/29/2024 at 5:01 P.M., indicated Resident K has not had a bowel movement since the last orders were received and administered. A new physician's order was received to give another dose of MiraLAX if no bowel movement happened and to give MiraLAX 17 grams three times a day for 4 days. There was no bowel movement documented for Resident K on 8/29/2024 and 8/30/2024. A Nursing Progress Note, on 8/30/2024 at 11:23 A.M., indicated a physician's order was received to repeat an abdominal x-ray on 8/30/2024. A		By what date the systemic changes for the deficiency will be completed: 12/27/2024.	

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	medium bowel movement on the evening shift was documented for Resident K on 8/31/2024. A Nursing Progress Note, on 9/2/2024 at 4:26 P.M., indicated Resident K's bowel sounds were present in all quadrants of the resident's abdomen. The resident's abdomen was firm and distended with discomfort noted on gentle palpation. An extra-large bowel movement was also noted. A Nursing Progress Note, on 9/2/2024 at 6:48 P.M., indicated the following results of the abdominal x-ray. " ...dilated large bowel loops noted in the central abdomen, maximum transverse diameter of 5.5 centimeters ...No significant interval change ...." A new order was received to repeat the abdominal x-ray on 9/4/2024 and to continue with the current orders. A Nursing Progress Note, on 9/5/2024 at 1:04 P.M., indicated bowel sounds were present with slight abdominal distention noted. The resident's last bowel movement charted, on 9/5/2024, was a medium size. The physician reviewed the abdominal x-ray and gave orders to continue the currently ordered plan of care. During an interview, on 11/27/2024 at 8:53 A.M., CNA 8 indicated Resident K was a one person assist and was incontinent of bowels at times. During an interview, on 11/27/2024 at 12:53 P.M., LPN 20 indicated the facility's bowel movement regimen included the following: two days of no bowel movement to give prune juice, three days of no bowel movement to give oral laxative, four day of no bowel movement to give suppository or enema and 5 days of no bowel movement or result to call the physician.			

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	A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, "Bowel Protocol", indicated, " ...To provide effective interventions for signs and symptoms of constipation that are consistent with current standards of practice ...1. Nursing staff document the resident's bowel movements each shift ...2. The evening shift nurses assesses the bowel movement data daily and responds according to the protocol and/or physician orders. 3. If no bowel movement is recorded for two days: a. Assess for signs and symptoms of constipation. b. If the resident is alert and oriented, ask about any unrecorded bowel movements and assess for constipation. c. If acute abdominal symptoms are present, contact the physician immediately. 4. If no bowel movement is recorded for 3 days: a. In the absence of acute abdominal symptoms, administer a PRN [as needed] laxative or enema as ordered by the physician. b. If no PRN is ordered, contact the physician and relay the resident's status and request a laxative and/or enema. c. If acute abdominal symptoms are present, contact the physician immediately. 5. After 4 days with no bowel movement or inadequate response to previous interventions, contact the physician ...." This citation is related to complaint investigation IN00447285. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on record review and interview, the facility failed to prevent a burn for 1 of 1 resident reviewed for accident hazards. (Resident M) Finding includes:	F 0689	It is the practice of this facility that the resident's environment remains as free of accident hazards as possible, and residents are assessed when	12/27/2024

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	A review of a facility reported incident was reviewed on 11/25/2024 at 11:12 A.M. The facility reported, on 11/20/2024 at 9:50 P.M., during skin rounds a nurse discovered an area on the bilateral inner legs of Resident M to be blistered. It was believed Resident M spilt soup on her lap. An investigation was initiated. The follow-up investigation indicated after interviewing staff, there were no witnesses to determine whether a hot liquid had spilt on Resident M's lap. Resident M required staff assistance to eat. The physician had examined the wounds and determined the wounds to be "nonthermal". The resident's care plan was reviewed and updated. A Witness Statement from CNA 16, dated 11/19/2024, indicated, " ...Around supper time at 6:10 P.M., she has her dinner in front of her. I got up to give [another resident name] his dinner. Start [sic] to feed [Resident M] when I seen she was missing her soup. I said to my co-worker, ok, you got no soup -n- [Resident M] said yes I did. I said were [sic, where] is it. She on my lap. I said omg [oh my god]. It was hot. So [I] put a cold wash cloth on her but I seen it was red. So I got her to bed. Check her again still red. N-on-11/20/2024 went to get her cleaned up I saw it has got red again. But yesterday I did tell the nurse, because it te [tell] my co/work [coworker] it was red. So tonight it still red to [so] told the nurse to check again". A Witness Statement written by LPN 17, dated 11/20/2024, indicated, on 11/19/2024, CNA 16 let her know Resident M had some redness on her leg. LPN 17 indicated observation of Resident M's legs indicated they were light pink in color. LPN 17 inquired to CNA 16 what happened and CNA 16 indicated she thought Resident M spilt soup		accidents occur. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Resident M areas have healed and care plan has been updated. Hot liquid assessment was updated intervention of placing soup in a cup with lid was added for resident. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents are at potential risk for injury while handling hot liquids. A hot liquid safety evaluation was completed on all residents. All residents determined to be at risk were referred to therapy for screening and appropriate interventions. Resident care plans updated. Temperature checks of hot liquids are completed at each meal by dietary department. Hot liquid mugs with lids have also been ordered. The hot liquid machine was serviced and temperatures adjusted. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policy on safety of hot	

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	on herself, but mentioned it happening a different day. LPN 17 indicated during Resident M's skin assessment; Resident M had blisters. A Witness Statement written by RN 18, dated 11/20/2024, indicated LPN 17 asked for a second opinion on Resident M's skin. RN 18 indicated upon observation there were small blisters between her thighs. LPN 17 indicated CNA 16 reported soup had fallen on Resident M's lap. CNA 16 had indicated she believed the incident happened on Sunday (11/17/2024) when she was working with CNA 19. A Witness Statement written by CNA 19, dated 11/20/2024, indicated Resident M did not have any soup. As CNA 19 had observed the situation she noticed Resident M had spilt her soup onto her lap. CNA 16 and CNA 19 took Resident M's lap blanket off and witnessed a red area on her left inner thigh. CNA 19 indicated LPN 17 observed the area and the incident occurred on 11/19/2024. A record review for Resident M was completed on 11/26/2024 at 2:18 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, contracture of right hand and physical debility. A Quarterly Minimum Data Set (MDS) assessment, dated 9/20/2024, indicated Resident M had severe cognitive deficiency, no impairment of the extremities, and required maximal/substantial assistance for eating. A Nursing Progress Note, on 11/20/2024 at 9:49 P.M., indicated during a skin assessment Resident M was noted to have blisters on her right and left thigh. A Hot Liquid Safety Evaluation, on 11/21/2024 at		liquids was reviewed by the IDT. An in-service was conducted with all facility staff on the policy and licensed nurses were in-serviced on assessing residents immediately after any hot liquid incidents. A performance improvement tool has been developed to monitor residents are evaluated on admission and at least quarterly for risk for injury while handling hot liquids and interventions from the assessment are in place and referred to therapy for screening and results added to care plan. How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/designee to complete routine auditing designee to ensure hot liquid safety evaluations have been completed and at risk residents have interventions in place on the care plan. Auditing to occur: 5 random residents weekly x's 30 days, then 5 random residents monthly x's 5 months for a total of 6 months of monitoring. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of	

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	10:05 A.M., for Resident M was completed. The evaluation indicated Resident M had cognitive impairment or drowsiness that impacted the resident's perception and awareness to hot liquids and safety measures including, but not limited to: altered comprehension and/or memory impairment, altered muscle strength of the arms, hands, and fingers, tremors or abnormal muscle movements of the arms, altered range of motion or contractures of the joints(s) to the dominant side of the wrist, fingers and hand, episodes of behavior which could cause injury if occurred while Resident M was handling hot liquids, and a history of spilling liquids. The interventions included a cup with lid or other adaptive cup, staff assistance and to drink hot liquids at the dining table. A Nursing Progress Note, on 11/21/2024 at 12:18 P.M., indicated Resident M was seen by the nurse practitioner and orders were received for Silvadene cream twice daily with nonadherent dressing. A Physician History and Physical, dated 11/21/2024, indicated Resident M had the diagnoses of non-thermal blister and contact with hot food. A Weekly Non-Pressure Other Injury Evaluation, on 11/21/2024 at 1:23 P.M., indicated an initial facility acquired right thigh toward the back blister measuring 7 centimeters by 1 centimeter. A Weekly Non-Pressure Other Injury Evaluation, on 11/21/2024 at 1:24 P.M., indicated an initial facility acquired left lower leg blister from a burn measuring 4 centimeters by 2 centimeters. A Care Plan for prevention for burns was not developed.		noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	

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During an interview, on 11/27/2024 at 12:55 P.M., LPN 20 indicated a Hot Liquid Safety Evaluation would be completed on admission and quarterly to determine risk of burns.

During an interview, on 11/27/2024 at 3:32 P.M., the Regional Director of Nursing Services indicated that the blisters were determined nonthermal from the physician, so further action was not needed.

A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, "Safety of Hot Liquids", indicated, " ...Residents will be evaluated for safety concerns and potential for injury from hot liquids. Appropriate precautions will be implemented to maximize choice of beverage while minimizing the potential for injury ...1. The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions. 2. Residents with these or other conditions may suffer from accidental burns and related complications stemming from thinner, more fragile skin that may burn more quickly and severely and take longer to heal. 3. Residents who prefer hot beverages with meals [i.e., coffee, tea, soup, etc.] will not be restricted from these options. Instead, staff will conduct regular Hot Liquid Safety Evaluation as indicated, and document the risk factor for scalding and burns in the care plan ...."

This citation is related to complaint investigation IN00447285.

3.1-45(a)(2)

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview the facility failed to ensure nebulizer equipment and nasal cannula tubing were stored and dated properly (Resident 16), failed to ensure nasal cannula tubing was changed per physician orders and oxygen concentrator filters were cleaned as needed (Resident 16) and failed to provide oxygen hydration equipment (Resident F) for 3 of 3 residents reviewed for respiratory therapy. Findings include: 1. During an observation, on 11/21/2024 10:13 A.M., the handheld aerosol nebulizer for Resident 53 was lying on the bedside table. There was no date on the oxygen tubing or on the nasal cannula. During an interview, on 11/21/2024 at 11:25 A.M., Resident 53 indicated the staff did not normally store the handheld aerosol nebulizer in bags. During an interview, on 11/21/2024 at 2:54 P.M., Resident 53 indicated the staff had placed a dated paper tape label on her nasal cannula about an hour ago. She indicated the nasal cannula was not changed. A date of 11/21/2024 was observed written on paper tape attached to the nasal cannula. During an observation, on 11/22/2024 at 9:57 A.M., the handheld aerosol nebulizer was observed lying on the over-the-bed table. During an observation, on 11/27/2024 at 8:48 A.M., the handheld aerosol nebulizer was	F 0695	It is the practice of this facility that the residents who receive respiratory care, receive said care consistent with professional standards considering their person-centered car plan, goals, and preferences. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Resident 53: Oxygen and Nebulizer tubing was replaced, dated, and placed in a labeled bag on 11/21/2024. An order was put in to place for proper care of tubing and handheld aerosol equipment on 12/04/2024. Resident 16 filter on concentrator was cleaned on 11/21/2024 and tubing was changed and dated. An order was placed for a cleaning schedule for concentrator filter on 12/04/2024. A humidifier bottle was added to resident F's oxygen concentrator on 11/21/2024. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents who are on O2 or Nebulizers have the potential to be affected. An audit was performed by nursing management on in	12/27/2024

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	observed attached to the nebulizer machine without a covering. A record review for Resident 53 was completed on 11/25/2024 at 12:16 P.M. Diagnoses included, but were not limited to: pneumonia, acute and chronic respiratory failure, obstructive sleep apnea and chronic obstructive pulmonary disease (COPD). A Quarterly Minimum Data Set (MDS) assessment, dated 10/1/2024, indicated Resident 53 was cognitively intact and received oxygen therapy. A Physician's Order, dated 8/18/2024, included the following: -oxygen at 2 liters per minute via nasal cannula for shortness of breath and change oxygen tubing every night shift on Sundays. A Physician's Order, dated 9/8/2024, indicated Albuterol Sulfate nebulization solution 2.5 milligrams per 3 milliliters inhale 3 milligrams via nebulizer two times a day for COPD. There was not an order to change or store the handheld aerosol nebulizer equipment. A current Care Plan, intiated on 7/27/2024, indicated Resident 53 had the potential for ineffective breathing related to chronic lung disease, pneumonia, acute and chronic respiratory failure with hypoxia, obstructive sleep apnea and COPD. The interventions included, but were not limited to, administer oxygen as ordered, change oxygen tubing weekly and to give breathing treatments as ordered. During an interview, on 11/27/2024 at 8:49 A.M., LPN 2 indicated nebulizer equipment should be stored in a bag with the resident's name on the		house residents with current O2 and Nebulizer treatment orders to ensure tubing and humidifiers have been changed timely, are dated, and that orders for changing/labeling tubing are accurate and filters are cleaned weekly and as needed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policy on Oxygen Administration was reviewed by the IDT. An in-service was conducted by DON/Designee on or before 12/27/2024 with all facility nursing staff on the policy. A performance improvement tool has been developed to monitor residents with current O2 and Nebulizer treatment orders to ensure orders for changing/labeling tubing are accurate and filters are cleaned weekly and as needed. How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/designee will complete routine auditing to ensure Oxygen Administration Policy is being followed and all tubing and cleaning schedules are up to date. Auditing to occur: 5 random residents weekly x's 30 days, 5 ransom residents monthly x's 5 months for a total of 6 months of	

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	155073	A. BUILDING 00 B. WING	11/27/2024

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	bag and the oxygen and nebulizer tubing should be dated. 2. The record for Resident 16 was reviewed on 11/25/2024 at 9:42 A.M. Diagnoses include, but were not limited to: chronic diastolic congestive heart failure, pacemaker, chronic obstructive pulmonary disease, and chronic kidney disease stage 3. During an observation, on 11/21/2024 at 3:25 P.M., Resident 16's oxygen tubing was dated 11/12/2024, and the filter to the back of the concentrator was covered with dust. During an observation, on 11/22/2024 at 9:47 A.M., the filter to the back of the oxygen concentrator was covered with dust. During an observation. on 11/26/2024 at 9:48 A.M., the filter to the back of the oxygen concentrator was covered with dust. Current Physician Orders included: Change O2 tubing and/or updraft tubing, including oxy ear to tubing every night shift on Thursday for Equipment change date and initial tubing. A current Care Plan, initiated on 10/17/2024, indicated the resident has Oxygen Therapy related to chronic obstructive pulmonary disease (COPD). Interventions included, but were not limited to: Give medications as ordered by physician. Monitor/document side effects and effectiveness. The resident has O2 at 2L (liters) via nasal prongs continuously to keep saturations above or equal to 90% as ordered. During an interview, on 11/26/2024 at 10:05 A.M., LPN 5 indicated the filter should have been cleaned and was not.		monitoring. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024. -	

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	3. The record for Resident F was reviewed on 11/25/2024 at 12:08 P.M. Diagnoses included, but were not limited to: retention of urine, neuromuscular dysfunction of the bladder, dementia, and Legionnaires disease. During an observation, on 11/22/2024 at 9:30 A.M., Resident F's oxygen tubing was applied straight into the machine with no humidification water bottle. During an observation, on 11/25/2024 at 9:12 A.M., Resident F's oxygen tubing was applied straight into the machine with no humidification water bottle. During an observation, on 11/26/2024 at 9:45 A.M., Resident F's oxygen tubing was applied straight into the machine with no humidification water bottle. A current Physician Order, initiated on 10/24/2024, indicated the following: Change oxygen tubing, and humidification bottle, clean oxygen filter, inspect easy foam wraps (replace if soiled or missing) every night shift every Thursday and as needed. During an interview, on 11/26/2024 at 10:03 A.M., LPN 5 indicated there should be a humidification bottle on the concentrator. On 11/27/2024 at 12:40 P.M. the Director of Nursing provided the policy titled, "Oxygen Administration", dated 2010, and indicated the policy was the one currently used by the facility. The policy indicated "... Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure... 3. Humidifier bottle... 12. Check the mask, tank,			

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	humidifying jar, ect., to be sure they are in good working order and area securely fastened. Be sure there is water in the humidifying jar and the the water level is high enough that the water bubbles as oxygen flows through...." 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review and interview, the facility failed to ensure physician ordered medications were given and available for 1 of 9 residents whose medications were reviewed. In addition, the facility failed to ensure narcotics were counted and documented every shift for 1 of 4 narcotic count logbooks reviewed. (Residents K and North narcotic count sheets) Findings include: 1. A record review for Resident K was completed on 11/26/2024 at 10:16 A.M. Diagnoses included, but were not limited to: Alzheimer's disease and constipation. A Significant Change Minimum Data Set (MDS) assessment, dated 9/13/2024, indicated Resident K had significant cognitive impairment and was frequently incontinent of bowel. Physician Orders for Resident K, dated 8/26/2024, indicated the following medications: bisacodyl 5 milligrams daily, bisacodyl 10 milligram suppository as needed, docusate sodium 100 milligrams twice daily for 3 days and Milk of Magnesia 30 milliliters as needed. (medications to soften stools and/or promote regular bowel movements)	F 0755	It is the practice of this facility to provide routine and emergency drugs and biologicals to our residents, or obtain them under agreement described in 483.70(f) The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Resident K medications to promote bowel movements are available on the medication cart and have been documented as administered. Narcotic logbooks were signed late by nurses who completed those counts but did not sign off. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents who are on Bowel Regimen Medications or are prescribed narcotic medications have the potential to be affected. An audit on all residents, Bowel	12/27/2024

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	The August 2024 Medication Administration Record indicated although biscodyl 5 milligram tab was ordered on 8/26/2024, the resident did not receive any tablets until 8/29/24. There was no documentation in Nursing Progress notes or the facility's bowel tracking system to indicate Resident K had had regular bowel movments from 8/26/2024 through 8/29/2024. The August 2024 Medication Administration Record indicated although docusate sodium 100 milligrams capsule twice daily was ordered on 8/26/2024 to be given through 8/29/2024, the resident did not received any capsules. The August 2024 Medication Administration Record indicated although milk of magnesia 30 milliliters as needed was ordered on 8/26/2024, the resident had not received any doses. The August 2024 Medication Administration Record indicated although bisacodyl 10 milligram suppository as needed was ordered on 8/26/2024, the resident had not received any doses. 2. A Medication Storage observation of the 400 hall medication cart was completed, on 11/25/2024 at 11:03 A.M., with LPN 2. The the narcotic log book lacked 24 signatures to show a narcotic count was completed. During an interview, on 8/9/2024 at 11:04 A.M., LPN 2 indicated the narcotic log sheets should have been signed every shift. On 11/27/2024 at 12:41 P.M., the Director of Nursing provided the policy titled, "Ordering and Receiving Medications", dated 5/20/2020, and		Regimen Medications was also conducte with all medication available and documented as administered. Resident care plans updated. An audit of all Narcotic Logbooks was conducted and concerns addressed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policies for Bowel Protocol and Controlled Medication Storage were reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policies on or before 12/27/2024. Performance improvement tools have been developed to monitor Narcotic Logbooks and Bowel Movement Regimen Medications. The bowel movement report will be reviewed five times a week during daily clinical meeting and a medication administration audit report from the EMR will be run daily during clinical meeting and pharmacy and physician contacted as indicated. . How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/designee will complete routine auditing of missed medications to ensure there are no concerns to ensure there are	

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	indicated the policy was the one currently used by the facility. The policy indicated "...Medications and related products are received from the pharmacy in a timely manner. The facility maintains accurate records of medications ordered and received... b. If not automatically refilled by the pharmacy, refills are ordered as follows: i. Reorder medication when a four day supply remains, in advance of need, to assure an adequate supply is on hand. When reordering medication that requires special processing, please contact the pharmacy for special processing...." On 11/27/2024 at 12:45 P.M., the Director of Nursing provided the policy titled," Controlled Medication Storage", dated 5/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. Regulations required that the facility have a system to account for the receipt, usage, disposition, and reconciliation of all controlled medication(s). The system includes but is not limited to: ...7. At each shift change, a physical inventory of all controlled medication(s), including the emergency supply, is conducted by two (2) licensed nurses and is documented on the controlled medication accountability record per facility procedure...." This citation relates to Complaint IN00442061. 3.1-25(a) 3.1-25(e)(2) 3.1-25(e)(3) 3.1-25(g)(3)		no concerns. DON/Designee will complete routine auditing to ensure there are no missing signatures in the narcotic log. Auditing for both to occur: 5 random residents weekly x's 30 days, 5 ransom residents monthly x's 5 months for a total of 6 months of monitoring. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	Based on observation, interview and record review, the facility failed to ensure medications were stored appropriately and medication carts were free of loose pills for 2 of 2 medication carts observed. (400 hall medication cart and 100 hall medication cart) Findings include: 1. During a medication storage observation, on 11/26/2024 at 11:03 A.M., with LPN 2 on the 400 hall med cart, the following was observed: 6 loose pills in 3 of the 4 main drawers. During an interview, on 11/26/2024 at 11:09 A.M., LPN 2 indicated the loose pills should not be in the medication cart. 2. During a medication storage observation, on 11/26/2024 at 11:16 A.M., with R.N. 15 on the 100 hall medication cart, the following was observed: - a box of glucose test strips that had expired on 9/25/2024. - 3 loose pills in 2 drawers. - a opened container of Miralax (laxative) with no opened date. During an interview, on 11/26/2024 at 11:18 A.M., R.N. 15 indicated the loose pills should not be in the medication cart and the laxative should have a date opened in it. On 11/27/2024 at 12:45 P.M., the Director of Nursing provided the policy titled, " Medication Cart Disinfecting" , undated and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this facility that the medication cart will be maintained in a clean and orderly manner at all times...."	F 0761	It is the practice of this facility that Drugs and biologicals used in the facility be labeled and stored in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: All loose pills and expired glucose strips were disposed of properly and opened undated MiraLax were disposed of immediately. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will. be taken; All residents have the potential to be affected. DON/Designee audited all medication carts and treatment carts for compliance with no new concerns noted. An audit of all medication carts and treatment carts will be completed weekly. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policies on Medication Cart Disinfecting and Medication	12/27/2024

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	3.1-25(j)		Storage were reviewed by the IDT. An in-service was conducted with all facility nurses and QMAs on the policies. A performance improvement tool has been developed to monitor Medication Carts and Treatment Carts to ensure there are no loose pills, expired meds or opened medications without dates . How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/designee will complete routine auditing to ensure Medication Carts and Treatment Carts are free from undated, unlabeled and loose medications. Auditing to occur: Carts will be audited weekly ongoing. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	
F 0812 SS=E	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review and interview, the facility failed to ensure food was stored and prepared in a sanitary manner for 1 of 1 kitchens observed. This deficient practice had the potential to affect 71 of 73 residents who consumed food from the kitchen. Findings include: During initial kitchen observations, on 11/21/2024 from 9:30 A.M. through 9:48 A.M. with the Dietary Manager (DM), the following was observed: - Opened cream base soup without an open date and stored unsealed. - Opened old fashioned biscuit gravy mix without an open date and stored unsealed. - Opened bag of coconut stored unsealed. - Opened pasta with no open date. - Opened chopped garlic sitting on a shelf with directions of to be refrigerate. - Spices of garlic herb seasoning, granulated garlic, granulated onion, parsley flakes and onion powder with no documented open date. - Mini freezer with heavy ice buildup. During an interview, on 11/21/2024 at 9:49 A.M., the Dietary Manager indicated the opened bags of food in the dry storage should have been sealed and/or in a baggie and have an open date documented on them, the minced garlic should have been refrigerated and the spices should have open dates on the containers. During an observation, on 11/26/2024 at10:30 A.M., the cream-based soup mix was still opened and not sealed. The mini freezer had heavy ice buildup. During an observation, on 11/26/2024 at 10:47	F 0812	It is the practice of this facility to provide our residents with food items that have been acquired, prepared, stored, and served in a manner that meets all local, state, and federal regulations for food safety. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: No Residents were identified as being affected by the deficient practice. All undated spices and open /unsealed or undated food was thrown away immediately. Mini Freezer with ice buildup was removed from service immediately. Maintenance Director inspected the sanitation concentration machine and repaired it on 11/26/2024. A new bucket was made and tested. Test strip indicated proper mixture. An audit was completed of the kitchen with no further issues identified of opened/unsealed or undated food. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents are at potential risk for the deficient practice. An audit was completed of the kitchen with no further issues identified of	12/27/2024

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	A.M., the sanitation bucket at the prep counter and at the dishwashing machine was tested for proper concentration. The test strip indicated a concentration of zero sanitation chemicals. During an interview, on 11/26/2024 at 10:49 A.M., the Dietary Manager indicated the concentration on the strip should have been between 200-400. During an interview, on 11/26/2024 at 2:12 P.M., the Dietary Manager indicated after changing the sanitation buckets, the buckets were tested again for concentration. The test strip indicated zero concentration. She indicated she had the maintenance department look at the automated sanitation disbursement system and the sanitation solution was not flowing through the tubing. It was unclear how long the chemical had not been mixing properly. During an interview, on 11/27/2024 10:35 A.M., the Dietary Manager indicated the mini freezer was not on a defrosting schedule, but the mini freezer was usually unplugged about every month and set outside to defrost. A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, "Dietary Stock Procedure", indicated, " ...To be sure all stock is properly put away as soon as possible after delivery ...4. Bulk items must be properly dated, with date received, expiration date, open date and new expiration date if needed ...5. All food needs to have open date on them once opened & expiration date, if it changes ...." A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, "Freezer Cleaning", indicated, " ...Freezers will be defrosted as needed [when frost is ½ inch thick,		opened/unsealed or undated food. Cleanslate was contacted and provided preventive maintenance on 12/16/2024 to ensure proper function. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policies for Dietary Stock Procedure, Freezer Cleaning, and Cleaning Cloths, Pads, Mops, and Buckets were reviewed by the IDT. An in-service was conducted with all facility dietary staff on the policies. A performance improvement tool has been developed to monitor that all food is dated and stored properly and that all sanitation buckets test to the appropriate level. Cleanslate will perform routine maintenance on a regular basis. How the corrective actions will be monitored to ensure the deficient practice does not recur; The Food Service Director/designee will complete routine auditing to ensure all food is dated and stored properly and that sanitation buckets test to the appropriate mixture. Auditing to occur: weekly ongoing. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be	

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	the freezer should be defrosted], or per the manufacturer's instructions ...." A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, "Cleaning cloths, Pads, Mops & Buckets", indicated, " ...Cleaning cloths should be kept in a container of clean sanitizing solution between use ...Periodically test the sanitizing solution to assure that it maintains the correct concentration ...." 3.1-21(h)(2) 3.1-21(h)(3)		reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process.. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure enhanced barrier precautions were in place for 1 of 1 residents observed during wound care. (Resident 60) and failed to store catheter tubing and drainage bags appropriately for 1 of 2 residents reviewed for catheters (Resident F). Findings include: 1. The medical record for Resident 60 was reviewed on 11/25/2024 at 9:04 A.M. Diagnoses included, but were not limited to: rhabdomyolysis, paroxysmal atrial fibrillation, depression, anxiety, neuromuscular dysfunction of bladder, pressure ulcer of left buttock, dementia and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 8/14/2024, indicated Resident 60 was severely cognitively impaired. The MDS indicated Resident 60 was dependent for eating, oral hygiene, toileting, showering/bathing, upper	F 0880	It is the practice of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections in the facility. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Resident 39 was not affected by this deficient practice. Resident F urinary catheter was changed to a fig leaf drainage catheter bag on 11/26/2024. A basin was placed as a barrier between urinary drainage bag and floor. How are other residents having the	12/27/2024

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(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
	and lower body dressing, footwear and personal hygiene. Resident had an indwelling urinary catheter and was always incontinent of bowel. Resident 60 had one pressure ulcer that was present upon admission. A Physician's Order for Resident 60, dated 8/26/2024, indicated to maintain enhanced barrier precautions every shift for precautions. A current Care Plan, reviewed on 11/13/2024, indicated Resident 60 had an unstageable pressure ulcer to the coccyx. Interventions included but were not limited to: apply treatments as ordered. During an observation, on 11/25/2024 at 9:27 A.M., an Enhanced Barrier Precaution instruction sign was present and visible next to Resident 60's television on the wall. During an observation of care, on 11/25/2024 at 2:02 P.M., Employee 10, Employee 12 and Employee 4 gathered in Resident 60's room and performed hand hygiene. Employee 10 placed a barrier on the bedside table and placed wound care supplies on top of barrier. Employee 10, 12, and 4 all wore clean gloves but none of the employees wore gowns or face masks. Both Employee 12 and 4 handled Resident 60's body while Employee 10 performed the dressing change. During an interview, on 11/27/2024 at 10:56 A.M., Employee 11 indicated the term Enhanced Barrier Precautions (EBP) meant staff were required to wear gowns, gloves, and sometimes a mask, depending on the task performed in the resident room. Employee 11 indicated EBP was indicated for staff when a resident required urinary catheter		potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents who have catheters or wounds have the potential to be affected by the alleged deficiency. Inservice completed on use of EBP for all nursing staff was completed. Audit was conducted to ensure all residents with catheters have a fig leaf drainage bag and that it is not touching the floor, no concerns identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policies on Enhanced Barrier Precautions and Catheter Care, Urinary were reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policies. A performance improvement tool has been developed to monitor that all residents with a catheter have fig leaf drainage bags present and EBP are being followed. How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/designee will complete routine auditing to ensure that all residents with a catheter have a fig leaf drainage bag and EBP is being followed. Auditing to occur: 5 random residents weekly x's 30	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	11/27/2024

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	care and/or wound care. During an interview, on 11/27/2024 at 11:05 A.M., Employee 3 indicated Enhanced Barrier Precautions meant staff were required to wear a gown and gloves when the staff gave residents Foley care and wound care. 2. The record for Resident F was reviewed on 11/25/2024 at 12:08 P.M. Diagnoses included, but were not limited to: retention of urine, neuromuscular dysfunction of the bladder, dementia, and Legionnaires disease. Current Physician Orders for Resident F included the following: 16 French Foley catheter with 10 cc balloon with drainage bag to gravity. May change as needed for leakage, dislodgement or occlusion. A current Care Plan, dated 8/12/2024, indicated the resident had the potential for a urinary tract infection related to indwelling catheter due to urine retention manifested by fever, increase in confusion. Interventions included but were not limited to: Change and maintain 16 FR Foley catheter with 10 cc in balloon, with drainage bag to gravity as ordered. Empty catheter every shift and record output. Keep catheter drainage bag inside an outer bag for covering- Keep tubing kink free. Watch for blocked or encrusted catheter, drainage tubing or bag and change as needed. Watch for complications of catheter use: urine leakage, pink or blood tinged urine, bladder pain or spasms. During an observation, on 11/25/2024 at 12:22 P.M., Resident F's urinary catheter drainage bag was resting on the floor. The urinary drainage bag had a hard plastic box attached to the outside with numbers of ml's (milliliter) documented on the plastic box. The box contained over 400 ml's of		days, 5 ransom residents monthly x's 5 months for a total of 6 months of monitoring. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 12/27/2024.	

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	dark orange colored urine. The Foley urinary drainage tube was filled with urine and was not able to drain into the drainage bag. During an observation, on 11/26/2024 at 9:53 A.M., the urinary drainage tube was on the floor. The box on the outside of the drainage bag was filled with over 400 ml of dark urine. The drainage tube had urine in it and was unable to drain into the drainage bag. During an interview, on 11/26/24 at 10:12 A. M., LPN 5 indicated the drainage bag was the one the resident had when she was admitted from the hospital and "we don't use those" and indicated the urinary drainage tubing should not be on the floor. On 11/21/2024 at 2:30 P.M., the Administrator provided a policy titled, "Enhanced Barrier Precautions", dated 4/12/2024 and indicated the policy was the one currently used by the facility. The policy indicated " ...Enhanced Barrier Precautions are to be implemented in addition to Standard Precautions...when facility identifies any resident with...chronic wounds..." On 11/27/2024 at 12:41 P.M., the Director of Nursing provided the policy titled, "Catheter Care, Urinary", dated 2014, and indicated the policy was the one currently used by the facility. The policy indicated "... Infection Control: ... b. Be sure the catheter tubing an drainage bag are kept off the floor. c. Empty the drainage bag regularly...." 3.1-18(a)			