STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00457283. This visit included a State Residential Licensure Survey. Complaint IN00457283 - No deficiencies related to the allegations are cited. Survey dates: April 27, 28, 29, 30 and May 1 and 2, 2025 Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 56 SNF: 2 Residential: 13 Total: 71 Census Payor Type: Medicare: 2 Medicaid: 7 Other: 49 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 13, 2025.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to honor a resident's right to	F 0550	Tag number: F 550 I. What corrective action(s)	05/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	self-determination and communication for 1 of 1 resident reviewed for Resident Rights. (Resident 19) Findings include: During an observation on 4/27/25 at 10:50 a.m., Resident 19 was lying in bed with a touch pad call light within reach. She indicated she was unable to turn and reposition herself and unable to call her family member. She relied on staff to help with all activities of daily living (ADLs). The Administrator had spoken to her about her frequent calls to her family member, telling her she called him too much and gave him too much information. Resident 19's clinical record was reviewed on 5/1/25 at 11:30 a.m. Diagnoses included cerebral palsy, obsessive-compulsive disorder, mild intellectual disabilities, fibromyalgia, and other abnormalities of gait and mobility. The resident's cognitive status was moderately impaired. An admission Minimum Data Set (MDS) assessment, dated 3/9/25, indicated Resident 19 was dependent on staff for eating, oral hygiene, toileting hygiene, showering/bathing, dressing, all transfers, and personal hygiene. The resident was always incontinent of both bladder and bowel. A Social Services note, dated 4/1/25 at 12:25 p.m., provided by the Administrator on 4/29/25 at 1:39 p.m., indicated both Social Services and the Administrator spoke with the resident regarding privacy and dignity. When staff was providing care for the resident, all electronic devices were to be shut off. Once care was completed, the staff would assist the resident with resuming the phone call.		will be accomplished for those residents found to have been affected by the deficient practice; Resident 19 has her phone on at beside 24 hours a day as requested by her. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit was completed of residents with cell phones. All were asked if they wanted or cared to be on their phone during care. All residents, except 19, stated no but if that changed were told to let staff know. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff were educated to allow audio use of residents phones during care, if requested by resident. If preference is to have phone on during care, this will be care planned and all nursing staff will be made aware. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality	

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	An Administrator note, dated 4/28/25, provided by the Administrator on 4/29/25 at 1:39 p.m., indicated about three to four weeks prior, Social Services and the Administrator went to talk to the resident about her phone usage during resident care. "...We explained that her being on the phone...with her [family member] during care was a dignity issue and that we would have her hang up during care and then assist her in calling her [family member] back when finished..." A Social Service note, dated 4/28/25, provided by the Administrator on 4/29/25 at 1:39 p.m., indicated around mid-March, the Administrator and Social Service Director went to discuss the phone issue with Resident 19. They told the resident she could not be on the phone while receiving care. The Administrator said, for the resident's own dignity, the resident should be off her phone while receiving care. During an interview with Resident 19 on 5/1/25 at 2:35 p.m., and the resident's family member who was on speaker phone, the resident indicated she was not in agreement with hanging up her phone during care. Both the resident and her family member indicated they used the speaker phone, not video calls, during care. The resident's family member indicated the resident needed help to be understood. Some people could not understand what the resident was saying when she spoke. Both Resident 19 and her family member wanted to be connected by phone, even while care was provided. During an interview with RN 6 on 5/1/25 at 2:39 p.m., she indicated the family member was always on speaker phone with the resident. RN 6 was not bothered by the phone calls, but indicated		assurance program will be put into place; Director of Nursing (DON)/designee will audit all new admission residents for preference of phone being on during care. Audits will be discussed in clinical meeting 5x's a week for 4 weeks, 3 x's a week for 4 weeks, then weekly x4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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	sometimes it could get loud between the noise going on in Resident 19's room and whatever was going on at the family member's residence. The volume could be turned down and/or the call could be muted during resident care. Whenever a physician or nurse practitioner was with Resident 19, the staff would let the family member know and tell him they would call him back after the provider was finished. During an interview with the Administrator on 5/1/25 at 4:48 p.m., she indicated the local Ombudsman had been apprised of the situation and had suggested the resident's phone should be hung up during care, as it was a dignity/privacy issue. During an interview with the Administrator on 5/1/25 at 4:50 p.m., she indicated the facility lacked a policy addressing resident phone usage during care. The local Ombudsman was unavailable for interview during the survey from April 27 through May 2, 2025 . 3.1-3(a)			
F 0576 SS=E Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy Based on interview and record review, the facility failed to ensure mail was distributed to the residents on Saturdays. This deficiency had the potential to affect 58 of 58 residents who resided in the facility. Findings include: During a Resident Council meeting, on 4/30/25	F 0576	Tag number: F576 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Mail delivery on Saturdays, has been restarted.	05/25/2025

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	beginning at 3:35 p.m., Resident 40 indicated the facility did not deliver mail to the residents on Saturdays. The activity department staff was to deliver mail after the business office manager sorted it. The business office manager did not work weekends. Residents 41, 45, 58, 10, 28, 51, 2, 33, and 25 indicated they did not receive mail on Saturdays. During an interview, on 5/1/25 at 10:06 a.m., the Activity Director (AD) indicated the activity department delivered mail to the residents. Mail was distributed on the days that the Business Office Manager /Financial Coordinator (BOM) was at the facility. The BOM received and sorted the mail and placed it on the front desk when it was ready for distribution to the residents. During an interview, on 5/1/25 at 10:14 a.m., the BOM indicated that she sorted the facility mail. She removed anything that the facility or the resident's representative was responsible for. Once mail was sorted, she took the mail to the front desk for the activity department to distribute to the residents. Her regular work schedule was Monday through Friday. A current facility policy, updated September 2015, titled "Mail Policy", provided by the Social Services Director on 5/1/25 at 4:23 p.m., indicated the following: "Policy: The residents have a right to receive mail. Guidelines: The follow procedure will be followed: ...3. Mail will be delivered Monday thru Saturday...." 3.1-3(s)(1)		II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. . III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; . Office manager, receptionist and activity department were educated on sorting and making sure the resident mail is delivered to the residents daily, Monday-Saturday IV. 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; The administrator/designee will audit mail delivery by asking 10 residents daily, Monday-Friday x 4 weeks, 10 residents 3 x a week, x 4 weeks then 10 residents weekly x 4 months. All residents will be asked about Saturday mail delivery every time during audit. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or	

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			until an average of 90% compliance or greater 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.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to provide an accurate code status for 1 of 1 resident reviewed for advance directives. (Resident 10) Findings include: Resident 10's clinical record was reviewed on 4/30/25 at 10:13 a.m. Diagnoses included hypertension and dementia. A quarterly Minimum Data Set (MDS) assessment, dated 1/16/25, indicated the resident was moderately cognitively impaired. The current, main page on Resident 10's electronic health record indicated a Do Not Resuscitate (DNR) code status. A current physician's order, dated 8/22/24,	F 0578	Tag number: F578 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 10's POA signed a POST form on 05/02/2025. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all POST forms were signed by the appropriate person.	05/25/2025

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	indicated "Do Not Resuscitate". A current care plan, initiated on 8/27/24, indicated Resident 10 had a signed and valid DNR in the event she should stop breathing and display no pulse, as a result of failure of the heart to contract effectively or at all. Interventions included I will be enabled to live to the limit of my potential ability physically, mentally, and spiritually, administer medications as ordered, encourage the resident and family members to discuss concerns, ensure the DNR is noted in the chart, follow advance directives as depicted in the resident's chart, honor choices made by the resident and/or family member, surrogate, or POA, and notify the physician of changes. Resident 10's physician orders for Scope of Treatment (POST) form, provided by the Administrator on 4/30/25 at 11:13 a.m., indicated Resident 10 had a full-code status and was to be provided cardiopulmonary resuscitation (CPR) and full interventions. The resident's POA (power of attorney) gave verbal consent for the full-code status. The Administrator indicated she was not aware of the conflicting advance directives information. The document she provided was the only signed code status for Resident 10. A current facility policy, titled "Advance Directives", provided by the Administrator on 4/30/25 at 11:49 a.m., indicated the following: "...Guidelines: For purposes of this policy and procedure, "Advanced Directives" means a written instrument, such as a living will or life prolonging procedure declaration, appointment of health care representative and power of attorney for health care purposes. These directives are established under state law and relate to the provision of medical care when the individual is		. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee educated nursing staff and social service director on the policy of Advanced Directives to include when a resident is capable to sign or a representative must sign. IV. 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; DON/designee will audit al new admissions/re-admissions to ensure the POST form has been signed by the correct person. Audits will be completed during clinical meetings 5 x week for 4 weeks, 3 x a week for 4 weeks, then weekly for 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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	incapacitated...1. At the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law...6. Copies of the resident's Advanced Directive shall be made and maintained in the resident's clinical record and financial folder...10. Advanced Directives shall be included in the resident's plan of care and will be reviewed during the care plan meeting with the resident and/or the resident's legal representative when present...." 3.1-4(5)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to follow physician orders regarding physician/nurse practitioner notification of a resident's weight gain for 1 of 23 residents reviewed for medications. (Resident 17) Findings include: Resident 17's clinical record was reviewed on 4/29/25 at 12:01 p.m. Diagnoses included essential (primary) hypertension (high blood pressure), type 2 diabetes mellitus with diabetic neuropathy, personal history of other diseases of the urinary system, presence of urogenital implants, presence of cardiac pacemaker, obstructive and reflux uropathy (blockage and flow from the bladder backs up into the ureters which connect to the kidneys), and chronic kidney disease, stage 3a (moderate decline in kidney function). A current order, dated 3/27/25, indicated to weigh the resident daily and notify the physician or nurse practitioner if the resident had a weight gain	F 0580	Tag number: F580 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Nurse Practitioner (NP) was notified immediately of changes in weight on 05/01/2025. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Audit was completed to identify residents with diagnoses that results in Physician/NP being notified, if there are any changes of condition, in the last 14 days to ensure that the physician/NP was notified in a timely manner.	05/25/2025

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	of three pounds in a day or five pounds in a week. The resident weighed 178 pounds on 4/11/25. On 4/18/25, she weighed 183.4 pounds with a greater than five-pound weight gain in the week. The physician was not notified. The resident weighed 178.5 pounds on 4/15/25 and 182.6 pounds on 4/16/25 which resulted in a greater than four pound weight gain in a day. The physician was not notified. During an interview, on 5/1/25 at 10:32 a.m., RN 6 indicated if the resident had a weight gain greater than three pounds, the physician was notified. The physician notification was documented in the progress notes. During an interview, on 5/1/25 at 10:46 a.m., RN 6 indicated she was unable to find where the physician had been notified of the resident's weight gain. During an interview, on 5/1/25 at 4:31 p.m., the DON indicated she expected the physician to be notified as ordered for the resident's weight gain.		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses were educated on notifying the Physician/NP with a change of condition or treatment plan. IV. 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; DON/designee will review documentation 5 x a week, Monday-Friday, during clinical meeting to monitor for timely Physician/NP notification of change in condition. Audits will be completed for 5x week for 3 months The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview, and record review, the facility failed to maintain a homelike environment related to a clean, sanitary environment in a resident's room for 1 of 3 resident's reviewed for environment. (Resident 34) Findings include: During an observation on 4/27/25 at 2:55 p.m., Resident 34's trash can overflowed. Trash was on the floor beside the bed. A mask lay on the floor in the entryway of the room. A second mask lay on the floor beside the oxygen concentrator. The bedside table was visibly dirty. A pile of clothing was on the bathroom floor underneath the sink. A navy-blue clothing item lay on top of the pile. During an observation on 4/28/25 at 10:48 a.m., the resident's room continued to have trash surrounding the trash can and on the floor beside her bed. The previously observed masks remained on the floor, laying in the same locations. The bedside table had a large area (the size of large dining plate) of dried, sticky residue. During an interview on 4/29/25 at 9:54 a.m., Resident 34 indicated that housekeeping emptied her trash and swept the floor on occasion. The	F 0584	Tag number: F584 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 34's room was deep cleaned on 05/01/25. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing and housekeeping were educated by Administrator/Housekeeping Supervisor cleaning protocol and schedule. If resident refuses cleaning services on any day, a	05/25/2025

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	floor had trash around the trash can and on the floor beside the bed. The masks continued to be on the floor, unmoved from previous locations. The bedside table continued to have large area (size of large plate) of dried, sticky residue. A pile of clothing lay on the floor underneath the bathroom sink, a navy-blue piece of clothing continued to lay on top of the pile. During an interview on 4/29/25 at 1:22 p.m., Housekeeper 12 indicated that housekeeping was to clean residents' rooms daily. Cleaning of Resident 34's room included vacuuming the carpet and mopping the hard floors daily if needed or a minimum of one day in between floor cleanings. Floors were to be swept where crumbs and debris could be seen. Bedside tables, countertops, and nightstands were to be cleaned off daily. The clothing on the resident's bathroom floor was to be picked up and taken to laundry by the nursing staff. Trash was emptied daily and the trash on the floor, including the masks, was to be picked up and disposed of. Resident 34's clinical record was reviewed on 4/30/25 at 9:53 a.m. Diagnoses included Guillain-Barre syndrome (condition in which the immune system attacks the nerves), difficulty in walking, abnormality of gait and mobility, chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breath), and osteoarthritis (arthritis that occurs when flexible tissue at the ends of bones wear down). A 2/5/25, annual, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. She required supervision or touching assistance with toileting hygiene, upper body assistance, and roll from left to right and moderate assistance with showering, lower body		cleaning refusal form will be filled out and kept with the housekeeping supervisor. IV. 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; Housekeeping supervisor/designee will audit 10 resident rooms, Monday-Friday, to ensure rooms are clean and tidy x 4 weeks, then 5 resident rooms x4 weeks and then 10 resident rooms a month x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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dressing, footwear, personal hygiene, toilet transfer, and sit to stand.

The resident's care plan lacked indication of non-compliance or refusal of housekeeping and/or environmental services.

During an interview on 4/30/25 at 10:32 a.m., Resident 34 indicated that housekeeping had offered to sweep her floor. Her floor was swept from the entryway to the window, the open area of the room, but not around her bed. The two masks remained on the floor in their previous locations. The bedside table remained with a dried, sticky residue. The resident was unable to recall the last time that someone wiped off her bedside table. Trash remained on the floor beside the bed.

During an interview on 5/1/25 at 4:32 p.m., the Administrator indicated she was overseeing the housekeeping department. Resident rooms were to have daily cleaning, with the focus being on floors, trash, bathroom, and then any other necessary area. She had staff clean Resident 34's carpet earlier this week. The resident's sticky bedside table should have been cleaned as well as any trash on floor should have been picked up. This was portrayed on the housekeeping schedule under the "daily" category. She clarified that a small area of Resident 34's carpet may have been cleaned due to staining, rather than the entire carpet.

A current, undated facility policy, titled "Housekeeping Services Policy", provided by the Administrator on 5/1/25 at 3:55 p.m., indicated the following: " ...Policy: It is the policy of the facility to maintain a clean, odor free, comfortable, and orderly environment in all health care and public areas, which meet the sanitation needs of the

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APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

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	facility and residents right for a safe, clean, comfortable homelike environment. Guidelines: ...2. The department shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt and hazards ... Environment: ...Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior environment are provided ...." A current, undated facility policy, titled "Housekeeping Cleaning Schedule", provided by the Administrator on 5/1/25 at 4:23 p.m., indicated the following: "Purpose: To establish a schedule which ensures the building and equipment is maintained in a clean and sanitary manner. All items may be cleaned more frequently, if necessary. 1. Daily ...c. work surfaces d. Resident Furniture e. Resident room floors ...." 3.1-19(f)(5)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure the resident's representative or resident was notified in writing of transfer/discharge appeal rights for 2 of 3 residents reviewed for hospitalizations. (Resident 31 and 52) Findings include: 1. Resident 52's clinical record was reviewed on 4/29/25 at 10:48 a.m. Diagnoses included alcoholic hepatic (liver) failure without coma, hepatic encephalopathy (disease or damage that affects the brain, leading to a change in mental state),	F 0623	Tag number: F623 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 31 and 52 have since returned to facility, no actions needed. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	05/25/2025

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	type 2 diabetes mellitus with hyperglycemia (high blood sugar), and thrombocytopenia (low platelet count in the blood which can cause prolonged bleeding). A progress note, dated 12/8/24 at 5:50 p.m., indicated the resident was admitted to the hospital for hepatic encephalopathy. The resident's clinical record lacked indication that the resident and the resident's representative were notified of the transfer/discharge appeal rights in writing for the resident's transfer to the hospital. During an interview, on 5/1/25 at 2:59 p.m., RN 6 indicated she was not sure if the notice of transfer and discharge form was sent with residents when they went to the hospital or if it was signed when discharged and kept by the facility. She transferred Resident 52 on 12/8/24 and did not send the transfer/discharge notice with the resident. 2. Resident 31's clinical record was reviewed on 4/29/25 at 2:59 p.m. Diagnoses included end stage renal disease, dependence on renal dialysis, paroxysmal atrial fibrillation (irregular heartbeat), unspecified diastolic heart failure, legal blindness, as defined in the USA, and non-ST-elevation (NSTEMI) myocardial infarction (heart attack). A progress note, dated 11/20/24 at 3:00 p.m., indicated the resident was admitted to the hospital for a diagnosis of pneumonia. The resident's clinical record lacked indication that the resident and the resident's representative were notified of the transfer/discharge appeal rights in writing for the resident's transfer to the		action(s) will be taken; An audit was completed of residents that were transferred to the hospital in the last 14 days to ensure that the notice of Transfer/Discharge and Bed Hold Policy were issued to the appropriate person. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses and the Social Service Director were re-educated regarding the completion of the Notice of Transfer/Discharge and Bed Hold Policy, to be given to resident/RP, upon a resident being transferred to the hospital and a copy put in the chart. IV. 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; All transfers to the hospital will be reviewed Monday-Friday in clinical meeting to ensure a copy of the Notice of transfer/discharge and Bed Hold Policy were issued at the time of transfer. The Social Service Director/designee will be responsible for these audits. Audits will be completed 5x a week for 3 months The results of these audits will be	

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	hospital. During an interview, on 5/1/25 at 3:34 p.m., the DON indicated the notice of transfer/discharge form with appeal rights was sent with residents when they went to the hospital. The paperwork was given to the Emergency Medical Service personnel (EMS). She was unable to locate additional information on who was notified of the transfer and given the transfer/discharge form with appeal rights. She was uncertain if Social Services sent the aforementioned paperwork to the residents' representatives. During an interview, on 5/1/25 at 4:17 p.m., the Social Services Director (SSD) indicated she did not do anything with the notice of transfer/discharge form with appeal rights. The nursing department gave the paperwork to the resident when the resident went out the door. A current facility policy, last revised 5/8/23, provided by the SSD on 5/1/25 at 4:23 p.m., titled "Notice of Transfer and Discharge," indicated the following: " ...Prior to discharge or transfer, the facility will: Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand ...." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)		reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to ensure the resident's representative or resident received a written notice of the bed hold	F 0625	Tag number: F625 I. What corrective action(s) will be accomplished for those	05/25/2025

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	policy at the time of transfer for 2 of 3 residents reviewed for hospitalizations. (Resident 31 and 52) Findings include: 1. Resident 52's clinical record was reviewed on 4/29/25 at 10:48 a.m. Diagnoses included alcoholic hepatic (liver) failure without coma, hepatic encephalopathy (disease or damage that affects the brain, leading to a change in mental state), type 2 diabetes mellitus with hyperglycemia (high blood sugar), and thrombocytopenia (low platelet count in the blood which can cause prolonged bleeding). A progress note, dated 12/8/24 at 5:50 p.m., indicated the resident was admitted to the hospital for hepatic encephalopathy. The resident's clinical record lacked indication that the resident and the resident's representative were notified of the bed hold policy in writing at the time of the resident's transfer to the hospital. During an interview, on 5/1/25 at 2:59 p.m., RN 6 indicated she was not sure if the bed hold policy notice was sent with residents when they went to the hospital or if it was signed when transferred and kept by the facility. She transferred Resident 52 on 12/8/24 and did not send the bed hold policy notice with the resident. 2. Resident 31's clinical record was reviewed on 4/29/25 at 2:59 p.m. Diagnoses included end stage renal disease, dependence on renal dialysis, paroxysmal atrial fibrillation (irregular heartbeat), unspecified diastolic heart failure, legal blindness, as defined in the USA, and non-ST-elevation (NSTEMI) myocardial infarction (heart attack).		residents found to have been affected by the deficient practice; Residents 31 and 52 have since returned to facility, no actions needed. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit was completed of residents that were transferred to the hospital in the last 14 days to ensure that the notice of Transfer/Discharge and Bed Hold Policy were issued to the appropriate person. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses and the Social Service Director were re-educated regarding the completion of the Notice of Transfer/Discharge and Bed Hold Policy, to be given to resident/RP, upon a resident being transferred to the hospital and a copy put in the chart. IV. 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; All transfers to the hospital	

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	A progress note, dated 11/20/24 at 3:00 p.m., indicated the resident was admitted to the hospital for a diagnosis of pneumonia. The resident's clinical record lacked indication that the resident and the resident's representative were notified of the bed hold policy in writing at the time of the resident's transfer to the hospital. During an interview, on 5/1/25 at 3:34 p.m., the DON indicated the bed hold policy notice was sent with residents when they went to the hospital. The paperwork was given to the Emergency Medical Service personnel (EMS). She was uncertain if the Social Services Director (SSD) sent the bed hold paperwork to the residents' representatives when the residents were transferred. During an interview, on 5/1/25 at 4:17 p.m., the SSD indicated she did not do anything with the bed hold policy notice. The nursing department gave the paperwork to the resident when the resident went out the door. A current facility policy, last revised 9/16/17, provided by the DON on 5/1/25 at 4:39 p.m., titled "Bed Hold and Return to Facility," indicated the following: " ...The facility's bed hold policy will be given to the resident and/or resident representative as follows: ...At the time of a transfer from the facility: In cases of emergency transfer, notice 'at the time of transfer' means that the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital ...."		will be reviewed Monday-Friday in clinical meeting to ensure a copy of the Notice of transfer/discharge and Bed Hold Policy were issued at the time of transfer. The Social Service Director/designee will be responsible for these audits. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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	3.1-12(25) 3.1-12(26)			
F 0655 SS=E Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan Based on interview and record review, the facility failed to ensure residents and/or resident representatives received a copy of their baseline care plans on admission for 5 of 5 residents reviewed for care plans. (Resident 8, 52, 57, 61, and 264) Findings include: 1. Resident 52's clinical record was reviewed on 4/29/25 at 10:48 a.m. Diagnoses included alcoholic hepatic (liver) failure without coma, hepatic encephalopathy (disease or damage that affects the brain, leading to a change in mental state), type 2 diabetes mellitus with hyperglycemia (high blood sugar), unspecified anemia, and thrombocytopenia (low platelet count in the blood which can cause prolonged bleeding). A progress note, dated 12/5/24 at 12:45 p.m., indicated the resident was admitted to the facility. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan prior to the completion of the comprehensive care plan. During an interview, on 5/1/25 at 11:04 a.m., the Social Services Director (SSD) indicated she had recently been educated that the baseline care plans were to be discussed with and given to the residents and their representatives during the admission process. She had a care plan meeting	F 0655	Tag number: F655 I What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 8,52, 57 and 264 have had their base line care plan reviewed with them and a copy given t0 them. Resident 61 is no longer in the facility. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit was done on all residents to ensure that all have reviewed and received a copy of their base line care plan. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Social Service Director was educated on base line care plans and making sure that each resident or their representative have received a copy.	05/25/2025

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	with the resident's representative 2/2025. She did not have a care plan meeting with the resident or the resident's representative 12/2024 nor provide a baseline care plan. 2. Resident 61's clinical record was reviewed on 4/29/25 at 9:12 a.m. Diagnoses included essential (primary) hypertension (high blood pressure), gastroesophageal reflux disease (stomach acid and content flow back up into the esophagus) without esophagitis (inflammation of the esophagus, Charcot's joint, right ankle, right foot, left ankle, and left foot (nerve damage, often due to diabetes, leads to weakening and collapse of bones and joints in the foot, resulting in a deformed shape), repeated falls, and cellulitis of the right lower limb and the left lower limb. Census information indicated the resident was admitted on 4/3/25. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan prior to the completion of the comprehensive care plan. During an interview, on 5/1/25 at 11:04 a.m., the SSD indicated she had not provided or discussed the baseline care plan with Resident 61. 3. Resident 8's clinical record was reviewed on 4/30/25 at 11:34 a.m. Diagnoses included repeated falls, hyperlipidemia, nicotine dependence, low back pain, unspecified secondary osteoarthritis (arthritis that occurs when flexible tissue at the ends of bones wear down), fibromyalgia (long-term condition that involves widespread body pain and tiredness), chronic viral hepatitis C (liver disease that results from hepatitis C virus), fracture of unspecified parts of lumbosacral spine		IV. 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; For each new admission, during Monday-Friday clinical meeting the IDT team will go over their base line care plan prior to the meeting with the resident/resident representative, to ensure it is complete and a copy has been made for the resident/resident representative to be given at the meeting. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indica	

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	(low back) and pelvis, subsequent encounter for fracture with routine healing, unspecified sequelae of cerebral infarction (long term effects of a stroke), dysphagia (difficulty swallowing) following cerebral infarction (stroke), irritable bowel syndrome, major depressive disorder, recurrent, unspecified, hemiplegia, unspecified affecting left nondominant side, unspecified severe protein-calorie malnutrition, and other abnormalities of gait and mobility Census information indicated the resident was admitted on 4/10/25. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. During an interview, on 4/30/25 at 3:00 p.m., the SSD indicated she tries to have a care plan within the first week of a resident's admission to the facility. She recently had been given instructions regarding baseline care plans. She had not been doing baseline care plans prior to receiving this education. 4. Resident 57's clinical record was reviewed on 5/01/25 at 11:20 a.m. Diagnoses included acute respiratory failure with hypoxia (lack of adequate oxygen supply), dissection (tear) of aorta, dysphagia (difficulty swallowing) following cerebral infarction (stroke), other paralytic syndrome following cerebral infarction affecting unspecified side (loss of movement or sensation), other neuromuscular dysfunction of bladder, neurogenic bowel (lack of communication between brain and bowel causing loss of normal bowel function), unspecified systolic congestive heart failure (heart unable to pump blood adequately), myopathy (disease process that			

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	affects the skeletal muscles), kidney failure, anemia, type 2 diabetes mellitus (high blood sugar), essential (primary) hypertension (high blood pressure), unspecified injury at T 11-T 12 level of thoracic spinal cord, pressure ulcer of sacral region, muscle wasting and atrophy (shrinking in size), difficulty in walking, and other abnormalities of gait and mobility. Census information indicated the resident was admitted on 12/16/25. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. 5. Resident 264's clinical record was reviewed on 5/01/25 at 12:33 p.m. Diagnoses included constipation, chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breath), malignant neoplasm of supraglottis (cancer of the upper part of the larynx, known as the voice box), gastrostomy status (tube feeding), unspecified atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), essential (primary) hypertension (high blood pressure), hyperlipidemia (high cholesterol), unsteadiness on feet, aphasia (language disorder that makes it difficult to read, write, and speak)), encounter for palliative care (receiving hospice care), and tracheostomy. Census information indicated the resident was admitted on 4/18/25. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. A current facility policy, last revised 11/17/17,			

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	titled "Baseline Care Plan," and provided by the DON on 5/1/25 at 4:39 p.m., indicated the following: " ...The resident and/or their representative shall receive a summary of the Baseline Care Plan prior to completion of the comprehensive care plan ... As a best practice, the interdisciplinary team should attempt to schedule an initial meeting with the resident and/or resident representative within 5 days of admission to review the baseline plan of care and make updates or revisions as indicated based on feedback and input of the resident and/or representative prior to the development of the comprehensive care plan."			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary Based on record review and interview, the facility failed to ensure a recapitulation of the resident's stay was included in the discharge summary when the resident discharged from the facility. (Resident 27) Finding includes: Resident 27's clinical record was reviewed on 4/29/25 at 1:01 p.m. Diagnoses included atrial fibrillation (irregular heartbeat), obstructive sleep apnea, other specified diabetes mellitus with diabetic neuropathy, bipolar disorder, unspecified, peripheral vascular disease, unspecified, gangrene, not elsewhere classified, and chronic kidney disease, stage 4 (severe). The resident was admitted on 5/2/19 and discharged on 4/21/2025 at 10:00 a.m. to another long-term care facility. Her discharge paperwork lacked a summary of the resident's stay in the facility.	F 0661	Tag number: F661 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 27 had already discharged to another facility, no action required II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice, if they discharge the facility. III. What measures will be put into place and what systemic	05/25/2025

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	A facility form, provided by the DON on 4/30/25 at 3:30 p.m., titled "Discharge instructions," included the resident's vital signs, the resident's ordered medications, the resident's equipment and referral needs, the resident's dietary needs, the resident's activities of daily living status, and the resident's skin conditions. The form lacked a section for a summary of the resident's stay, and it was not included in the notes section of the form. During an interview, on 5/1/25 at 3:38 p.m., the DON and the ADON indicated they had been unable to locate a summary of the resident's facility stay in the resident's record or that one had been provided on discharge from the facility and were unaware one was required. 3.1-36(a)(1)		changes will be made to ensure that the deficient practice does not recur; All nurses will be trained on what to include in the discharge summary note. A check list was created to assist nurses in writing a recapitulation of the residents stay. IV. 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; DON/designee will go over each discharge summary in clinical meeting to ensure all information is included/completed. Audits will be completed 5x a week x 3 months. The IDT team will ensure the discharge summary includes a recapitulation of the residents stay. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to follow physician orders regarding daily weight monitoring and administration of blood pressure medication according to ordered parameters for 2 of 23 residents reviewed for medications. (Residents 17 and 5) Findings include: 1. Resident 17's clinical record was reviewed on 4/29/25 at 12:01 p.m. Diagnoses included essential (primary) hypertension (high blood pressure), type 2 diabetes mellitus with diabetic neuropathy, personal history of other diseases of the urinary system, presence of urogenital implants, presence of cardiac pacemaker, obstructive and reflux uropathy (blockage and flow from the bladder backs up into the ureters which connect to the kidneys), and chronic kidney disease, stage 3a (moderate decline in kidney function). A current order, dated 3/27/25, indicated to weigh the resident daily and notify the physician or nurse practitioner if the resident had a weight gain of three pounds in a day or five pounds in a week. The medication administration record for 4/1/25 through 4/1/28 indicated the resident was not weighed for 11 of 28 days. During an interview, on 5/1/25 at 10:32 a.m., RN 6 indicated the resident required daily weights. The medication administration record was lacking multiple weights. She was unable to locate additional weights for the resident.	F 0684	Tag number: F684 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; NP was notified of weight change and blood pressures being lower that parameters for residents 5 and 17. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Audit was completed to identify residents with diagnosis that result in the MD/NP needing to be notified if any changes of condition in the last 14 days to ensure that the MD/NP were notified in a timely manner. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses will be re-educated regarding notifying the MD/NP with change of conditions and/or treatment plan.	05/25/2025

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	During an interview, on 5/1/25 at 4:31 p.m., the DON indicated she expected weights to be obtained daily as ordered.2. Resident 5's clinical record was reviewed on 4/30/25 at 8:56 a.m. Diagnoses included heart failure, chronic obstructive pulmonary disease (breathing difficulty), chronic respiratory failure (decreased oxygen), hypertension (high blood pressure), and dementia. Current orders included carvedilol (antihypertensive) 12.5 milligrams twice a day (start date 4/5/25). Hold if systolic blood pressure is less than 120 millimeters of mercury (mmhg). A Mediation Administration Report (MAR), for April 2025, indicated the resident received carvedilol when her systolic blood pressure was below the physician indicated parameters as follows: On April 8th p.m., had a systolic blood pressure of 112 mmhg. On April 12th a.m., had a systolic blood pressure of 112 mmhg. On April 12th p.m., had a systolic blood pressure of 107 mmhg. On April 13th a.m., had a systolic blood pressure of 116 mmhg. On April 14th a.m., had a systolic blood pressure of 116 mmhg. On April 16th a.m., had a systolic blood pressure of 104 mmhg.		IV. 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; DON/designee will review documents, to include meds being given outside of B/P parameters and weight change, in clinical meeting 5x a week x 3 months, to monitor for timely MD/NP notification of change of condition. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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	On April 17th a.m., had a systolic blood pressure of 118 mmhg. On April 17th p.m., had a systolic blood pressure of 116 mmhg. On April 18th a.m., had a systolic blood pressure of 110 mmhg. On April 18th p.m., had a systolic blood pressure of 110 mmhg. On April 21st a.m., had a systolic blood pressure of 100 mmhg. On April 21st p.m., had a systolic blood pressure of 114 mmhg. On April 26th a.m., had a systolic blood pressure of 103 mmhg. On April 26th p.m., had a systolic blood pressure of 98 mmhg. On April 29th p.m., had a systolic blood pressure of 95 mmhg. A 4/7/25, admission, Minimum Data Set (MDS) assessment indicated the resident had an active diagnosis of hypertension and heart failure. During an interview, on 4/30/25 at 9:20 a.m., QMA 13 indicated if the resident's vital signs were below the physician parameters, she would hold the medication and notify the nurse on duty. She would then write a progress note explaining why the medication was held. On the MAR, it would show a reason code if the medication was held instead of a check mark indicating the medication was administered.			

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	During an interview, on 4/30/25 at 10:21 a.m., LPN 14 indicated if a medication was outside the parameters, she would notify the physician. In the MAR, she would indicate the medication was not administered with a reason code. During an interview, on 4/30/25 at 2:40 p.m., the ADON indicated Resident 5's carvedilol showed it was administered when her blood pressure was below the medication parameter. During an interview, on 4/30/25 at 3:05 p.m., the Administrator indicated the facility did not have a policy on medication administration regarding parameter, but the facility followed the state guidelines. A facility policy, last revised 10/17/19, provided by the Social Services Director on 5/1/25 at 4:23 p.m., titled "Weights," indicated the following: " ...Each resident shall be weighed on admission and at least monthly thereafter or in accordance with Physician orders ...." 3.1-37(a)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning During observation, record review, and interview, the facility failed to change, label, and date oxygen and nebulizer supplies for 4 of 4 residents (Resident 5, 34, 56, and 264) and ensured residents received the correct flow rate of oxygen for 1 of 4 residents reviewed for oxygen use of 8 residents in the facility who required supplemental oxygen (Resident 56). Findings include:	F 0695	Tag number: F695 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All oxygen and nebulizer supplies were changed out and dated for residents 5, 34, 56 and 264	05/25/2025

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	1. Resident 34's clinical record was reviewed on 4/30/25 at 9:53 a.m. Diagnoses included respiratory failure, hypertension (high blood pressure), anxiety, and heart failure. Current orders included change out, date, and label oxygen humidifier and tubing every Sunday night. Oxygen at 4 liters per minute (LPM) continuously via nasal cannula. During an observation, on 4/27/25 at 2:55 p.m., Resident 34's oxygen tubing bag was dated 2/2/25. During an observation, on 4/30/25 at 10:32 a.m., Resident 34's oxygen tubing bag was dated 2/2/25. During an interview, on 4/27/25 at 3:54 p.m., QMA 21 indicated Resident 34's oxygen tubing bag was labeled 2/2/25. During an interview, on 4/29/25 at 1:39 p.m., LPN 22 indicated oxygen tubing, bag, and nebulizers were changed every Sunday night. LPN 22 verified Resident 34's oxygen tubing bag was dated 2/2/25. 2. Resident 56's clinical record was reviewed on 4/29/25 at 2:01 p.m. Diagnoses included stomach cancer, gastric ulcers, breathing abnormality, and depression. Current orders included change out, date, and label oxygen tubing and humidifier every Sunday night, and oxygen at 2 LPM via nasal cannula as needed (PRN). During an observation, on 4/27/25 at 4:05 p.m., Resident 56's oxygen tubing was dated 3/30/25, but had been marked over as 4/13/25. His oxygen		II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; . All residents who us oxygen and/or nebulizers supplies were audited, changed out and dated. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee educated all nurses and QMAs on changing of oxygen supplies and dating of them. Schedule is to do every Sunday on night shift unless needed before. IV. 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; DON/designee to round on Mondays to ensure all oxygen and nebulizer supplies have been changed out and dated. An update will be given in Tuesdays clinical meeting. Audits will be completed weekly x 6 months The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved	

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	was running at 3 LPM. During an interview, on 4/27/25 at 4:21 p.m., LPN 17 indicated oxygen tubing should be changed weekly. She verified Resident 56's oxygen tubing was dated 4/13/25. During an observation, on 4/30/25 at 2:24 p.m., Resident 56's oxygen was set at 3 LPM. During an interview, on 4/30/25 at 2:44 p.m., LPN 14 indicated she wasn't sure how many liters per minute Resident 56 required. LPN 14 verified Resident 56's flow rate was 3 LPM. 3. Resident 5's clinical record was reviewed on 4/30/25 at 8:56 a.m. Diagnoses included heart failure, chronic obstructive pulmonary disease (breathing difficulty), chronic respiratory failure (decreased oxygen), hypertension, dementia, dependence on supplemental oxygen, and obstructive sleep apnea (breathing pauses during sleep). Current orders included change out, date, and label nebulizer mask and tubing every Sunday on night shift. Change out, date, and label oxygen humidifier and tubing every Sunday. During an observation, on 4/27/25 at 2:44 p.m., Resident 5's nebulizer mask was dated 4/13/25. There was no label or date on Resident 5's oxygen tubing or humidifier. During an interview, on 4/27/25 at 3:59 p.m., LPN 14 indicated oxygen tubing, humidifier and nebulizer mask are changed every Sunday. The third shift nurse was responsible for changing out the oxygen tubing, nebulizer mask and humidifier. Resident 5's nebulizer mask was dated 4/13/25 and		x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	her oxygen tubing and humidifier were not dated. 4. Resident 264's clinical record was reviewed on 5/1/25 at 12:33 p.m. Diagnoses included hypertension, status tracheostomy, and chronic obstructive pulmonary disease (difficulty breathing). Current orders included change out, date and label all tubing, bags, and set up every Sunday night. During an observation, on 4/27/25 at 11:29 a.m., Resident 264's humidification bottle was not dated. During an observation, on 4/28/25 at 10:46 a.m., Resident 264 did not have an oxygen bag or date on his humidification bottle or nebulizer mask. During an interview, on 4/27/25 at 3:54 p.m., QMA 21 indicated she was unable to locate Resident 264's oxygen tubing bag and there was no date on his oxygen tubing, nebulizer mask or humidifier bottle. During an interview, on 4/29/25 at 1:39 p.m., LPN 22 indicated Residents oxygen tubing, bag, and nebulizers get changed every Sunday night. LPN 22 verified Resident 264 did not have an oxygen tubing bag and his humidification bottle was undated. A current facility policy, revised on 1/17/19, titled "Oxygen & Respiratory Equipment - Changing / Cleaning", provided by the Administrator on 5/1/24 at 12:21 p.m., indicated the following: Guidelines: Purpose: 1. To provide guidelines to employees for changing all disposable respiratory supplies. 2. To ensure the safety of residents by			

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	providing maintenance of all disposable respiratory supplies. 3. To minimize the risk of infection. Procedure: ...2. Nasal Cannula. a. Nasal cannulas are to be changed once a week and PRN ....c. A clean plastic bag with a zip loc or draw string, etc. will be provided to store the cannula when it is not in use. It will be dated with the date the tubing was changed...4. Oxygen Humidifiers. a. Oxygen humidifiers should be changed weekly or as needed and will be dated when changed ...." 3.1-47(6)			
F 0801 SS=F Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff Based on interview and record review, the facility failed to ensure the Dietary Manager completed the required education to meet the qualifications for a dietary manager. This deficiency had the potential to impact 58 of 58 facility residents who received meals from the facility kitchen. Finding includes: The employee record form, completed by the facility and provided following entrance conference on 4/27/25, indicated the Dietary Manager had been employed by the facility since 2/1/25 and lacked a dietary manager certification. During an interview, on 4/30/25 at 3:00 p.m., the Dietary Manager indicated he was in the process of getting his food manager certification. During an interview, on 5/1/25 at 11:59 a.m., the Nurse Consultant indicated the Dietary Manager did not have any food service manager certifications.	F 0801	Tag number: F801 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. Dietary managers has started classes. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	05/25/2025

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	During an interview, on 5/1/25 at 3:08 p.m., the Dietary Manager indicated he had twenty years of food service experience but was not technically a dietary manager until he started at the facility. He was not currently certified but was getting ready to take the examination to be certified. The Corporate Dietary Consultant came to the facility about every two weeks. He had seen the dietician once since he had started the position in February 2025. He stayed in contact with the dietician through emails and phone as needed. A current dietary manager job description, signed by the Dietary Manager on 2/1/25, provided by the Administrator on 5/1/25 at 4:51 p.m., indicated the following: " ...Must be possess Food Service Sanitation Manager Certification ...." 3.1-20(e)		recur; The facility will maintain a qualified dietary manager at all times. The dietary manager is now awaiting a testing date, all classes are finished. On 05/30/25 passed and now fits requirements for a qualified dietary manager. IV. 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; The administrator/designee will audit the dietary manager's employee file monthly to ensure the facility always maintains a qualified dietary manager. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure meals were at an appetizing temperature for 12 of 15 residents reviewed for palatable meals. (Resident 17, 35, 61,	F 0804	Tag number: F804 I. What corrective action(s) will be accomplished for those residents found to have been	05/25/2025

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	116, 23, 4, 53, 38, 56, 7, 2, and 30) Findings include: During an interview, on 4/27/25 at 10:12 a.m., Resident 61 indicated the food was always cold. During an interview, on 4/27/25 at 4:28 p.m., Resident 17 indicated the food was generally not hot at all. She was getting used to eating cold scrambled eggs. During a Resident Council meeting, on 4/30/25 at 3:35 p.m., the resident group indicated the room tray meals, especially in the evening, were cold. A facility document, provided during the entrance conference on 4/27/25, indicated breakfast was at 7:45 a.m., lunch at 12:30 p.m., and dinner at 5:45 p.m. During an observation, on 4/30/25 at 6:27 p.m., a closed meal cart was on the D Hall unit. At the same time, RN 6 indicated the meal cart had just arrived. During an observation, on 4/30/25 at 6:31 p.m., CNA 18, 19, and 20 began serving trays. During an observation, on 4/30/25 at 6:47 p.m., the meal cart on the E Hall unit arrived During an observation, on 4/30/25 at 6:56 p.m., the last meal tray on the meal cart for D Hall was delivered. During an interview, on 4/30/25 at 6:58 p.m., Resident 56 stuck his finger in his food and indicated his chili dog and French fries were served ice cold.		affected by the deficient practice; No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff was educated on ways to ensure meals are being delivered to resident rooms at an appetizing temperature. Plate warmers are being utilized for hot food to help with keeping hot food at an appetizing temperature. All staff who are food handlers have been educated on sanitary conditions. IV. 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; Dietary manager/designee will audit meal trays daily to ensure appropriate food temps.	

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	During an interview, on 4/30/25 at 7:01 p.m., Resident 23 indicated her French fries were served cold. During an interview, on 4/30/25 at 7:02 p.m., Resident 30 indicated his French fries were served cold. During an interview, on 4/30/25 at 7:03 p.m., Resident 35 indicated the French fries were cold when he got the tray, but he was hungry, so he ate them. During an interview, on 4/30/25 at 7:06 p.m., Resident 4 indicated his French fries were served cold. During an interview, on 4/30/25 at 7:07 p.m., Resident 7 indicated his burger and fries were served cold. During an interview, on 4/30/25 at 7:11 p.m., Resident 116 indicated her French fries were not even warm. They were very cold. During an interview, on 4/30/25 at 7:12 p.m., Resident 53 indicated her French fries were cold, and she did not eat them. During an interview, on 4/30/25 at 7:13 p.m., Resident 38 indicated her chili dog was more cold than warm. During an interview, on 4/30/25 at 7:16 p.m., Resident 17 indicated her French fries were cold and the chili dog was barely warm when she got it. She had stayed in the facility previously, and she thought the meals used to come out on heavy warmer plates, now they were on regular plates.		Temps will be monitored 10 meal trays each meal x 4 weeks, 5 meal trays each meal x 4 weeks and then 1 meal tray weekly x4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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	During an interview, on 4/30/25 at 7:17 p.m., Resident 2 indicated her food was cold and not good. During an interview, on 4/30/25 at 7:32 p.m., CNA 18 indicated, most of the time when the food came out on the carts, it was not hot. She had to warm up the residents' food in the microwave often. During an interview, on 5/1/25 at 4:21 p.m., the Administrator indicated the residents' food should be warm when it was served. She had heard about the cold food at supper from last evening, and an in-service had been completed. A facility policy, dated 2020, provided by the Social Services Director on 5/1/25 at 4:23 p.m., titled "Monitoring Food Temperatures for Meal Service," indicated the following: " ...Food temperatures will be monitored to prevent foodborne illness and ensure foods are served at palatable temperatures ...." 3.1-21(a)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure food was prepared and served under safe sanitary conditions regarding food handling and hand washing. This deficient practice had the potential to affect 55 of 55 residents who received their meals from the kitchen. Findings include: During a lunch service observation, on 04/29/25	F 0812	Tag number: F812 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the	05/25/2025

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	12:30 p.m. to 1:15 p.m., the following food handling and food service concerns were observed: Dietary Employee 7 (DE 7) propelled a resident forward in her wheelchair and locked the wheelchair brake. She did not perform hand hygiene before touching a set of tongs to place a lemon slice into a drink. She then touched the back of another female staff member before she lifted a container of lemon slices, with her left thumb touching the inside of the lemon slice container. Dietary Employee 8 (DE 8) grabbed a hot dog bun with his bare hands, place it on a plate, and opened it. No hand hygiene was performed. DE 8 crossed his ungloved hands, placing his hands on his waist and lower back. He went through meal tickets one by one like he was dealing cards. He scratched his left nostril with his left index finger. He then grabbed a plate, and his left thumb touched the food portion of the plate. No hand hygiene was performed. DE 8 grabbed two hot dog buns and a hamburger bun with his bare hands. He used his hands to open the hot dog/ hamburger bun on the plate. No hand hygiene was performed. DE 8's left thumb kept touching the food portion of the plate while he plated food. During an interview, on 4/29/25 at 1:20 p.m., DE 7 indicated she did not reposition a resident's wheelchair, but she did lock their brake. During an interview, on 4/29/25 at 1:24 p.m., DE 8 indicated he touched the buns with his bare		same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All dietary staff was educated on safe and sanitary conditions while handling and serving food. IV. 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; Dietary manager/designee will audit 3 meal services daily, Monday-Friday, x 4 weeks, 2 meal services daily Monday-Friday, x4 weeks and then 6 meal services weekly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	hands. He also touched his hips and shirt with his bare hands. During an interview, on 4/30/25 at 3:00 p.m., the Dietary Manager indicated staff should not touch buns with their bare hands. The dietary employees should not touch any part of their clothing, glasses, or face without performing hand hygiene. 3.1-21(i)(3)		plan of correction as indicated.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00457283. Complaint IN00457283 - No deficiencies related to the allegations are cited. Survey dates: April 27, 28, 29, 30 and May 1 and 2, 2025 Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 56 SNF: 2 Residential: 13 Total: 71 Census Payor Type: Medicare: 2 Medicaid: 7 Other: 49	R 0000		

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	Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 13, 2025.			
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency Based on record review and interview, the facility failed to ensure a minimum of one awake staff member certified in CPR (cardiopulmonary resuscitation) with a hands-on training component was on site for 21 of 21 shifts reviewed for staffing sufficiency. This deficiency had the potential to affect 15 of 15 residents residing in the facility. Finding includes: The facility staffing schedule for 4/26/25 through 5/2/25 and employee CPR and first aid certifications, provided by the Administrator on 5/2/25 at 9:39 a.m., were reviewed and indicated 21 of 21 shifts lacked a staff member certified in CPR with a hands-on training component. During an interview, on 5/2/25 at 11:22 a.m., the Administrator indicated she did not have additional employee CPR certifications. She indicated the National CPR Foundation (online training company) was used by the facility for CPR certifications and did not require a hands-on training component. During an interview, on 5/2/25 at 11:38 a.m., the Administrator indicated she did not have a facility policy on CPR.	R 0117	Tag number: R117 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. . III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; An audit was completed on employee files to compile a list. DON will set up CPR/first aid hands on training for all staff. Scheduler was educated on scheduling at least 1 staff member	05/25/2025

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	Guidance from the National CPR Foundation website, accessed on 5/2/25 at 12:49 p.m., at https://nationalcprfoundation.com/support/, indicated the following: " ...Do I need hands-on training? ... if your employer or licensing board requires a hands-on component or a skills check, please visit CPRNearMe.com [an online company that provides a range of life-saving skills training providers, including hands-on and skills-check training for assessments] ...."		with a current hands on CPR/first aid certification for each shift IV. 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; DON/designee will audit schedule daily to ensure each shift has at least 1 CPR/first aid certification staff working. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview, the facility failed to ensure a current medication self-administration evaluation was completed for 1 of 7 residents reviewed for self-administration of medications. (Resident 8) Findings include:	R 0216	Tag number: R216 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 8s self-medication administration assessment has	05/25/2025

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	During an interview on 5/2/25 at 11:00 a.m., Resident R8 indicated that the facility staff filled his weekly pill box and then he self-administered his own medications throughout the week. The weekly pill box sat on the resident's kitchen table. Resident R8's clinical record was reviewed on 5/2/25 at 11:45 a.m. Diagnoses included hypertension, chronic obstructive pulmonary disease, dysphagia, and cerebral infarction without residual deficits. A current physician's order indicated the resident could self-administer medications, including PRNs (as needed), after staff set up the pill box. A "Medication Self Administration Safety Assessment", dated 11/27/23, provided by the Regional Director of Operations (RDO) on 5/2/25 at 2:00 p.m., indicated the determination was made that R8 could self-administer medication, and the medications were to be set up in a planner prior to self-administration. The RDO indicated the 11/27/23 assessment was the most current assessment on file. During an interview, on 5/2/25 at 2:13 p.m., the DON indicated medication self-administration assessments were to be done quarterly and as needed.		been done. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit was done to ensure all other assessments were done on residents that self-administer the medications. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON and ADON were educated on self-administration assessment being done prior to allowing a resident to start administering their own meds. IV. 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; Administrator/designee will audit charts on all new residential admissions weekly or as admissions occur to ensure all self-administration assessments are completed and in chart prior to allowing resident to self-administer. The results of these audits will be	

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			reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were completed and signed by the resident and/or their representative for 4 of 7 residents reviewed for service plans. (Residents 16 and 17) Findings include: 1. Resident R16's clinical record was reviewed on 5/2/25 at 1:39 p.m. Diagnoses included generalized anxiety disorder, major depressive disorder legal blindness, incontinence of urine, unsteady gait, and history of falls. The clinical record included a form under a tab named "service plan." The "Service Plan Report" contained three sections labeled focus, goal, and interventions/tasks. The focus section indicated	R 0217	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 16 and 17 service plans have been updated, reviewed and signed by each resident. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit was don on all service plans to ensure they had been updated, reviewed and signed.	05/25/2025

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	the resident had diagnosis of major depression disorder, required assistance with arranging medical appointments, had impaired visual function related to being legally blind, had a full code status, required prompting, verbal reminders and/or physical escort with engaging in social activities of interest, used psychotropic medications (drugs that affect mood, behavior, thoughts, or perceptions), was at risk for psychosocial well-being related to medically imposed restriction related to COVID-19, made inappropriate sexual comments to a female staff member, and had memory loss with impaired decision making. The "service plan" lacked specific services required by the resident which included laundry assistance, medication assistance, and assistance with activities of daily living. During an interview, on 5/2/25 at 12:27 p.m., the Administrator indicated the resident's change in level of care did not affect the resident's cost. All residents signed on admission the admission contract which encompassed the services that were included in the resident's stay at the facility. The admission contract was not specific as to which services the resident required. During an interview, on 5/2/25 at 3:46 p.m., the Administrator indicated she was uncertain as to what document in the resident's record was the service plan or where the service plan was located. During an interview, on 5/2/25 at 3:38 p.m., the Regional Director of Operations indicated the "Service Plan Report" was more like a care plan and not a service plan. The service plan should say what help the resident needs and what services the facility provides. The facility had		III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Social Service Director has been educated on all steps to the service plan. A calendar has been created of when service plans are due, with a reminder to get signatures on it. IV. 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; Administrator/designee will audit the residential service plans as they happen from the created calendar x6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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	signed "Service Plan Reports", but not actual service plans. The facility needed to revise their process to ensure they were signing service plans. 2. Resident R17's clinical record was reviewed on 5/2/25 at 11:28 a.m. Diagnoses included anemia, chronic obstructive pulmonary disease, generalized anxiety disorder, schizophrenia, unspecified psychosis not due to substance or known physiological condition, and other specified joint disorders. The clinical record contained a form under a tab named "service plan." The "Service Plan Report" contained three sections labeled focus, goal, and interventions/tasks. The focus section indicated the resident had a signed do not resuscitate statement, was able to use tobacco products independently, was a new admit to the facility and took a psychotropic medication, had a psychosocial well-being problem, was at risk for signs and symptoms of COVID-19, enjoyed group activities, had a diagnosis of schizophrenia, had the potential to be verbally aggressive, and had memory loss/dementia. The "service plan" lacked specific services required by the resident which included laundry assistance, medication assistance, and assistance with activities of daily living. During an interview, on 5/2/25 at 4:27 p.m., the Administrator indicated the facility did not have a service plan policy and followed state regulations on service plans.			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency Based on observation, record review, and	R 0302	Tag number: R302	05/25/2025

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	interview, the facility failed to ensure over-the-counter medications were labeled for 1 of 5 residents reviewed for medications. (Resident R9) Finding includes: During an observation, on 5/2/25 at 8:50 a.m., QMA 13 prepared the medications for Resident R9. She removed three-over-the-counter medications from the medication cart. The bottles were not labeled with the resident's name nor the physician's name. The unlabeled medications included aspirin 81 milligrams (mg), iron sulfate 325 mg, and multivitamins. During an interview, at the same time as the above observation, QMA 13 indicated she knew the medications belonged to Resident 9 because she (QMA 13) put the medications in the medication cart in the resident's section and did not notice the medications were unlabeled. The medications should be labeled with the resident's name and doctor. Resident 9's clinical record was reviewed on 5/2/25 at 9:18 a.m. Diagnoses included atherosclerotic heart disease of the native coronary artery without angina pectoris, essential (primary) hypertension, anemia, unspecified, and type 2 diabetes mellitus. Current orders included aspirin 81 mg daily, ferrous sulfate 325 mg daily, and multivitamin daily. During an interview, on 5/2/25 at 9:28 a.m., the DON indicated over-the-counter medications should be labeled with the resident's name, directions, and the physician's name.		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 9s over the counter medications have all been labeled. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who use over the counter medications have the potential to be affected by the alleged deficient practice. An audit was done of all medications to ensure names were on every item. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nurses and QMAs have been educated on labeling all over the counter medications. IV. 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; DON/designee will audit the residential medication cart daily, Monday-Friday x4 weeks, 3 times a week x 4 weeks and then	

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	A facility policy, last revised 7/2/19, provided by the Administrator on 5/2/25 at 11:38 a.m., titled "Medication Storage," indicated the following: " ...Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels ...."		weekly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure a tuberculin (TB) skin test was completed on or prior to admission for 1 of 7 residents reviewed for TB administration. (Resident 9) Findings include: Resident R9's clinical record was reviewed on 5/2/25 at 2:10 p.m. The record lacked documentation that a TB skin test had been administered on or prior to her admission. The resident was admitted to the facility on 3/31/25. During an interview, on 5/2/25 at 3:10 p.m., the ADON indicated she was not able to provide any documentation that a TB skin test had been completed. A current facility policy, revised on 4/22/22, titled	R 0410	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 9 received a TST test on 05/02/2025 II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An audit was completed for the residential residents to ensure all residents have received a TST. III. What measures will be put into place and what systemic	05/25/2025

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	"TB Testing-Resident", provided by the Administrator on 5/2/25 at 4:27 p.m., indicated the following: "Purpose: To reduce exposure and transmission of tuberculosis in the facility by performing screening of residents and prompt initiation of TB protocol and/or treatment. Guidelines: Assessment and Testing of Residents upon Admission: Each resident must have a health assessment upon admission, including significant past or present infectious diseases and signs and symptoms of tuberculosis (TB) ...A tuberculin skin test must be completed within three months prior to admission or upon admission unless there is documentation of a previous positive TB test ...."		changes will be made to ensure that the deficient practice does not recur; Nursing staff educated on administering a TST to residents upon admission. IV. 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; DOM/designee will audit all new admission to ensure they have received a TST. Audits will be completed 5 x a week x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	