STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 00 B. WING	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY NURSING AND REHABILITATION CENTER	5600 E 16TH ST INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00456672. Complaint IN00456672 - Federal/State deficiencies related to the allegations are cited at F0550 and F0677. Survey dates: April 21, 22, 23, 24, and 25, 2025 Facility number: 000012 Provider number: 155029 AIM number: 100274900 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 1 Medicaid: 44 Other: 9 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 2, 2025.	F 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.** **The Facility formally requests a desk review of the following plans of correction.**	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to ensure residents' respect and dignity were maintained for 2 of 3 residents reviewed for dignity, 3 of 8 resident interviews in abuse investigations, and 3	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	05/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keshia Polston	Regional Vice President of Operations	05/17/2025

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	residents randomly observed during dining. (Resident B, D, F, J, K, L, M, and N) Findings include: 1. The clinical record for Resident J was reviewed on 4/22/25 at 11:30 a.m. The diagnoses included, but were not limited to, cellulitis. The Admission Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident J was cognitively intact. An interview was conducted with Resident J on 4/22/25 at 11:18 a.m. She indicated the staff were disrespectful during care. The staff needed training to not rush during care. They were rushing and "jerk" you around. It was rough, but not abusive. 2a. The clinical record for Resident D was reviewed on 4/22/25 at 12:00 p.m. The diagnoses included, but were not limited to, depression. The Quarterly MDS assessment, dated 12/24/24, indicated Resident D was cognitively intact. 2b. The clinical record for Resident K was reviewed on 4/22/25 at 1:00 p.m. The diagnoses included, but were not limited to, hypertension. The Annual MDS assessment, dated 1/21/25, indicated Resident K was cognitively intact. An abuse investigation into a reportable incident, dated 4/20/25, was provided by the Corporate Executive Director on 4/23/25 at 10:55 a.m. The file included, but was not limited to, the following documentation:		Employee CNA 2 was suspended and appropriate actions were taken. Clothing protectors are supplied at each meal for residents M, L, and N. Residents B, D, F, and K are being provided care per preference and in a dignified manner. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. All residents will be interviewed on care preferences and if being treated with respect and dignity by May 31, 2025. ED or Designee will educate all staff on resident rights/ policy by May 31, 2025. MDS coordinator or Designee will update resident care profiles by May 31, 2025. Clothing protectors will be made available to all residents at each meal. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ED or Designee will educate all staff on resident rights policy by May 31, 2025.	

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	A statement by Resident D indicating the staff during care handled her "roughly." A statement by Resident K indicated the staff were rough during care at times. On one occasion, it felt like the staff person was digging her nails in his skin during incontinent care. An interview was conducted with Resident K on 4/24/25 at 10:26 a.m. He indicated Certified Nurse Aide (CNA) 2 was having a "bad day." She at times has had an attitude. There was a time, CNA 2 was wiping him so fast during incontinent care; she dug her nails in his skin. 3. The clinical record for Resident F was reviewed on 4/23/25 at 3:54 p.m. The diagnoses included, but were not limited to, anxiety, panic disorder, post-traumatic stress disorder, depression, borderline personality disorder, and schizoaffective disorder. An MDS assessment, dated 3/18/25, indicated Resident F was cognitively intact. An interview was conducted with Resident F on 4/22/25 at 3:38 p.m. She indicated she was treated differently because she was more able-bodied. CNA 2 had a poor attitude and demeanor. She was not polite and never smiled. Resident F had to make her own bed because CNA 2 would not do it. She had a hard time getting laundry done because staff said she can do it herself. She was made to put her laundry in a bag and put it by the door by some staff and others told her differently. A grievance was filed by Resident F on 2/8/25. She indicated CNA 2 always picked on her and told her to make her own bed. If Resident F didn't like the meal that was served or wanted seconds, CNA 2 told her to go get it herself and she didn't		Meal Manager will ensure clothing protectors are available for resident use and that residents are offered clothing protectors by May 31, 2025. ED or Designee will complete supply order to ensure clothing protectors are available for all residents at their request for all meals by May 31, 2025. ED or Designee will round each shift to ensure residents are provided care with dignity and respect. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·To ensure compliance the ED/Designee will complete a resident rights CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The resident rights CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	like taking care of a resident who can do things herself. Resident F would request ice water and CNA 2 would bring half a cup of water to upset her. CNA 2 knew Resident F had a history of mental illness and would pick on her to upset her. She reported CNA 2 several times in the past and requested that CNA 2 no longer care for her. An interview was conducted with CNA 2 on 4/24/25 at 9:52 a.m. She indicated she had received abuse training and resident rights training. She regularly took care of Resident F who didn't need assistance with anything and did her own ADLs (activities of daily living). CNA 2 would strip her bed, and the resident would make it. She also brought the resident ice and water when she asked. Their relationship was fine until several months ago when CNA 2 stopped doing hair and nails for the residents, but Resident F wanted CNA 2 to continue to bring beauty supplies. After this, Resident F would get "flustered" and aggravated due to her mental illness and make smart comments which CNA 2 would ignore. She wasn't sure if the resident asked to have a different CNA or if the facility re-assigned her to "keep the peace." 4. The clinical record for Resident B was reviewed on 4/22/25 at 12:00 p.m. The diagnoses included, but were not limited to, stroke. The Quarterly MDS assessment, dated 12/24/24, indicated Resident B was cognitively intact. During an interview with Resident B on 4/21/25 at 6:50 p.m., she indicated the staff would come in and yell at her because she pressed the call light at the wrong time. 5a. The clinical record for Resident M was reviewed on 4/24/25 at 12:25 p.m. The diagnoses			

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	included, but were not limited to, dementia. 5b. The clinical record for Resident L was reviewed on 4/24/25 at 12:25 p.m. The diagnoses included, but were not limited to, dementia. 5c. The clinical record for Resident N was reviewed on 4/24/25 at 12:25 p.m. The diagnoses included, but were not limited to, dysphagia (inability to swallow). On 4/24/25 at 12:25 p.m., lunch service in the main dining room was randomly observed. Resident L, Resident M, and Resident N had facility tablecloths folded and tied around their necks while sitting and waiting for their meals. During an interview on 4/24/25 at 12:26 p.m., the Minimum Data Set Coordinator indicated she was unsure why table clothes were being used as clothing protectors. During an interview on 4/25/25 at 12:37 p.m., the Nurse Consultant indicated the facility had clothing protectors available to be used in the dining room. An interview was conducted with Nurse Consultant 13 on 4/25/25 at 1:04 p.m. She indicated the staff were expected to treat the residents respectfully. A policy titled "Resident's Rights", dated 11/2015, noted "Each resident shall be treated with consideration, respect, and full recognition of his dignity, and individuality ...the Resident has a right to a dignified existence, self-determination and communication with, and access to, persons and services inside and outside the Facility ..."			

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F 0565 SS=D Bldg. 00	This citation relates to Complaint IN00456672. 3.1-3(a) 3.1-3(t) 3.1-3(v)(1) 483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Based on interview and record review, the facility failed to follow up on grievances for 2 of 2 residents reviewed for grievances. (Resident B and Resident 41) Findings include: 1. The clinical record for Resident B was reviewed on 4/22/25 at 12:00 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly Minimum Data Set (MDS) assessment, completed 1/20/25, indicated she was cognitively intact. An interview was conducted with Resident B on 4/21/25 at 7:01 p.m. She indicated she had filed grievances and had not heard anything about a follow-up from the facility. Resident B indicated she was missing an arm sling, a backpack, a purse, and a box of crackers. An interview was conducted with the Social Services Consultant on 4/24/25 at 2:32 p.m. The Social Services Consultant indicated she could not find the grievances filled out by Resident B. Social Services Director (SSD) 4 indicated she spoke with Resident B and filled out grievances. SSD 4 indicated she did not know where the original grievances were located.	F 0565	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Grievance form completed for resident 41 regarding resident H entering his room. Grievance form completed for resident B regarding missing items. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. ED or designee reviewed all grievances received for the past 30 days to ensure the grievance was addressed, and resident was satisfied with the resolution. ED or Designee will educate all staff on grievance policy/procedure by May 31, 2025. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	05/31/2025

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	2. The clinical record for Resident 41 was reviewed on 4/23/25 at 2:00 p.m. The diagnoses included, but were not limited to, borderline personality disorder. A Quarterly MDS assessment, dated 9/16/24, indicated the resident was cognitively intact. Resident 41 was interviewed on 4/22/25 at 10:31 a.m. He indicated that within the last year, he entered his room and found Resident H sitting on his bed. He got angry, yelled, and swore at him to get out of his bed. Resident H stood up and staff came in to assist him back to his own room. Resident 41 was mad because the resident had done this before, and wanted his sheets changed because of Resident H's incontinence. Staff told Resident 41 he cannot yell or swear at other residents, but he was upset at finding the resident in his room again. He told a CNA (certified nurse aide) and the Weekend Supervisor about the incident. The Weekend Supervisor was interviewed on 4/24/25 at 10:48 a.m. She indicated Resident 41 told her about the incident several weeks ago. He was upset about the incident because Resident H frequently wanders into other residents' rooms. The Weekend Supervisor asked if he wanted her to fill out a grievance and he said yes. She completed the grievance and placed it into a bag in the conference room for the Director of Nursing (DON) to look over on Monday, which was her usual procedure for grievance forms. The DON was interviewed on 4/24/25 at 12:47 p.m. She did not recall seeing the grievance form. She hadn't heard of any residents having issues with Resident H's wandering, because he was pleasant and easily redirected.		**practice does not recur?** ED or Designee will educate all staff on grievance policy/procedure by May 31, 2025. ED or Designee will review all grievances in morning meeting to ensure appropriate follow-up and resolution. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the ED/Designee will complete a grievance policy CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months ED or designee. The grievance policy CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	The Executive Director (ED) and Social Services Consultant were interviewed on 4/24/25 at 11:56 a.m. They could not locate the grievance Weekend Supervisor had filled out regarding the incident with Resident H. The ED said Resident 41 was usually very serious about his grievances and was likely very upset that Resident H was incontinent and sat on his bed. However, staff changed his sheets at the time of the incident, so they considered the issue resolved. A policy titled "Resident Concerns and Grievances", revised 1/2019, noted "If a concern/grievance of any kind is noted, the Concern/Grievance form is used ...The Executive Director/Grievance Official will sign off on all completed concerns/grievance forms, ensuring resident and/or family satisfaction ...All concern forms are to be maintained on-site for a minimum of three years." 3.1-3(k) 3.1-3(l)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from abuse for 2 of 3 residents reviewed for abuse. (Resident 37 and Resident 42) Findings include: 1. The clinical record for Resident 42 was reviewed on 4/22/25 at 9:00 a.m. The diagnoses included, but were not limited to, stroke, major depressive disorder, physical debility, unsteadiness on her feet, and anxiety disorder.	F 0600	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 37 was evaluated by psych and is receiving continued psych services. New interventions in place and careplanned. Resident 42 has been monitored and displays no signs or symptoms of psychosocial distress. **How will**	05/31/2025

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	The Quarterly Minimum Data Set (MDS) assessment, dated 3/16/25, indicated Resident 42 was moderately cognitively impaired. The resident had impairments with her upper and lower extremities on one side. She utilized a walker and wheelchair. She required substantial assistance with dressing but was able to sit to stand independently with no assistance. A behavior care plan, dated 10/4/24, indicated Resident 42 had exhibited verbal aggression towards staff and anxiousness. 2. The clinical record for Resident 37 was reviewed on 4/22/25 at 9:57 a.m. The diagnoses included, but were not limited to, schizoaffective disorder, bipolar disorder, anxiety disorder, and post-traumatic stress disorder. The Quarterly MDS assessment, dated 3/24/25, indicated Resident 37 was cognitively intact. The resident did not have any impairments with his upper or lower extremities. He utilized a walker and a cane. He was independent and did not need assistance with dressing and walking. A behavior care plan, start date of 4/17/25, indicated Resident 37 had been refusing medications and lab draws. A behavior care plan, start date of 4/17/25 with a revision date of 4/22/25, indicated Resident 37 had exhibited behaviors of self-pleasuring in common areas and sexually inappropriate behaviors with staff and a female peer. The interventions, but were not limited to, "Ensure resident's safety... Provide resident with privacy to self pleasure himself... Remove from immediate area to further evaluate needs."		**you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. All interviewable residents will be interviewed using abuse questionnaires, to ensure no other residents have been abused. ED or Designee will educate all staff on our resident rights and abuse policy by May 31, 2025. **What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?** ED or designee will educate all staff on our resident rights and abuse policy by May 31, 2025. All staff will be educated monthly for six months and more often as needed regarding prevention, identification, reporting of abuse, and resident rights. DNS or designee will round each shift to ensure residents are free from abuse. ED or designee will attend resident council meeting with permission to discuss reporting concerns to the ED immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**? To ensure compliance the	

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	A nursing note, dated 4/17/25, indicated Resident 37 had "refused all meds during shift, resident tearful during shift, attempting to hug and kiss staff member, resident not easily directed, resident pulling out his penis and asking staff members to look at him, resident stated 'look at me' while resident pulled on his penis while lying in bed, resident asked to pull curtain and not pull out penis in front of staff, resident continued to jerk at his penis. writer pulled resident's curtain to give resident privacy, new and worsening event opened, DON [Director of Nursing] notified, MD [Medical Director] notified via MD binder of residents med refusal and behaviors." A nursing note, dated 4/18/25, indicated "Resident refused all medication this shift, the writer went back the second time and found resident masturbating, gave resident some room and went back and resident was requesting for hug and kisses from writer ..." A behavior note, dated 4/19/25, indicated the resident was exhibiting behaviors of grabbing staff and kissing them on the neck. The resident was educated on the inappropriate behavior. "The resident becoming aggressive towards staff in his attempt to touch/kiss them and he is pulling out his private parts and asking staff to look while he plays with himself." The medical provider was made aware of the increase in behaviors. A behavior note, dated 4/20/25 at 1:49 p.m. indicated the resident attempted to inappropriately touch the staff members. The resident was educated regarding the inappropriate behavior and redirection was provided. A nursing progress note, dated 4/20/25 at 4:35		ED/Designee will complete an abuse prohibition and investigation CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by ED or designee. The abuse prohibition and investigation CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	p.m., indicated Resident 37 had gone into Resident 42's room and touched and kissed her inappropriately. Resident 37 was sent to the emergency room for evaluation. A reportable incident to the Indiana Department of Health, dated 4/20/25 at 3:07 p.m., indicated Resident 37 had entered Resident 42's room and touched her chest. The investigation for the reportable incident between Resident 37 and Resident 42 was provided by the Corporate Executive Director on 4/23/25 at 10:55 a.m. The file included, but was not limited to, the following documentation: A typed statement by the Social Services Director, dated 4/21/25, indicated "...This a.m. I spoke with [Resident 37] to get more information on what happened 4/20/25 with him and a female peer [Resident 42]. Resident was laying across his bed on him [sic] stomach. Resident refused to look at the writer or sit up. Resident did not answer the writer's questions and told writer to get out of his room using profane language. After two more attempts, the resident continued on demanding that the writer leave the room. The writer excused herself and allowed resident to have space to himself." A typed statement by the Social Services Director, dated 4/22/25, indicated Resident 42 had stated Resident 37 had attempted to touch her and requested to have sexual relations. She refused. Resident 42 had indicated she does feel safe and not in danger. The resident denied any psychological distress from the incident. An observation and interview were conducted of Resident 37 in his room on 4/21/25 at 6:33 p.m. The			

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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
	resident was observed in bed with a blanket over his head. The resident was pleasant but had refused an interview. During that time, there was no observation of a staff person present by the resident's room nor in the resident's room providing one on one supervision. An observation and interview were conducted with Resident 42 on 4/22/25 at 11:44 a.m. The resident was observed in her room, dressed, and sitting in her wheelchair by her bed. She indicated Resident 37 had "attempted to rape" her a few days ago. Resident 37 had ambulated into her room and started touching her. She was clothed, but he was trying to remove her breast from her bra and touch her vagina. The staff came into her room and removed Resident 37 from her room. The resident had never done that before. Resident 42 indicated she felt safe in the facility with no concerns. An interview was conducted with the Business Office Manager on 4/23/25 at 3:40 p.m. She indicated, on 4/20/25, she had observed one of the Certified Nurse Aides (CNAs) bringing Resident 37 to the conference room. CNA 2 had reported she was going to get the nurse. Resident 42 had inappropriately touched Resident 37. An interview was conducted with the Corporate Executive Director on 4/23/25 at 3:56 p.m. She indicated a staff person should always be present while providing one on one supervision. Resident 37 should not have been left alone at any time on the evening of 4/21/25. An interview was conducted with CNA 2 on 4/24/25 at 9:44 a.m. She indicated she was the CNA that had brought Resident 42 to the conference room. On Sunday, 4/20/25, she			

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	155029	A. BUILDING 00 B. WING	04/25/2025

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	overheard Resident 42 yelling out in the hallway, "Someone help me!" She and two other staff members had gone into the resident's room and observed Resident 42 sitting in her wheelchair using her arms pushing Resident 37 away from her. He was touching her breast. The residents were clothed. Resident 37 was redirected away from the resident and out of the room. She took Resident 42 to the conference room and reported the incident to the Weekend Supervisor (WS) 8. During that time, Resident 42 was "highly upset and afraid." An interview was conducted with WS 8 on 4/24/25 at 10:49 a.m. She indicated a CNA had reported Resident 42 was brought into the conference room. It had been witnessed regarding Resident 37 inappropriately touching Resident 42. During an interview with Resident 42, she had reported to the WS 8 that Resident 37 had ambulated in her room and "climbed on top of her" while she was in her wheelchair. He put his hands on her vagina and breast while kissing her neck. Three CNAs came into the room and removed Resident 42 from her room. During that time, Resident 42 was crying and upset during the interview. The WS 8 indicated after receiving the report that she notified the Executive Director (ED), Director of Nursing (DON), and the police department. Resident 42 and Resident 37 were immediately placed on one-on-one supervision. After police arrival, Resident 37 was sent to the hospital for a psychiatric evaluation. He later returned to the facility and was placed back on-one-on one supervision. An interview was conducted with CNA 22 on 4/24/25 at 2:50 p.m. She indicated she was one of the three staff members that had observed the incident between Resident 37 and Resident 42.			

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	She heard a sound in the hallway like a "baby crying." She and two other staff members rushed into Resident 42's room. Resident 42 was sitting in her wheelchair crying and Resident 37 was rubbing on her breast and vagina. The residents were clothed at that time. CNA 22 had to remove Resident 37's hands off Resident 42. He then was redirected out of her room. After, the residents were placed on one-on-one supervision until the police and ambulance arrived. Resident 37 was sent out to the hospital. An abuse policy was provided by the Executive Director on 4/22/25 at 8:55 a.m. It indicated, "...Policy: It is the policy of [Name of corporation] to provide each resident with an environment that is free from abuse... [Name of corporation] will not permit residents to be subjected to abuse by anyone... other residents... Definitions/Examples of Abuse... Sexual abuse - nonconsensual sexual contact of any type with a resident. Examples may include but not be limited to fondling, touching, rubbing... kissing ...." 3.1-27(a)(1)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview and record review, the facility failed to maintain evidence that an allegation of abuse was thoroughly investigated for 2 of 3 residents reviewed for abuse (Resident 37 and Resident 42). Findings include: 1. The clinical record for Resident 42 was reviewed on 4/22/25 at 9:00 a.m. The diagnoses included,	F 0610	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 37 was evaluated by psych and is receiving continued psych services. New interventions in place and careplanned. Resident 42 has been monitored and displays no signs or symptoms of psychosocial	05/31/2025

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	but were not limited to, stroke, major depressive disorder, physical debility, unsteadiness on her feet, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/16/25, indicated Resident 42 was moderately cognitively impaired. The resident had impairments with her upper and lower extremities on one side. She utilized a walker and wheelchair. She did need substantial assistance with dressing but was able to sit to stand independently with no assistance. 2. The clinical record for Resident 37 was reviewed on 4/22/25 at 9:57 a.m. The diagnoses included, but were not limited to, schizoaffective disorder, bipolar disorder, anxiety disorder, and post-traumatic stress disorder. The Quarterly MDS assessment, dated 3/24/25, indicated Resident 37 was cognitively intact. The resident did not have any impairments with his upper or lower extremities. He utilized a walker and a cane. He was independent and did not need assistance with dressing and walking. A Nursing Progress Note, written by Weekend Supervisor (WS) 8 at 4/20/25 at 4:30 p.m., indicated Resident 42 had reported that a male resident (Resident 37) had entered her room without permission and attempted to touch and kiss her inappropriately. The Power of Attorney, Physician, Executive Director, and the Director of Nursing Services had been notified. An interview was conducted with the Weekend Supervisor (WS) 8 on 4/24/25 at 10:49 a.m. She indicated a CNA (certified nurse aide) had reported Resident 42 was brought into the conference room. It had been witnessed, Resident		distress. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. Regional Director of Clinical Services or Designee will conduct education with the Executive Director and Director of Nursing Services related to investigation of alleged violations including having evidence of thorough investigations by May 31, 2025. All reportables received for the last 30 days will be reviewed by ED to ensure there is a thorough investigation per policy. **What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?** Regional Director of Clinical Services or Designee will conduct education with the Executive Director and Director of Nursing Services related to investigation of alleged violations including having evidence of thorough investigations by May 31, 2025. All reportable files for the upcoming months will be reviewed by Home Office Support Staff to ensure thorough investigation has been completed and appropriate interventions in place for each occurrence. **How the corrective action (s) will be monitored to ensure the**	

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	37 inappropriately touching Resident 42. During an interview with Resident 42, she had reported to WS 8 that Resident 42 had ambulated in her room and "climbed on top of her" while she was in her wheelchair. He put his hands on her vagina and breast while kissing her neck. Three CNAs came into the room and removed Resident 37 from her room. During that time, Resident 42 was crying and upset during the interview. WS 8 indicated after receiving the report, she notified the Executive Director (ED), Director of Nursing (DON), and the police department. Resident 42 and Resident 37 were immediately placed on one-on-one supervision. After the police arrival, Resident 37 was sent to the hospital for a psychiatric evaluation. He later returned to the facility and placed back on one-on-one supervision. She had spoken with the DON and the ED when the incident happened. On 4/25/25 at 9:12 a.m., the Executive Director (ED) provided the completed investigation file for the reportable incident between Resident 37 and Resident 42. The completed investigation file did not include a statement from WS 8. During an interview on 4/25/25 at 2:45 p.m., the Corporate Executive Director (CED) indicated that WS 8 had reported the incident to the ED and DON. The incident between Resident 37 and 42 had been reported to the Indiana Department of Health. She did not believe there was an actual written statement, but WS 8 had written progress notes about the incident in each of resident's medical records. An abuse policy was provided by the Executive Director on 4/22/25 at 8:55 a.m. It indicated, "...Policy: It is the policy of [Name of corporation] to provide each resident with an environment that		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete an abuse prohibition and investigation CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by ED or designee. The abuse prohibition and investigation CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	is free from abuse... [Name of corporation] will not permit residents to be subjected to abuse by anyone... other residents... Definitions/Examples of Abuse... Sexual abuse - nonconsensual sexual contact of any type with a resident. Examples may include but not be limited to fondling, touching, rubbing... kissing... Investigation...Resident to Resident Abuse...4. The staff member in charge will initiate the investigation immediately 5. The executive Director will be notified immediately of the report and the initiation of the investigation... Statements will be taken from individuals witnessing the incident... Resident Abuse- Staff member, volunteer, or visitor...The investigation will include... facts and observations by involved employees... facts and observations by witnessing employees... facts and observations from others who might have pertinent information... Facts and observations by the supervisor or individual whom the initial report was made..." 3.1-28(d)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on interview and record review, the facility failed to timely refer a resident with a new diagnosis of a psychiatric condition for a Level 2 assessment for 1 of 5 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for Preadmission Screening and Resident Review (Resident 33 and Resident 41). Findings include: 1. The clinical record for Resident 33 was reviewed on 4/22/25 at 2:33 p.m. The diagnoses included,	F 0644	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility will ensure a Level 2 is completed for resident 33. Facility will ensure a level 1 is completed for resident 41 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with a new	05/31/2025

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	but were not limited to, dementia and schizoaffective disorder. A Psychiatric Progress Note, dated 5/15/24, indicated the Preadmission Screening and Resident Review (PASRR) had no history of serious mental illness, intellectual disability, or developmental disability. A Quarterly Minimum Data Set (MDS) assessment, completed 11/5/24, indicated Resident 33 was cognitively intact. The diagnosis of schizoaffective disorder was not included in the MDS assessment. A Physician's Assistant (PA) progress note, dated 11/4/24, indicated the diagnosis of schizoaffective disorder had an onset date of 10/30/24. The plan was to administer olanzapine (anti-psychotic medication) 5 milligram (mg) which had been started the previous week. The clinical record did not contain information that a Level 1 or Level 2 review had been completed after the addition of the schizoaffective disorder diagnosis on 10/30/24. A Quarterly MDS assessment, completed 2/5/25, included the diagnosis of schizoaffective disorder. During an interview on 4/25/25 at 1:45 p.m., the Social Service Director (SSD) indicated Resident 33 had been referred for a Level 2 review the previous day. 2. The clinical record for Resident 41 was reviewed on 4/24/25 at 9:22 a.m. The diagnoses included, but were not limited to, borderline personality disorder. A Preadmission Screening and Resident Review		psychiatric diagnosis post-admission have the potential to be affected by the deficient practice. SSD or Designee will complete a 1x audit for all residents with a current psychiatric diagnosis to ensure a Level 1 has been completed so that a Level 2 will be triggered for completion by May 31, 2025. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** SSD or Designee will complete a 1x audit for all residents with a current psychiatric diagnosis to ensure a Level 1 has been completed so that a Level 2 will be triggered for completion. SSD or designee will review residents daily in clinical meeting who have a new psychiatric diagnosis to ensure a Level 1 is completed so that a Level 2 is triggered for completion. Regional Social Services Support will educate SSD on requirements and process for new Level 1s by May 31,2025. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the SSD/Designee will complete a Level 2 CQI audit tool for six months with audits being	

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	(PASRR), dated 3/1/23, indicated the resident did not qualify for a Level 2 screening due to having no mental illness diagnoses. A Quarterly MDS assessment, dated 9/16/24, indicated the resident had no mental illness diagnoses and was cognitively intact. A Psychiatric Progress Note, dated 12/4/24, indicated Resident 41 had been diagnosed with borderline personality disorder with an onset date of 11/6/24. Due to the resident's behaviors and symptoms, he started Depakote (medication used to treat mood issues and behaviors) 250 milligrams at bedtime. The clinical record did not contain information that a Level 1 or Level 2 review had been completed after the addition of the borderline personality disorder diagnosis on 11/6/24. The Social Services Director (SSD) was interviewed on 4/23/25 at 1:54 p.m. She indicated she had not done a new Level 1 screening for Resident 41's new diagnosis, but that it was on her list to be completed. She would try to complete it as soon as possible, likely the next day. She was not sure what the time frame was for when a Level 1 needed to be completed after a new diagnosis. On 4/25/25 at 8:38 a.m., the Executive Director (ED) provided a copy of a newly completed Level 1 screening for Resident 41. A policy titled "PASRR Policy", dated 11/2017, indicated "It is the policy of this facility to ensure that any Pre-admission Screening and Resident Review [PASRR] recommendations which impact those with an Intellectual, Mental Disability or		completed once weekly for one month, and then monthly for 5 months by SSD or designee. The Level 2 CQI ol will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	related conditions are completed as prescribed and PASRR assessments are updated with significant changes in mental or physical status ...Any resident with an Intellectual, Mental Disability or related condition will be referred to the designated mental health or intellectual disability authority with a significant change in mental or physical status."			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to timely pull a resident up in bed as requested repeatedly and provide consistent showers for 1 of 7 residents observed during medication administration and 1 of 2 residents reviewed for activities of daily living (ADL) care. (Resident E and Resident B) Findings include: 1. The clinical record for Resident E was reviewed on 4/22/25 at 10:30 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, and stroke resulted in hemiplegia (loss of strength on one side). The Quarterly Minimum Data Set (MDS) assessment, dated 1/17/25, indicated Resident E was moderately cognitively impaired. The resident had upper and lower impairments on one side with substantial maximum assistance by a staff member to roll left and/or right and sit to lying position. An observation was conducted of Resident E during a medication administration with Qualified Medication Aide (QMA) 10 on 4/21/25 at 6:47 p.m. The resident was observed in bed. The resident's	F 0677	What accomplished for those residents found to have been affected by the deficient practice? Resident E was pulled up in bed by staff per resident preference. Staff have been educated on resident positioning in bed.Resident B was given a shower and shower preferences were reviewed and updated on profile for this resident. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. DNS or Designee will complete a 1x audit of all residents for shower preferences to ensure preferences have been obtained. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All staff will be educated	05/31/2025

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	head was not positioned at the top of the bed. The resident requested to be pulled up in bed. QMA 10 indicated at that time, Certified Nurse Aide (CNA) 22 was "busy" and would be with her when available. During that time, CNA 23 entered the resident's room requesting bleach wipes from QMA 10. At that time, Resident E requested again to be pulled up in bed. QMA 10 indicated CNA 22 would pull her up when she was done with another resident. After, QMA 10 left the resident's room and continued with medication administration with other residents. An interview was conducted with QMA 10 on 4/21/25 at 6:50 p.m. She indicated she would let CNA 22 know Resident E needed to be pulled up in bed when she saw her. An observation was conducted of Resident E in bed with Nurse Consultant 12 present in the room on 4/21/25 at 7:35 p.m. The resident's head was not positioned at the top of the bed. The resident indicated CNA 22 had not been into her room to pull her up in bed. During an interview with the Director of Nursing on 4/24/25 at 12:17 p.m. She indicated QMA 10 should have asked CNA 23 to assist with pulling Resident E up in bed. 2. The clinical record for Resident B was reviewed on 4/22/25 at 12:00 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly MDS assessment, completed 1/20/25, indicated she was cognitively intact. An ADL care plan, revised on 2/20/25, indicated " ... Assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between ...'		on timely ADL care and ADL care per resident preference. DNS or Designee will complete a 1x audit of all residents for shower preferences to ensure preferences have been obtained. DNS or Designee will audit shower sheets daily to ensure residents are receiving bathing per their preference. Care Companions or Designee will interview residents to re ADL c provided timely and per preference **How the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete an ADL Care CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee . The ADL Care CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	An interview was conducted with Resident B on 4/21/25 at 6:53 p.m. She indicated she does not get her showers as scheduled on a regular basis. She indicated her shower days were Monday and Thursday during the day. On 4/25/25 at 8:37 a.m., the Executive Director (ED) provided shower sheets for Resident B. The following date(s) were indicative of Resident B not receiving a shower on her scheduled shower days: 3/21/25, 4/17/25, and 4/21/25. An interview was conducted with Resident B on 4/25/25 at 10:49 a.m. She indicated she did have a shower, and her hair was washed on 4/24/25. She also indicated she did not get a shower or bed bath on 4/21/25. An interview was conducted with the Director of Nursing (DON) on 4/25/25 at 10:56 a.m. She indicated Resident B was scheduled for showers on Monday's and Thursdays. A partial bed bath was to be given to Resident B in between shower days. The DON indicated there was no policy on ADL care. She provided a copy of the AM (morning) Care Nursing Skills Competency check list. This citation relates to Complaint IN00456672. 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(b)(2) 3.1-38(b)(6)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care	F 0684	What action(s) will be	05/31/2025

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	Based on observation, interview, and record review, the facility failed to administer medications and treatments as ordered for 1 of 5 residents reviewed for dignity, 1 of 5 residents reviewed for unnecessary medications, and 1 of 4 residents reviewed for activities of daily living. (Resident G, Resident 42, and Resident E) Findings include: 1. The clinical record for Resident G was reviewed on 4/22/25 at 12:12 p.m. The diagnoses included, but were not limited to, liver transplant and major depressive disorder. A physician's order, dated 10/10/24, indicated Resident G was to receive mycophenolate mofetil (immunosuppressive medication) 500 milligrams (mg) twice daily; to be given one hour prior or two hours after eating. A Quarterly Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident G was cognitively intact. During an interview on 4/22/25 at 12:12 p.m., Resident G indicated he had a liver transplant and had gone several days without his immunosuppressive medications. The facility had run out of his medication. He was worried because he did not want to have his transplant rejected by his body. The February, March, and April 2025 Medication Administration Record (MAR) indicated Resident G had not received his mycophenolate mofetil 500 mg as ordered on the following days: 2/2/25, 2/3/25, 3/5/25, 3/6/25, 3/7/25, 3/8/25, 3/9/25, 3/10/25, 3/11/25, and 4/18/25. The MAR indicated the reason for the missed doses was the drug was		accomplished for those residents found to have been affected by the deficient practice? Resident G's immunosuppressive medication was reviewed for availability. Resident G is receiving medication as ordered. MD was notified and no new orders were received. Resident 42 monitored for adverse reactions from missed accu-check and insulin administrations. MD notified and no new orders received to continue diabetic regimen. Resident E assessed for side effects of improper Preparation H administration. Vitals assessed and MD notified of medication error/improper medication administration, no new orders were received. **How will you identify other residents having the potential to be affected by the same deficient and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. DNS or Designee will educate and review Scope of Practice with all Certified Nursing Assistants by May 31, 2025. DNS/Designee reviewed all missed and unavailable medication administration for the last 30 days, if any identified MD was notified. DNS/Designee reviewed all residents receiving insulin to ensure residents were receiving insulin as ordered. **What measures will be**	

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	155029	A. BUILDING 00 B. WING	04/25/2025

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	unavailable. During an interview on 4/25/25 at 2:34 p.m., the Doctor of Medicine (MD) indicated Resident G not receiving his scheduled mycophenolate mofetil as ordered was not good practice. 2. The clinical record for Resident 42 was reviewed on 4/22/25 at 9:00 a.m. The diagnoses included, but were not limited to, stroke, major depressive disorder, physical debility, unsteadiness on her feet, and anxiety disorder. A physician order, dated 3/11/25, indicated the resident was to receive 14 units of aspart insulin three times a day. The order did not include parameters to hold the insulin. The April 2025 Medication Administration Record indicated the following days and times the aspart insulin was not administered as ordered: 4/2/25 - 12:00 p.m. - blood sugar reading of 94 = the insulin was not administered, 4/8/25 - 5:00 p.m. - there was no documentation recorded, 4/9/25 - 5:00 p.m. - there was no documentation recorded, 4/10/25 - 8:00 a.m. - blood sugar reading of 62 = the insulin was not administered, 4/15/25 - 12:00 p.m. - blood sugar reading of 75 = the insulin was not administered, and 4/23/25 - 12:00 p.m. - blood sugar reading = 129 = the insulin was not administered. An interview was conducted with the Director of Nursing on 4/25/25 at 11:29 a.m. She indicated she was unable to provide any reason nor provide documentation the medical provider was aware Resident 42's aspart insulin was not administered as ordered on 4/2/25, 4/8/25, 4/9/25, 4/10/25,		**put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DNS or Designee will review all missed and unavailable medication administration daily in clinical to ensure residents receive ordered medications. DNS or Designee will review all diabetic residents' blood glucose levels as ordered during clinical. Out of range levels will be reported to MD for review. DNS or Designee will review Administration Compliance report and Clinical Unavailable Medication report daily to identify medications that are unavailable and that need refilled/resupplied. DNS or Designee will educate nurses on timely administration, running the Administration Compliance report during their shift to identify missed administrations, and proper notification to MD of missed administrations. DNS or Designee will educate and review Scope of Practice with all Certified Nursing Assistants by May 31, 2025. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete a Pharmacy Service and Recommendations/ Diabetic Monitoring CQI audit tool for six	

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	4/15/25, and 4/23/25. 3. The clinical record for Resident E was reviewed on 4/22/25 at 10:30 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, and stroke resulted in hemiplegia (loss of strength on one side). The Quarterly MDS assessment, dated 1/17/25, indicated Resident E was moderately cognitively impaired. A physician order, dated 11/12/24, indicated the staff was to apply 1% of Preparation H cream in the rectum every shift. The staff was to monitor the resident's blood pressure and heart rate. A physician order, dated 10/17/24, indicated the staff was to apply 20% Preparation H witch hazel pads during incontinent care every shift as needed. An observation was conducted of incontinent care for Resident E with Certified Nurse Aide (CNA) 30 on 4/22/25 at 10:24 a.m. During the incontinent care, the resident had reported to CNA 30 her rectum was burning. The resident had requested for cream to be applied to her rectum. At that time, CNA 30 removed her gloves and left the resident's room. She then returned to the resident's room with a tube labeled Preparation H. She then squeezed the cream into her hands and applied the cream around the resident's rectum. At that time, CNA 30 indicated the Preparation H rectal cream was provided to her to apply due to the resident's complaints of burning. During an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 4/25/25 at 11:29 a.m., the DON indicated CNA		months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Pharmacy Service and Recommendations/ Diabetic Monitoring CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	30 should not be applying the Preparation H rectal cream to Resident E. 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure the resident's oxygen provided was as ordered for 1 of 7 residents observed during medication administration. (Resident E) Findings include: The clinical record for Resident E was reviewed on 4/22/25 at 10:30 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, and stroke resulted in hemiplegia (loss of strength on one side). The Quarterly Minimum Data Set assessment, dated 1/17/25, indicated Resident E was moderately cognitively impaired. A physician order, dated 9/25/24, indicated Resident E was to receive two liters of oxygen via nasal cannula (tubing that delivers oxygen through the nose) every shift. An observation was conducted of Resident E during a medication administration with Qualified Medication Aide (QMA) 10 on 4/21/25 at 6:47 p.m. The resident was observed in bed with her nasal cannula out of her nose lying on her chest. QMA 10 educated the resident at that time; she needed the nasal cannula in her nose to receive the oxygen. QMA 10 assisted the resident with placement of the nasal cannula in her nose. The	F 0695	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident's E's oxygen was titrated back to correct oxygen setting per MD order and a respiratory assessment and oxygen saturation was performed by a licensed nurse to assess respiratory status. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents that require oxygen therapy have the potential affected by the deficient practice. DNS or Designee will conduct a 1x audit for all residents that utilize oxygen therapy, verifying their physician's order with the actual oxygen liter settings on the residents' oxygen concentrators by May 31, 2025. DNS or Designee will provide education to nursing staff regarding verifying oxygen therapy orders against oxygen setting on concentrators by May 31, 2025. **What measures will be put into place or what systemic**	05/31/2025

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	resident's oxygen concentrator was observed on five liters of oxygen. QMA 10 indicated the resident should be on two liters of oxygen not five liters of oxygen. QMA 10 was unable to control the oxygen levels on the oxygen concentrator. QMA 10 would notify the nurse. Then, she left the resident's room and continued to administer medications to other residents. There was no observation of QMA 10 reporting to the nurse that the resident was receiving oxygen inconsistent with the physician's orders. An observation was conducted of Resident E with Nurse Consultant (NC) 12 on 4/21/25 at 7:35 p.m. The resident was in bed wearing her nasal cannula in her nose. The oxygen concentrator was set on five liters. After reviewing the resident's oxygen order, NC 12 indicated the resident should be on two liters. She then titrated the oxygen down to two liters and assessed the resident's oxygen saturations. An oxygen therapy procedure was provided on 4/23/25 at 4:42 p.m. It indicated "...Verify resident and physician order..." 3.1-47(a)(6)		**changes will you make to ensure that the deficient practice does not recur?** DNS or Designee will provide education to nursing staff regarding verifying oxygen therapy orders against oxygen setting on concentrators by May 31, 2025. DNS/Designee will conduct rounds each shift to ensure oxygen therapy is provided as ordered. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete an Oxygen Therapy CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Oxygen Therapy CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, interview, and record	F 0697	What corrective action(s) will be accomplished for those residents	05/31/2025

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	review, the facility failed to provide adequate pain control for 2 of 2 residents reviewed for pain medication. (Resident D and Resident J) Findings include: 1. The clinical record for Resident D was reviewed on 4/24/25 at 4:08 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, completed on 3/5/25, indicated she was cognitively intact. A physician's order, dated 3/4/25, indicated to administer Tylenol 1000 milligrams (mg) every six hours as needed for pain. During an interview with Resident D on 4/21/25 at 7:07 p.m., she indicated she asked Licensed Practical Nurse 5 (LPN 5) for Tylenol at 3:00 p.m. She indicated she was still waiting for LPN 5 to administer the requested Tylenol. An observation was conducted of an interview with LPN 5 with Nurse Consultant (NC) 13 on 4/21/25 at 8:20 p.m. LPN 5 indicated he had not gotten to Resident D's medication pass at that time. He was in the process of preparing medication for Resident D's roommate. NC 13 requested LPN 5 to stop with roommate's medication pass and administer Resident D's Tylenol. LPN 5 administered two, 500 mg tablets of Tylenol by mouth to Resident D. An interview was conducted with NC 13 on 4/21/25 at 8:25 p.m. She indicated the medication should be administered shortly after it was requested.		found to have been affected by the deficient practice? Pain assessment completed on Resident D and PRN pain medication provided per MD order Pain assessment completed on Resident J and PRN pain medication provided per MD order **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents that are at risk for pain have the potential to be affected by this deficient practice. DNS/designee interviewed residents who receive PRN pain medication to ensure residents are receiving pain as requested and per MD order. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DNS or Designee will complete education with nursing staff regarding timely administration of pain medication by May 31, 2025. Care Companions or Designee will interview residents to ensure residents are receiving medications timely. DNS or Designee will review missed and late administrations daily in clinical meeting to identify untimely pain medication administration. DNS/Designee will review the facility activity report	

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	2. The clinical record for Resident J was reviewed on 4/22/25 at 11:30 a.m. The diagnoses included, but were not limited to, cellulitis. The Admission MDS assessment, dated 3/24/25, indicated Resident J was cognitively intact. A care plan, dated 3/20/25, indicated Resident J was "at risk for pain related to cellulitis of right lower limb, cellulitis of left lower limb, chronic venous hypertension with ulcer and inflammation of bilat [bilateral] lower extremity, chronic kidney disease, HTN [hypertension], anemia in other chronic disease, localized edema." A physician order, dated 3/21/25, indicated the resident was to receive 5-325 milligrams of hydrocodone as needed every 12 hours. An interview was conducted with Resident J on 4/22/25 at 11:18 a.m. She indicated there were long delays in receiving pain medication. She had to wait 30 minutes to an hour, at times, to receive pain medication after she had requested them. An interview was conducted with Resident J on 4/23/25 at 9:57 a.m. She indicated she was in pain and had requested two staff members that had previously come into her room for pain medication. She had started asking for pain medication between 8:00 a.m. and 9:00 a.m. that morning. The resident indicated her pain level was a four utilizing a pain scale of one being the least amount of pain to ten being the most amount of pain. She would like pain medication to relieve her pain. An observation and interview were conducted with LPN 25 on 4/23/25 at 10:01 a.m. LPN 25 was observed administering medications to other		daily in clinical meeting to identify prn pain medications requested and administered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete Pain audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Pain Management CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	residents at that time. She indicated she was made aware by the Certified Nurse Aides (CNAs) that Resident J requested for pain medication. At 10:08 a.m., LPN 25 went into Resident J's room and spoke with her about her pain. 3.1-37(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on interview and record review, the facility failed to timely document behaviors and to initiate new interventions to the plan of care for a resident with dementia with behaviors of wandering and urinating in inappropriate places for 1 of 2 residents reviewed for accidents. (Resident H) Findings include: 1a. The clinical record for Resident H was reviewed on 4/22/25 at 2:40 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, Alzheimer's disease, and anxiety. A Quarterly Minimum Data Set (MDS) assessment, completed 2/24/25, indicated Resident H was severely cognitively impaired, was able to ambulate 150 feet in the corridor with supervision of staff, and was occasionally incontinent of urine. 1b. The clinical record for Resident 41 was reviewed on 4/23/25 at 2:00 p.m. The diagnoses included, but were not limited to, borderline personality disorder. A Quarterly MDS assessment, dated 9/16/24,	F 0744	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident H Behavior Care Plan updated to address wandering and exit seeking and urinating in inappropriate locations. **How will you identify other residents having the potential to be affected by the same deficient practice and corrective action will be taken?** All residents have the potential to be affected by the deficient practice. All residents with new or in the last 30 days were reviewed to ensure new interventions were in place to address the behaviors and care plans updated. SSD or Designee will educate all staff on Behavior Management Program by 5/31/2025. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** SSD or Designee will review New/Worsening Behavior	05/31/2025

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	indicated Resident 41 was cognitively intact. Resident H's clinical record contained a progress note, dated 1/29/25, which indicated Resident H had displayed the behavior of exit-seeking and attempting to exit the kitchen door. The intervention used was to allow staff to walk outside with him to get some fresh air. The root cause was determined to be that Resident H was demented and fixated on going home. The intervention was to decrease access to the culinary department. A Provider progress note, dated 2/20/25, indicated Resident H had been seen for a comprehensive visit. He was less focused on getting out of the facility. The psychiatric provider had recently increased his Depakote (medication for seizures and mood stabilization) with effectiveness. A Social Service progress note, dated 3/3/25, indicated Resident H was followed up with regarding a negative verbal interaction with a fellow resident and daughter. Resident H did not recall the interaction and was going about his daily routine. During an interview on 4/22/25 at 10:31 a.m., Resident 41 indicated that within the last year, he entered his room and found Resident H sitting on his bed. Resident 41 had got angry, yelled, and swore at him to get out of his bed. Resident H stood up and staff came in to assist Resident H back to his own room. Resident 41 was mad because Resident H had done this before, and wanted his sheets changed because of Resident H's incontinence. Resident 41 had told a CNA (certified nurse aide) and the Weekend Supervisor about the incident.		Events and Behavior Communication Notes with IDT Behavior Event Review. Corresponding care plans with new interventions will be written/updated daily. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete a Behavior Management CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Behavior Management CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	A care plan, last reviewed on 4/22/25, indicated Resident H may intrusively wander when looking for the bathroom, dining room or the porch. Resident has cognitive impairment related to Alzheimer's disease. The goal was for him to be easily redirected. The interventions, initiated on 9/25/23, were to redirect the resident to his room after meals, when looking for bathroom, and for staff to ask him if he was looking for bathroom, activity room, and to redirect the resident. A care plan, last reviewed on 4/22/25, indicated Resident H experienced the following behavior expressions of urinating in various places in the room and hallway due to his dementia. The goal was for him to not experience lasting distress, would not cause distress to others, and would not cause harm to self or others. The interventions, initiated on 8/21/24, were to assist with and offer routine toileting and to address any immediate needs such as hunger, thirst, pain, boredom, loneliness, or tiredness. A care plan, last reviewed on 4/22/25, indicated Resident H was at risk for intrusive wandering and exit seeking. He needed decreased access to the culinary department when not in service due to the resident attempting to exit the building via culinary exit doors and that resident was fixated on the need to go home. The goal was for him to be easily redirected. The interventions, initiated on 9/5/23, was for staff to assist in taking the resident outside during appropriate weather and as needed, assist him to his own room, and to assess for unmet needs. During an interview on 4/24/25 at 10:48 a.m., the Weekend Supervisor (WS) indicated Resident 41 had told her about the incident of Resident H lying in his bed several weeks ago. Resident 41			

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	was upset about the incident because Resident H frequently wandered into other residents' rooms. Resident H definitely wanders; he had walked into other rooms before. Resident H had used other residents' bathrooms and sat on other beds because he was confused. The WS had suggested using stop signs on doors to deter Resident H from entering other residents' rooms. During an interview on 4/24/25 at 12:47 p.m., the Director of Nursing (DON) indicated she could not recall stop signs being suggested as an intervention for Resident H's wandering behaviors. Resident H did wander but was easily redirected. The DON had not heard of any other residents having issues with Resident H's wandering because he was pleasant and easily redirected. During an interview on 4/25/25 at 1:45 p.m., the Social Service Director (SSD) indicated there had been an incident between Resident H and Resident 41, a couple of weekends ago. She was unaware of the negative interactions Resident H had experienced that was referenced in the 3/3/25 progress note. Resident H did wander and would walk by his door at times. There had not been any new interventions attempted to make his room more identifiable for him. If a resident has a known behavior, the nursing staff should document the behavior using a behavior communication note. New or worsening behaviors should be documented using a New or Worsening Behavior Event. The facility held monthly behavior meetings, but the behavior communication notes were not always reviewed in the meeting. Resident H's clinical record did not contain information about Resident H wandering into Resident 41's room and lying in his bed. His plan			

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	155029	A. BUILDING 00 B. WING	04/25/2025

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	of care had not been updated with new interventions such as the use of stop signs. There was no stop signs observed on any of the residents' rooms. On 4/23/25 at 4:43 p.m., the Executive Director provided the Behavior Management Policy, last revised in August 2022, which indicated "...It is the policy of... to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and /or accommodating a resident's behavioral expressions...When a behavioral expression occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior in Matrix. If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/ Worsening Behavior Event. New or worsening behaviors are reviewed by the IDT [Interdisciplinary Team] for assessment and preventative actions. New/Worsening Behaviors include...Behaviors that had potential for risk to others including sexual advances, intrusive wandering, exit seeking...The IDT review is a discussion with the team as to the behavioral expression, an evaluation of interventions, presentation of new interventions if applicable and an assessment of any underlying causes of the behavior...If the behavioral expression is not new, worsening or high risk; the nurse will record the behavior in the progress notes using the Behavior Communication Note. The IDT will review progress notes the next business day to determine if immediate follow up action is required for the behavior communication. If the behavior requires an interdisciplinary response as			

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	described above, the IDT will complete the IDT behavior review. If not, the plan of care will be reviewed and updated if needed to include a description of the behavior and effective interventions... Resident with documented behaviors will have a Behavioral Health Monthly Review..." 3.1-37(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to timely follow-up on pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident B) Findings include: A. The clinical record for Resident B was reviewed on 4/22/25 at 12:00 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly Minimum Data Set (MDS) assessment, completed 1/20/25, indicated she was cognitively intact. A pharmacy recommendation, dated 2/19/25, indicated the discontinuation of fenofibrate (used together with a proper diet to reduce and treat high cholesterol and triglyceride [fat- like substance] levels in the blood) 54 milligrams (mg) daily. If medication was discontinued a fasting lipid panel was to be collected at the 4-week mark and every 12 months. On 2/29/25 the Doctor of Medicine (MD) signed the pharmacy recommendation in agreement to discontinue fenofibrate and lab recommendations.	F 0756	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Lipid panel was ordered on 5/5/2025 for Resident B and MD notified of results. Resident B's prophylactic was discontinued and MD notified of discontinuation **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. DNS/Designee reviewed pharmacy recommendations received for the past 30 days to ensure recommendations were addressed with MD notification and orders were updated as needed DNS/Designee reviewed all pharmacy recommendations for residents receiving antibiotics to ensure pharmacy	05/31/2025

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	The MD ordered a fasting lipid panel to be drawn on 3/3/25. A physician's order, dated 2/19/25, was noted for a lipid panel lab draw for 3/3/25. The facility was unable to provide results of this lab being completed. B. The Executive Director (ED) provided a copy of Resident B's urology notes, dated 8/2/24, on 4/25/25 at 9:12 a.m. The notes indicated " ... UA [urine analysis] today clear- she is currently in rehab setting- sill [sic] start suppressive PO [by mouth] abx [antibiotic] with macrodantin [nitrofurantoin] - convert to self-start therapy with Bactrim once she returns home. f/u [follow up] in about 6 months ..." A physician's order, dated 8/5/24, was noted for nitrofurantoin 50 milligrams (mg) once a day. The order was discontinued on 12/3/24. An email from the urologist, dated 10/3/24, was received from the ED on 4/25/25 at 9:12 a.m. The email indicated Resident B's insurance would not cover nitrofurantoin but would cover trimethoprim. A physician's order, dated 10/11/24, was noted for trimethoprim 100 mg once a day with no end date recorded. A pharmacy recommendation, dated 11/20/24, indicated "...Please discontinue nitrofurantoin and trimethoprim while monitoring for signs and symptoms of recurrent UTI [urinary tract infection]. If prophylactic therapy should not be discontinued, please document the intended duration of therapy or stop date ..." On 11/20/24, the MD signed the document with the		recommendations are followed and MD notified for the past 30 days **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DNS or Designee will review ordered labs daily in clinical meeting to ensure labs are completed. DNS or Designee will review any resident with ordered antibiotics during daily clinical meeting. DNS or Designee will communicate with prescribing physician regarding Mcgreer's criteria, allowing for MD review. DNS or Designee will review pharmacy recommendations as received to ensure recommendations are completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance DNS or Designee will complete a Pharmacy Recommendation CQI tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee Pharmacy Recommendation CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not	

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	recommendation to refer to urology for management. During an interview with the Director of Nursing (DON) on 4/25/25 at 10:15 a.m., she indicated the resident did not go to the urology appointment in February of 2025. Resident B was on a prophylactic antibiotic but could not recall if urology was consulted about a rationale for continuation of the antibiotic. She could not explain why Resident B was on two prophylactic antibiotics at the same time. A policy entitled "Antibiotic Stewardship Program", review date of 1/2023, was provided by the ED on 4/25/25 at 2:30 p.m. The policy indicated "...Policy: The facility shall establish key elements for antibiotic prescribing and a system to monitor and manage antibiotic use. Antibiotic stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients." " ...Procedure: The facility will establish an antibiotic stewardship team (AST) ... 1. The AST will explore quality improvement and resident safety for opportunities that could incorporate antibiotic stewardship activities." 3.1-25(i)		achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	
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 ensure open and/or expiration dates were on insulin medication for 1 of 3 medication carts observed. (Resident 7, Resident 22, and Resident F) Findings include:	F 0761	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Insulin pens for resident 7, F, and 22 were discarded per destruction policy and new insulin pens were initiated and dated. **How will you**	05/31/2025

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	1. The clinical record for Resident 7 was reviewed on 4/22/25 at 11:30 a.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 9/4/24, indicated the staff was to administer 18 units of Novolin (intermediate-acting insulin) twice a day. 2. The clinical record for Resident F was reviewed on 4/22/25 at 11:45 a.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 3/11/25, indicated the staff was to administer 24 units of Humalog (fast acting insulin) three times a day. 3. The clinical record for Resident 22 was reviewed on 4/22/25 at 12:00 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A physician order, dated 4/18/25, indicated the resident was to receive a sliding scale of lispro insulin (fast acting insulin) three times a day. An observation was conducted of a medication cart with Registered Nurse (RN) 24 on 4/25/25 at 11:06 a.m. During that time, Resident 7's Novolin insulin, Resident F's Humalog insulin, and Resident 22's lispro insulin did not have a written open or expiration date. An interview was conducted with RN 24 on 4/25/25 at 11:10 a.m. She indicated the insulin medication should have open dates. A medication storage policy was provided by the Executive Director on 4/25/25 1:09 p.m. It indicated "...Purpose of Policy: To provide guideline and procedure on the storage and expiration dates of medications... Procedure... 7. Medications should		**identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents that utilize multi-use injectable medication have potential to be affected by this deficient practice. All resident's insulin was reviewed by DNS/Designee to ensure all have appropriate labels. DNS or Designee completed a 1x audit on all medication carts to ensure medications are dated according to our medication storage policy by May 31, 2025. ED or Designee will complete education with all nurses regarding our medication storage policy by May 31, 2025. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ED or Designee will complete education with all nurses regarding our medication storage policy by May 31, 2025. DNS or Designee will audit medication carts for expired, unlabeled, and discontinued medications. **How the corrective action(s) will be monitored to ensure the deficient will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete a medication storage CQI audit tool for 6 months with audits being	

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	have an expiration date on the label..." 3.1-25(k)(6)		completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The medication storage CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure food was served at palatable temperatures for 4 of 4 residents reviewed for food and 14 of 54 residents that attend resident council. (Residents' B, D, 22, J, K, 33, 28, 13, 31, 4, G, H, 25, 23, E, 41, 6, and 48) Findings include: 1. The clinical record for Resident J was reviewed on 4/22/25 at 11:30 a.m. The diagnoses included, but were not limited to, cellulitis. The Admission Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident J was cognitively intact. An interview was conducted with Resident J on 4/22/25 at 11:18 a.m. She indicated the food was served cold.	F 0804	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Foods will be checked for appropriate temperatures when served to residents. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All resident have the potential to be affected by the deficient practice. ED or Designee will educate culinary staff on appropriate food temperatures by May 31, 2025. Care Companions or Designee will interview residents weekly for concerns	05/31/2025

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	2. The April 2025 resident council minutes were provided by the Activities Director on 4/23/25 at 9:31 a.m. The resident attendees were the following: Residents' 6, 23, H, 33, 41, 13, 25, 28, and G. The council indicated the food temperatures were not appropriate. During a resident council meeting on 4/23/25 at 11:05 a.m., the council attendees were the following: Residents' K, 33, 28, 13, 31, 4, G, H, 25, 23, E and 48. The council indicated the food was served cold. 3. The clinical record for Resident G was reviewed on 4/22/25 at 12:20 p.m. The diagnoses included, but were not limited to, liver transplant and major depressive disorder. A Quarterly MDS assessment, dated 3/24/25, indicated Resident G was cognitively intact. During an interview on 4/22/25 at 12:12 p.m., Resident G indicated the food was often served cold. He had received meals that were "ice cold". He had filed grievances about the food, but it did not seem to get any better. 4. The clinical record for Resident 22 was reviewed on 4/23/25 at 10:34 a.m. The diagnoses included, but were not limited to, acute respiratory failure. A Quarterly MDS assessment, completed 2/22/25, indicated she was cognitively intact. During an interview on 4/21/25 at 6:33 p.m., she indicated the eggs were awful and cold. 5. The clinical record for Resident D was reviewed on 4/24/25 at 4:08 p.m. The diagnoses included, but were not limited to, diabetes mellitus.		regarding food temperatures and palatability. Grievances will be completed as appropriate. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ED or Designee will audit a test tray for proper food temperatures and palatability. ED or Designee will monitor temperature logs daily to ensure compliance. Care Companions or Designee will interview residents weekly for concerns regarding food temperatures and palatability. Grievances will be completed as appropriate. **How the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the ED/Designee will complete a food temperature and palatability CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months ED or designee . The food temperature and palatability CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not	

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	A Quarterly MDS Assessment, completed on 3/5/25, indicated she was cognitively intact. During an interview on 4/21/25 at 7:21 p.m., she indicated meals were not consistent, sometimes they were good, and other times they were not. Resident D indicated breakfast was usually the best meal, and the rest go downhill from there. 6. The clinical record for Resident B was reviewed on 4/22/25 at 12:00 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly MDS assessment, completed 1/20/25, indicated she was cognitively intact. During an interview with Resident B on 4/21/25 at 6:58 p.m., she indicated the food could use improvement. During an observation and interview on 4/24/25 at 12:45 p.m., the Regional Culinary Manager 3 (RCM 3) brought a test tray into the conference room. The temperatures were obtained by RCM 3, using the dietary department's thermometer. The tenderloin sandwich was 126.3 degrees Fahrenheit, the baked beans were 153 degrees Fahrenheit, and the pears were 50.7 degrees Fahrenheit. RCM 3 indicated the temperature for the tenderloin sandwich was below the proper holding temperature, and the pears were above the proper holding temperature. 3.1-21(a)(2) 3.1-21(i)(2)		achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary			

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	A. Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean and in good repair, the staff contained their hair in the kitchen, and food was not open to air, labeled, dated and not expired. This had the potential to affect 54 of 54 residents that eat food prepared in the facility kitchen. B. Based on observation, interview, and record review, the facility failed to cover trash cans when not in use in the kitchen with the potential to affect 54 or 54 residents who receive food out of the facility kitchen. Findings include: A. On 4/21/25 at 6:25 p.m., the facility kitchen was observed with Dietary Aide (DA) 15. The walk- in refrigerator was observed to have a metal can of butterscotch pudding with a piece of plastic wrap covering the open can. The can did not contain a date on which it was opened. There was an undated plastic storage container of macaroni and cheese, an undated jar of beef base, an undated bottle of orange juice and grape juice which were half empty, an undated container of ranch and Caesar salad dressing, an undated jar of pickle relish, a bag of pre-made scrambled eggs with no date, an undated plastic storage container of peaches, plastic wrapped open containers of deli ham, American cheese, and deli turkey with no open dates. There was a package of pepperoni that was open to air with no open date. There was a tray containing small bowls of peaches and a tray containing small bowls of mandarin oranges which were open to air and undated. There was a tray containing a thawed ground beef roll with red liquid present on the tray that was undated. There was a tray with a bag of thawed chicken that was	F 0812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Dietary staff were educated on proper hairnet usage, labeling/dating, and trash can placement within kitchen/properly securing lids when not in use. The butterscotch pudding, macaroni and cheese, beef base, orange juice, grape juice, salad dressings, pickle relish, scrambled eggs, peaches, deli meat, cheese, package of pepperoni, small bowls of peaches and oranges, thawed ground beef, thawed chicken were discarded. In the dry storage area, the bin of blueberry muffin mix was discarded. The dry storage floor was cleaned. The trash cans have lids. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the deficient practice. Culinary staff will be educated on hairnet usage, labeling/dating, and trash can placement within kitchen/properly securing lids when not in use by May 31, 2025. Culinary manager/designee inspected all food storage areas to ensure all food was properly	05/31/2025

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	present with no date. The dry storage area was observed to have a storage bin of oats with no lid and a package of blueberry muffin mix labeled open 3/11/25 and use by 4/10/25. The floor of the dry storage area had a sticky substance present on it. During an interview on 4/21/25 at 6:50 p.m., DA 15 indicated the kitchen floor had been that way since she started. She had worked at the facility for a week and a half. She was not sure why the food items were not covered. She had not been instructed on dating items. She had been shown how to use the date label maker. On 4/23/25 at 12:10 p.m., lunch service was observed in the facility kitchen. DA 17 was observed at the tray line setting up trays with silver wear and placing small bowls of grapes on trays. He had a growth of hair on his upper lip and chin. His beard net was around his neck and not covering his beard. DA 17 indicated his beard net should be in place over his facial hair while he was serving food. During an interview on 4/23/25 at 1:45 p.m., the Dietary Manager (DM) indicated items in the refrigerator should be labeled and dated with the date opened and a discard date. Food items should be covered while in the refrigerator. The items identified on 4/21/25 had been disposed of. The floor in the dry storage area was "sticky". The staff had mopped the floor, and she was unsure why it was still sticky. Staff with facial hair should wear beard nets while preparing and serving food. On 4/23/25 at 2:58 p.m., the Corporate Executive Director provided the Food Storage Policy, last		covered and labeled. Culinary manager/designee ensured all hair of employees in the kitchen, hair is properly covered . Culinary manager/designee ensured trash cans have appropriate lids and are in place. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Culinary staff will be educated on hairnet usage, labeling/dating, and trash can placement within kitchen/properly securing lids when not in use monthly for six months and as needed by May 31, 2025. ED or Designee to complete culinary manager AM daily checklist 3x weekly to ensure compliance with hairnet usage, labeling/dating, trach can placement and lid usage. Culinary manager/designee will complete inspections of refrigerator and dry storage area daily to ensure food is appropriately labeled and covered, floors are clean, hair of employees is contained and trash cans have appropriate lids. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	reviewed May 2023, which indicated "...Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored at appropriate temperatures and by methods designed to prevent contamination...Leftover prepared foods and processed meats such as lunchmeat, are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared, and marked to indicate the date by which the food shall be consumed or discarded. Leftover foods can be held at 41 degrees F [Fahrenheit] or less for no more than 3 days. The day the food was prepared shall be counted as Day 1...Food items that are not considered potentially hazardous including, commercially prepared mayonnaise, salad dressing, mustard, ketchup, BBQ sauce, pickles, and pickle relish will be labeled when opened and, to ensure quality, used or disposed of within 90 days of the opening or per the use-by-date, whichever comes first. Follow the manufacturer's directions regarding the need to refrigerate after opening in order to preserve quality. The day the original container is opened shall be counted as day 1...Dry Storage... All foods shall be covered or wrapped tightly, labeled, and dated." On 4/23/25 at 2:58 p.m., the Corporate Executive Director provided the Culinary Personal Hygiene Policy, last revised May 2024, which indicated "...Culinary employees with facial hair must also wear a beard restraint..." B. On 4/21/25 at 6:25 p.m., the facility kitchen was observed with Dietary Aide (DA) 15. The dry storage area was observed to have an unattended busing cart with a trash can attached to the end of the cart. The trash can had food waste visible and there was no lid on the trash can.		**into place**? To ensure compliance ED/Designee will complete a Culinary Manager AM daily checklist CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by ED or designee. The Culinary Manager AM daily checklist CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	On 4/23/25 at 12:20 p.m., the dry storage area was observed with the Dietary Manager (DM). An unattended busing cart with a trash can on the end was observed in the dry storage area. The trash can was uncovered and had food substances present in the can. The soiled dish area of the kitchen had an unattended trash can with food items present in the can. The lid to the trash can was sitting beside it. There were no staff using the trash can. During an interview on 4/23/25 at 1:45 p.m., the DM indicated she was unsure if the busing cart trash can had a lid, but the trash bag could have been removed prior to it being placed in the area. The trash can in the soiled dish area should have been covered when not in use. On 4/23/25 at 2:58 p.m., the Corporate Executive Director provided the Kitchen Safety Guidelines, last revised February 2025, which indicated "...Plastic liners are to be used inside all trash containers and the containers are kept covered with lids..." 3.1-21(i)(2) 3.1-21(i)(3) 3.1-21(i)(5)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control was maintained by utilizing hand hygiene prior to administering eye drop medications and to follow infection control practices by not timely removing feces and urine from a bedside table,	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? QMA 10 was educated on infection control with a special focus hygiene with medication	05/31/2025

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	and failure to wear a gown while disposing of bodily fluids for a resident in Enhanced Barrier Precautions for 2 of 7 residents observed during medication administration and 1 of 1 resident observed for Enhanced Barrier Precautions. (Resident H, Resident 29 and Resident 27) Findings include: 1. The clinical record for Resident H was reviewed on 4/21/25 at 6:30 p.m. The diagnoses included, but were not limited to, glaucoma (eye condition that damages optic nerve). A physician order, dated 4/17/25, indicated the resident was to receive one drop of timolol eye drops in both eyes twice a day. An observation was conducted of eye drop administration to Resident H with Qualified Medication Aide (QMA) 10 on 4/21/25 at 6:35 p.m. QMA 10 was observed at the medication cart pulling the medications for Resident H. During that time, QMA 10 touched the mediation cards, water cups, water pitcher, the medication cart drawers and keys. After, she entered the resident's room and administered the pill medications to the resident. She then administered the eye drops. There was no observation of hand hygiene prior to the administration of the medications nor the eye drops. 2. The clinical record for Resident 29 was reviewed on 4/21/25 at 6:57 p.m. The diagnoses included, but were not limited to, hypertension. A physician order, dated 4/8/25, indicated the resident was to receive two drops of Lumigan eye drops in both eyes at bedtime.		administration Resident H had no adverse outcome from the alleged deficient practice NC #2 was educated on infection control with special focus on EBP protocols. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents receiving medications from QMA 10 had the potential to be affected by the alleged deficient practice. All residents with MDRO, chronic wounds, or indwelling devices have the potential to be affected by the deficient practice. An audit was conducted on all residents with MDRO, chronic wounds, and/or indwelling devices to ensure staff aware of those residents on EBP **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** DNS or Designee will complete education with all staff on infection control with a special focus on hand hygiene and EBP by May 31, 2025. DNS or Designee will audit residents requiring EBP and provide EBP “badge buddies” to staff. DNS/Designee will conduct rounds each shift to ensure proper hand hygiene is being performed with medication administration. DNS/Designee will conduct rounds each shift to	

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	An observation was conducted of eye drop administration to Resident 29 with QMA 10 on 4/21/25 at 6:57 p.m. QMA 10 was preparing and pulling medications at the medication cart for Resident 29. She was observed touching medication cards, keys, medication cart drawers, water cups and water pitcher. She then went into the resident's room. QMA 10 touched the resident's bedside table during the pill medication administration. After, she administered the eye drops to the resident by pulling the resident's bottom eye lid down. There was no observation of hand hygiene prior to administration of the resident's medications nor eye drops. An interview was conducted with QMA 10 on 4/21/25 at 7:26 p.m. She indicated she was unsure if she should wear gloves to administer eye medications, but she should utilize hand hygiene. An interview was conducted with the Director of Nursing on 4/24/25 at 12:17 p.m. She indicated the staff should be utilizing hand hygiene prior to the administration of eye drops. 3. Resident 27's clinical record was reviewed on 4/22/25 at 11:45 a.m. The diagnoses included, but were not limited to, human immunodeficiency virus (HIV), viral hepatitis B, Crohn's disease, and colostomy status (an externally connected bag to collect stool from the intestines). A Minimum Data Set (MDS) assessment, dated 3/6/25, indicated the resident was cognitively intact. A care plan, initiated on 2/21/25, indicated the resident required assistance and/or monitoring of morning and evening care, nutrition, hydration, and elimination.		ensure proper infection control techniques are followed for residents with EBP. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete a Infection Control CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Infection Control CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	A care plan, initiated on 3/24/25, indicated the resident preferred to keep his urinal and colostomy containers at the bedside and he refused to allow staff remove them or clean his bedside table. It indicated Resident 27 had been educated on the potential hazards of having bodily fluids in containers next to food containers. A care plan, initiated on 2/23/25, indicated the resident required assistance with ADLs (activities of daily living) including eating and toileting. A care plan, initiated on 2/28/25, indicated "the resident is at risk of transferring or becoming colonized with an MDRO [multidrug resistant organism] and requires enhanced barrier precautions due to an indwelling medical device, a chronic wound that requires a dressing, or colonization or infection with a MDRO in which contact precautions do not apply." A care plan approach, initiated on 2/28/25, indicated staff were to wear gowns and gloves prior to high contact resident care activities. An event report, dated 3/23/25, noted "Res [Resident] empty [sic] colostomy bag inside of cups and cylinders and leave them on bedside table along with urine. res is able to use restroom but refuses to get up ...staff asked res to use restroom and empty colostomy bag or feces into trash bag ...educate resident on emptying bag into toilet or biohazardous bag." A resident progress report, dated 3/24/25, indicated Resident 27 had a behavior of storing urine and feces on his bedside table in cylinders because he had a preference of keeping track and recording his outputs. Nursing staff was to offer to record output and discard the waste.			

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An event report, dated 3/27/25, noted "res [resident] is able to ambulate to restroom but refuses to [sic] res has cylinders of urine and feces sitting at bedside table wanting staff to empty them for him ...staff encouraged resident to use urinal or restroom and to empty bags into a trash/biohazard bag and secure the bag."

On 4/21/25 at 7:51 p.m., Resident 27 was observed lying in bed with two open containers full of liquid stool sitting on his bedside table next to him, along with a urinal filled with dark yellow liquid. He had a colostomy bag attached to his abdomen which had liquid stool in it. A pizza box was sitting in a wheelchair next to the bed.

Resident 27 was interviewed on 4/21/25 at 7:51 p.m. He indicated he emptied his own colostomy bag into the containers. Sometimes he emptied the containers himself but would also ask staff to empty them.

On 4/21/25 at 7:55 p.m., the Nurse Consultant (NC) was notified about the containers of stool present on Resident 27's bedside table. She entered his room, performed hand hygiene and donned gloves. She grabbed one of the containers and took it to the restroom to dump it. She did not put on a gown.

Resident 27 was interviewed on 4/22/25 at 11:09 a.m. He indicated he was okay with the state of his room. It would be nice if the staff came in and cleaned more.

A hand hygiene policy was provided by the Executive Director on 4/23/25 at 4:42 p.m. It indicated "Purpose of Policy: To provide a standardized approach to Hand hygiene to reduce

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	or minimize the transmission of infection from potential microorganisms on the hands of all employees...5. Moments of hand hygiene...Before touching a resident...After touching a resident...After touching resident surroundings..." A facility policy titled "Enhanced Barrier Precautions", revised 3/2025, noted the purpose was to "reduce transmission of multi-drug resistant organisms by wearing gown and gloves during high contact resident care activities with all residents who are at higher risk of acquiring or spreading an MDRO ...Enhanced Barrier Precautions expands the use of PPE [personal protective equipment] beyond situations in which exposure to blood and bodily fluids is anticipated, it refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing." 3.1-18(b)(2) 3.1-18(l)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to promote a homelike environment for 3 of 5 residents reviewed for environment (Residents L, 9, and 17). Findings include: An observation was made on 4/21/25 at 7:49 p.m. The blinds in Resident L's room were broken. An observation was made on 4/22/25 at 9:41 a.m. Resident 9's room smelled strongly like urine and	F 0921	What accomplished for those residents found to have been affected by the deficient practice? Resident L and 17 had blinds replaced. Resident 9's room was deep cleaned and wall was painted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the	05/31/2025

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	there was an area of scraped paint on the wall behind the bed. An observation was made on 4/22/25 at 10:14 a.m. The blinds in Resident 17's room were broken. In an interview with Resident 17, on 4/25/25 at 1:18 p.m., he indicated the broken blinds bothered him, especially when he had company, and they had been that way for three years. A walk-through tour was conducted with the Maintenance Supervisor (MS) and Housekeeping Supervisor (HS) on 04/25/25 at 1:10 p.m. During the tour, Resident L and Resident 17's blinds were broken. Resident 9's room smelled like urine and the paint on the wall was scraped. The MS was interviewed on 4/25/25 at 1:14 p.m. He indicated he was aware of the broken blinds in Resident 17 and Resident L's rooms, and they were on his list to be repaired. He had one box of blinds in his office and needed to order more but had to wait to see what next month's budget looked like. He was already aware of the scraped paint on the wall in Resident 9's room and needed to find the correct shade of paint for the repair. He expected to complete the work within the next few weeks. He was not able to provide any documentation or work orders. The HS was interviewed on 4/25/25 at 1:16 p.m. He indicated housekeeping staff were aware of the urine odor in Resident 9's room and they cleaned and mopped it daily. They would also spray an odor eliminator in the room daily. He thought the resident's mattress was the source of the odor and needed replaced. Nurse Consultant (NC) 13 was interviewed on		deficient practice. The Maintenance Supervisor or Designee will complete an audit on all resident rooms for broken blinds by May 31, 2025. The Maintenance Supervisor or Designee will complete an audit on all resident rooms for areas needing painted by May 31, 2025. Housekeeping Supervisor or Designee will complete an audit on all rooms for odor an by May 31, 2025. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** The Maintenance Supervisor or Designee will complete an audit on all resident rooms for broken blinds by May 31, 2025. The Maintenance Supervisor or Designee will complete an audit on all resident rooms for areas needing painted by May 31, 2025. Housekeeping Supervisor or Designee will complete an audit on all rooms for odor and cleanliness by May 31, 2025. Care Companions or Designee will create a work order for any resident rooms needing blinds repaired/replaced and walls needing patched or painted. Maintenance supervisor/designee will audit rooms weekly to ensure items are in good condition and are painted as needed Housekeeper will monitor rooms for odors and	

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	4/25/25 at 3:23 p.m. She indicated the facility did not have a specific policy for a homelike environment. A policy titled "Resident Rights," dated 11/2015, indicated "Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs ...the Resident has a right to a dignified existence, self-determination and communication with, and access to, persons and services inside and outside the Facility ..." 3.1-19(f)(5) 3.1-19(k) 3.1-19(l)(6)		cleanliness, and address concerns immediately. Supervisor or Designee will ensure resident rooms are on according to need. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance Maintenance Director/Designee will complete a Blinds/Paint and Deep Clean CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by Maintenance Director or designee. The Blinds and Deep Clean CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	