STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NORTH VERNON	701 HENRY STREET NORTH VERNON, IN 47265

(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. Survey dates: June 8, 9, 10, 11, and 12, 2025 Facility number: 010996 Provider number: 155665 AIM number: 200232210 Census Bed Type: SNF/NF: 101 Total: 101 Census Payor Type: Medicare: 2 Medicaid: 92 Other: 7 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 16, 2025.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation. This provider alleges compliance as of June 29, 2025. The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to ensure residents were deemed appropriate to self-administer medications prior to leaving medications at the residents bedside unsupervised for 2 of 2 residents reviewed for self-administering medications. (Residents 78 and 37) Findings include:	F 0554	**F554 Resident Self-Admin Meds – Clinically Appropriate** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 Residents 78 and 37 were identified during the time of observation. Licensed nurses and QMAs educated on	06/29/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Daniel Kern	Executive Director	06/25/2025

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	1. During an observation and interview, on 06/10/25 at 11:49 A.M., Resident 78 was reclining on her bed in her room. A medication cup was sitting on the resident's over the bed table. The medication cup contained one half of a round white tablet and one small red and white capsule. The resident indicated the medications were Lyrica (a pain medication) and her anxiety pill. She did not know the name of her anxiety pill. Sometimes the staff left them at the bedside and sometimes they stood at the bedside and watched her take them. If the staff member knew her, they would leave them at the bedside. If they did not know her, they would stand there and watch her take them. No staff members were in or near the immediate area of the resident's room. Other residents were independently mobile and propelling themselves down the hallway. The clinical record was reviewed on 06/11/25 at 10:05 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/05/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stoke, anxiety, depression, and respiratory failure. During an interview, on 06/11/25 at 11:40 A.M., the DON indicated there were no residents currently in the building who self-administered their medications. 2. During an observation and interview, on 06/08/25 at 10:19 A.M., Resident 37 was sitting on the side of the bed in her room. There were three medication cups sitting on the resident's bedside table. One medication cup contained three small white capsules, the second one contained a large white capsule, and the third one contained a large round pill broke in half, a medium round peach colored pill, one large round pill, one medium round white pill. The resident indicated the		self-administration of medications by June 29, 2025. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents have the potential to be affected. 2 DNS/ADNS will conduct an audit of the facility for residents with 'Medication Self-Administration Safety Screen' evaluations on June 22, 2025. 3 DNS/ADNS will complete new 'Medication Self-Administration Safety Screen' evaluations on any resident(s) wishing to self-administer medications by June 23, 2025. 4 DNS/ADNS will conduct a facility-wide spot check during medication pass to check for medications left at bedside by June 24, 2025. 5 Licensed nurses and QMAs educated on self-administration of medications by June 29, 2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 DNS/ADNS will conduct an audit related to medications left at the bedside 2x/week x4 weeks, weekly x4 weeks, and monthly x6 months. 2 DNS/ADNS will conduct an audit on new admission(s) and/or readmission(s) for residents	

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	medications were hers and the nurse had left them for her to take. No staff members were in or near the resident's room or in the hallway outside the resident's room. The clinical record was reviewed on 06/10/25 at 11:03 A.M. A Quarterly MDS assessment, dated 04/21/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, heart failure, dementia, anxiety, and depression. During an interview, on 06/11/25 at 9:54 A.M., Licensed Practical Nurse (LPN) 3 indicated medications should not have been left at the resident's bedside. A resident should be watched while they take their medications unless they were assessed to self-administer. During an interview, on 06/11/25 at 11:17 A.M., the DON indicated the resident did not have a self-administration assessment. She was not safe to self-administer any of her medications. The current facility policy titled, "Medication Administration", dated 01/02/2024, was provided by the DON on 06/11/25 at 11:40 A.M. The policy indicated, "...23. Unless the resident has been assessed for safe self-administration of medications, medications are not to be left unattended for the resident to consume at a later time." The "MEDICATION SELF-ADMINISTRATION SAFETY SCREEN" records for the last six months for Resident 78 were provided by the Director of Nursing (DON) on 06/11/25 11:15 A.M. There was only one record for this resident. The record, with an effective date of 04/02/25, indicated the resident required assistance with medication		wanting to self-administer medications and the 'Medication Self-Administration Safety Screen' evaluation(s) Monday-Friday during clinical meeting x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1 For quality assurance, the DNS or ADNS will review any findings during clinical meeting, with subsequent correction action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined. Date corrections will be completed by: **June 29th 2025**	

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	administration and the "Resident may NOT self-administer medications". Ongoing assessment should occur at a minimum of quarterly. 3.1-11(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to revise a resident's care plan related to prophylactic antibiotic usage for 1 of 21 residents reviewed for care plans. (Resident 58) Findings include: Resident 58's clinical record was reviewed on 06/11/25 at 3:24 P.M. A Quarterly Minimum Data Set assessment, dated 02/28/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, diabetes, and renal insufficiency. The resident had an indwelling urinary catheter. The resident's current physician's orders included, but were not limited to the following: - An open-ended physician's order, with a start date of 02/13/25, for Cephalexin (an antibiotic) 500 milligrams, once daily for prophylaxis for recurrent UTIs (Urinary Tract Infections). The resident's Electronic Medication Administration Records for February, March, April, May, and June 2025 indicated the resident received the antibiotic daily since 02/13/25. The resident's complete Care Plan Report was	F 0657	**F657 Care Plan Timing and Revision** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 58 was identified during the time of observation. The deficiency was corrected on June 12, 2025. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents on prophylactic antibiotics have the potential to be affected. 2. DNS/ADNS will conduct a facility-wide audit for residents on prophylactic antibiotics and revise the care plan, if needed, by June 13, 2025. 3. RAI Specialist will educate clinical management on care plan accuracy and compliance with antibiotic medications by June 17, 2025. What measures will be put into place and what systemic changes	06/29/2025

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	reviewed on 06/12/25 at 10:45 A.M. and lacked a care plan for the prophylactic antibiotic usage. During an interview, on 06/12/25 at 11:05 A.M., the Director of Nursing indicated the resident's family reported the resident had a history of UTIs. The resident's urologist ordered the prophylactic antibiotic. The facility called to see about discontinuing the antibiotic, but the urologist wanted the resident to continue to receive the medication daily. The resident's care plan should have been updated to indicate she was receiving the prophylactic antibiotic. The current facility policy, titled "Comprehensive Care Plan", dated 11/01/24, was provided by the Director of Nursing on 06/12/25 at 1:42 P.M. The policy indicated, "...The comprehensive care plan will describe, at a minimum...services...to maintain the resident's/patient's highest practicable physical, mental, and psychosocial well-being..." 3.1-35(b)(1)		will be made to ensure that the deficient practice does not recur? 1. DNS/ADNS will conduct an audit related to prophylactic antibiotics and care plan accuracy 2x/week x4 weeks, weekly x4 weeks, and monthly x6 months. 2. DNS/ADNS will audit new admission(s) and/or readmission(s) for prophylactic antibiotics and care plan accuracy Monday-Friday during clinical meeting x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or ADNS will review any findings during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined. Date corrections will be completed by: **June 29th 2025**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for cardiac medications for 3 of 21 residents reviewed for quality of care. (Residents 58, 15, and 7)	F 0684	**F684 Quality of Care** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	06/29/2025

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	Findings include: 1. Resident 58's clinical record was reviewed on 06/11/25 at 3:24 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/28/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hypertension, and coronary artery disease. The resident's current physician's orders included, but were not limited to, an open-ended order, with a start date of 01/11/25, for Midodrine 10 milligram (mg) tablet, three times a day. The resident was to receive one tablet by mouth, at 8:00 A.M., 12:00 P.M., and 8:00 P.M., for hypotension. The medication was to be held if the resident's systolic blood pressure (top number) was greater than 120. The Electronic Medication Administration Record (EMAR) for May 2025 indicated the resident received the medication when the systolic blood pressure was over 120 on the following dates and times: - On 05/02/25 at 12:00 P.M., when the blood pressure was 136/80, - On 05/03/25 at 8:00 P.M., when the blood pressure was 140/63, - On 05/05/25 at 12:00 P.M., when the blood pressure was 122/64, - On 05/06/25 at 12:00 P.M., when the blood pressure was 124/74, - On 05/08/25 at 12:00 P.M., when the blood pressure was 128/74, - On 05/11/25 at 8:00 A.M., when the blood pressure was 128/72, at 12:00 P.M., when the blood pressure was 132/70, and at 8:00 P.M., when the blood pressure was 124/78,		1. Residents 58, 15, and 7 were identified during the time of observation. Dr. Neese reviewed hold parameters for the identified residents on June 16, 2025 with no new orders. Licensed nurses and QMAs educated on following NP/MD orders related to hold parameters by June 29, 2025. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents receiving cardiac medications with hold parameters have the potential to be affected. 2. DNS/ADNS will conduct an audit of the facility for residents with cardiac medications with hold parameters on June 23, 2025. 3. Licensed nurses and QMAs will be educated on following NP/MD orders related to cardiac medications with hold parameters by June 29, 2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS/ADNS will conduct an audit of the administration of cardiac medications with hold parameters to determine if medications given or held per NP/MD order 2x/week x4 weeks, weekly x4 weeks, and monthly x6 months. 2. DNS/ADNS will conduct an audit on new admission(s) and/or	

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	- On 05/12/25 at 8:00 A.M., when the blood pressure was 128/74, and at 12:00 P.M., when the blood pressure was 124/72, - On 05/16/25 at 8:00 P.M., when the blood pressure was 128/68, - On 05/20/25 at 12:00 P.M., when the blood pressure was 126/70, and at 8:00 P.M., when the blood pressure was 123/67, - On 05/21/25 at 8:00 A.M., when the blood pressure was 136/68, at 12:00 P.M., when the blood pressure was 124/72, and at 8:00 P.M., when the blood pressure was 129/68, - On 05/24/25 at 12:00 P.M., when the blood pressure was 123/63, and - On 05/29/25 at 8:00 A.M., when the blood pressure was 128/70, at 8:00 P.M., when the blood pressure was 133/69. 2. The clinical record for Resident 15 was reviewed on 06/10/25 at 10:30 A.M. A Quarterly MDS assessment, dated 03/06/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, hypertension, neurogenic bladder, and aphasia. The resident had an indwelling urinary catheter. An open-ended physician's order, with start date of 12/11/24, indicated the resident was to receive Losartan (a blood pressure medication) 50 mg, once a day for hypertension. The staff were to hold the medication if the systolic blood pressure was less than 120 or the heart rate was less than 60. The March, April, May, and June 2025 EMAR indicated the resident received the medication when their systolic blood pressure was less than 120 on the following dates: - On 03/06/25 when the blood pressure was 108/61,		readmission(s) for residents on cardiac medications and collaborate with NP/MD if hold parameters are needed Monday-Friday during clinical meeting x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS o ADNS will review any findings during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined. Date corrections will be completed by: **June 29th 2025**	

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	- On 03/11/25 when the blood pressure was 97/55, - On 03/19/25 when the blood pressure was 91/50, - On 04/01/25 when the blood pressure was 101/62, - On 04/03/25 when the blood pressure was 107/65, - On 04/06/25 when the blood pressure was 101/65, - On 04/10/25 when the blood pressure was 106/68, - On 04/23/25 when the blood pressure was 108/60, - On 04/30/25 when the blood pressure was 108/60, - On 05/01/25 when the blood pressure was 109/66, - On 05/21/25 when the blood pressure was 93/59, - On 06/04/25 when the blood pressure was 108/63, and - On 06/06/25 when the blood pressure was 103/63. 3. The clinical record for Resident 7 was reviewed on 06/10/25 at 02:32 P.M. A Quarterly MDS assessment, dated 05/30/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, amputation, anemia, hypertension, obstructive uropathy, diabetes, seizure disorder, anxiety, and depression. A current, open-ended physician's order, with a start date of 04/07/25, indicated the resident was to receive Midodrine 10 mg, three times a day at 8:00 A.M., 12:00 P.M., and 8:00 P.M. The staff were to hold the medication if the residents systolic blood pressure was greater than 120. The April, May, and June 2025 EMAR indicated the resident had received the medication when			

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	their systolic blood pressure was greater than 120 on the following dates and times: - On 04/27/25 at 8:00 A.M., when the blood pressure was 129/51, - On 04/28/25 at 12:00 P.M., when the blood pressure was 136/69 and 8:00 P.M., when the blood pressure was 129/74, - On 05/05/25 at 12:00 P.M., when the blood pressure was 129/47, - On 05/10/25 at 8:00 A.M., when the blood pressure was 134/50 and 12:00 P.M., when the blood pressure was 138/48, - On 05/17/25 at 8:00 A.M., when the blood pressure was 134/62 and 12:00 P.M., when the blood pressure was 134/62, - On 05/22/25 at 8:00 P.M., when the blood pressure was 151/63, - On 05/27/25 at 12:00 P.M., when the blood pressure was 136/43, - On 05/29/25 at 8:00 P.M., when the blood pressure was 127/45, - On 06/03/25 at 8:00 A.M., when the blood pressure was 140/60, - On 06/07/25 at 8:00 P.M., when the blood pressure was 122/60, - On 06/09/25 at 12:00 P.M., when the blood pressure was 128/59, and - On 06/10/25 at 12:00 P.M., when the blood pressure was 143/56. During an interview, on 06/11/25 at 11:10 A.M., Licensed Practical Nurse 2 indicated if a resident's medication had hold parameters, she would obtain the vital signs and if they were outside the parameters to give the medication then she would not administer it to the resident. She would document in the EMAR that the medication was not administered due to it being outside the parameters.			

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	The current facility policy titled, "Medication Administration" was dated 01/02/2024, was provided by the Director of Nursing on 06/11/25 at 11:40 A.M. The policy indicated, "...Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters..." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to ensure proper placement of a urinary catheter drainage bag for a resident that received prophylactic antibiotics for Urinary Tract Infections (UTIs) for 1 of 4 residents reviewed for indwelling urinary catheters. (Resident 58) Findings include: On 06/09/25 at 10:28 A.M., Resident 58 was observed in her room in bed. The resident's urinary catheter drainage bag was hanging on the side of her bed. Dark yellow urine with sediment was visible in the tubing. There was a mat on the floor next to the bed and the bed was in a lower position. About two inches of the drainage bag was resting on the bare floor in the space between the bed and the floor mat. Resident 58 was observed in the A-Hall dining room on 06/10/25 at 12:12 P.M. The resident's catheter drainage bag was hanging under her wheelchair, with about an inch of the drainage bag resting on the floor.	F 0690	**F690 Bowel/Bladder Incontinence** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 58 continues to reside at the facility with urinary catheter. Deficiency was corrected at the time of observation. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents with urinary catheters have the potential to be affected. 2. DNS/ADNS will conduct an audit of the facility for residents with urinary catheters by June 22, 2025. 3. All staff will receive education on Urinary Catheter care and Infection Control related to	06/29/2025

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	Resident 58's clinical record was reviewed on 06/11/25 at 3:24 P.M. A Quarterly Minimum Data Set assessment, dated 02/28/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, diabetes, and renal insufficiency. The resident had an indwelling urinary catheter. The resident physician's orders included, but were not limited to the following: - An open-ended physician's order, with a start date of 02/13/25, for Cephalexin (an antibiotic) 500 milligrams, once daily for prophylaxis for recurrent UTIs. The resident recieved the medication every day as ordered. During an interview, on 06/10/25 at 2:57 P.M., the Corporate Clinical Support Nurse indicated no part of an indwelling urinary catheter should be touching the floor. The current facility policy, titled "Indwelling Catheter", dated 01/02/24, was provided by the Director of Nursing on 06/12/25 at 1:32 P.M. The policy indicated, "...if an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice..." 3.1-41(a)(2)		catheters by June 29, 2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS/ADNS will audit infection control related to correct placement of catheter bags 2x/week x4 weeks, weekly x4 weeks, and monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or ADNS will review any findings during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x 6 months or until substantial compliance has been determined. Date corrections will be completed by: **June 29th 2025**	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview, and record review, the facility failed to follow physician's orders related to medication administartion for 1 of	F 0755	**F755 Pharmacy Services/Procedures/Pharmacist/Records**	06/29/2025

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	155665	A. BUILDING 00 B. WING	06/12/2025

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	21 residents reviewed for pharamcy services. (Resident 23) Findings include: During an observation, on 06/09/25 at 8:48 A.M., RN 4 sanitized her hands and prepared medications for Resident 23. After placing all the medications into a cup that included, but was not limited to, a Potassium Chloride Extended-Release 10 milliequivalent (MEQ) tablet, she poured the medications into a pouch, crushed the medications, placed them back into the medication cup, and added applesauce. The medications were administered to the resident. The current, open-ended physician's order, with a start date of 07/13/23, indicated the resident was to receive Potassium Chloride 10 MEQ Extended-Release tablet, once a day. The staff were to place the medication in applesauce and allow it to dissolve. The tablet was not to be crushed. During an interview, on 06/11/25 at 12:07 P.M., the Director of Nursing (DON) indicated if a physician's order stated to not crush a medication, then it should not have been crushed. The current facility policy titled, "Medication Administration" was dated 01/02/2024, was provided by the Director of Nursing on 06/11/25 at 11:40 A.M. The policy indicated, "...Administer medication as ordered in accordance with manufacturer specifications...Crush medications as ordered. Do not crush medications with "do not crush" instructions..." 3.1-48(c)(2)		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 23 was identified during the time of observation. Dr. Neese was notified on June 11, 2025 with no new orders. Kelsey Brown, NP gave new order to change potassium to liquid on June 13, 2025. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents receiving potassium chloride ER have the potential to be affected. 2. DNS/ADNS will conduct an audit of the facility for residents with potassium chloride ER on June 22, 2025. 3. DNS/ADNS will conduct an audit of all residents in the facility that require crushed medications. DNS/designee will collaborate with NP/MD for orders for liquid potassium, if necessary, by June 23, 2025. 4. DNS/ADNS/Unit Manager will add ‘Do not crush’ on all potassium chloride ER orders and place ‘Do not crush’ labels on the potassium chloride ER blister packs by June 23, 2025. 5. Licensed nurses and QMAs will be educated on ‘Do Not Crush Meds,’ specifically potassium chloride ER by June 29, 2025.	

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			6. Licensed nurses and QMAs will receive a copy of 'Do Not Crush Med' list by June 29, 2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS/ADNS will conduct an audit of the administration of potassium chloride to determine if medication was administered appropriately 2x/week x4 weeks, weekly x4 weeks, and monthly x6 months. 2. DNS/ADNS will conduct an audit on new orders, new admission(s), and/or readmission(s) for residents on potassium chloride ER for 'do not crush' on medication order, 'do not crush' label on medication blister pack, and collaborate with NP/MD if liquid form is needed during clinical meeting x6 months. 3. DNS/ADNS will provide newly hired staff, i.e. licensed nurses and/or QMAs with a copy of 'Do Not Crush Med' list during orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or ADNS will review any findings during clinical meeting, with subsequent correction action and education for identified staff members.	

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			2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined. Date corrections will be completed by: **June 29th 2025**	
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 store medications appropriately related to outdated/undated medications for 3 of 4 medication carts observed. (A, B, and C Hall medication Carts) Findings include: The A-Hall Medication Cart was observed on 06/11/25 at 10:14 A.M., with Licensed Practical Nurse 2. The following was observed: - an unopened vial of insulin Lispro for Resident 59 that was undated, - an opened Symbicort inhaler for Resident 17 that was undated, and - an opened Albuterol inhaler for Resident 17 that was undated. The B-Hall Medication Cart was observed on 06/11/25 at 10:19 A.M., with LPN 6. The following was observed: - a Combivent inhaler for Resident 65, that was dated 01/30/25. The C-Hall Medication Cart was observed on 06/11/25 at 10:27 A.M., with LPN 3. The following was observed:	F 0761	**F761 Label/Store Drugs and Biologicals** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1 Residents 59, 17, 65, and 16 were identified during the time of observation and insulin and inhalers were discarded per facility policy. Medication re-ordered from pharmacy. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 All residents receiving insulin and inhalers have the potential to be affected. 2 DNS/ADNS will conduct an audit of medication carts by June 24, 2025. 3 Nursing staff to be educated on Storage and Labeling of Medication guidelines by June 29, 2025. What measures will be put into place and what systemic changes	06/29/2025

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	- an opened vial of Humalog for Resident 16 that was 3/4 full that was undated. The nurse indicated it came from the pharmacy on 06/08/25 and wrote that as the open date on the vial. During an interview on 06/11/25 at 11:37 A.M., the Director of Nursing (DON) indicated all insulins should have dates on them if they were in the medication cart. If they were not opened, then they should have been in the refrigerator. The albuterol inhalers were good for one year after they were opened, the Symbicort and Combivent were good for 90 days. The inhalers should have had open dates and should be discarded after they expired. The current "Product Expiration Dates" with a revision date of May 2023, was provided by the DON on 06/11/25 at 1:38 P.M. The policy indicated, "...Insulin vials...Room Temperature Exp [expiration] date...28 days...Albuterol [aerosol]...12 months...Combivent...3 months...Symbicort...90 days..." 3.1-25(o)		will be made to ensure that the deficient practice does not recur? 1 DNS/ADNS will audit medication carts at random for date and expired insulin pens/vials and inhalers 2x/week x4 weeks, weekly x4 weeks, and monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or ADNS will review any findings during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined. Date corrections will be completed by: **June 29th 2025**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to follow appropriate guidelines related to the use of hair coverings in the kitchen and store foods in a sanitary manner related to unlabeled and outdated foods and for 1 of 3 kitchen observations, and failed to follow appropriate infection control guidelines related to hand hygiene for 1 of 4 dining observations. (D-Hall Dining Room)	F 0812	**F812 – Food Procurement, Storage/Prepare/Serve-Sanitary** What corrective action(s) will be accomplished for those residents who found to have been affected by the deficient practice? 1 All items found to be improperly dated at the time of observation were immediately	06/29/2025

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	Findings include: 1. During the initial tour of the kitchen on 06/08/25 at 10:10 A.M., Activity Aide 12 was observed in the kitchen preparing drinks near the coffee pots. The Activity Aide had a long beard the touched his collar bone that was not contained in a beard net. The kitchen refrigerators were observed on 06/08/25 at 10:12 A.M. and contained the following: - An undated rectangular metal pan covered in plastic wrap that contained tuna salad, - A large, lidded container 3/4 full of Dijon pork. The label indicated the pork was prepared on 06/02/25, and was to be used 06/05/25, - A 1/3rd full gallon of milk, with a best by date of 05/26/25, and - A 1/3 full clear pitcher of tomato juice. The label indicated the juice was made on 06/03/25 and was to be used by 06/06/25. During an interview, on 06/08/25 at 10:18 A.M., the Assistant Dietary Manager indicated the Activity Aide's beard should have been covered. The tuna salad should have been labeled with a "prepared on" date. The pork, milk, and tomato juice were expired and should have been thrown out. The current facility policy, titled "Staff Attire", dated 10/2023, was provided by the Administrator on 06/12/25 at 10:26 A.M. The policy indicated, "...All staff members will have...facial hair properly restrained..."		removed from the refrigerators and discarded 2 Staff member that was found to not have been wearing a beard restraint was educated on proper procedures when entering the kitchen to retrieve items for activities including proper hair/beard restraints to be used. 3 Staff who serve food in facility will be educated on proper hand washing procedures during meal service. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1 A facility wide inspection of all refrigerators containing food meant for residents was initiated and no further items were found improperly labeled/dated. All staff to be in-serviced on proper hair restraints to be worn while in the kitchen and hand washing procedures during food service. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1 Staff in-services to be provided for all staff regarding proper procedures for labeling and dating food stored, Proper usage of hair/beard restraints, and proper handwashing procedures to be followed during food/meal service. In-services to be completed by	

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	The current facility policy, titled "Food Storage: Cold Foods", dated 02/2023, was provided by the Administrator on 06/12/25 at 10:26 A.M. The policy indicated, "...All foods will be...labeled and dated..."2. The D-Hall Dining room meal service was observed on 06/08/25 at 11:51 A.M. Certified Nurse Aide (CNA) 9 pushed a chair in the dining room using her hands, touched her nose with her left hand, sat down in a chair by three residents sitting at the table nearest the kitchen door, touched her face and ear with her right hand, then served a meal tray to Resident 6. CNA 9 touched the resident's plate and napkin, unrolled the napkin, took out the silverware, removed the foil from the resident's baked potato, chopped it up with the resident's fork holding the fork in her right hand, opened the resident's sour cream packet, and squirted the sour cream on the resident's potato. The resident picked up the fork and fed herself. CNA 9 used hand sanitizer then served a tray to another resident. During an interview, on 06/11/25 at 2:11 P.M., CNA 9 indicated when serving meal trays, staff were to use hand sanitizer after each tray and wash their hands after three to five trays. Staff were not to touch themself before serving meal trays. The current Handwashing-Hand Hygiene policy, with an effective date of 03/01/25, was provided by the DON on 06/12/25 at 10:26 A.M. The policy indicated, "...If hands are not visible soiled, use an alcohol-based hand rub...for all the following situations... After direct contact with residents...After contact with objects...in the immediate vicinity of the resident..." 3.1-21(i)(2)		6/25/2025 2 Food service manager or Manager in Training will perform audits refrigerators throughout facility, hair/beard restraint usage in kitchen and will monitor and audit staff during resident meal service for proper hand hygiene 5x weekly x6 months. This plan will be revised as warranted. Audits to start 6/23/2025 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1 For quality assurance, the facility Administrator or Director of Nursing will review any findings 5 days a week during morning meeting, with subsequent corrective action and education for identified staff members. 2 Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. Date corrections will be completed by: **June 29th 2025**	

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F 0880 SS=E Bldg. 00	3.1-21(i)(3) 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines during a wound dressing change, and for indwelling urinary catheter management for 4 of 21 residents reviewed for infection control. (Residents 2, 100, 101, and 15) Findings include: 1. A wound dressing change for Resident 2 was observed on 06/10/25 at 10:41 A.M., with Licensed Practical Nurse (LPN) 7 and LPN 10. The LPN's donned gowns in the hallway from a cart of supplies sitting next to the resident's room door. LPN 10 donned gloves. With her gloves on, she reached into her pocket on her scrubs, got her treatment cart keys out, and used them to open the cart. She gathered treatment supplies, took them into the resident's room, laid the supplies on the over bed table, went into the bathroom located in the resident's room, did not turn on the water or change gloves, came out with paper towels, and put the paper towels on the over bed table. LPN 10 opened several gauze pads and made a stack, touching the gauze pads with her gloved hands. The LPNs rolled the resident towards LPN 7, who held the resident on their side. LPN 10 sprayed a wound cleanser, Hibiclens, on a gauze pad from the stack, and wiped the resident's tennis ball sized bleeding wound located on her left buttock. LPN 10 patted the wound with more gauze pads in an attempt to stop the bleeding. She applied a small amount of a protective paste, Triad, when LPN 7 indicated the treatment was supposed to be	F 0880	**F880 Infection Prevention & Control** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident 2, 15, 100, 101 continues to reside at the facility with urinary catheter. Deficiency was corrected at the time of observation. 2. Resident 2 continues to reside at the facility with wounds. Staff educated on wound care and infection control related to wound care on June 29, 2025. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents with urinary catheters and wounds have the potential to be affected. 2. Staff will be educated on Urinary Catheter Care, Wound Care, Infection Control related to catheters, and Infection Control related to wound care (i.e. hand washing) by June 29, 2025. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS/designee will audit	06/29/2025

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	Xeroform gauze (a non-adherent mesh infused with healing ointment). LPN 10 wiped off the Triad paste with a gauze pad, applied the Xeroform gauze to the wound bed, applied a border dressing, removed her gloves, washed her hands, and donned clean gloves to treat the next wound. The clinical record for Resident 2 was reviewed on 06/11/25 at 10:09 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/27/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, stroke, hypertension, and neurogenic bladder. The current physician's order for the resident's wound on her left buttock indicated the wound was to be cleansed with Hibiclens, rinsed thoroughly, patted dry, Xeroform gauze applied to the wound bed, and covered with a border foam dressing. The LPN failed to change their gloves after touching contaminated objects and failed the rinse the wound thoroughly after using the Hibiclens cleansing agent. During an interview on 06/11/25 at 3:26 P.M., RN 4 indicated when providing wound treatments, once you don your gloves you should not touch anything below your waist, including door knobs, anything in your pockets, or anything dirty that had not been cleaned immediately prior. Staff should wash their hands and change gloves if they come into contact with a possibly contaminated item. The current "Handwashing-Hand Hygiene" policy, with an effective date of 03/01/25, was provided by the Director of Nursing (DON) on		infection control practices related to correct placement of catheter bags and infection control related to hand hygiene with wound care 2x/week x4 weeks, weekly x4 weeks, and monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DNS or ADNS will review any findings during clinical meeting, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x 6 months or until substantial compliance has been determined. Date corrections will be completed by: **June 29th 2025**	

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	06/12/25 at 10:26 A.M. The policy indicated, "...If hands are not visible soiled, use an alcohol-based hand rub...for all the following situations... After direct contact with residents...After contact with objects...in the immediate vicinity of the resident..." 2. Resident 100 was observed in the A-Hall dining room on 06/10/25 at 12:12 P.M. The resident's indwelling urinary catheter drainage bag was hanging under her wheelchair and touching the floor. The resident's sling used to transfer her with a mechanical lift was visible at her shoulders. On 06/10/25 at 1:33 P.M., the resident was propelling themselves down the D-Hall in her wheelchair. Her indwelling urinary catheter bag was dragging on the floor. At 1:35 P.M., a staff member assisted the resident by pushing her down the D-Hall, down the hallway with the staff offices, and to the A-Hall dining room to an activity. The sound of the bag dragging the floor was audible. On 06/10/25 at 2:05 P.M., a staff member was observed pushing the resident down the A-Hall all the way to the A-Hall dining room with the bottom of the indwelling urinary catheter bag dragging on the floor. The blue cover on the bag was flipped back as it was dragging on the floor. The clinical record for Resident 100 was reviewed on 06/10/25 at 2:46 P.M. An Entry MDS assessment indicated the resident was admitted to the facility on 06/04/25. The resident's diagnoses included, but were not limited to, diabetes and acute neurological disorder. During an interview and observation, on 06/10/25 at 2:57 P.M., Corporate Clinical Support, while			

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	observing the resident in the A-Hall dining room, indicated no part of an indwelling urinary catheter should be touching the floor. 3. On 06/10/25 at 1:51 P.M., Resident 101 was in bed in their room. His bed was in a low position and two to three inches of his indwelling urinary catheter bag was directly touching the floor. No barrier was noted between the catheter bag and the bare floor. During an interview and observation on 06/10/25 at 3:04 P.M., Qualified Medication Aide (QMA) 8 indicated the resident was a complete assist with care. His indwelling urinary catheter bag should not be touching the floor without a barrier between the floor and the bag. The bag had two to three inches directly touching the floor. The clinical record was reviewed on 06/10/25 at 2:41 P.M. An Admission MDS assessment, dated 06/05/25, indicated the resident was rarely/never understood. The resident's diagnoses included, but were not limited to, stroke and benign prostatic hyperplasia. The resident had not had a urinary tract infection (UTI) in the last 30 days.4. During an observation, on 06/11/25 at 9:10 A.M., Resident 15 was sitting in her recliner in her room. Her indwelling urinary catheter bag was hooked to the right side if the chair with approximately one inch of the bag resting on the bare floor. During an observation, on 06/11/25 at 11:02 A.M., Resident 15 was sitting in her recliner in her room. Her indwelling urinary catheter bag was hooked to the right side if the chair with approximately one inch of the bag resting on the bare floor. During an observation, on 06/11/25 at 2:12 P.M., Resident 15 was sitting in her recliner in her room.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING 00 B. WING	06/12/2025

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	Her indwelling urinary catheter bag was hooked to the right side if the chair with approximately one inch of the bag resting on the bare floor. During an observation and interview, on 06/11/25 at 2:13 P.M., Resident 15 was sitting in her recliner in her room. Her indwelling urinary catheter bag was hooked to the right side if the chair with approximately one inch of the bag resting on the bare floor. CNA 5 indicated the resident's catheter bag should not have been lying on floor. She moved the urinary catheter bag and hung it on the bed frame. The clinical record for Resident 15 was reviewed on 06/10/25 at 10:30 A.M. A Quarterly MDS assessment, dated 03/06/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, hypertension, neurogenic bladder, and aphasia. The resident had an indwelling urinary catheter. The current facility policy, titled "Indwelling Catheter", dated 01/02/24, was provided by the Director of Nursing on 06/12/25 at 1:32 P.M. The policy indicated, "...if an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice..." 3.1-18(b) 3.1-18(l)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules.	F 9999	**F9999** **What corrective action(s) will be accomplished for those residents who found to have**	06/29/2025

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	This rule is not met as evidence by: The employee records were provided by the Human Resources (HR) Director on 06/10/25 at 2:00 P.M. Certified Nurse Aide (CNA) 14 was hired to the facility on 05/06/25. During an observation of the employee license book on 06/10/25 at 3:15 P.M., CNA 14's license was noted to be expired on 05/07/25. CNA 14 had worked on the following dates in May and June 2025: - On 05/09/25, - On 05/16/25, - On 05/18/25, - On 05/19/25, - On 05/21/25, - On 05/22/25, - On 05/23/25, - On 05/26/25, - On 05/27/25, - On 05/30/25, - On 06/01/25, - On 06/02/25, - On 06/04/25, - On 06/06/25, - On 06/09/25, and - On 06/10/25. During an interview, on 06/12/25 at 9:30 A.M., the Director of Nursing (DON) and HR Director indicated the CNA's license was expired and she was renewing it at that time. During an interview, on 06/12/25 at 2:27 P.M., the DON indicated CNA 14 should not have worked with an expired license.		**been affected by the deficient practice?** 1 The Staff member was able to take action and have her certification reinstated immediately upon identification of the lapse. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.** 1 No other residents were affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** 1 A full audit was completed of all licensed and certified staff with no other findings of lapsed certificates or licenses. 2 Our online tracking tool was updated to ensure that all current staff licenses and certification are entered correctly to ensure that staff and management are notified prior to the expiration. All new hires will be updated in the system to include any license or certifications with the renewal date. This will update the facility HR Director to ensure that all licenses remain up to date and in compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	The current facility policy titled, "Background Check & License Verification", with an effective date of 12/01/2024, and was provided by the Administrator on 06/12/25 at 11:07 A.M. The policy indicated, "...To conduct...license verifications...For all applicants applying for a position as a certified nurse aide, the human resources department will contact the nurse aide registry of the state in which the individual is certified...to verify that the applicant's certification is in good standing..."		**assurance program will be put into place?** 1 For quality assurance, the facility Administrator or HR Director will monitor all current and future staff licenses to ensure that all are kept up to date. 2 Findings will be reported at the QA meeting monthly x6 months and will continue until 100% compliance is achieved. Date corrections will be completed by: **June 29th 2025**	