STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. BUILDING 00 B. WING	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON'S CROSSING HEALTH CAMPUS	395 8TH AVENUE TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 10, 11, 12, 13, 14, 17, and 18, 2025 Facility number: 013335 Provider number: 155830 AIM number: 201290670 Census Bed Type: SNF/NF: 53 Residential: 38 Total: 91 Census Payor Type: Medicare: 29 Medicaid: 15 Other: 47 Total: 91 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 24, 2025.	F 0000	The submission of this plan of correction does not indicate an admission by Harrison's Crossing Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Harrison's Crossing Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by 3/6/2025	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation and record review, the facility failed to ensure a resident was treated in a dignified manner during 1 of 1 random meal service observation (Resident 8).	F 0558	1 1. What corrective action was taken for the resident affected by the alleged deficient practice. Resident 8 suffered no ill effects from the alleged deficient practice. A clothing protector was	03/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sean Medsker	Executive Director	03/07/2025

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	Findings include: On 2/14/25 at 10:05 a.m., Resident 8 was observed eating a meal at the nurses' station table with several other residents who were not eating. The resident was observed spilling food over their clothing. Certified Nurse Aide (CNA) 20 was standing next to the resident and talking to him. On 2/14/25 at 10:07 a.m., during an interview, CNA 20 acknowledged the resident should have a clothing protector, but she forgot to put one on because he was in the hall. The employee did not obtain a clothing protector, and the resident continued to spill food over himself. On 2/14/25 at 10:10 a.m., during an interview, CNA 13, indicated the resident did need a clothing protector. She obtained a washcloth and cleaned the resident's clothing and applied a clothing protector. The resident repeatedly told the employee he was sorry he had spilled his food. The employee reassured him it was okay, and the resident thanked her. On 2/14/25 at 10:30 a.m., the medical record of Resident 8 was reviewed. The resident was admitted to the facility on 8/15/2019. Diagnosis included, but were not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) without dyskinesia (uncontrolled, involuntary muscle movements ranging from shakes, tics and tremors to full-body movements), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), and dysphagia (difficulty swallowing).		offered and placed on the resident per his preference. 2.What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. Clothing protectors were offered to residents per their preference. 3 3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur. Staff have been educated to ensure residents are offered clothing protectors per their preference. As a measure of ongoing compliance, DHS or designee will audit to ensure residents in the dining room during meals to ensure clothing protectors are provided to residents per their preference, audits will consist of 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months 4 4. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing	

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	A quarterly Minimum Data Set (MDS) assessment, dated 12/6/24, indicated the resident required assistance of one person for eating and was not cognitively intact. A care plan, dated 8/15/19, indicated the resident had diagnosis of Parkinson's disease requiring assist with activities of daily living (ADL) care. Interventions included, but were not limited to, provide assistance during ADL care to include but not limited to eating, toileting, bed mobility, transfers, wheelchair mobility, ambulation. On 2/14/2025 at 11:32 a.m., the Clinical Nurse Consultant provided a document, titled, "Resident Rights," dated 12/17/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose ...To ensure resident rights are respected and protected and provide an environment in which they can be exercised ...2. Our residents have the right to ...a. Be treated with dignity and respect ...." 3.1-3(v)(1)		monitoring will continue past 6 months if warranted until 100% compliance met.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination Based on interview and record review, the facility failed to ensure a resident was provided showers as preferred for 1 of 26 residents reviewed for choices (Resident 2). Findings include: During an interview, on 2/10/25 at 11:34 a.m., Resident 2 indicated it had been almost 2 weeks since she last had a shower. She was scheduled to receive 3 showers a week, on Monday, Wednesday, and Friday. She further indicated the	F 0561	1. What corrective action was taken for the resident affected by the alleged deficient practice. Resident 2 suffered no ill effects from the alleged deficient practice. Resident be offered showers per their preferences. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. Active residents have the potential	03/06/2025

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	shower in her room was too cold and she was waiting for it to be fixed by the maintenance worker. Resident 2's record was reviewed on 2/12/25 at 11:52 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively intact and required two-person physical assist with transfers. A care plan, dated 4/19/22, indicated profile care guide. Interventions included, but were not limited to, perform transfers 2 assist with gait belt and showers on Monday, Wednesday, and Friday on the evening shift. Review of point of care documentation, dated January 13 through February 12, 2025, indicated Resident 2 did not receive a shower on 1/29/25, 1/31/25, 2/3/25, 2/5/25, 2/7/25, 2/10/25. Review of shower sheets, dated 2/5/25, indicated Resident 2 had refused her shower because the water in her room was still too cold. The shower sheet lacked documentation that staff had offered the resident an alternative shower to use. Review of shower sheet, dated 2/7/25, indicated Resident 2 had refused her shower because it was too cold. The shower sheet lacked documentation that staff had offered the resident an alternative shower to use. During an interview, on 2/12/25 at 11:24 a.m., Resident 2 indicated the shower was now fixed and was hoping to get back on her regular schedule of shower days, she indicated the staff never offered her an alternative shower to use when the water in her room was too cold.		to be affected by the alleged deficient practice. Active residents have been audited to ensure they get their showers per their preferences. 3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur. Nursing staff have been educated on offering showers per a resident's preference. DHS or designee will audit showers to ensure they are given per resident preference 5 days a week X4 weeks, then every other week for 2 months, and then monthly for 3 months 4. How will corrective actions be monitored to ensure the alleged deficient practice does not recur. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	During an interview, on 2/12/25 at 2:18 p.m., the Clinical Support Nurse indicated the resident should have been offered an alternative shower if hers was too cold. During an interview, on 2/12/25 at 2:20 p.m., the Director of Health Services (DHS) indicated they had a spa area where the resident could have used a shower or in an unoccupied room. During an interview, on 2/13/25 at 9:30 a.m., the Administrator indicated the facility did have a spa that residents could use for showers, but the room was cold, and most residents did not like to use it. Staff should have offered the resident an alternative shower to use. On 2/13/25 at 11:43 a.m., the Clinical Support Nurse provided a document, with a revised date of 5/11/17, titled, "Resident Rights Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Purpose: To ensure resident rights are respected and protected and provide an environment in which they can be exercised ...2. Our residents have a right to: a. Be treated with dignity and respect ...." 3.1-3(u)(3)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify the physician of significant weight loss for 1 of 6 residents reviewed (Resident 15). Findings include: On 2/12/25 at 10:19 a.m., the medical record of	F 0580	1. What corrective action was taken for the resident affected by the alleged deficient practice. Resident #15 suffered no ill effects of alleged deficient practice. Resident was followed by MD/NP for weight loss related to their diuretics as ordered.	03/06/2025

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	Resident 15 was reviewed. The resident was admitted to the facility on 1/23/25. Admission diagnosis included, but was not limited to, fracture of the right femur (fracture of the long thigh bone of the leg), cardiomyopathy (a disease of heart muscle. It causes the heart to have a harder time pumping blood to the rest of the body), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), Lymphedema (swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), edema (swelling caused by too much fluid trapped in the body's tissues). An admission Minimum Data Set Assessment (MDS) dated 1/27/25, indicated the resident was administered a diuretic (medication to reduce extra fluid in the body) and was short of breath during the assessment period. A care plan, dated 1/23/25, indicated the resident was receiving high risk medications, received diuretic medication. Intervention included, but were not limited to, observe and report effectiveness as needed. A physician order, dated 1/25/25, indicated to adminster Lasix 40 mg (milligrams) one tablet by mouth two times per day. A review of the resident's weight record indicated the resident had 19.5 % weight loss, 37.5 pounds in less than 30 days. Admission weight on 1/24/25 was recorded as 192.3 pounds. On 2/4/25 recorded weight was 163 pounds. On 2/12/25 recorded weight was 154.8 pounds. A physician order, dated 2/6/25, indicated to adminster Lasix 40 mg, one tablet by mouth one		2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. Residents at risk have been audited to ensure MD notifications have been completed for significant weight loss. 3.What systemic measures or changes are put in place to assure the alleged deficient practice does not recur. Nurse leaders have been educated to complete MD notification for significant weight loss as appropriate. As a measure of ongoing compliance, DHS or designee will audit residents during Clinical care meeting (CCM) to ensure proper MD notification, weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months 4. For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100%	

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	time per day for diagnosis of edema. On 2/11/25 a nutrition progress note indicated the root cause of weight loss was due to decreased swelling of bilateral lower extremities with diuretic treatment and compression wraps. A nurse progress note, on 12/6/25, indicated the resident was seen by the Nurse Practitioner (NP). Lasix was decreased to 40 mg daily from 40 mg twice daily. Compression wraps were ordered on 2/3/25. The record lacked documentation of physician notification of the increased and continual weight loss. NP visit notes did not indicate a plan of treatment had been in place for reduction of edema, a review of current weight loss status or continuation of weight loss plan. The NP note lacked notification to the attending physician of the weight loss. On 2/14/25 at 2:10 p.m., during an interview with the residents physician and the Director of Health Services (DHS) the physician indicated the weight loss was due to administration of Lasix to decrease massive abdominal edema. He acknowledged he had not reviewed the residents weight loss until 2/14/25. The physician acknowledged the medical record lacked documentation of notification of the weight loss, though the NP had seen the resident on 2/6/25 and decreased the Lasix to 40 mg daily. The physician acknowledged the record lacked notification of significant weight loss or of continual plan to reduce edema. On 2/18/2025 at 1:37 p.m., the Clinical Nurse Consultant provided a document titled, "Physician Provider Notification Guidelines,"		compliance met.	

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	dated12/17/24, and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose ...ensure the resident's physician or practitioner (may include NP, PA or clinical nurse specialist) is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care ...11. Attempts to notify the physician/provider and their response should be documented in the resident electronic health record ...." 3.1-5(a)(2)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment had been coded correctly for 1 of 18 MDS assessments reviewed (Resident 45). Findings include: Resident 45's closed record was reviewed on 2/17/25 at 8:51 a.m. The profile indicated the resident's diagnoses included, but were not limited to, cerebral infarction (stroke- a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) and metabolic encephalopathy (a change in how the brain works due to an underlying condition). The census indicated the resident had been admitted to the facility on 11/2/24 and discharged on 11/27/24. A discharge observation form, dated 11/27/24,	F 0641	No POC needed	03/06/2025

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	indicated the resident had discharged home with home health care (a wide range of health care services that you can get in the home for an illness or injury). A discharge, return not anticipated MDS assessment, dated 11/27/24, indicated the resident had a planned discharge to a short-term general hospital. A Social Services progress note, dated 11/20/24 at 9:07 a.m., indicated a care conference had been held attended by the resident's family and the Social Services Director (SSD). The family indicated the resident would discharge home with home health care services. A progress note, dated 11/27/24 at 10:20 a.m., indicated the resident had discharged home with home health care services. During an interview, on 2/17/25 at 9:11 a.m., the SSD indicated the resident had not been discharged to the hospital but had discharged home with home health care services. During an interview, on 2/17/25 at 9:18 a.m., the MDS Coordinator indicated she had hit the incorrect button when completing the discharge, return not anticipated MDS assessment. The assessment had been coded incorrectly. The "CMS (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," dated October 2024, indicated, "...A2105: Discharge Status: ...Coding Instructions...Code 01, Home/Community: if the resident was discharged to a private home...." 3.1-31(a)			

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure a resident's urostomy (a surgical opening in the belly that re-directs urine away from a bladder that's diseased, had been injured, or isn't working as it should) catheter bag (a bag that collects urine) was kept from coming in contact with the floor for 1 of 2 residents reviewed for catheters (Resident 4). Findings include: During a meal service observation, on 2/10/25 at 11:51 a.m., Resident 4's urinary catheter bag was observed to be in contact with the floor. During a random observation, on 2/10/25 at 12:49 p.m., Resident 4 was propelling herself in her wheelchair out of the dining room. Her urinary catheter bag was in contact with the floor and dragging underneath her wheelchair. During a random observation, on 2/11/25 at 9:29 a.m., Resident 4 was in the therapy room. Her urinary catheter bag was in contact with the floor. During a random observation, on 2/11/25 at 10:46 a.m., Resident 4 was being assisted in her wheelchair by a staff person down the hallway to participate in an activity. The resident's urinary catheter bag was dragging on the floor under her wheelchair. Resident 4's record was reviewed on 2/12/24 at 2:28 p.m. The profile indicated the resident's diagnoses included, but were not limited to,	F 0690	1. What corrective action was taken for the resident affected by the alleged deficient practice. Resident 4 was not affected by alleged deficient practice. Resident's dignity bag was repositioned so it didn't touch the ground. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. Residents with catheter bags in dignity bags were observed to ensure the bag was not touching the floor. 3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur. Clinical staff were educated to ensure dignity/catheter bags are positioned to ensure proper placement off of the floor. As a measure of ongoing compliance, DHS or designee will audit catheter/dignity to ensure bags are in proper placement 5 days a week X4 weeks, then every other week for 2 months, and then monthly for 3 months 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus	03/06/2025

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	personal history of urinary tract infections (UTI-an infection in any part of the urinary system), and disorder of the kidney and ureter (a blockage where the ureter and kidney meet which may cause the kidney to swell and eventually stop working). An admission Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident had no cognitive deficit and had a urostomy. A care plan, dated 12/27/24, indicated the resident had an ostomy to divert her urine. The care plan lacked documentation to maintain the catheter bag and/or tubing from coming contact with the floor. An event document, dated 1/13/25, indicated the resident had developed a UTI that was not present upon admission. During an interview, on 2/13/25 at 10:06 a.m., Certified Resident Care Assistant (CRCA) 9 indicated urinary catheter bag and/or tubing should not come into contact with the floor. During an interview, on 2/13/25 at 11:44 a.m., the Clinical Support nurse indicated the resident's urinary catheter bag should not have been in contact with the floor. On 2/12/25 at 10:01 a.m., the Executive Director (ED) provided a document, with a review date of 12/16/24, titled, "Preserving Dignity with Indwelling Catheter," and indicated it was the policy currently being used by the facility. The policy indicated, "...SOP (Standards of Practice) Details: 1...e. Urinary drainage bags and catheter tubing should be kept from touching the floor surface...."		Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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F 0726 SS=D Bldg. 00	3.1-41(a)(2) 483.35(a)(3)(4)(c) Competent Nursing Staff Based on record review and interview, the facility failed to ensure proper administration of scheduled medication by nursing staff and failed to ensure competent nursing staff removed a PICC line (a thin, flexible tube that's inserted into a vein in the arm and ends in a large vein near the heart) for 2 of 5 residents reviewed for unnecessary medications (Resident 14 and 20). Findings include: 1. Resident 14's record was reviewed on 2/11/25 at 2:00 p.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A quarterly Minimum Data Set (MDS) assessment, dated 1/31/25, indicated the resident had moderate cognitive impairment and was on an anti-anxiety medication. A care plan, dated 5/3/22, indicated the resident has a diagnosis of anxiety disorder. Interventions included, but were not limited to, medications per order and psych services as needed. A physician order, dated 12/30/24, indicated to administer alprazolam (anti-anxiety medication) 0.5mg (milligrams) by mouth four times a day. Administration hours were 7 to 9:00 a.m., 1 to 1:30	F 0726	1. What corrective action was taken for the resident affected by the alleged deficient practice. Resident 14 and 20 was not affected by alleged deficient practice. Residents requested medications early. Resident with PICC line was discontinued and pulled and was monitored for bleeding. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. Residents who request medications early were reviewed to adjust times as needed. Residents with PICC lines were reviewed to ensure lines were pulled within the nurses scope of practice and orders placed for RN to pull PICC line. 3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur. Nurses have been educated on medication administration policy, PICC line scope of practice and medication administration time change procedures. As a measure of ongoing compliance, the director of health services (DHS) or designee will audit to ensure medications are being	03/06/2025

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	p.m., 4 to 5 p.m., and 8 to 10 p.m. Review of December 2024 Medication Administration Record (MAR) indicated the following: a. On 12/6/24, Licensed Practical Nurse (LPN) 21 documented that he administered Resident 14's alprazolam medication at 6:35 p.m. and the medication was not due until 8 to 10:00 p.m. b. On 12/12/24, LPN 21 documented that he administered the resident's alprazolam mediation at 6:35 p.m. and the medication was not due until 8 to 10:00 p.m. Review of January 2025 MAR indicated the following: a. On 1/4/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:56 p.m. and the medication was not due until 8 to 10:00 p.m. b. On 1/17/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:25 p.m. and the medication was not due until 8 to 10:00 p.m. c. On 1/24/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:28 p.m. and the medication was not due until 8 to 10:00 p.m. d. On 1/31/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:44 p.m. and the medication was not due until 8 to 10:00 p.m. Review of February 2025 MAR indicated the		administered per MD order 5 days a week X4 weeks, then weekly X4 weeks, then every other week x4 weeks, then monthly X3 months. As a measure of ongoing compliance, the DHS or designee will audit to ensure PICC line procedures are followed. Audits will be completed on like residents 5 days a week x4 weeks, then weekly x4 weeks, then every other week x4 weeks, then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	following: a. On 2/1/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:30 p.m. and the medication was not due until 8 to 10:00 p.m. b. On 2/6/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:32 p.m. and the medication was not due until 8 to 10:00 p.m. Resident 14's record lacked documentation that the physician was ever notified that the resident was requesting her medication to be administered early. During an interview, on 2/11/25 at 3:01 p.m., Registered Nurse (RN) 4 indicated she wasn't sure if they could administer medication outside of the timeframe, she would have to check the policy. During an interview, on 2/11/25 at 3:02 p.m., LPN 5 indicated nursing staff may administer medication an hour before or after the medication administration time. During an interview, on 2/12/25 at 9:46 a.m., the Clinical Support Nurse indicated nursing staff may administer medication an hour before or after the medication administration times. Staff should notify the doctor if residents were requesting the medication earlier. Medications should be administered as ordered by physicians. The facility was not aware that the LPN was administering medications outside of the hour window. On 2/12/25 at 10:19 a.m., the Clinical Support Nurse provided a document, dated 12/1/21, titled,			

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	"Medication Administration Times Procedural Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, " ... To ensure mediation is administered in resident centered fashion and documented in medical record ...f. The nurse shall give the resident options of administration to ensure appropriate spacing of administration ...." 2. On 2/11/25 at 1:59 p.m., the record of Resident 20 was reviewed. The resident was admitted to the facility on 1/31/25. Diagnosis included, but were not limited to, Surgical amputation right foot toes, (removal of the toes on the right foot due to disease), (MRSA) methicillin resistant staphylococcus aureus infection (a bacterial infection that is resistant to some antibiotic treatments), osteomyelitis (inflammation or swelling that occurs in the bone from an infection somewhere else in the body that has spread to the bone), gangrene the death of body tissue due to a lack of blood flow or a serious bacterial infection) of the foot, proteus mirabilis (bacteria causing serious infection in the body) as the cause of diseases classified elsewhere, pseudomonas (bacterial causing serious infection in the body) as the cause of diseases. On 2/3/25 an admission Minimum Data Set Assessment (MDS) assessment indicated the resident was cognitively intact. A care plan, dated 1/31/25, indicated the resident required IV medication related to infection/osteomyelitis, cellulitis (a deep infection of the skin caused by bacteria), and MRSA. Interventions included but were not limited to: administer IV as ordered, IV site care as ordered. Upon admission to the facility a peripherally inserted central venous catheter PICC/Central			

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	Line (a thin, flexible tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava) was inserted into the residents arm. The IV (intravenous) was used to administer antibiotic medication to treat bacterial infections. A physician order, dated 1/31/25, administer piperacillin-tazobactam reconstituted (mixed with sterile water solution) administer 4.5 gram in100 mL (milliliters) over 30 minutes through intravenous administration (medications administered into a vein) every 6 hours for diagnosis of MRSA. A physician order, dated 1/31/25, indicated to administer vancomycin reconstituted solution 1,000 mg (milligrams) administer 1 gram in 250 mL (sterile water solution) over 1 hour through intravenous administration every 12 hours to be administered at 10:30 a.m., and 10:30 p.m. for diagnosis of MRSA. A physician order, dated 1/31/25, with a designated implementation date of 3/5/25, indicated dressing covering PICC/CL IV was to be changed every 5 days and to measure external IV catheter (the length of the IV catheter outside of the body), and enter the measurement into the medication note. The Treatment Administration Record (TAR) indicated the dressing was changed on 2/4/25 when a new PICC/CL IV was placed and changed again on 2/6/25. Review of the TAR lacked documentation indicating the PICC/CL IV had been measured since admission as ordered by the physician.			

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	Nurse progress note, dated 2/6/2025 at 10:14 a.m., entered by Licensed Practical Nurse (LPN) 14 indicated the following: "resident showered this shift. When resident was getting out of shower he took the PICC line drsg (dressing) off, when he removed drsg it pulled PICC out and inch and was visibly bleeding when i arrived in resident room. PICC was removed access RN was called promptly to replace line... bleeding was stopped... no c/o [complaints of] from patient at this time". On 2/10/25 at 2:20 p.m. an entry was made in the medical record by LPN 23. The documentation indicated LPN 23 drew blood from the PICC/CL for lab testing. The medical record lacked documentation of physician order to draw blood from the PICC/CL IV or documentation that a licensed Registered Nurse (RN) completed the blood draw. The medical record lacked documentation of an assessment by an RN prior to and after blood draw from the PICC/CL line. On 2/13/25 at 9:31 a.m., observed PICC/CL dressing. The dressing was soiled and edges starting to roll. The dressing was dated 2/6/25. On 2/13/25 at 9:50 a.m., during an interview with the Director of Health Services (DHS) she indicated the implementation date was a data entry error, and the dressing should have been changed on 2/11/25. On 2/14/25 at 10:10a.m., during an interview Licensed Practical Nurse (LPN) 14 indicated on 2/6/25 Resident 20 was in the shower and the resident attempted to remove the dressing over the PICC/CL IV and pulled on the IV. She indicated the PICC/CL IV was pulled out			

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	approximately one inch from the arm and was bleeding slightly. The LPN applied pressure to the arm for a minute to ensure it was no longer bleeding. She notified the DHS of the incident. She returned to the resident's room with another LPN and removed the PICC/CL from the residents arm and notified the Registered Nurse (RN) who would replace the PICC/CL IV. The LPN acknowledged she did not notify the physician of the incident and did not obtain an order to remove the PICC/CL IV. The employee indicated the DHS was in the facility and the DHS had notified the physician and obtained an order to remove the IV. The medical record lacked documentation of physician notification and order to remove the PICC/CL IV. The medical record lacked documentation of the length of the PICC/CL IV after removal, of pressure being applied to the area for a specific amount of time after removal, or an assessment of the IV site by a licensed RN before and after removal of the IV. On 2/14/25 at 10:40 a.m., during interview with the Registered Nurse Clinical Consultant (RNCC) and Director of Health Services (DHS), the DHS failed to verify she notified the physician for an order to remove the IV or of an assessment being completed by an RN before or after removal. The RNCC indicated an LPN was not licensed or permitted to remove a PICC/CL or draw blood from a PICC/CL IV. The RNCC acknowledged a central line IV catheter must be assessed by an licensed RN and only removed by a qualified licensed RN trained specifically in PICC/CL IV insertion and			

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	removal. On 2/14/2025 at 11:32 p.m., the RNCC provided a document titled, "Catheter Insertion and Care ," dated 12/15, and indicated it was the policy currently being used by the facility. The policy indicated, "...General Guidelines ...1, A prescriber must write an order for a CVAD or midline to be removed ...7. The nurse or practitioner removing the catheter must have proven competency in this procedure ....Procedure ...1. The procedure for removing CVAD and midlines is different for each catheter. 2. This procedure must be performed by a person who is certified in the removal procedure and demonstrates clinical competency in removing catheter ...D. Peripherally Inserted Central Catheter (PICC) ...4. Catheter can be placed or removed at the bedside or in the hospital setting by a Certified Specialty Nurse (Verify with the State Nurse Practice Act) ...6. Catheter length is measured for baseline comparison upon removal. Catheter measurements are compared to baseline to verify that all of catheter has been removed ...11. No blood pressure or phlebotomy should be done on arm that contains PICC ...." 3.1-14(i)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure justification for the long-term use of antibiotics for 1 of 26 residents reviewed for antibiotic use (Resident 1). Findings include: Resident 1's record was reviewed, on 2/12/25 at	F 0757	**F757**-Drug Regimen is Free from Unnecessary Drugs 1. What corrective action was taken for the resident affected by the alleged deficient practice. Residents 1 was not affected by alleged deficient practice. Resident is seen by outside MD	03/06/2025

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	2:44 p.m. The profile indicated that the resident's diagnoses included, but were not limited to, urinary tract infection (UTI - an illness in any part of the urinary tract the system of organs that make urine) and chronic kidney disease stage 3 (a person has moderate damage to their kidneys, with a noticeable decline in kidney function). A quarterly Minimum Data Set (MDS) assessment, dated 11/15/24, indicated the resident had moderate cognitive impairment and was always incontinent with bowel and urine. A physician order, dated 6/12/23 with no discontinue date, indicated to administer doxycycline hyclate (antibiotic) 100 mg (milligrams) by mouth once daily for UTI prophylaxis (tending to prevent or ward off, preventive). Review of Resident 1's notes indicated the last documented UTI was on 12/20/24 per a nursing progress note. During an interview, on 2/14/25 at 9:29 a.m., the Clinical Support Nurse indicated the Medical Director had prescribed the prophylactic antibiotic back in 2023 for the resident and was no longer Resident 1's primary care doctor. She was unable to provide documentation that the physician had documented a justification for the long-term antibiotic use. During an interview, on 2/14/25 at 2:10 p.m., the Medical Director indicated that he had not been informed of the best practice regarding antibiotic stewardship and the use of prophylactic antibiotic treatment. Review of a typed statement, dated 2/14/25,		and medical director reviews antibiotic stewardship monthly. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. Residents on prophylactic antibiotics have the potential to be affected by the alleged deficient practice, residents have been reviewed and educated MD on long term prophylactic antibiotic use. 3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur. The IDT (interdisciplinary team) and MDs have been educated on long term prophylactic antibiotic use and request MD to review for continued use as appropriate. As a measure of ongoing compliance, the director of health services (DHS) or designee will audit to ensure prophylactic antibiotics are reviewed per MD and discontinued as warranted 5 days a week X4 weeks, then every other week for 2 months, and then monthly for 3 months 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as	

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	indicated the Medical Director had prescribed the antibiotic for UTI prophylaxis due to the resident being prone to UTI's. The resident had since changed doctors, and the new physician continued with the medication. During an interview, on 2/17/25 at 8:55 a.m., the Clinical Support Nurse indicated they had not been able to get a hold of Resident 1's primary care doctor regarding prophylactic antibiotic use, and to obtain a justification for the use of it. On 2/11/25 at 3:00 p.m., the Administrator provided a document, dated 11/10/17, titled, "Antibiotic Stewardship Guideline," and indicated it was the current policy being used by the facility. The policy indicated, " ...Purpose: Optimize the treatment of infections by ensuring the residents who require an antibiotic, are prescribed the appropriate antibiotic. Reduce the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use ...6. Pharmacy provider will assist in review of all antibiotic usage for appropriateness. 7. Antibiotic use will be calculated on monthly basis for QAPI purposes ...." 3.1-48(a)(2) 3.1-48(a)(4)		warranted.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to ensure abnormal involuntary movement scale (AIMS) assessments (a 12-item clinician-rated scale to assess severity of involuntary movements of the mouth, face,	F 0758	1. What corrective action was taken for the resident affected by the alleged deficient practice. Residents 31, 5, and 15 suffered no ill effects from the alleged deficient practice. Residents had	03/06/2025

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	extremities, and trunk in residents taking neuroleptic [psychiatric drugs that treat mental health symptoms] medications) were conducted for 3 of 5 residents reviewed for unnecessary medications (Residents 31, 5, and 15). Findings include: 1. Resident 31's record was reviewed on 2/11/23 at 2:03 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance (a condition where a person with dementia [a group of brain conditions that cause memory loss, thinking problems, and difficulty doing daily tasks] experiences a range of behavioral changes. A quarterly Minimum Data Set (MDS) assessment, dated 1/17/25, indicated the resident had severe cognitive deficit and received antipsychotic medication (drugs used to treat symptoms of psychosis [hallucinations: sights, sounds, smells, tastes, or touches that a person believes to be real but are not real, delusions: false beliefs], and dementia) on a routine basis. A care plan, dated 7/17/24, indicated the resident had been admitted on an antipsychotic medication. Interventions included, but were not limited to, monitor for side effects of the medication. A physician's order, dated 7/12/24, indicated to administer a 100 milligram (mg) tablet of quetiapine (antipsychotic medication) two times a day. A pharmacy recommendation, dated July 2024, recommended to complete an AIMS assessment on the resident.		updated AIMS assessments completed right away. 2. What corrective action was taken for those residents having the potential to be affected by the alleged deficient practice. Like residents have the potential to be affected and have been reviewed for current AIMS assessment. 3. What systemic measures or changes are put in place to assure the alleged deficient practice does not recur. Nursing staff and clinical leaders were educated on completing AIMS assessment as required. As a measure of ongoing compliance, director of health services (DHS) or designee will audit AIMS assessment ensure they are completed as required and timely. As a measure of ongoing compliance, director of health services (DHS) or designee will AIMS assessments 5 days a week X4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	The record lacked documentation that an AIMS assessment had been completed. During an interview, on 2/11/25 at 3:40 p.m., the Clinical Support nurse indicated the facility was unable to produce AIMS assessments for the resident. The AIMS assessment had not been completed. 2. Resident 5's record was reviewed on 2/11/25 at 3:22 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance (a condition where a person with dementia [a group of brain conditions that cause memory loss, thinking problems, and difficulty doing daily tasks] experiences a range of behavioral changes). An admission Minimum Data Set (MDS) assessment, dated 1/21/25, indicated the resident had severe cognitive deficit and received antipsychotic medication (drugs used to treat symptoms of psychosis [hallucinations: sights, sounds, smells, tastes, or touches that a person believes to be real but are not real, delusions: false beliefs], and dementia) on a routine basis. A care plan, dated 1/20/25, indicated the resident had a diagnosis of dementia with behaviors and was treated with antipsychotic medication. Intervention included, but were not limited to, observe for adverse side effects of medication. A physician order, dated 1/18/25, indicated to administer a 50 milligram (mg) tablet of Seroquel XR (extended-release antipsychotic medication) one time a day for diagnosis of unspecified dementia with other behavioral disturbance. The record lacked documentation that an AIMS			

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	assessment had been completed. During an interview, on 2/11/25 at 3:40 p.m., the Clinical Support nurse indicated the facility was unable to produce AIMS assessments for the resident. The AIMS assessment had not been completed. 3. Resident 15's record was reviewed on 2/11/25 at 3:27 p.m. The profile indicated the resident's diagnoses included, but were not limited to, dementia with agitation (a resident with the loss of cognitive functioning who becomes restless and worried and experienced the inability to settle down) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). An admission Minimum Data Set (MDS) assessment, dated 1/27/25, indicated the resident had no cognitive deficit and received antipsychotic medication (drugs used to treat symptoms of psychosis [hallucinations: sights, sounds, smells, tastes, or touches that a person believes to be real but are not real, delusions: false beliefs], and dementia) on a routine basis. A care plan, dated 1/27/25, indicated the resident had come from the hospital with an antipsychotic medication due to post operative (after surgery) hallucinations. Interventions included, but were not limited to, observe for adverse side effects of the medication. A physician's order, dated 2/6/25, indicated to administer a 25 milligram (mg) tablet of Seroquel (antipsychotic medication) with Special Instructions: To be given with a 50 mg tablet, for a total of 75 mg, two times a day.			

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	155830	A. BUILDING 00 B. WING	02/18/2025

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	A physician's order, dated 2/6/25, indicated to administer a 50 mg tablet of Seroquel with Special Instructions: To be given with a 25 mg tablet, for a total of 75 mg, two times a day. The record lacked documentation that an AIMS assessment had been completed. During an interview, on 2/11/25 at 3:40 p.m., the Clinical Support nurse indicated the facility was unable to produce AIMS assessments for the resident. The AIMS assessment had not been completed. On 2/12/25 at 10:21 a.m., the Clinical Support nurse provided a document, with a review date of 12/17/24, titled, "Guidelines for: Abnormal Involuntary Movement Scale (AIMS)," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedures: 1. A licensed nurse will complete an AIMS scale assessment on all residents on antipsychotic medications...3. The AIMS assessment will be repeated for residents taking antipsychotic medications every six (6) months or as needed for displaying symptoms...." 3.1-48(a)(3) 3.1-48(a)(5)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure employees were sanitizing hands while providing meal service during 1 of 2 dining observations, and the facility failed to ensure sanitary measures were maintained while	F 0812	1. No resident suffered ill effects from the alleged deficient practice. 2. Active residents have the potential to be affected. Staff were educated to complete hand hygiene as appropriate and dietary	03/06/2025

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	obtaining temperature readings of prepared food with a food temperature measuring device during 1of 2 dietary food service observations. Findings include: 1. On 2/10/25 at 12:06 p.m. observed Dietary Assistant 18 assist a resident by repositioning her wheelchair and moving the chair closer to the table. The employee then obtained food for another resident and failed to sanitize his hands between residents. Observed several employees entering kitchen by touching the door handle and did not sanitize their hands before serving residents their meal. Observed Certified Nurse Aide (CNA) 19, serve food to residents and did not sanitize hands between residents. Observed CNA 19 entering the kitchen multiple times pushing on the door handle and did not sanitize hands before serving food to residents. Hand sanitizer was available in the dining area. Hand washing sink was available inside of the kitchen service area for employees to use. On 2/11/25 at 11:30 a.m., during interview the Clinical Nurse Consultant acknowledged the employs did not need to touch the kitchen door to open it as it had a push bar on the door and employees should sanitize between residents while serving food. On 2/13/2025 at 11:43 a.m., the Clinical Nurse Consultant provided a document titled, "Guideline for Handwashing/Hand Hygiene," dated 2/9/17, and indicated it was the policy currently being used by the facility. The policy indicated, "...1. All		staff were educated to clean thermometers as appropriate after taking food temperatures. 3. Dietary staff have been educated on proper cleaning of thermometers during food temps and staff assisting during dining services have been educated for proper hand hygiene during meal service. As a measure of ongoing compliance, executive director (ED) or designee will observe for hand hygiene during meal service weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. As a measure of ongoing compliance ED or designee will monitor to ensure thermometer cleaning is completed during food temperature checks. Audits will be completed weekly x4 weeks, then every other week x2 months and then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	healthcare workers shall utilize hand hygiene frequently and appropriately ...b. Before/after preparing/serving meals, drinks ...." 2. On 2/18/25 at 11:36 a.m., during observation of food temperature testing with Dietary Cook (22), the employee tested the temperature of the meat and then tested the temperature of the other food items on the steam table and the cold food with a food temperature measuring device then wiped the device on a napkin. The employee failed to disinfect the temperature device between each food item. On 2/18/25 at 11:45 a.m., during interview employee 22, acknowledged she had not sanitized the temperature device between each food item. She acknowledged she should have sanitized the device and indicated she did not have any wipes available. On 2/18/25 at 11:47 a.m. during interview the Dietary Manager acknowledged the cook should have wiped the food temperature measuring device between each food item and wipes were available in the main kitchen. On 2/18/2025 at 1:29 p.m., the Clinical Nurse Consultant provided an undated document, titled, "guidelines," and indicated it was the policy currently being used by the facility. The document indicated, "...Equipment food-contact surfaces and utensils shall be cleaned as follows ...3. Between uses with raw fruits and vegetables and with potentially hazardous food. 4. Before using or storing a food temperature measuring device ...." 3.1-21(i)(1) 3.1-21(i)(3)			

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