STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00451305 and IN00449389. Complaint IN00451305 - No deficiencies related to the allegations are cited. Complaint IN00449389 - Federal/State deficiencies related to the allegations are cited at F0677. Survey dates: January 28, 29, 30, 31, and February 3 and 4, 2025 Facility number: 000172 Provider number: 155272 AIM number: 1000267130 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 5 Medicaid: 69 Other: 25 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 12, 2025.	F 0000		
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula Carroll	HFA	02/24/2025

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

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	Based on interview and record review, the facility failed to address grievances that were reported in resident council meetings for 9 of 9 residents that attended a resident council meeting. (Residents' 1, 8, 12, 28, 39, 63, 67, 71, and 73) Findings include: The November 2024, December 2024, and January 2025 resident council minutes did not indicate any concerns that were discussed with the following departments: nursing, housekeeping, laundry, business office, activities, and maintenance. A resident council meeting was conducted on 1/29/25 at 2:00 p.m. The resident attendees were Residents' 1, 8, 12, 28, 39, 63, 67, 71, and 73. During the meeting, the resident council indicated the staff do not answer the call lights timely. This had been ongoing for a while and had not improved. It was not discussed at previous resident council meetings. An interview was conducted with the Activities Director on 2/3/25 at 8:58 a.m. She indicated grievances discussed in the resident council meetings were only recorded in the meeting minutes if the entire group had reported a concern. The facility encouraged individual residents that have concerns/grievances in the meetings to fill out grievance forms that were posted throughout the facility. Their concerns can be addressed sooner versus having to wait three weeks for the next resident council meeting. A resident council policy was provided by the Regional Vice President of Risk Management on 2/3/25 at 2:15 p.m. It indicated, "...1. It is the expectation of [name of corporation] that all	F 0565	Corrective actions accomplished for those residents founds to be affected by the alleged practice: The facility completed follow up interviews with resident's 1, 8, 12, 28, 39, 63, 67, 71, and 73. Any concerns were placed on a grievance and the facility followed up on the concerns to achieve resident satisfaction. Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: An AD HOC resident council meeting was conducted and any resident concerns were placed on grievances and the facility followed up until resident satisfaction was met. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to the Activities Director utilizing the Grievance Policy with emphasis on completing a grievance form for concerns brought up during resident council. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The ED/Designee will attend resident council each month for the next 3 months to ensure all concerns are placed on a	03/07/2025

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	Administrators offer to attend the Resident Council Group meeting. While it is the residents' choice to have staff in attendance, Administration should ask permission to attend (even for a short appearance) to assure residents that all grievances and concerns are as important to the management team as they are to the residents...4. Document the Resident Council Meeting on the Resident Council Minutes Form. Any concerns voiced at the meeting should be documented on the Concern Form and distributed to the appropriate Department Head. 5. Facility should follow the 'Resident Grievance Procedure' for any concerns identified." 3.1-3(k) 3.1-3(l) 3.1-7(b)		grievance form during the resident council meeting. Any discrepancies will be immediately corrected, and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for a resident's ability to communicate and regarding Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for communication and 1 of 1 resident reviewed for PASRR (Resident E and Resident 28). Findings include: 1. The clinical record for Resident E was reviewed on 1/29/25 at 11:27 a.m. The diagnoses included, but were not limited to, diabetes and malnutrition. An Annual MDS assessment, completed 1/2/25, indicated Resident E had clear speech. He was	F 0641	Corrective actions accomplished for those residents founds to be affected by the alleged practice: Resident E's MDS was modified on 1/31/25. Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: MDS coordinator reviewed MDS's completed in the last 30 days to ensure accuracy related PASRR and ability to communicate. Measures put in place and systemic changes made to ensure the alleged deficit practice does	03/07/2025

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	rarely or never able to understand what was said to him or to make himself understood. During an interview on 1/31/25 at 11:37 a.m., Unit Manager 4 indicated Resident E was able to speak and understand English enough to communicate his needs. During an interview on 2/3/25 at 11:20 a.m., Resident E indicated the facility staff treated him well. During an interview on 2/3/25 at 11:31 a.m., the Social Service Assistant indicated Resident E could make his needs known, but at times he would not answer questions. During an interview on 2/3/25 at 4:05 p.m., the Float Minimum Data Set Coordinator indicated that the Annual MDS assessment could have been coded as sometimes able to make his needs known and to understand others. 2. The clinical record for Resident 28 was reviewed on 01/29/25 at 3:43 p.m. The diagnoses included, but were not limited to, paranoid schizophrenia, major depressive disorder, and congestive heart failure. A PASRR Level II, conducted on 1/13/20, indicated the resident did not require specialized services. "Important information...Since this evaluation has determined that you have a PASRR condition., If you admit to a Medicaid-certified nursing facility, or if you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR condition in the Minimum Data Set (MDS) assessment record. The facility should mark yes to question A1500 on the MDS, 'Is the resident currently considered by the state level II PASRR		not recur: Education was provided to the MDS coordinator utilizing the RAI manual with emphasis on PASRR coding and ability to communicate. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: R2C2/ Designee will audit 5 MDS's per week for 4 weeks, then 3 MDs's per week for 4 weeks, then 1 resident per week for 1 month to ensure each MDS is accurate. Any discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	process to have serious mental illness and/or intellectual disability or a related condition?' Also, your specific PASRR condition(s) should be checked in question A1510, 'Level II Preadmission Screening and Resident Review (PASRR) Conditions." The Admission MDS assessment, dated 10/04/24, indicated the resident had not been evaluated by PASRR level II and did not identify level II PASRR conditions. During an interview with the Corporate MDS Coordinator on 01/31/25 at 2:48 p.m., she indicated that question A1500 on the MDS, completed on 10/04/24, had been answered inaccurately. On 2/04/25 at 10:15 a.m. the Vice President of Risk Management confirmed the facility uses the Resident Assessment Instrument (RAI) as the facility's policy for completing MDS assessments.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to ensure nail care was provided and to ensure lotion was applied with personal hygiene for 2 of 6 residents reviewed for activities of daily living (ADLs). (Resident B and Resident E) Findings include: 1. The clinical record for Resident B was reviewed on 1/28/25 at 3:30 p.m. The diagnoses included, but were not limited to, respiratory failure. An 11/25/24 Quarterly Minimum Data Set (MDS)	F 0677	Corrective actions accomplished for those residents founds to be affected by the alleged practice: Resident B's nails were immediately trimmed and filed to appropriate length. Resident E had lotion applied immediately. Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: The facility completed an audit of all resident nails and trimmed any nails that needed or referred to	03/07/2025

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	assessment indicated Resident B was cognitively impaired. The staff was to provide substantial/maximal assistance with bathing. An ADL care plan, dated 10/10/24, indicated "...offer shower evening shift, Tuesday and Friday..." Observations were conducted of Resident B on 1/28/25 at 3:32 p.m., 1/31/25 at 10:52 a.m., and 2/3/25 at 11:25 a.m. Resident B's nails were observed long in length. An interview was conducted with Resident B's Representative on 1/30/25 at 3:48 p.m. She indicated Resident B was not provided with good hygiene care. An interview was conducted with Licensed Practical Nurse (LPN) 1 on 2/3/25 at 11:34 a.m. She indicated nail care should be provided on shower days. She would trim Resident B's fingernails. 2. The clinical record for Resident E was reviewed on 1/29/25 at 11:27 a.m. The diagnoses included, but were not limited to, diabetes and malnutrition. A care plan, last revised on 1/6/25, indicated Resident E required assistance with ADL care. The goal was for him to maintain his current level of function. The interventions included, but were not limited to, provide maximum assistance with personal hygiene and offer showers on the night shift twice weekly. A Skin and Wound Note, dated 1/21/25, indicated his skin was dry and he had a history of chronic wounds. The physical examination indicated his skin was thin, fragile, dry, and flaky. The preventative measures were to use emollient (moisturizing lotion) as needed for skin dryness		podiatry as needed. The facility also checked skin on all residents and no other resident were noted to be affected with dry skin. (1/31/25) Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to direct care givers utilizing the Routine Resident Care policy with emphasis on nail and skin care. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: DON/Designee will visually observe 5 resident per week for 4 weeks then3 resident per week for 4 weeks then 1 resident per week for 4 weeks to ensure nails are trimmed and skin is not dry or flaky. Any discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	over his entire body. On 1/31/25 at 2:28 p.m., Resident E was observed lying in bed. His legs had dry, flaky patches on them. During an interview on 1/31/25 at 2:30 p.m., Certified Nurse Aide (CNA) 5 indicated Resident E required total assistance with ADL care, and did not refuse care when offered. On 2/3/25 at 11:20 a.m., Resident E was observed in his bed. He had dry, flaky patches of skin on both of his arms and legs. Resident E indicated he would like lotion for his skin. He did not think he had any lotion in his room. The clinical record did not contain a physician's order for lotion application to the skin. During an interview on 2/3/25 at 1:45 p.m., Registered Nurse (RN) 6 indicated lotion was applied to Resident E's skin, but he may need a different type of lotion. A bathing-shower policy was provided by the Regional Vice President of Risk Management on 2/3/25 at 2:15 p.m. It indicated "...This checklist identifies the steps needed to assist an individual with a shower. It also provides rationales to explain why these steps are performed...Hygiene: Help the individual dry their body, apply desired toiletries, dress, and complete other personal hygiene needs. Promotes comfort and cleanliness...." This citation is related to Complaint IN00449389. 3.1-38(a)(3)(A) 3.1-38(a)(3)(E)			

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F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care Based on observation, interview, and record review, the facility failed to timely provide foot care to 1 of 2 residents reviewed for skin conditions. (Resident 7) Findings include: The clinical record for Resident 7 was reviewed on 1/30/25 at 10:33 a.m. His diagnoses included, but were not limited to, traumatic brain injury, dementia, chronic pain, and chronic obstructive pulmonary disease. The 12/12/24 Quarterly MDS (Minimum Data Set) assessment indicated he required substantial/maximal assistance for putting on and taking off footwear. The ADL (activities of daily living) self-care performance deficit care plan, revised 5/28/24, indicated he required assistance with ADLs, due to a functional deficit related to traumatic brain injury. The physician's orders indicated podiatry, as needed, effective 4/1/24. The 5/11/23 podiatry consent form indicated he requested to be seen for podiatry services, and to please have the podiatrist examine him for thickened, dystrophic (deformed, discolored, or thickened,) and/or painful nails with increased risk of infection. An observation and interview were conducted with Resident 7 in his room on 1/30/25 at 10:36	F 0687	Corrective actions accomplished for those residents founds to be affected by the alleged practice: Resident #7 was referred to podiatry. Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: The facility completed an audit of all resident nails and trimmed any nails that needed or referred to podiatry as needed. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to nursing staff utilizing the Foot Care policy with emphasis on nail trimming and podiatry referral process. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The DON/Designee will complete visual observations of 5 residents toenail per week for 4 weeks then 3 residents per week for 4 weeks then 1 resident per week for 4 weeks to ensure toe nails are trimmed per policy. Any discrepancies will be immediately corrected and education will be provided.	03/07/2025

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	a.m. He was lying in bed with his feet exposed, not wearing any socks. Both feet had several extremely thick, long, yellowish toenails, that curved around the end of his toes. The toenail on his right big toe was thick and raised a quarter inch from the base. Resident 7 indicated he wanted to see a podiatrist, but every time he discussed it with staff, it never happened. Resident 7's electronic health record did not include any documented podiatry consultations. An interview was conducted with the SSA (Social Services Assistant) on 1/31/25 at 2:09 p.m. He indicated when a resident signed their consent form to be seen for podiatry services, the facility faxed the consent form to the podiatry provider, who then sent the facility a schedule for when the resident could be seen for an initial visit. Then the resident was seen every sixty days thereafter. The SSA reviewed Resident 7's clinical record at this time, and indicated he did not see any podiatry consults for him. The podiatrist was most recently at the facility earlier this week. An observation of Resident 7's feet was made with UM (Unit Manager) 4 on 1/31/25 at 2:22 p.m. UM 4 removed both socks from Resident 7's feet. Both feet appeared the same as during the, 1/30/25 10:36 a.m., observation with several extremely thick, long, yellowish toenails, that curved around the end of his toes, and his right big toenail was thick and raised a quarter inch from the base. An interview was conducted with Resident 7, on 1/31/25 at 2:22 p.m., during the above observation. He indicated he talked to staff about podiatry services, but nothing ever happened, and he never saw the podiatrist.		The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	An interview was conducted with UM 4, on 1/31/25 at 2:22 p.m., just after observation of Resident 7's feet. She indicated she was unaware of the condition of Resident 7's feet. His big toe needed referred to podiatry, and the other toenails were pretty long, but she thought nursing may be able to cut them. An interview was conducted with the RVPRM (Regional Vice President of Risk Management) on 2/4/25 at 3:00 p.m. She indicated the facility was unable to locate any verification Resident 7 was seen by podiatry after signing his 5/11/23 podiatry consent form. The Foot Care policy was provided by the RVPRM on 1/31/25 at 3:07 p.m. It read, "Foot care is often performed in conjunction with shower/bathing. However, some residents may require additional care or be unable to perform this care while showering or is unsafe to do so. Foot care will be provided by nursing personnel for those residents unable to perform this task. Foot care is considered bathing of feet and regular trimming of toenails... In some residents, foot care including trimming of nails should only be performed by a professional." 3.1-47(a)(7)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure care planned fall interventions were implemented timely for 1 of 2 residents reviewed for positioning (Resident 63). Findings include:	F 0689	Corrective actions accomplished for those residents founds to be affected by the alleged practice: Resident 63's floor mat was being washed and was put in place when finished.	03/07/2025

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	The clinical record for Resident 63 was reviewed on 01/28/25 at 1:50 p.m. The diagnoses included, but were not limited to, personal history of transient ischemic attack, muscle weakness, and abnormal posture. A care plan, dated 04/04/24, indicated Resident 63 was at risk for falls. The goal was for the resident not to sustain major injury related to falls. The interventions included, but were not limited to, a mat to be placed on the floor at bedside, bed in lowest position, and ensure that bed locks are engaged, initiated on 07/25/22. On 01/28/25 at 11:43 a.m., Resident 63 was observed lying in bed with no mat on the floor at bedside. On 01/31/25 at 09:27 a.m., Resident 63 was observed lying in bed eating breakfast with no mat on the floor at bedside. On 02/03/25 02:09 p.m., Resident 63 was observed lying in bed with no mat on the floor at bedside. On 02/03/25 02:11 p.m., an interview was conducted with Certified Nurse Aide (CNA) 3. When asked why Resident 63 did not have a mat on the floor at bedside she indicated she was unsure. CNA 3 indicated if the use of a mat on the floor at the bedside was included in a resident's care plan, then it should be in use at bedside. A Fall Prevention and Management Policy was provided by the Regional Vice President of Risk Management on 02/04/25 at 11:25 a.m. It indicated, " ...If the resident is identified to be at risk for falls, a care plan should be initiated that includes a plan to potentially diminish the risk for falls. The care		Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: All residents that have fallen have the potential to be affected. The facility reviewed the plan of care for all residents that had a fall within the last 30 days and visually validated that the preventative interventions were in place. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to direct care givers utilizing the Fall Management policy with emphasis on implement interventions to prevent falls. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The DON/Designee will conduct visual observations of 5 residents per week for 4 weeks then 3 resident per week for 4 weeks then 1 resident per week for 4 weeks to ensure fall intervention are in place. Any discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for	

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	plan can include interventions that address environmental factors, ADL [activities of daily living] factors, risk factors that result from dementia and other mental diagnoses, medical diagnosis that put the resident at higher risk ..." 3.1-45(a)(2)		a minimum of six months and then randomly thereafter for further recommendation.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to serve food at palatable temperatures for 4 of 4 residents reviewed for food (Resident 24, Resident 14, Resident C, and Resident 44). Findings include: 1 a. The clinical record for Resident 24 was reviewed on 1/30/25. The diagnoses included, but were not limited to, heart failure. A Quarterly Minimum Data Set (MDS) assessment, completed 11/1/24, indicated he was cognitively intact. During an interview on 1/30/25 at 10:04 a.m., Resident 24 indicated his food was not always hot when he received it. 1 b. The clinical record for Resident 14 was reviewed on 1/29/25 at 10:20 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease. A Quarterly MDS assessment, completed 11/06/24, indicated he was cognitively intact. During an interview on 1/29/25 at 10:29 a.m.,	F 0804	Corrective actions accomplished for those residents founds to be affected by the alleged practice: The temperature of the food was checked prior to the tray being placed on the cart and was at appropriate temperature. Resident 24, Resident 14, Resident C, and Resident 44 were offered an alternate tray. Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: All resident that have a PO diet have the potential to be affected. No other residents brought forward complaints about the food temperature. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to the Dietary Manager utilizing the Food Temperature Policy with emphasis on ensuring food is served at appropriate	03/07/2025

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	155272	A. BUILDING 00 B. WING	02/04/2025

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	Resident 14 indicated when food was delivered the hot items were not hot and the cold items were not cold. 1 c. The clinical record for Resident 44 was reviewed on 1/29/25 at 10:00 a.m. The diagnoses included, but were not limited to, anxiety disorder. An Admission MDS assessment indicated Resident 44 was cognitively intact. An interview was conducted with Resident 44 on 1/29/25 at 10:13 a.m. He indicated his meal trays that were delivered to his room; the food was always cold. 1 d. The clinical record for Resident C was reviewed on 1/29/25 at 1:00 p.m. The diagnoses included, but were not limited to, anxiety disorder. A Quarterly MDS assessment, dated 12/24/24, indicated Resident C was cognitively intact. An interview was conducted with Resident C on 1/29/25 at 2:22 p.m. She indicated she received meals delivered to her room. The food items were delivered cold when they should be hot, and the cold food items are warm when they should be cold. On 2/3/25 at 12:35 p.m., a test tray was observed on the Cambridge Hall food cart. The test tray was removed from the cart, leaving two more room trays to be passed to residents. The temperatures of the food items on the test tray were obtained by the Dietary Manager (DM). The pork roast was 112 degrees Fahrenheit (F), the seasoned rice was 123 degrees F, and the mixed vegetables were 135 degrees F. During an interview on 2/3/25 at 12:35 p.m., the		temperature. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The DM/Designee will complete audits of food temperatures with each meal to ensure the food is delivered at an appropriate temperature. Any discrepancies will be immediately corrected, and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	DM indicated that food was served from the steam table at a minimum of 135 degrees F. During an interview on 2/3/25 at 12:54 p.m., the DM indicated residents had the option of having food warmed up if it was cold. She was unaware that food should be held at 135 degrees F until delivered to the residents' room. A food quality and palatability policy were provided by the Regional Vice President of Risk Management on 2/3/25 at 2:08 p.m. It indicated, "...Policy Statement. Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs...Procedures...2. The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Pointe (HACCP) and time and temperature guidelines as outlined in the Federal Food Code. 3. Food and liquids/beverages are prepared in a manner, form and texture that meets each resident's needs..." 3.1-21(a)(2) 3.1-21(i)(2)			
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 maintain infection control by not donning on personal protective equipment (PPE) while providing respiratory care for 1 of 2 random observations of respiratory care. (Resident 75)	F 0880	Corrective actions accomplished for those residents founds to be affected by the alleged practice: The RT was immediately provided education on Enhanced Barrier precautions on 1/28/25. Identification of other residents	03/07/2025

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	Findings include: The clinical record for Resident 75 was reviewed on 1/28/25 at 11:00 a.m. The diagnoses included, but were not limited to, acute respiratory distress syndrome, tracheostomy, and acute respiratory failure. A physician order, dated 10/22/24, indicated the resident was in enhanced barrier precautions every shift. An observation was made of Resident 75 in his room with Respiratory Therapist (RT) 2 on 1/28/25 at 11:49 a.m. RT 2 was observed at Resident 75's bedside providing respiratory care to the resident. At that time, RT 2 was not observed wearing a gown while providing respiratory care. An interview was conducted with the Regional Vice President of Risk Management on 1/28/25 at 3:42 p.m. She indicated RT 2 should have been wearing PPE while providing respiratory care. An Enhanced Barrier Precaution policy was provided by the Regional Vice President of Risk Management on 2/3/25 at 2:08 p.m. It indicated, "...Policy: Enhanced Barrier Precautions (EBP) refer to an infection control interventions designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include... device care or use:...tracheostomy/ventilator..." 3.1-18(b)(2)		having the potential to be affected by the same alleged practice and corrective action taken: All residents with orders for Enhanced Barrier precautions have the potential to be affected. No other staff were seen providing with appropriate PPE. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to all staff utilizing the Enhanced Barrier Precaution policy with emphasis on donning PPE while providing direct care to residents. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The DON/Designee will complete visual observations of care for 5 resident per week for 4 weeks, then 3 residents per week for 4 weeks then 1 resident per week for 4 weeks to ensure staff don PPE when providing care. Any discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to maintain residents' room in a clean manner and good repair for 2 of 10 residents reviewed for environmental concerns. (Resident 47 and 60) Findings include: 1. An observation of Resident 60's room was made on 1/29/25 at 1:34 p.m. The restroom floor had no tile or flooring. There were a significant number of small, brownish spots on the ceiling above her bed. The ceiling vent cover between her bed and restroom was pulling away from the ceiling. An environmental tour was conducted with the Maintenance Director and Administrator on 2/4/25 at 2:40 p.m. During the tour, Resident 60's room was observed. An interview was conducted with Resident 60 at that time. The small, brownish spots on the ceiling above her bed remained, and the ceiling vent cover between her bed and restroom remained pulled away from the ceiling. There was a screw on one side of the vent that was no longer affixed to the drywall above it. The restroom flooring was now placed, but there was a puddle of water built up in the back left corner of the restroom, next to the commode. Resident 60 indicated the commode leaked every time you flushed it. She spoke with Maintenance Technician 5 and another staff member about the leaky commode. It was supposed to be fixed prior to the placement of the new flooring, but it wasn't. The puddle of water had been there all week, since	F 0921	Corrective actions accomplished for those residents founds to be affected by the alleged practice: Housekeeping was sent to clean resident 60's room immediately and all the spots were cleaned from the ceiling. The ceiling vent was repaired. The flooring has been approved for repair. Resident 47's grab bar was cleaned immediately. Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken: The facility completed an environmental walk through and no others concerns were noted. Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur: Education was provided to Maintenance Director and Housekeeping Supervisor utilizing the Resident Right Policy with emphasis on providing a safe and sanitary environment. How the corrective measures will be monitored to ensure the alleged deficit practice does not recur: The ED/Designee will complete environmental rounds 5 time per	03/07/2025

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	the new flooring was placed. The brownish spots on the ceiling above her bed and ceiling vent pulling away from the ceiling were both like that when she moved into the room a couple of years ago. An interview was conducted with the Maintenance Director on 2/4/25 at 2:40 p.m., during and after observation of Resident 60's room. He indicated he was unaware of the brownish spots above her bed, the leaky commode, and the ceiling vent pulling away from the ceiling. The spots on the ceiling looked like some sort of spill to him. As far as the leaky commode, there must have been some sort of miscommunication with the staff who laid the flooring. No one informed him of the leaky commode, and he would have needed to know about it for it to be fixed. 2. The clinical record for Resident 47 was reviewed on 1/30/25 at 11:00 a.m. The diagnoses included, but were not limited to, dementia. On 1/30/25 at 11:00 a.m., Resident 47 was observed lying in bed. The grab bar on the left side of her bed had a dried tan substance on the bar. On 2/4/25 at 12:10 p.m., Resident 47 was observed with Certified Nurse Aide (CNA) 7. The grab bar on the left side of her bed had a tan dried substance present on it. CNA 7 indicated it was most likely dried food and attempted to wipe it off with a paper towel. The tan substance was not able to be wiped off with a paper towel. CNA 7 indicated the grab bar needed cleaned. The Resident Rights policy was provided by the RDCO (Regional Director of Clinical Operations) on 2/4/25 at 3:13 p.m. It read, "Definitions: Dignity:		week for 4 weeks then 3 times per week for 4 weeks then 1 time per week for 4 weeks to ensure the ceilings are clean, vents are secured and bedrails are clean. Any discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation.	

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	a state worthy of honor or respect; includes but not limited to speaking respectfully to resident, providing privacy for care and treatment, providing safe and secure housing, sanitary food and hydration; respecting resident choice and attending to needs in a timely fashion. Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents." 3.1-19(f)(5)			