STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING 00 B. WING	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUTSONWOOD AT BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00444279, IN00443258, and IN00444186. Complaint IN00444279 - No deficiencies related to the allegations are cited. Complaint IN00443258 - No deficiencies related to the allegations are cited. Complaint IN00444186 - No deficiencies related to the allegations are cited. Survey dates: October 16, 17, 18, 21, and 22, 2024 Facility number: 000514 Provider number: 155503 AIM number: 100266800 Census Bed Type: SNF/NF: 66 Total: 66 Census Payor Type: Medicare: 7 Medicaid: 48 Other: 11 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 2024.	F 0000	Annual Survey Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130 Dear Ms. Buroker, On oct22, 2024 an annual survey (DDPX11) along with complaint survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of Nov 22, 2024. Please feel free to call me with any further questions at 1 (812) 446-2636. Respectfully submitted, Manoj Berry (Executive Director) Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record	F 0550	F 550 D Resident Rights	11/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Manoj Berry	Executive Director	11/18/2024

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

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	review, the facility failed to ensure contracted staff completed a resident assessment and vital signs in privacy for 1 of 1 resident reviewed for privacy (Resident 26). Findings include: During the meal service on the memory care unit, on 10/16/24 at 12:04 p.m., Resident 26 was sitting in her Broda chair (a wheelchair or seating device designed to provide comfort and support for long-term patients) at a table waiting for lunch to be served. A contracted hospice nurse entered the dining area where Resident 26 was sitting. Hospice Nurse 23 obtained vital signs on Resident 26. The nurse obtained a temporal (forehead) temperature, blood pressure (using a wrist cuff), pulse oximeter reading, heart rate, and a circumference of her right arm (using a tape measure). The hospice nurse leaned in next to the resident's ear to ask her some questions about how she was feeling. There were several residents sitting at the table during this time along with the licensed practical nurse and certified nurses' aide. During an interview, on 10/16/24 at 12:09 p.m., Licensed Practical Nurse (LPN) 7 indicated the hospice nurse should not be completing an assessment or vital signs on a resident during meal service. Resident 26's record was reviewed on 10/17/24 at 2:53 p.m. The profile indicated the resident diagnoses included, but were not limited to, unspecified dementia (a person's mild cognitive impairment has yest to be diagnosed as a specific type of dementia) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: The contracted company was notified of occurrence, and education was provided to the contracted staff to maintain privacy for residents and on resident rights. 2)How the facility identified other residents:Any resident residing in the building had the potential to be affected by the alleged deficient practice, none were identified. 3)Measures put into place/ System changes: The contracted company will reeducate their staff to ensure privacy is always maintained while assessing residents. Documentation of such will be provided from the contracted company to the facility. DON/Designee will complete a random audit of 2 contracted staff weekly for 3 months then monthly for 3 months	

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	life). A quarterly Minimum Data Set (MDS) assessment, dated 9/29/24, indicated the resident was severely impaired cognitively and was on hospice services. During an interview, on 10/17/24 at 8:37 a.m., the Director of Nursing (DON) indicated the hospice nurse should not have completed an assessment or vital signs during meal service on a resident. During an interview, on 10/18/24 at 8:55 a.m., the Administrator indicated that he had spoken with the hospice nurse and she was aware that she should not have completed an assessment and vital signs on the resident during meal service. She was in a hurry and wasn't thinking. On 10/17/24 at 8:51 a.m., the DON provided an undated document titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, " ...V ...The resident has the right to personal privacy and confidentiality ...A. Personal privacy includes accommodations, medical treatment...I Dignity: A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition in his or her individuality ..." 3.1-3(t)		to ensure privacy is always maintained while assessing the residents. Education will be provided immediately for failure to do so. Facility will notify contracted company for continued noncompliance. 4)How the corrective actions will be monitored: DON/Designee is responsible for compliance. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance:11/22/2024	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observations, interviews, and record review, the facility failed to ensure a call light device was within reach for 1 of 16 residents observed for call lights (Resident 7).	F 0558	F 558 Reasonable Accommodations Needs/preferences The facility requests paper	11/22/2024

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	Findings include: On 10/17/24 at 10:08 a.m., observed Resident 7 in his room, sitting in a Broda chair (a wheelchair or seating device designed to provide comfort and support for long-term patients) facing the window. He was leaning to the right side of the chair, the left side of his face was directly in the sunlight, the room temperature was hot, and his cheeks were reddened. Two button-press call lights were observed to be on the beds, not within reach of the resident. On 10/17/24 at 10:13 a.m., requested assistance from Certified Nursing Assistant (CNA) 5, upon entering Resident 7's room, she indicated the room was hot and that it looked like the resident was leaning to get out of the sunlight. She indicated the resident did not have his call light, but he did not use it. Before leaving the room, she provided him with a button-press call light. On 10/21/24 at 1:34 p.m., observed Resident 7 resting in bed with eyes closed. Two button-press call lights were observed to be in a recliner at the foot of the bed, not within reach of the resident. During an interview on 10/21/24 at 1:57 p.m., the Director of Nursing (DON) indicated that if a resident had mobility problems, moved around a lot in bed, or could not remember to use a button-press call light, they could have soft touch call devices (sensitive to touch). She indicated that everyone was to have a call device. On 10/22/24 at 10:53 a.m., Resident 7's record was reviewed. His diagnoses included, but were not limited to, Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills,		compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: The call light was placed within reach of Resident #7. 2)How the facility identified other residents: Any resident who resides in the facility has the potential to be affected by the alleged deficient practice. An audit was completed to ensure the call lights are within reach of the residents. Identified issues will be corrected immediately upon identification with 1-1 education and/or disciplinary measures. 3)Measures put into place/ System changes: Reeducation was provided for all staff with emphasis on ensuring the call light remains within the residents' reach at all times. DON/Designee will audit 5 residents 5 times weekly for 4 weeks, 3 residents 2 times weekly for 4 weeks, 3 residents 1 times weekly for 4 months to ensure call light is within reach of the	

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	and eventually the ability to carry out everyday tasks), cognitive communication deficit (range of difficulties that can affect a person's ability to think, communicate, and function in social situations), and dementia (neurological conditions that cause a person to lose the ability to think, remember, and reason to the point that it interferes with their daily life). A quarterly Minimum Data Set (MDS) assessment, dated 9/26/24, indicated Resident 7's cognitive skills for daily decision making was moderately impaired. A care plan, edited 10/22/24, with a problem start date of 11/12/18, indicated Resident 7 was at risk for falls related to poor safety awareness, required assistance with activities of daily living, was incontinent of bowel and bladder, had a diagnosis of Alzheimer's disease, and had a history of falls. On 10/22/24 at 11:43 a.m., observed a hospice nurse in Resident 7's room, two soft touch call devices had been installed. During an interview on 10/22/24 at 12:03 p.m., the Administrator (ADM) indicated that he installed the soft touch call device and was not aware that Resident 7 did not have one before yesterday, but if a resident was not able to use a button-press call device, they should have a soft touch. If they are not able to press it or remember to press it, when they move it would activate the call light system. On 10/22/24 at 2:39 p.m., the DON provided an undated document, titled, "Call Lights: Accessibility and Timely Response", and indicated it was the policy currently being used by the facility. The policy indicated, " ...The		resident. 4)How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 11/22/2024	

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	purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light ...Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system, including cognitive and physical ability to use the call light. Special accommodations will be identified on the resident's person-centered plan of care, and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.). Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room ...The call system should be accessible to a resident lying on the floor ...Process for responding to call lights ...If assistance is needed with a procedure, summon help by using the call light ...." 3.1-3(v)(1)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record reviews and interviews, the facility failed to ensure a pharmacy recommendation was addressed for 1 of 5 residents reviewed for unnecessary medications (Resident 32).	F 0758	F 758 Free from Unnecessary Psychotropic meds/Prn use. The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of	11/22/2024

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	Findings include: On 10/21/24 at 9:27 a.m., pharmacy recommendations were reviewed for Resident 32. A recommendation, printed 10/23/23, indicated that the resident was receiving Zoloft (medication used to treat depression, anxiety, and other disorders) 50 milligrams (mg) daily, and asked the physician to determine if a gradual dose reduction may be attempted. The physician signed and dated the form on 10/25/23 indicating to decrease the Zoloft to 25 mg daily. A recommendation, printed 12/17/23, notified the physician to investigate the recommendation made on 10/23/23 for the gradual dose reduction because their record indicated that the Zoloft would be decreased to 25 mg, however a dose reduction had not been ordered. A record review was conducted on 10/21/24 at 10:12 a.m. Resident 32's diagnoses included, but were not limited to, major depressive disorder (depressed mood or loss of interest in activities for a prolonged period), and dementia with behavioral disturbance (a group of neurological conditions that cause a person to lose the ability to think, remember, and reason to the point that it interferes with their daily life). A nursing progress note entered by the Director of Nursing (DON), recorded as a late entry on 10/26/24 at 8:51 a.m., for 10/25/23, indicated there was a pharmacy recommendation to decrease Zoloft to 25 mg daily. The physician and psychologist agreed. Resident 32 was notified, and they would continue to monitor. A physician's order, dated 4/19/23, indicated to		compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1)Immediate actions taken for those residents identified: Resident #32 pharmacy recommendations were completed. 2)How the facility identified other residents:Any resident who resides in the facility has the potential to be affected by the alleged deficient practice. DON/Designee completed an audit on the pharmacy recommendations for the last 30 days to ensure all recommendations have been completed. No discrepancies were noted. 3)Measures put into place/ System changes:DON or Designee will review 10 pharmacy recommendations monthly x 6 months to ensure these have been completed.4)How the corrective actions will be monitored:The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	administer Zoloft 50 mg, one tab by mouth daily. The record lacked documentation of the order being changed until 12/20/24. During an interview on 10/21/24 at 11:40 a.m., the Assistant Director of Nursing (ADON) indicated that she was not sure if the pharmacy recommendation in question had been worked on the day that they had split them up because there were so many. The DON had to leave and take oxygen to another facility that day, and it may have gotten missed in the mix of things. During an interview on 10/21/24 at 3:07 p.m., the DON indicated that after the behavior meeting related to the pharmacy recommendation, she left everything on her desk and left to deliver oxygen to another facility. On her way she was in a car accident and did not return for 6 months. While she was gone, the current ADON and corporate nursing support were responsible for resuming unfinished work. During an interview on 10/21/24 at 3:07 p.m., the ADON indicated that when she picked up the stack of pharmacy recommendations off the DON's desk after the accident, she did not know where she had left off. She went on to the next recommendation without realizing it had not been completed, and did not notice it was not done until the next meeting in December. Everything she thought was done she moved it to the side. She indicated she thought it was done, but did not verify it had been completed in the resident's electronic medical record. On 10/22/24 at 11:23 a.m., the Administrator (ADM) provided an undated document, titled, "Medication Orders", and indicated it was the policy currently being used by the facility. The		plan of correction as indicated.5)Date of compliance: 11/22/2024.	

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	policy indicated, " ...Documentation of Medication orders. a. Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR) ...g. when a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing "DC'd" and the date, or discontinue the order as per the electronic software instructions and retype the new order...h. Enter the new order on the MAR or ensure the new order is in the electronic MAR ...i. notify resident's sponsor/family of new medication order ...5. a. Handwritten order signed by the physician - The charge nurse on duty at the time the order is received should note the order and enter it on the physician's order sheet or electronic order format, if not written by the physician. If necessary, the order should be clarified before the physician leaves the nursing station ...." 3.1-48(a)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, record review, and interview, the facility failed to ensure proper handling of oral medications during the medication administration pass and failed to ensure medication was administered according to manufacture guidelines resulting in a medication error rate of greater than 5 percent for 2 of 4 residents reviewed for medication administration (Residents 10 and 217). Findings Include:	F 0759	F 759 Free of medication Errors. The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The	11/22/2024

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	On 10/22/24 at 7:10 a.m., during routine medication administration observation, Registered Nurse 18 placed medications for Resident 10 into her bare hand then placed the medications in a medication cup, and then administered medications to the resdient. The RN prepared Novolog insulin with an insulin pen (a pre-filled pen device filled with insulin. Doses are provided in one-unit increments for insulin medicines) The nurse failed to first prime the pen according to manufacture guidelines prior to administration of the insulin to Resident 10. Observed the nurse administer Arnuity Ellipta 200 mcg (micrograms) 1 inhalation, (an inhaled corticosteroid (ICS) medicine. ICS medicines help prevent symptoms of asthma by reducing airway inflammation) to Resident 10. The nurse failed to instruct the resident to swish and spit with water after administration of the medication as instructed on the medication prescription label directions. On 10/22/24 at 7:47 a.m., during medication administration, Registered Nurse 18 placed medications for Resident 217 into her bare hand then placed the medications in a medication cup, and administered medication to the resident. The RN prepared Levemir insulin and Fiasp insulin with an insulin pen to be administered to Resident 217. The nurse failed to first prime the pen according to manufacture guidelines prior to administration of insulin to the resident. On 10/22/24 at 7:50 a.m., during an interview, RN 18 indicated the medications should be placed into the medication cup and not into her bare hands. She acknowledged the insulin pens should be primed prior to preparing insulin for administration.		plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1)Immediate actions taken for those residents identified:RN# 18 was immediately reeducated on proper medication administration and following manufacturer guidelines with emphasis on inhaler and insulin administration. 2)How the facility identified other residents:Any resident who receives medication has the potential to be affected by the alleged deficient practice. None were identified. 3)Measures put into place/ System changes:Reeducation was provided to the licensed nurses with emphasis on proper medication administration and following manufacture guidelines including inhaler and insulin administration. Identified issues will be corrected immediately upon identification with 1-1 education and/or disciplinary measures. DON/Designee will observe one random licensed nurse medication administration 3 times weekly x4 weeks then 2 times weekly x 4 weeks and then 1 time weekly for 4 months to ensure proper medication administration and manufacture guidelines are being followed. 4)How the corrective actions will be monitored:The results of these audits will be reviewed in the Quality Assurance	

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	Manufacture guidelines to prime the Fiasp insulin pen prior to administration include. "Turn the dose selector to select 2 units hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top press and hold in the dose button until the dose counter shows "0". Check to make sure the dose selector is set at 0. Turn the dose selector to select the number of units you need to inject". Manufacture guidelines to prime the Levemir insulin pen prior to administration include. "Before each injection, prime your pen by performing an air shot. Turn the dose selector to select 2 units. Press and hold the green push button. Make sure a drop of insulin appears at the needle tip turn the dose selector to the number of units you need to inject". On 10/21/2024 at 11:00 a.m., the Director of Nursing (DON) provided a document titled, "Medication Administration," dated 2024, and indicated it was the policy currently being used by the facility. The policy indicated,"...Policy Explanation and Compliance Guidelines ...14. Remove medication from source, taking care not to touch medication with bare hand ...." On 10/21/2024 at 11:00 a.m., the Director of Nursing (DON) provided a document titled, "Insulin Pen", dated 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines ...11. Procedure ...g. Attach pen needle ...i. Remove the pen cap from the insulin pen ...iii. Screw the pen needle onto the insulin pen. h. Prime the insulin pen. i. dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger and watch to see that at least one drop appears ...."		Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.5)Date of compliance: 11/22/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING 00 B. WING	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUTSONWOOD AT BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

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	On 10/22/2024 at 10:00 a.m., the Director of Nursing (DON) provided a document titled, "Inhaler Administration," dated 8/14/2019, and indicated it was the policy currently being used by the facility. The policy indicated,"...Procedure ...11. These are general instructions, so be certain to follow specific directions that accompany the inhaler ...." 3.1-48(c)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure a multi-dose insulin vial was discarded within 28 days of use and insulin pens containing multiple doses of insulin were dated appropriately and discarded within 28 days of use for 2 of 2 medication carts observed. Findings include: On 10/21/24 at 10:30 a.m. an observation of medication cart 1 found a multidose vial of Amaolg insulin, prescribed for Resident 2 was filled on 8/13/24. No date opened was observed on the label or the bottle. On 10/21/24 at 10:35 a.m., an observation of medication cart 2 found 2 Lantus insulin pens prescribed for Resident 20 dated as opened on 9/1/24 and 9/15/24. A Basaglar insulin pen prescribed for Resident 6 did not have a date opened on the pen. The prescription label indicated it was opened on 9/1/24	F 0761	p="" paraid="1001644039" paraeid="{59015a8f-0ec4-4d5d-b938-8d33fa1d2e18}{161}">F 761 Label/Store drugs and Biologicals.The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1)Immediate actions taken for those residents identified: The insulin vial and insulin pen were discarded immediately. 2)How the facility identified other residents: DON/Designee audited	11/22/2024

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	On 10/21/24 at 10:35 a.m., during an interview with Licensed Practical Nurse (LPN) 12 the nurse indicated. Once opened an insulin vial and pen are good for 30 days. On 10/21/23 at 10:54 a.m., during an interview with the Director of Nursing (DON) she indicated insulin pens expired 28 days after opening. On 10/21/24 at 11:32 a.m., the medical record of Resident 20 was reviewed. The record indicated that the resident was admitted with diagnosis including, but not limited to, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) Physician order included but not limited to, Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL (milliliters)); amount: 20 units; subcutaneous (under the skin) At Bedtime. On 10/21/24 at 11:32 a.m., the medical record of Resident 6 was reviewed. The record indicated that the resident was admitted with diagnosis including but not limited to diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) Physician orders included but not limited to, Basaglar KwikPen U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); amt: 7 units hs (hour of sleep); subcutaneous at Bedtime On 10/21/24 at 11:32 a.m., the medical record of Resident 2 was reviewed. The record indicated that the resident was admitted with diagnosis including, but not limited to, diabetes (a disease that occurs when your blood glucose, also called		all medication carts for any outdated or undated insulin vials or pens. None were noted. 3)Measures put into place/ System changes:Reeducation was provided to the licensed nurses on medication expiration dates related to insulin pens and vials.¿ Identified issues will be corrected immediately upon identification with 1-1 education and/or disciplinary measures. DON/Designee will audit medication carts 5 times weekly x4 weeks, then 3 times a week x 4 weeks, and then 1 time a week for 4 months to ensure there are no outdated or undated insulin vials or pens. 4)How the corrective actions will be monitored:The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.5)Date of compliance: 11/22/2024.	

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	blood sugar, is too high). Physician order included but not limited to Amelog, Admelog SoloStar U-100 Insulin (insulin lispro) insulin pen; 100 unit/mL; amt: 15 units; subcutaneous Special Instructions: Hold if BS (blood sugar) < (less than) 120 Twice A Day. FDA (Food and Drug Administration) guidelines for multi dose vials of insulin dated, Content current as of 09/19/2017, indicate the following guidance. "Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days and continue to work". On 10/21/2024 at 11:00 a.m., the Director of Nursing (DON) provided a document titled, "Insulin Pen," dated 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...9. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation ...." On 10/21/2024 at 11:00 a.m., the DON provided a document, titled, "Medication administration)," dated 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines ...13. Identify expiration date. If expired, notify nurse manager ...." 3.1-25(j) 3.1-25(m)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record	F 0812	F812 FOOD PROCUREMENT,	11/22/2024

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	review, and record review, the facility failed to ensure snacks were served in a sanitary manner for 1 of 1 random snack distribution observations. Findings include: During a random snack distribution observation, on 10/21/24 at 10:03 a.m., Activity Assistant 8 was on the memory care unit and was removing fudge round cream cookies from its plastic packaging and removing the snack with her bare hands and handed cookies to 7 different residents. The activity assistant was not observed using gloves or hand sanitizer during the observation. During a second observation, on 10/21/24 at 10:05 a.m., Certified Nurse's Assistant (CNA) 9 went into the nutrition room (kitchenette area) and got some milk for a male resident and she also removed a fudge round cream cookie from its plastic packing with bare hands and handed it to the male resident. She then touched the resident's shoulder and headed down the hallway. The CNA was not observed using gloves or hand sanitizer during the observation. During an interview, on 10/21/24 at 10:13 a.m., CNA 10 indicated she would place on a pair of gloves when serving a resident, a food item or use the plastic cover to hand the resident the item. The CNA indicated staff should not touch food with their bare hands. During an interview on 10/21/24 at 10:15 a.m., Qualified Medication Aide (QMA) 11 indicated she would open the end of the plastic packaging and let the resident pull out the snack item, if they are unable then she would use gloves. Staff should not touch food with their bare hands.		STORE/PREPARE/SERVE-SANITARY. The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1)Immediate actions taken for those residents identified:CNA #9 and Activity assistant #8 were immediately reeducated by the Administrator on safe food handling and hand hygiene. 2)How the facility identified other residents:All residents have the potential to be affected by the alleged deficient practice. None were identified.3)Measures put into place/ System changes:Reeducation on proper food handling and hand hygiene has been provided to all staff. Dietary Manager/Designee will audit 3 staff members 3 times weekly for 4 weeks, then 3 staff members 2 times weekly for 4 weeks, then 3 staff member 1 times weekly for 4 months for proper Handwashing, Hand Hygiene and food handling.	

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	During an interview, on 10/21/24 at 11:33 a.m., the Administrator indicated staff should not touch food with bare hands and he would be speaking with staff about this and providing an in-service on safe food handling. On 10/21/24 at 10:39 a.m., the Administrator provided a document with a date of 8/14/2019, titled, "Food Safety and Sanitation," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Purpose: Follow all local, state, and federal standards and regulations in order to assure a safe and sanity food service department ... B. Employees ...will handle all foods safely ...." 3.1-21(i)(3)		Identified issues will be corrected immediately upon identification with 1-1 education and/or disciplinary measures. 4)How the corrective actions will be monitored:The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.5)Date of compliance:11/22/2024.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review the facility failed to document insulin administration for 1 of 5 residents reviewed for medication administration (Resident 23). Findings include: On 10/21/24 at 9:36 a.m., the medical record of Resident 23 was reviewed. The resident was admitted to the facility on 10/2/23. Admitting diagnosis included but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), with diabetic neuropathy (a type of nerve damage that	F 0842	F 0842 Resident Records. The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1)Immediate actions taken for those residents identified:MD was immediately	11/22/2024

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	can occur if you have diabetes), Gastroesophageal reflux disease (GERD) (a common condition in which the stomach contents move up into the esophagus). Physician Order, dated 3/11/24, indicated to administer Lispro Insulin Per Sliding Scale. If Blood Sugar is less than 60, call MD (Medical Doctor). If Blood Sugar is 180 to 220, give 2 Units. If Blood Sugar is 221 to 260, give 4 Units. If Blood Sugar is 261 to 300, give 6 Units. If Blood Sugar is 301 to 350, give 8 Units. If Blood Sugar is 351 to 400, give 10 Units. If Blood Sugar is greater than 400, call MD. Protonix (medication used for GERD) 40 mg (milligrams)1 daily. Physician Order, dated 9/9/24, indicated to administer 10 units subcutaneous (under the skin) of Basaglar KwikPen U-100 Insulin (insulin glargine) insulin pen at bedtime. Physician Order, dated 9/30/24, indicated to administer 8 units subcutaneous of lispro insulin pen100 unit/mL three times a day. On 10/21/24 at 9:32 a.m., review of the electronic medication administration record (EMAR) of Resident 23 was reviewed. The record indicated in the months of September and October the following medications were not documented as being given. Lispro sliding scale: 9/2 at 7:00 am, 9/10 11:30 am, 9/26 at 11:30 a.m. Lispro sliding scale: 10/6 at 5:00 pm, 10/10 at 5 pm, 10/15 at 7:00 am, 10/19 at 5:00 pm Lispro insulin 8 units: 10/15/24 at 7:00 a.m., 10/26/24 at 11:30 a.m. Protonix 40 mg: 9/2/24 6:00 a.m., 10/6/24 4:00 p.m., 10/10/24 4:00 p.m., 10/15/24 6:00 a.m.		notified about Resident #23 omitted documentation on EMAR and no new orders were given by MD.2)How the facility identified other residents:Any resident who resides in the facility has the potential to be affected by the alleged deficient practice. A facility wide audit was completed for all current residents in the last 30 days to ensure EMAR documentation was not omitted. MD was notified of any concerns noted. 3)Measures put into place/ System changes:Reeducation was provided to licensed nurses and QMA's with emphasis on completing documentation during medication administration. Identified issues will be corrected immediately upon identification with 1-1 education and/or disciplinary measures. DON/Designee will review the EMAR 5 days a week x 4 weeks, then 3 days a week x 4 weeks, and then 1 day a week for 4 months to ensure EMAR documentation is complete. 4)How the corrective actions will be monitored:The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as	

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	The annual Minimum Data Set (MDS) assessment, dated 9/17/24, indicated the resident was cognitively intact and was administered insulin during the look back assessment period. A care plan, dated 10/16/23, indicated Diabetes - risk for complications related to diagnosis of diabetes. Interventions included but were not limited to administer medication as ordered. On 10/21/2024 at 11:00 a.m., the Director of Nursing (DON) provided a document titled, "Medication Administration) ," dated 2024, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Explanation and Compliance Guidelines ...20. Sign MAR after administered ...." 3.1-50(f)		indicated.5)Date of compliance: 11/22/2024.	
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 proper handwashing was completed during for resident care, and failed to ensure proper handling of the glucometer meter (small portable machine that's used to measure how much glucose [type of sugar] is in the blood) during medication administration for 2 of 2 residents reviewed during medication administration observation (Residents 10 and 217). Findings include: On 10/21/24 at 11:36 a.m., during routine handwashing observation, Licensed Practical Nurse (LPN)12 washed her hands and turned off	F 0880	F880 D Infection Prevention and Control The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state	11/22/2024

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	the faucet with her bare hands. Then dried her hands with a paper towel. On 10/21/24 at 11:36 a.m., during medication administration, LPN 12 obtained the blood sugar reading of Resident 31 using a glucometer meter. The nurse wiped the machine with Sani wipe cleanser wipe (a disposable wipe used to disinfect and clean non-porous surfaces and medical devices) and set the glucometer aside on a paper towel. The nurse failed to keep the device wet for 2 minutes as per the manufacture guidelines. On 10/22/24 at 7:10 a.m., during medication administration, Registered Nurse 18 obtain the blood sugar reading of Resident 10, using a glucometer. The nurse wiped the machine with Sani wipe cleanser wipe and set the glucometer aside on a paper towel. The nurse failed to keep the device wet for 2 minutes as per the manufacture guidelines. On 10/22/24 at 7:15 a.m., during routine handwashing observation, Registered Nurse (RN) 18 washed her hands and turned off he faucet with her bare hands then dispensed the paper towel and dried her hands. On 10/22/24 at 7:20 a.m., during interview with RN 18, the nurse indicated she cleaned the glucometer and let air dry. She did not know how long the glucometer must remain wet. She indicated it would be dry when she was going to use it again for the next resident. On 10/22/24 at 11:00 a.m., the Administrator provided a copy of the directions for use of the Sani-Cloth Wipes. The directions indicated." Allow the surface to remain wet for (2) minutes. Let air dry."		law. 1)Immediate actions taken for those residents identified: LPN #12 and RN #18 were re-educated per Director of Nursing on cleaning/disinfecting glucometers per manufactures guidelines and on proper hand washing procedures. Residents #10 and # 217 had no adverse effects identified. 2)How the facility identified other residents: Any resident residing in the building had the potential to be affected, none were identified. Reeducation was provided to the licensed staff on sanitizing the glucometers per the manufacture guidelines. All staff were reeducated on proper handwashing technique. 3)Measures put into place/ System changes: DON/Designee will complete one random audit 5 times a week for 4 weeks then 3 times a week for 4 weeks and then 1 time a week for 4 months to ensure manufacture guidelines are being followed regarding sanitizing of glucometers as well as proper handwashing technique. Identified issues will be corrected immediately upon identification with 1-1 education and or disciplinary measures. 4)How the corrective actions will be monitored: Results of these audits will be	

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	On 10/22/2024 at 10:00 a.m., the Director of Nursing (DON) provided a document, titled, "Hand Hygiene and glove use," dated 6/17/21, and indicated it was the policy currently being used by the facility. The policy indicated, "...Handwashing using soap and water ...5. Turn the water off by using paper towel ...." On 10/22/2024 at 10:00 a.m., the Director of Nursing (DON) provided an undated document, titled, "Cleaning and Disinfecting Blood Glucose Meters", and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure ...9. using gloves as indicated wash with disinfectant and allow for drying time as indicated per manufacturer ...11. Follow manufacturer's guidelines for cleaning and disinfecting of glucose meters ...NOTE ...When selecting a disinfecting cleaning product, you will want to look at contact time. IN other words, you want to be aware of the length of time the disinfectant must be in contact with the item being cleaned for the germ/bacteria to be considered killed. Some product it may be as short as one minute, another product it may be ten (10) minutes ...." 3.1-18(b)		reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance:11/22/2024.	