STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00453820, IN00452635, and IN00451232 . Complaint IN00453820 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00452635 - Federal/State deficiencies related to the allegations are cited at F688. Complaint IN00451232 - Federal/State deficiencies related to the allegations are cited at F550. Survey dates: March 9, 10, 11, 12, and 13, 2025 Facility number: 000222 Provider number: 155329 AIM number: 100274950 Census Bed Type: SNF/NF: 95 SNF: 3 Total: 98 Census Payor Type: Medicare: 3 Medicaid: 76 Other: 19 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 17, 2025.	F 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans of correction.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Omar K Johnson	Executive Director	03/28/2025

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

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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 ensure residents' dignity was respected for 3 of 4 residents reviewed for abuse. (Residents' J, K, and L) Findings include: 1. The clinical record for Resident K was reviewed on 3/10/25 at 10:00 a.m. The diagnoses included, but were not limited to, heart disease. A Quarterly Minimum Data Set (MDS) assessment, dated 1/8/25, indicated Resident K was cognitively intact. An interview was conducted with Resident K on 3/10/25 at 10:09 a.m. She indicated she had reported Licensed Practical Nurse (LPN) 22 to the Executive Director (ED). He was always "hateful" and "rude" towards her. LPN 22 was changing her humidifier for her oxygen, and during that time, the interaction between LPN 22 and Resident K was not respectful. LPN 22 had made rude statements to her and stuck up his middle finger. She had stated to him, "you're not my daddy", and he responded, "you're not my mama." She expected LPN 22 to apologize to Resident K for being treated that way, but she had not received an apology. LPN 22 no longer worked at the facility. A reportable incident to the Indiana Department of Health with an investigation file was provided, on 3/10/25 at 3:38 p.m., from the ED. The incident report, dated 2/4/25, indicated Resident K had reported "customer care concerns" with a staff member (LPN 22) on 2/3/25. The follow up	F 0550	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The residents in question have the right to dignity and respect. Residents are entitled to all the freedom and privileges of any other citizens. LPN #22 no longer works in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. 1x resident interviews will be completed by Customer Care Representatives by 3/29/2025 to ensure resident rights and dignity are being met. ED/Designee will in-service all Nursing staff on resident rights and dignity. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ——The ED/designee will be responsible for monitoring or	03/29/2025

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	completed indicated the other staff person, Certified Nurse Aide (CNA) 6, had been in the resident's room at the time of the incident and did not witness LPN 22 being rude to Resident K. The investigation file of the incident between LPN 22 and Resident K included, but was not limited to, the following documents: An e-mailed statement by CNA 6, dated 2/6/25, indicating she had asked LPN 22 to assist her with Resident K's roommate. During that time, she observed LPN 22 and Resident K "bickering" back-and-forth with each other. She did not hear any cussing during the interaction between LPN 22 and Resident K. She did hear Resident K request for LPN 22 not to speak to her. LPN 22's response was "Okay. You don't want to talk to me." After, CNA 6 had exited the room first with LPN 22 coming from behind, so she had not observed LPN 22 sticking up his middle finger at Resident K prior to exiting the room. A typed statement by LPN 22, dated 2/3/25, indicated on 2/3/25 at approximately 5:00 a.m., he was in Resident K's room preparing to change out oxygen tubing and condenser water for Resident K. The resident, he believed, had gotten upset because she had been woken up while changing the oxygen supplies. The resident had declined for staff to change out her oxygen supplies at that time. LPN 22 had explained the oxygen items needed to be changed and exchange the old ones with new ones. CNA 6 provided care to Resident K's roommate and requested his assistance. During that time, Resident K was shouting random negative comments like "you're not my dad so you can't tell me when to change anything". As LPN 22 was helping CNA 6, Resident K would say something negative towards LPN 22 about every two to three minutes,		auditing all care companion audits. All residents will be interviewed weekly to ensure residents are treated with dignity and respect by care companion. Results of interviews will be monitored by ED/designee. - **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·To ensure compliance the ED/designee will complete a Resident Rights POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a ED or designee. The Resident Rights POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. **By What date will the systematic changes be completed** Compliance date 3/29/2025	

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	or so, with no reaction from LPN 22. LPN 22 and CNA 6 finished up with the roommate and as they both were walking out of the room and LPN 22 was pulling the door closed, Resident K yelled out she was going to tell everyone and today was LPN 22's last day. Typed resident statements were included in the investigation file. It indicated the following statements from Resident L and Resident J: Resident L was asked, "Did nurse [LPN 22] ever cuss at you or made you feel upset?" Resident L responded, "When I'd [sic] didn't do what he wanted one day, we got into an argument, he was like, man F*** you. So, I told him, F*** you back." Resident J was asked, "Did nurse [LPN 22] ever cuss at you or made you feel upset?" Resident J responded, "He is pushy and rude. Always trying to make me take stuff I don't want to take too forceful for me." 2. The clinical record for Resident J was reviewed on 3/10/25 at 12:00 p.m. The diagnoses included, but were not limited to, heart failure. A Significant Change MDS assessment, dated 1/14/25, indicated Resident J was cognitively intact. An interview was conducted with Resident J on 3/11/25 at 12:13 p.m. He indicated LPN 22 was "pushy" and "demanding." He would wake him up in the middle of night and want him to do something. For example, "Take a sip of water." If he declined, LPN 22 would not take no for an answer. Resident J had requested he did not want LPN 22 back in his room anymore due to being			

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	disrespectful. 3. The clinical record for Resident L was reviewed on 3/10/25 at 1:00 p.m. The diagnoses included, but were not limited to, quadriplegia. A Quarterly MDS assessment, dated 1/30/25, indicated Resident L was cognitively intact. An interview was conducted with Resident L on 3/11/25 at 2:19 p.m. He indicated he did have an argument with LPN 22 a while back. He rushes through care and doesn't listen. During an argument with LPN 22, he had stated to Resident L, "shut the f*** up," and he responded, with repeating the same words he said back to him. The nurse just didn't want to listen to what he had to say. He had spoken to the Director of Nursing (DON) and the ED about the incident. LPN 22 was disrespectful. It was addressed and over now. It did not happen again. An interview was conducted with the ED on 3/13/25 at 9:49 a.m. He indicated he had completed the investigation into the reportable incident between Resident K and LPN 22. During the investigation, he had also spoken to Resident L and Resident J. A discussion with LPN 22 was provided and included education about his mannerisms. LPN 22 had stated to the ED he was just trying to "coach" the residents to have a better life and encourage them to be healthier. LPN 22 meant well, but he was disrespectful. LPN 22 has been on medical leave since the incident. A resident's rights policy was provided by the DON on 3/13/25 at 1:59 p.m. It indicated, "...In accordance with this right to dignity and respect, residents are entitled to all of the freedom and privileges of any other citizen. The resident also			

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	has obligations and responsibilities to the Community staff and other residents...Every resident in a long-term care facility shall have at least the following rights... (18) Each resident shall be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs..." This citation relates to complaint IN00451232. 3.1-3(t)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, interview, and record review, the facility failed to ensure a call light was in reach for 1 of 1 resident reviewed for call lights (Resident G). Findings include: The clinical record for Resident G was reviewed on 3/11/25 at 10:00 a.m. The diagnoses included, but were not limited to, anemia, cancer, heart failure, diabetes, hemiplegia caused by stroke (weakness on one side of the body), and depression. A Quarterly Minimum Data Set assessment, completed 12/20/24, indicated Resident G's preferred language was Spanish, and she needed an interpreter to communicate with doctors or health staff. It also indicated Resident G was cognitively intact with impairment of her right upper extremity. An observation was conducted of Resident G on	F 0558	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident G will have call light within reach. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. An audit will be completed by DNS/designee by 3/29/2025 of all residents to ensure call light within reach. An in-service will be completed by DNS/designee by 3/29/2025 on call light placement.	03/29/2025

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	3/12/25 at 9:39 a.m. Resident G was in bed and her call light cord was attached to the wall mount on the wall next to the bed. The cord went behind the resident's bed, and it was hanging in front of the headboard near the ground on the right side of the bed. The call light was out of sight and out of reach of the resident. In an interview with Resident G on 3/12/25 at 9:39 a.m., the resident indicated she was aware she did not have her call light. "Sometimes she has it and sometimes she does not." She indicated when she does have her call light, she knows how to use it. At 10:36 a.m., Laundry Aide 11 was asked to give Resident G her call light. Laundry Aide 11 then told Certified Nurse Aide (CNA) 9, who was in another resident room, that Resident G needed her call light handed to her. When CNA 9 came out of the resident's room, she was asked if Resident G used her call button to request help and CNA 9 indicated Resident G does use the call light. During an observation of Resident G on 3/12/25 at 1:46 p.m., her call light was still in the same place and positioned behind her bed as it was that morning. The Director of Nursing (DON) was interviewed in Resident G's room on 3/13/25 at 10:48 a.m. The resident's call light cord was observed plugged into the wall on top left side of the bed, underneath her pillow, out of sight, and out of reach. The DON indicated their policy indicates the call light should be within reach, and she believed the call light was currently in reach of the resident. The resident was asked, at that time, to reach for her call light. The resident pulled the pillow from behind her head, then placed the pillow back, and attempted to feel around for her call light. She was unable to reach the call light.		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An in-service will be completed by DNS/designee with all staff by 3/29/2025 on Call light placement. DNS/Designee will round each shift to ensure call lights are in place. **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?** ·To ensure compliance the DNS/Designee will complete Call light POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by DNS or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.	

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	The DON then grabbed the call light and handed it to the resident. During an interview with the DON on 3/13/25 at 1:05 p.m., she indicated they do not have a policy on call lights, and they just follow the standards of care for call light use and availability. 3.1-3(v)(1)		**By What date will the systematic changes be completed** Compliance date 3/29/2025	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to get residents up to a wheelchair and complete regular hair shampooing for 1 of 4 residents reviewed for ADLs (Activities of Daily Living). (Resident G) Findings include: The clinical record for Resident G was reviewed on 3/11/25 at 10:00 a.m. The diagnoses included, but were not limited to, anemia, cancer, heart failure, diabetes, hemiplegia caused by stroke (weakness on one side of the body), and depression. A Quarterly Minimum Data Set assessment, completed 12/20/24, indicated Resident G's preferred language was Spanish, and she needed an interpreter to communicate with doctors or health staff. It also indicated Resident G was cognitively intact with impairment of her right upper extremity. On 3/12/25 at 9:39 a.m., Resident G was observed in her room, lying in bed wearing a hospital gown. The resident's hair was oily, stringy, and tangled	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident G, who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident G is receiving shower, hair wash per resident preferences. Resident G will be offered to get up daily and shower/shampoo her hair. A wheelchair will be present in the resident room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** —— All residents have the potential to be affected. —— DNS/Designee will Audit	03/29/2025

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	in the back. She indicated she had not had a shower, a full bed bath, or her hair shampooed in about 10-12 days. She asked the staff to wash her hair, but they did not. The staff had not gotten her up to her wheelchair in "a long time." She used to have a wheelchair in her room, but she had not seen it for many days. No wheelchair was observed in the room. She indicated she would like to get up to a wheelchair. She does remember the staff using "a machine" to get her up, but she has not seen the machine in "a long time." During an interview on 3/12/25 at 11:46 a.m. with Licensed Practical Nurse (LPN) 10, she indicated the resident's showers were scheduled for Tuesdays and Fridays. While the resident does not frequently refuse care, she "has been known to" in the past. She could communicate well with Resident G, who makes her needs known well enough. The resident was a Hoyer lift with a two people assist to transfer and said there should be a wheelchair in the resident's room. The Assistant Director of Nursing Services (ADNS), who attended the interview, indicated the resident does have a wheelchair, but she does not know where it was. The resident had told them she likes to stay in a hospital gown and stay in bed. During an interview with Certified Nurse Aide (CNA) 9 on 3/12/25 at 1:55 p.m., she indicated she gave the resident a partial bed bath the day prior (3/11/25) because the resident requested a partial bed bath instead of a full one. During an observation and interview with Resident G on 3/13/25 at 9:53 a.m., she indicated she had not yet received a complete bed bath or shower this week, and her hair had still not been washed. Resident G's hair was very oily, stringy, matted, and now had some flakes of skin near her		Care profiles related to WC to ensure Wheelchairs are present in rooms. Care companion to conduct QIS Questions on personal choices/showers to ensure resident ADL care is provided per resident preference, resident profile will be updated per resident preference. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·An in-service will be completed by DNS/Designee by 3/29/2025 for all staff to ensure resident personal choices/preferences are met. ·An in-service will be completed by DNS/Designee on 3/29/2025 for all staff to ensure resident wheelchairs are available in resident rooms. ·DNS/Designee will round each day to ensure resident is receiving ADL care per preference. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance, the	

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	scalp. She indicated a wheelchair was now in her room, and it was the first time she had seen one in "many days." She would like to get up to the wheelchair. The Director of Nursing (DON) provided shower sheets, on 3/13/25 at 10:48 a.m., which covered the period from 2/4/25 to 3/11/25. According to the shower sheet for 3/11/25, the CNA documented she had given the resident a complete bed bath and shampooed the resident's hair. Prior to the 3/11/25 documentation, the last time staff documented washing the resident's hair was on 2/25/25. During an interview with the Occupational Therapist (OT) on 3/13/25 at 9:11 a.m., she indicated she did a new evaluation with the resident, on 3/12/25, after the Speech Therapist (ST) referred the resident to her for evaluation for a wheelchair. The ST wanted the resident to be up in a wheelchair in the dining room for meals. She thought she had an 18-inch wheelchair but needed a larger one. The resident's wheelchair was not available when she did her evaluation, and she could not speak to what nursing had been doing to get the patient out of bed. The resident had a decline in bed mobility since she was last seen a year ago, had right arm hemiparesis (weakness), increased left arm weakness, and needed a different wheelchair. She communicated well with the resident using gestures and the resident understood more English than she speaks. She indicated the resident did seem receptive to using the wheelchair and she will be working on getting a larger wheelchair for the resident. During an interview with the ST on 3/13/25 at 9:24 a.m., she indicated she evaluated Resident G, on		DNS/Designee will complete POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by a DNS or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. **By What date will the systematic changes be completed** Compliance date 3/29/2025	

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	3/4/25, to assess swallowing due to the resident's emergency oral surgery. She wanted to make sure the resident was on an appropriate diet. She indicated Resident G did not want to try a puree diet and wanted to stay on a regular diet. She wants her up in a wheelchair in the dining room for meals, "just to get her out of her room." During an interview with the Therapy Manager on 3/13/25 at 9:30 a.m., she indicated when Resident G first admitted, she was using an 18-inch wheelchair, but therapy then put her in a 20-inch wheelchair, and that should be utilized by nursing staff currently. During an interview with the DON on 3/13/25 at 10:48 a.m., she indicated the ADNS had found the resident's wheelchair and put it in the room that morning. The wheelchair may not have been in the resident's room this week if it had been taken to be cleaned. She indicated the night shift CNAs have assigned room wheelchairs to wash on different days of the week. They take the wheelchair to the shower room, wash it, then line them up in the gym to dry overnight. They bring them back in the morning once they are dry, but if they forget, the day shift will come get them. Otherwise, the wheelchair stays in the resident's room when not being cleaned. She indicated this morning, the resident asked LPN 10 if she could get up to her wheelchair. However, when the DON came in later to assist, the resident told her she did not want to get up. Resident G was observed shaking her head "no" while the DON made this statement. A care plan for ADLs, dated 4/12/24, indicated Resident G required assistance with ADLs related to impaired mobility and the history of a cerebrovascular accident (stroke). Her ability to participate in ADL care fluctuated from the			

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	morning to evening, and day to day. The goal was for Resident G to have their needs met daily with staff assistance as evidenced by being neat, clean, well-groomed, and dressed appropriately. Resident G was a two-staff person assisting with the use of a Hoyer (mechanical) lift and assistance with bathing as needed per the resident's preference. The approach was to offer showers twice a week with a partial bed bath in between. A care plan approach, added 3/12/25, indicated Resident G preferred to stay in bed "most of the time". A care plan, dated 5/7/24, indicated the resident had impaired mobility related to right side body weakness. The care plan approaches included, "Encourage resident to participate in transfer and bed mobility activities ...Notify therapy of declines in mobility or improvement in mobility." A physician order, initiated on 5/24/24, indicated the resident was to have a Hoyer (a mechanical device that helps move people with limited mobility) and two people assist with transfers to bed and wheelchair. Another order, initiated on 10/16/24, indicated that a foam cushion should be on the seat of the resident's wheelchair. A care plan, dated 6/10/24, indicated Resident G "Refuses ADL care at times." The care plan approach was to "Educate resident on the possible negative effects from refusing ADL care at times." During an interview with the DON on 3/13/25 at 1:05 p.m., she indicated they do not have a policy on ADLs, and that they just follow standards of care. This citation relates to Complaint IN00453820.			

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	3.1-38(a)(2)(A) 3.1-38(a)(2)(B) 3.1-38(a)(3)(B)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, interview, and record review, the facility failed to ensure a resident with contractures (abnormal shortening or tightening of muscle tissue the renders the muscle highly resistant to stretching and can lead to permanent disability) received splint application as recommended by therapy staff for 1 of 2 residents reviewed for rehabilitation services. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/11/25 at 10:25 a.m. The diagnoses included, but were not limited to, hemiplegia (one-sided paralysis) and hemiparesis (one-sided muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side, contracture of left wrist, contracture of left knee, contracture of left hand (fingers), contracture of left elbow, and muscle wasting and atrophy. An Admission Minimum Data Set (MDS) assessment, dated 1/10/25, indicated Resident B was cognitively intact, had impairment on one side of the upper and lower extremity, substantial assistance with upper body dressing, and dependent for lower body dressing. An activities of daily living (ADL) care plan, initiated on 1/4/25 and revised on 1/16/25, indicated Resident B required assistance with	F 0688	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Thefacility must ensure that a resident who enters the facility without limited range of motion does not experience a reduction in range of motion unless the resident's clinical condition deteriorates, that a reduction in range of motion is unavoidable. A Resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Resident B has a splint applied per order.	03/29/2025

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	ADLs related to weakness and impaired mobility due to contractures to the left wrist, left knee, left fingers, and left elbow. The approach included physical and occupational therapy as ordered/indicated but no utilization of a splint. A physical therapy note, dated 1/24/25, indicated restorative nursing program set up and training for bilateral lower extremity and range of motion exercises. Restorative nursing aide demonstrated good understanding of the program. An occupational therapy note, dated 2/2/25, indicated the resident will safely wear a grip hand splint and an elbow extension splint on the left elbow for up to four hours with minimal signs of redness, swelling, discomfort or pain to prevent progression of contractures. An interview conducted with Therapy Manager, on 3/10/25 at 10:45 a.m., indicated Resident B had contractures and was receiving therapy services. Resident B "fired" all the therapy staff but was agreeable to receive the application of a splint, and such was done by nursing staff. The therapy staff conducted an in-service with all the nursing staff to ensure proper application of the splints. The clinical record for Resident B, reviewed on 3/11/25 at 10:27 a.m., did not include any physician orders for the application of splints. The clinical record for Resident B did not include any care plan related to the application of splints. An observation and interview conducted with Resident B, on 3/10/25 at 11:45 a.m., indicated no splint was observed to the left hand. Resident B indicated he should have a splint for his left hand, but the staff never apply the splint.		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. DNS/Designee to conduct an audit on splints to ensure compliance with nursing measures, order and resident choice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/Designee will keep a running list of residents with splints and will round each day to ensure resident has splint applied per order. DNS/Designee will round each day to ensure residents with orders for splints have the splints in place. Education will be provided to Nursing staff on splint use and restorative program. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DNS/Designee will be responsible for monitoring/auditing	

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	An observation and interview conducted with Resident B, on 3/11/25 at 3:39 p.m., indicated no splint was observed to the left hand. A policy entitled Restorative Nursing Program, revised 11/2018, was provided by the Director of Nursing on 3/11/25 at 2:08 p.m. The policy indicated the restorative nursing programs include active or passive range of motion and splint or brace assistance. The process of the program was coordinated, supervised and carried out by nursing staff. A resident-centered care plan will be developed by the nurse and include measurable objectives, specific interventions to maintain or improve function, or to prevent, to the extent possible, further declines in resident function. This citation relates to Complaint IN00452635. 3.1-42(a)(2)		the POC QAPI tool completed Weekly times 4 weeks, monthly times 5 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. **By What date will the systematic changes be completed** Compliance date 3/29/2025	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation and interview, the facility failed to ensure postings of current daily working staff. This had the potential to affect 98 of 98 residents that reside in the facility. Findings include: Random observations were made of the facility on 3/09/25 at 10:35 a.m., 10:44 a.m., and 11:27 a.m. The posting of current daily working staff in the facility was dated 3/07/25. An interview was conducted, on 3/13/25 at 9:42 a.m., with the Nurse Schedule Coordinator (NSC). She indicated she completes the staffing sheets that are posted in the facility daily and leaves	F 0732	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Staff Posting has been updated.** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the	03/29/2025

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	them for the night shift nurse to post them first thing the following morning. She indicated the night shift nurse forgot to remove the daily working staffing sheet, dated 3/07/25, and post the current staffing sheet. During an interview with the Executive Director (ED) on 3/13/25 at 10:10 a.m., he indicated the NSC usually posted the current daily working staff sheet. If it is a Saturday, nursing staff may forget to post the sheet. The NSC does come in on the weekends at times to help with supplies, so she will also post the daily work schedule if it had not been done. On 3/13/25 at 2:00 p.m., the Director of Nursing (DON) provided the Posted Nurse Staffing Data and Retention Requirements policy. It indicated, " ...Policy: It is the policy of [name of facility corporation] to make staffing information readily available in a readable format and publicly posted to residents and visitors at any given time ...Procedure: 1. The facility must post the following information at the beginning of each shift. a. The facility name b. The current date c. Resident census d. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered nurses ii. Licensed practical nurses iii. Certified nurse aides ..."		alleged deficient practice. Scheduler/Designee education on daily posting **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by DNS/designee by 3/29/2025 on importance of maintaining compliance with daily posting. ·DNS/Designee will check the staffing posting daily to ensure the document is posted and accurate. **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?** To ensure compliance the DNS/Designee will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a DNS or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including	

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			termination of the responsible employee **By What date will the systematic changes be completed** Compliance date 3/29/2025	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on observation, interview, and record review, the facility failed to hold insulin when a blood sugar was below the physician's prescribed perimeters for 1 of 1 randomly observed insulin administration (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 3/9/25 at 11:31 a.m. The diagnoses included, but were not limited to, diabetes. A care plan, dated 10/21/24, indicated she was at risk for adverse effects of hyperglycemia (high blood sugar), or hypoglycemia (low blood sugar) related to use of glucose lowering medication and diagnosis of diabetes. The goal was for her not to experience symptoms of hyperglycemia or hypoglycemia. The interventions included monitoring blood sugar and administer medications as ordered. A physician's order, dated 12/30/24, indicated she was to receive insulin lispro (fast acting insulin) 12 units three times a day with meals; hold if blood sugar was less than 150 milligrams per deciliter (mg/dL).	F 0760	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 20/51 is receiving insulin as ordered per physician. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents receiving insulin have the potential to be affected by the alleged deficient practice. Audit of medication/insulin orders to be completed by DNS/Designee to check for insulin parameters to ensure hold task is attached to each order. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	03/29/2025

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	On 3/9/25 at 11:31 a.m., Licensed Practical Nurse (LPN) 25 was randomly observed administering medications to Resident 20. LPN 25 performed a blood sugar check on Resident 20 with a reading of 122. She went to the medication cart and opened a new lispro insulin pen. She primed the pen with two units of insulin, looked at the Medication Administration Record to check the lispro insulin order, and then set the insulin pen to administer 12 units of insulin lispro. LPN 25 gathered her supplies and entered Resident 20's room. LPN 25 asked Resident 20 where she wanted to receive her insulin and Resident 20 indicated she would like the insulin shot in her left arm. LPN 25 cleansed an area on Resident 20's upper left arm with alcohol and was preparing to administer 12 units of lispro insulin to Resident 20. The insulin administration was stopped. During an interview on 3/9/25 at 11:55 a.m., LPN 25 indicated the physician's order for Resident 20 included to hold the lispro insulin if her blood sugar was less than 150. LPN 25 indicated Resident 20's insulin lispro, 12 units, should have been held and not given. On 3/12/25 at 11:00 a.m., the Clinical Nurse Consultant (CNC) provided the Medication Administration Skills Competency, last revised July 2023, which read "...Perform the 5 rights of medications: Right Resident, Right Time, Right Dose, Right Route, Right Time..." 3.1-48(c)(2)		An in-service will be completed by DNS/designee on 3/29/2025 for all licensed staff to include ensuring insulin order are administered as ordered. DNS/designee will review daily orders during clinical meetings to verify and ensure all insulins are given as ordered. **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?** To ensure compliance the DNS/Designee will complete POC CQI tool once weekly for one month, and time monthly for 5 months by a nurse manager or designee. The CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. **By What date will the systematic changes be completed** Compliance date 3/29/2025	
F 0812 SS=F	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure expired food was disposed of timely with the potential to affect 98 of 98 residents that receive food from the kitchen. (Facility) Findings include: The facility kitchen was observed with Culinary Aide 2 (CA) on 3/9/25 at 9:45 a.m. The inspection of the dry storage was conducted with CA 2. During an interview with CA 2, he indicated the top dates on the boxes were delivery dates and bottom dates were expiration dates. The following food items were observed outdated in the dry storage: One bag of graham cracker crumbs - expired 3/5/25, Eleven bags of sugar free Jell-O - expired 2/26/25, Fourteen bags of pork flavored gravy mix- expired 3/5/25, Six bags of cream soup base- expired 3/6/25, Brownie mix- opened 9/14/24 and expired 11/15/24, Cake mix- expired 8/28/24, Streusel topping- expired 11/8/24, Chocolate chips- expired 1/21/25, Two boxes of assorted Jell-O- expired 2/22/25, Twelve bags of vanilla pudding- expired 3/6/25, Cake mix- expired 2/28/25, Four bags of gravy mix- expired 2/28/25, Nine boxes of corn starch- expired 2/5/25, A container of peanut butter - expired 3/6/25, Rainbow sprinkles - expired 3/6/25, Large storage bin of oatmeal- expired 3/6/25, and Large storage bin of thickener- expired 3/1/25. During the inspection of the walk-in refrigerator, the Dietary Manager (DM) indicated the items	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Facility to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The identified graham crackers, jello, sugar free jello, pork gravy mix, cream soup, brownie mix, cake mix, streusel topping, chocolate chips, vanilla pudding, corn starch, peanut butter, rainbow sprinkles, oatmeal, thickener, uncovered pies, peanut butter and jelly sandwiches, green peppers, lettuce cheese and cucumber were destroyed **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. ED/Designee will Inservice all Culinary Staff on food services and Distribution The Dietary Manager reviewed the dry storage area, refrigerator area to ensure food was properly covered and was not	03/29/2025

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	that were expired should have been removed and disposed of properly. In the walk-in refrigerator, there were pies that were cut and ready for service. However, they were not covered while being stored in the walk-in refrigerator. The DM indicated the pies should have been covered while in the walk-in refrigerator. The following items were observed outdated in the walk-in refrigerator: Eight pre-made peanut butter and jelly sandwiches- expired 3/8/25, Box of green peppers- expired 2/25/25, Two bags of shredded lettuce- expired 3/4/25, Box of lettuce- expired 2/25/25, Shredded cheese- expired 1/25/25, and Six English cucumbers- expired 3/5/25. During an interview on 3/10/25 at 10:05 a.m., the DM indicated all expired food items had been removed. The DM was planning on conducting an in-service with staff, on 3/10/25, to ensure the policies were understood and followed. On 3/10/25 at 1:35 p.m., the food storage policy, revised 5/2023, was provided by the Executive Director. The policy indicated food should be covered and/or stored in covered containers. The food must be clearly labeled and dated with the date of preparation and the date the food should be discarded or consumed. Opened food should have the date marked and not exceed the manufacturer's use-by-date. During an interview on 3/13/25 at 11:16 a.m., the Director of Nursing indicated 98 residents receive a tray from the kitchen at each meal service. 3.1-21(i)(2) 3.1-21(i)(3)		outdated **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ED/Designee to complete audit tool on dating and labelling in dry storage. ED/Designee to complete audit tool on dating and labelling in walking refrigerator. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the ED/Designee will complete QAPI/POC. audit tool weekly for 4 weeks and monthly for five months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The audit tool will be reviewed monthly by the IDT for six months after which the IDT will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date will the systematic changes be completed** Compliance date 3/29/2025	

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F 0847 SS=D Bldg. 00	483.70(n)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements Based on interview and record review, the facility failed to ensure a binding arbitration agreement was explained to the resident representative and signed by the resident representative for 2 of 3 residents reviewed for arbitration agreements. (Resident 42 and Resident 88) Findings include: 1. The clinical record for Resident 42 was reviewed on 3/13/25 at 11:09 a.m. The diagnoses included, but were not limited to, dementia, age-related physical debility, hypertension, cognitive communication deficit, muscle weakness, and difficulty in walking. Resident 42 was admitted to the facility on 10/28/24. An Order Appointing Temporary Guardian document, file date 10/23/24, indicated a temporary guardian was ordered for Resident 42. The powers of the guardian included, but were not limited to, to consent in writing to the medical or surgical treatment of Resident 42 and to enter into contracts for the admission of Resident 42 to any health care facility reasonably deemed necessary for the safety and well-being of Resident 42. The temporary guardian preceded for a period of 90 days. An Admission Minimum Data Set (MDS) assessment, dated 11/4/24, indicated Resident 42 was severely cognitively impaired. An Arbitration Agreement, dated 10/31/24, indicated Resident 42 signed the arbitration agreement and initialed that she understood the	F 0847	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Affected resident's Arbitration Agreements resident 42 and 88 have been signed by Guardian/POA. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. ED/Designee will complete a facility wide audit to ensure all Arbitration Agreements have been signed by resident/qualified Responsible Party. All Admission staff will be Inserviced by ED/Designee on signing Arbitration Agreements by 3/29/2025. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All Admission staff will be In serviced by ED/Designee on signing Arbitration Agreements by 3/29/2025.	03/29/2025

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	155329	A. BUILDING 00 B. WING	03/13/2025

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	nature of the agreement, understood she wasn't required to enter into the agreement, understood the right to terminate or withdraw from the agreement within 30 days of signing, and acknowledged she entered into the agreement freely and voluntarily. The document was also signed by Admission Staff 3. Admission Staff 3 signed the bottom of the Arbitration Agreement that indicated the following, "...Acknowledgement: By signing below, I hereby attest that the Resident, who is in an alert and oriented state of mind, designated or authorized the above-named legal representative, in my presence, to sign this agreement on behalf of Resident...." An Order Appointing Guardian document, file date of 1/9/25, indicated Resident 42 was deemed incapable of managing their person and property because of a diagnosis of dementia and stroke. Resident 42 was rendered unable to make health care decisions on her own and found to be an incapacitated person. An interview conducted with Admission Staff 3, on 3/13/25 at 10:20 a.m., indicated Resident 42 admitted to the facility with no power of attorney, no family, or any contact person. Resident 42 ended up being a candidate for a guardian and was appointed one, effective January of 2025. Admission Staff 3 indicated she had to explain the agreement to Resident 42 about three times because it was difficult for Resident 42 to understand. 2. The clinical record for Resident 88 was reviewed on 3/13/25 at 10:58 a.m. The diagnoses included, but were not limited to, dementia, chronic pain, hypertension, age-related cognitive decline, and muscle weakness. Resident 88 was admitted to the		·Arbitration agreements will be reviewed by ED/designee to ensure appropriate individuals have signed the agreement. · **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** POC/QAPI Tool will be utilized weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By What date the systematic changes be completed** Compliance date 3/29/2025	

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	facility on 9/6/24. Resident 88's daughter was listed as her power of attorney (POA) for financial and health care purposes. An Admission MDS assessment, dated 9/12/24, indicated Resident 88 was cognitively impaired. An Arbitration Agreement, dated 9/9/24, indicated Resident 88 signed the arbitration agreement and initialed that she understood the nature of the agreement, understood she wasn't required to enter into the agreement, understood the right to terminate or withdraw from the agreement within 30 days of signing, and acknowledged she entered into the agreement freely and voluntarily. The document was also signed by Admission Staff 3. Admission Staff 3 signed the bottom of the Arbitration Agreement that indicated the following, "...Acknowledgement: By signing below, I hereby attest that the Resident, who is in an alert and oriented state of mind, designated or authorized the above-named legal representative, in my presence, to sign this agreement on behalf of Resident...." An interview conducted with Admission Staff 3, on 3/13/25 at 10:20 a.m., indicated Resident 88's POA was her daughter. The POA had some personal items that came up and the daughter was unable to come into the facility and sign the paperwork that consisted of the binding arbitration agreement. So, Admission Staff 3 contacted Resident 88's POA over the phone and the POA verbally stated it was okay for Resident 88 to sign the binding arbitration agreement. Admission Staff 3 indicated there was an option to sign the binding arbitration agreement electronically.			

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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control was maintained by not ensuring hand hygiene was performed prior to donning gloves, failed to utilize hand hygiene during a medication administration, popping pill medication in bare hands for 3 of 6 residents randomly observed for medication administration, and not donning personal protective equipment (PPE) during bathing and dressing for 1 of 1 resident reviewed for dialysis. (Resident 2, Resident 12, Resident 20, and Resident 24) Findings include: 1. The clinical record for Resident 20 was reviewed on 3/9/25 at 11:31 a.m. The diagnoses included, but were not limited to, diabetes. On 3/9/25 at 11:31 a.m., Licensed Practical Nurse (LPN) 25 was randomly observed performing a blood glucose check for Resident 20. LPN 25 gathered the supplies to conduct the blood glucose check from the medication cart, including a pair of disposable gloves. LPN 25 entered Resident 20's room and informed Resident 20 about the need to obtain a blood glucose check. LPN 25 donned the disposable gloves, cleansed Resident 20's finger with an alcohol swab, and performed the blood glucose check. LPN 25 did not perform hand hygiene prior to donning the disposable gloves. 2. The clinical record for Resident 12 was reviewed on 3/12/25 at 9:00 a.m. The diagnoses included, but were not limited to, hypertension.	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility to establish and maintain infection control and prevention programs. The facility is to establish a system to prevent, Identify, Report, investigate, and control infections and communicable diseases for all residents and visitors. All affected residents will be free from unsafe infection control practices. LPN 25 has been educated on donning gloves during blood glucose check LPN 26 has been educated on cleansing hands during medication administration Resident 24 has been educated on medication administration infection control protocols. CAN 5 and 7 have been educated on appropriate PPE during ADL care. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	03/29/2025

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	On 3/12/25 at 8:53 a.m., LPN 26 was randomly observed administering a nasal spray to Resident 12. LPN 26 gathered Resident 12's medications and nasal spray from the medication cart, along with a pair of disposable gloves. LPN 26 entered Resident 12's room and informed Resident 12 she had her medications and nasal spray. LPN 26 donned a pair of disposable gloves and administered Resident 12's nasal spray. LPN 26 then picked up the plastic cup of oral medications with her gloved hands and handed the cup to Resident 12. LPN 26 did not perform hand hygiene prior to donning the disposable gloves. During an interview on 3/12/25 at 9:05 a.m., LPN 26 indicated she normally performed hand hygiene prior to donning disposable gloves. 3. The clinical record for Resident 24 was reviewed on 3/9/25 at 12:00 p.m. The diagnoses included, but were not limited to, chronic pain. A physician order, dated 11/15/24, indicated Resident 24 was to receive 1000 milligrams (mg) of Tylenol three times a day for moderate pain as needed (PRN). An observation was conducted of a medication administration for Resident 24 with Unit Manager (UM) 8 on 3/9/25 at 11:09 a.m. UM 8 was observed at the medication cart preparing to administer 1000 mg of Tylenol to Resident 24. UM 8 opened the medication cart and pulled a medication card out and popped two tablets of Tylenol in his bare hands. He then placed the two tablets in a medication cup and administered the medication to the resident. UM 8 had not utilized hand hygiene prior to preparing the medication administration.		**corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. A Hand Hygiene in-service will be completed by DNS/Designee for all staff. Hand Hygiene checks offs will be completed by DNS/Designee for all staff. An in-service will be completed by DNS/Designee on Infection Prevention [hand hygiene/EBP] by 3/29/2025. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·A Hand Hygiene in-service will be completed by DNS/Designee for all staff. · Hand Hygiene checks offs will be completed by DNS/Designee for all staff. ·An in-service will be completed by DNS/Designee on Infection Prevention [hand hygiene/EBP] by 3/29/2025. ·DNS/Designee will round each shift to ensure staff are following appropriate infection control practices. **How will the corrective action (s) be monitored to ensure the**	

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	An interview was conducted with UM 8 on 3/9/25 at 11:15 a.m. He indicated he does not normally touch the medication with his bare hands. 4. The clinical record for Resident 2 was reviewed on 3/10/25 at 9:00 a.m. The diagnoses included, but were not limited to, renal disease. A Quarterly Minimum Data Set (MDS) assessment, dated 1/16/25, indicated Resident 2 was cognitively intact. A care plan, revision date of 1/23/25, indicated the resident required enhanced barrier precautions. The interventions included but were not limited to, the staff was to wear gown and gloves prior for high contact care activities. An observation was conducted of Resident 2 in her room on 3/10/25 at 9:15 a.m. The resident was observed in her bed wearing a gown. An enhanced barrier precaution sign was observed on her wall. The resident indicated, at that time, she had a port in her right leg for dialysis and a gastrostomy tube (surgically inserted tube in stomach). She will be going to dialysis soon. During that time, Certified Nurse Aide (CNA) 5 and CNA 7 had entered the resident's room and indicated they were going to get her ready for dialysis. The CNAs were observed going into the bathroom filling a basin of water and donning gloves. The CNAs were not observed donning on PPE prior to bathing and dressing the resident. An interview was conducted with Resident 2 on 3/11/25 at 12:19 p.m. She indicated the staff will don gloves, but do not don a gown while bathing and dressing her. A Standard and Transmission-Based Precautions		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. **By What date the systematic changes be completed** Compliance date 3/29/2025	

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	(Isolation) Policy was provided by Director of Nursing on 3/11/25 at 2:08 p.m. It indicated, "...hand hygiene... Perform hand hygiene: Before having direct contact with a resident...Enhanced Barrier Precautions (EBP): An intervention designed to reduce the transmission of resident organisms that employs targeted use of gown and glove use during high contact resident care activities. Enhanced Barrier Precautions expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, it refers to the use of gown and gloves during high-contact resident are activities that provide opportunities for transfer of MDROs [multidrug resistant organism] to staff hands and clothing. Enhanced barrier precautions are used for: Resident(s) with chronic wounds and/or indwelling medical devices, regardless of their MDRO status..." A hand hygiene policy was provided by the Director of Nursing on 3/11/25 at 2:08 p.m. It indicated, "...Procedure: Healthcare personnel should use an alcohol-based hand rub or wash the soap and water for the following clinical indications...Immediately after glove or PPE removal...B. Indication for hand-rubbing but not limited to...Before and after removing glove..." 3.1-18(b)(2) 3.1-18(l)			