STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. BUILDING 00 B. WING	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MUNCIE CARE CENTER	2701 LYN-MAR DR MUNCIE, IN 47304

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 28, 29, 30, and May 1 and 2, 2025 Facility number: 000097 Provider number: 155687 AIM number: 100290970 Census Bed Type: SNF/NF: 104 Total: 104 Census Payor Type: Medicare: 4 Medicaid: 73 Other: 27 Total: 104 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 12, 2025.	F 0000	The preparation,submission and implementation of this POC does not constitute an admission or agreement with the facts and conclusions set forth survery report. Our POC was prepared and executed as a means to continously improve the quality of care and comply with all applicable federal and state regulations. The facililty hereby requesting a desk review of our POC to this survey.	
F 0551 SS=D Bldg. 00	483.10(b)(3)-(7)(i)-(iii) Rights Exercised by Representative Based on record review and interview, the facility failed to ensure the designated resident health care representative signed medical consent forms for 1 of 1 resident reviewed for health care representation. (Resident 256) Finding includes: Resident 256's clinical record was reviewed on	F 0551	F 551 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident KH's court appointed healthcare representative was notified once he returned from his	05/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaushik Patel	Executive Director	06/10/2025

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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	4/30/25 at 10:59 a.m. Diagnoses included schizoaffective disorder, bipolar disorder, and other cirrhosis of the liver. The admission date was 4/25/25. A 5/20/24 court document titled, "Order Appointing Health Care Representative," indicated Resident 256 had been declared legally incompetent and appointed a legal health care representative. The health care representative was not related to Resident 256 and had full authority to make health care decisions. A 4/25/25 alert note indicated Resident 256's daughter told staff she was not the resident's health care representative. A voice mail message was left for the legal health care representative. A 4/26/25 mental health consent form was signed by Resident 256's daughter. A 4/26/25 psychotropic medications informed consent form was signed by Resident 256's daughter. A 4/26/25 Indiana Physician Order for Scope of Treatment (POST) form was signed by Resident 256's daughter, which declared the resident was to receive all life saving measures. A 4/28/25 social services general note indicated the facility tried to contact the court appointed health care representative and was informed he was on vacation through 5/5/25. A 5/2/25 social services general note indicated the facility spoke with the legal representative's appointed contact person for the court appointed health care representative and was given verbal approval to send the resident to the emergency		vacation that next of kin (KH's daughter) signed consent forms upon admission. Healthcare Representative stated that it was fine, the daughter is an active part of resident's plan of care and agreed to what was signed. New POST and consent to treat were signed through verbal consent Chip, the court appointed healthcare rep to continue the current plan of care. Resident has been discharged from the facility since 05/03/2025. ¿ -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit all admissions from the last 30 days to ensure that, if the resident was not their own responsible party, the consents were signed by the resident's representative. ¿ -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nursing staff regarding Rights Exercised by Representatives to include who	

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	room as necessary. During an interview, on 5/2/25 at 11:14 a.m., the Administrator indicated he was aware Resident 256 had a legal health care representative and had sent the facility Admission Contract by electronic mail (e-mail). The health care representative was on vacation and had not signed the contract yet. During an interview, on 5/2/25 at 11:46 a.m., the Social Services Director (SSD) indicated she was aware Resident 256 had a legal health care representative, but he was on vacation and could not be reached. The facility contacted the daughter, since she was listed as an emergency contact and the consents needed signed promptly. The SSD had not sent these consents to the health care representative by e-mail. The SSD had recently spoken with the legal representative's appointed contact person to get verbal permission to send the resident out for evaluation. During an interview, on 5/2/25 at 2:44 p.m., the Administrator indicated the facility had made attempts to contact the health care representative. Resident 256's daughter was asked to sign the consent forms while waiting for the health care representative to return from vacation. No additional information was provided by the facility prior to exit on 5/2/25.		can sign consents upon admission. Ongoing audit to be completed by DNS or designee to monitor admissions to ensure consents are being signed by resident representative, if resident is not their own responsible party, complete 3 admitted residents X weekly x 8 weeks, 1 admitted resident x weekly x 8 weeks and monthly thereafter. ¿ -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	
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 notify the physician of elevated blood pressures for 1 of 5 residents reviewed for unnecessary medications. (Resident 39)	F 0580	F 580 -what corrective action(s) will be accomplished for those residents found to have been affected by the	05/25/2025

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	Finding includes: Resident 39's record was reviewed on 4/29/25 at 2:21 p.m. Diagnoses included malignant neoplasm of frontal lobe, malignant neoplasm of parietal lobe, and essential (primary) hypertension. Current physician orders included, Aldactone (blood pressure medication) tablet 50 milligram (mg) one tablet by mouth one time a day, hydrochlorothiazide (blood pressure medication) 50 mg tablet by mouth in the morning, amlodipine besylate (blood pressure medication) 10 mg tablet give one tablet by mouth one time a day, and clonidine (blood pressure medication) 0.3 mg tablet give one tablet by mouth two times a day. An alert note dated 1/25/25 at 9:27 a.m. indicated the resident was admitted to the hospital for a stroke. Review of blood pressure readings from 4/1/25 through 5/1/25 indicated the following: 4/1/25 8:47 p.m. 200/90 mmHg (millimeters of mercury), 4/2/25 7:53 p.m. 200/101 mmHg, 4/9/25 8:48 p.m. 189/100 mmHg, 4/12/25 7:51 a.m. 176/107 mmHg, 4/13/25 7:11 a.m. 190/96 mmHg, 4/13/25 11:10 a.m. 190/96 mmHg, 4/29/25 2:20 a.m. 222/138 mmHg, 4/30/25 3:07 a.m. 198/102 mmHg, and 5/1/25 2:42 a.m. 195/100 mmHg. The resident's clinical record lacked physician notification for these elevated blood pressures. During an interview with LPN 15 on 5/1/25 at 3:32		deficient practice Resident WH blood pressures reviewed, and MD notified of abnormal blood pressures with no new orders given. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed on all blood pressures from the last 14 days to ensure that MD notification was obtained on abnormal blood pressure values. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education with nursing staff on notification of changes policy. Ongoing audit to be completed by DNS or designee to ensure MD notification on abnormal blood pressures, to 5 X weekly x 4 weeks, 3 x weekly x 4 weeks and monthly thereafter. -how the corrective action will be	

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	p.m., she indicated there was not a standard protocol for notifying the physician of abnormally high blood pressure. If she had obtained an abnormal blood pressure, the physician would have been notified immediately. During an interview with LPN 17 on 5/2/25 at 1:55 p.m., she indicated the physician was working to stabilize the resident's blood pressure and noted recent changes in his medication. The resident was scheduled to see the physician again on 5/7/25 for a follow up. Although there was not an order, staff let the physician know about the resident's blood pressure every week. Blood pressures for the resident during her shifts were 140s/80s and she would have called for blood pressure over 140. During an interview with the DON on 5/2/25 at 2:57 p.m., she indicated there was no standing protocol for physician notification regarding abnormal vital signs unless directly ordered by the physician. The DON indicated the physician should have been notified of blood pressures outside the resident's baseline. A current, undated facility policy titled, "Notification of Changes", provided by the DON on 5/2/25 at 12:03 p.m. included the following: "Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification....Definitions: "Need to alter treatment significantly" means a need to stop a form of treatment because of adverse consequences (such as adverse drug reaction), or commence a new form of treatment to deal with a problem (for example, the use of any medical procedure, or		monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	

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	therapy that has not been used on that resident before)...Circumstances requiring notification include:...b. Potential to require physician intervention...3. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute Condition. iii. Exacerbation of a chronic condition...." 3.1-5(a)(2) 3.1-5(a)(3)			
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 provide notifications of hospitalization to the Long-Term Care Ombudsman for 1 of 3 residents reviewed for hospitalizations. (Resident 60) Finding includes: During an interview with Resident 60 on 4/28/25 at 1:44 p.m., he indicated he was hospitalized last month with pneumonia. Resident 60's record was reviewed on 5/1/25 at 11:19 a.m. Diagnoses included heart failure, end stage renal disease (kidney failure), dependence on renal dialysis, chronic obstructive pulmonary disease (COPD), and pneumonia. A progress note dated 3/12/25 at 10:18 p.m. indicated the resident was sent to the hospital by ambulance. A nurse's note dated 3/18/25 at 10:32 p.m. indicated the resident returned to the facility via	F 0623	F-623 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident MS hospitalization was turned in and submitted to the ombudsman portal. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed on all transfer/discharges for the month of April to ensure that Ombudsman was notified of resident status. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with Social Services Director and Alzheimer's Care Unit Director on the Long-term Care	05/25/2025

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	ambulance at 6:00 p.m. During an interview with the SSD on 5/1/25 at 3:52 p.m., she indicated Ombudsman notifications for transfers and discharges had not been sent out for March 2025 and were usually sent within the first week of the next month. She was in charge of sending Ombudsman notifications. Resident 60 was hospitalized on 3/12/25 and the Ombudsman should have been notified. During an interview with the DON on 5/2/25 at 9:06 a.m., she indicated the facility did not have a policy regarding Ombudsman notification. A undated document titled, "Indiana Long Term-Term Care Ombudsman Program", provided by the DON on 5/2/25 at 9:06 a.m. included the following: "Report the following to both the State LTC Ombudsman (SLTCO) and your local LTC Ombudsman Representative: Acute Emergency Transfer When a resident is transferred on an emergency basis to an acute care facility and expected to return, the SLTCO must be notified. Information from facilities regarding emergency transfers should be provided in a monthly list to the SLTCO, which should include resident's names, dates of transfer, facilities to which residents were transferred, and reasons for the transfers...." A table in the document indicated when a resident experiences a transfer or discharge to a hospital, notice to the Ombudsman is required when practicable, and can be via a monthly list. 3.1-12(a)(6)(A)		Ombudsman Program. audit to be completed by or to ensure list of resident transfers/discharges submitted to the Ombudsman. Audit to residents X monthly x 2 months, 3 residents x monthly x 2 months and 1 resident monthly x 2 months. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr			

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	Based on interview and record review, the facility failed to ensure bed hold policies were provided to the resident and/or responsible parties at the time of the hospital transfer for 2 of 3 residents reviewed for hospitalization. (Residents 48 and 60) Findings include: 1. During an interview on 4/28/25 at 2:57 p.m., Resident 48 indicated she was hospitalized a couple months ago for about a week and did not receive any paperwork regarding a bed hold. Resident 48's record was reviewed on 4/29/25 at 2:37 p.m. Diagnoses included chronic respiratory failure, congestive heart failure, chronic obstructive pulmonary disease (COPD), centrilobular emphysema, asthma, and pneumonia. A progress note, dated 1/26/25 at 4:38 p.m., indicated the resident was sent to the hospital for difficulty breathing. A progress note, dated 1/31/25 at 6:40 p.m. indicated the resident returned from the hospital. The clinical record lacked indication of bed hold notification or policy was provided to the resident or representative. 2. During an interview with Resident 60 on 4/28/25 at 1:44 p.m., he indicated he was hospitalized last month with pneumonia. He did not receive paperwork or notification of the bed hold or the facility's policy regarding bed holds. Resident 60's record was reviewed on 5/1/25 at 11:19 a.m. Diagnoses included, heart failure, end stage renal disease, chronic obstructive pulmonary disease, and pneumonia.	F 0625	F 625 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident MS and TB were educated on bed hold policy from previous hospitalizations. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed on all transfers to hospital from the last 14 days to ensure that the resident and/or their representatives were notified of the Bed Hold Policy. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nursing staff on transfer and discharge policy. Ongoing audit to be completed by DNS or designee on transfers to hospital to ensure resident or representative were notified of Bed Hold Policy. Audit to be completed 5 X weekly x 4 weeks, 3 x weekly x 4 weeks, 1 x	05/25/2025

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	A progress note dated 3/12/25 at 10:18 p.m. indicated the resident was transferred to the hospital. A progress note dated 3/18/25 at 10:52 p.m. indicated the resident returned to the facility at 6:00 p.m. The clinical record lacked indication of bed hold notification or the bed hold policy was given to the resident or representative. During an interview with the DON on 5/1/25 at 3:39 p.m., a copy of the facility bed hold policy and Notice of Transfer/Discharge was provided. The DON could not provide evidence of who these forms were given to, as they were typically sent with the ambulance staff when the resident was transferred. During an interview with the DON on 5/1/25 at 4:32 p.m., she indicated the facility was unable to find bed hold notifications in either resident's clinical record. A current undated policy titled, "Notice of Bed Hold Policy", obtained from the DON on 5/1/25 at 3:39 p.m., indicated the following: " ...Our facility is required by state and federal law to inform you of our bed hold policy...." 3.1-12(a)(25) 3.1-12(a)(26)		weekly x 4 weeks and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to provide catheter care	F 0690	F 690 -what corrective action(s) will be	05/25/2025

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	in a manner to reduce the risk of contamination for 1 of 1 resident reviewed for catheter services (Resident 46). Findings include: During an observation on 5/2/25 at 2:08 p.m., CNA 14 performed ABHR (alcohol based hang rub) prior to entry the resident's room. A PPE (personal protective equipment) cart was located just inside the door. CNA 14 donned gloves but no gown. She bent down and emptied resident 46's catheter bag into a plastic graduated cylinder. She emptied the cylinder in the toilet, then removed her gloves and donned a new set, which she pulled from the pocket of her scrubs. No hand hygiene was performed. She then filled two plastic buckets with soap and water, placed washcloths into them and placed the buckets on the resident's bed. The CNA then assisted the resident to stand at his walker, placing her gloved hands on his left arm and shirt, as well as the walker, resulting in contaminated gloves. Using her contaminated gloved hands, she pulled down his pants, removed his brief, and put the soiled brief into a trash can, touching the trash bag. With the same soiled gloves, the CNA obtained several washcloths and one bucket and wiped the resident's genitalia and the catheter tubing. Using the same gloved hands she obtained a second and third wash cloth and repeated the process. She obtained two clean washcloths and dried the resident's genitalia and catheter tubing. Using the same gloves, the CNA obtained a clean brief that was on his bed, placed the brief on him, pulled up his pants, touched the privacy curtain, and began placing the soiled washcloths in a trash bag. She took off her contaminated gloves and washed her hands in the sink.		accomplished for those residents found to have been affected by the deficient practice Resident MB had catheter care performed again per policy and no adverse effects were noted, with 1:1 education to CNA that originally performed catheter care. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed at random with nursing staff for residents with catheters to ensure adherence to catheter care policy. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nursing staff on catheter care policy. Ongoing audit to be completed by DNS or designee on catheter care with employee catheter care check offs for residents with catheters. Audit to be completed 5 X weekly x 4 weeks, 3 x weekly x 4 weeks, 1 x weekly x 4 weeks	

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	During an interview following the observation, CNA 14 indicated she was unsure if she needed to perform hand hygiene after taking off soiled gloves. Gowns should be worn in an EBP (enhanced barrier precaution) room, but she forgot to don one. Resident 46's clinical record was reviewed on 4/29/25 at 2:43 p.m. Current diagnoses included malignant neoplasm of the prostate, benign prostatic hyperpiesia with urinary tract symptoms, history of urinary tract infections (UTI), and schizophrenia. Resident 46 had current physician's orders for the following: change 18 french catheter monthly and as needed (3/21/25), change Foley catheter bag weekly and as needed (2/17/25), Foley catheter care every shift and as needed (8/8/23), flush catheter with 50 cc of saline daily at bed time (8/10/23), and observe for signs and symptoms of UTI-leaking, burning with urination, increased frequency of urination, cloudy urine, flank pain, fever or abdominal cramps every shift. Notify doctor if signs or symptoms are observed (8/8/23). Sign outside resident's room. Gown and gloves for all interactions with resident. Used for residents with MDRO (multi-drug resistant organism) or have a high risk of MDRO acquisition (Residents with wounds or indwelling medical devices). Used for high activity interactions with resident. Face shields should be used for any task that have high potential for splash or spray (4/6/24). A 3/19/25, quarterly, Minimum Date Set (MDS) assessment, indicated the resident had an indwelling catheter and required substantial assistance for toileting.		and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	

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	155687	A. BUILDING 00 B. WING	05/02/2025

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	The resident had a current, 9/4/24, care plan problem/need regarding the use of an indwelling catheter. An approach for this need was to provide catheter care each shift (5/12/22). The goal for this need was for the resident to be free of complications related to the use of a catheter (revised 9/4/24). The resident was observed in common areas with a catheter bag attached to his wheelchair during the following dates and times: 4/28/25 at 10:27 a.m., 4/29/25 at 9:56 a.m., and on 5/1/25 at 10:16 a.m. and 11:32 a.m. During an interview with the IP (Infection Preventionist) on 5/2/25 at 2:44 p.m., she indicated during catheter care for a resident on EBP, supplies should be gathered in the room, hand hygiene should be performed, a gown donned, with gloves and potentially a mask if the task might incur splash. If gloves were soiled, they should be removed. Hand hygiene should be done if hands were soiled. Then a new pair of gloves should be donned and if necessary, all other PPE. PPE should be donned during high-contact care activities. A current, undated, facility policy titled, "Catheter Care," provided by the IP on 5/2/25 at 3:49 p.m. indicated "...Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care....15. Using a circular motion, cleanse the meatus with a clean cloth moistened with water and perineal cleaner (soap)...." 3.1-41(a)(1)			
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

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Bldg. 00	Based on record review and interview, the facility failed to follow Registered Dietician recommendations and notify the physician for a resident experiencing significant weight loss for 1 of 4 residents reviewed for nutrition. (Resident 42) Finding includes: Resident 42's clinical record was reviewed on 4/30/25 at 2:58 p.m. Diagnoses included essential hypertension, morbid severe obesity due to excess calories, and type 2 diabetes mellitus. An overweight/obesity care plan, initiated on 8/5/21, indicated the resident received a carbohydrate controlled regular textured diet, experienced 5.7 percent (%) weight loss in 30 days, and weight loss in 180 days. Interventions included the following: Diet as ordered (8/5/21) and monitor meal intakes (8/5/21). A current care plan, initiated on 12/28/24, indicated the resident had behaviors and would refuse to be weighed. A current order, initiated 2/28/25, indicated a regular texture consistent carbohydrate diet. Resident 42's meal consumption, for the last 30 days was reviewed and indicated the resident typically ate 76-100 % of her meals, occasionally 51- 75 % of meals, and rarely 0-25 % of meals. Resident 42's weight record was reviewed and indicated the following: 291.6 pounds (lbs) on 10/22/24, 283.6 lbs on 11/5/24, 281.6 lbs on 1/20/25, 281.4 lbs on 2/1/25, 265.4 lbs on 3/2/25, and 256.8 lbs on 4/27/25.	F 0692	F 692 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident LWs weights and NAR recommendations were reviewed, MD and diet changed per RD recommendation with MD approval. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed on all resident's weight changes and RD recommendations from NAR the last 14 days to ensure MD notified of significant weight changes and RD recommendations were ordered. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nursing staff on notification of changes and one on one education with DNS on ensuring RD recommendations are	05/25/2025

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	A 3/5/25, quarterly, Minimum Data Set (MDS) assessment, indicated Resident 42 was cognitively intact, required set up assistance from staff for eating, and was on a physician prescribed weight-loss regimen. Resident 42 weighed 266 lbs. on 3/2/25. A 3/12/25, Interdisciplinary team (IDT) Nutrition At Risk (NAR) note indicated Resident 42 weighed 265.4 lbs on 3/2/25 and had experienced a significant weight loss in 30 days, the previous weight was 281.4 lbs on 2/1/25. The recommendation was to discontinue the carbohydrate control portion of the diet to improve intake, continue to evaluate for weight changes, and update the care plan as appropriate. A 3/21/25, IDT NAR note indicated Resident 42 weighed 265.4 lbs on 3/2/25 and 281.4 lbs on 2/1/25. The recommendation was to discontinue the carbohydrate control portion of the diet to improve intake, continue to evaluate for weight changes, and update the care plan as appropriate. A 3/26/25, IDT NAR note indicated Resident 42 weighed 265.4 lbs on 3/2/25 and 281.4 lbs on 2/1/25. The recommendation was to discontinue the carbohydrate control portion of the diet to improve intake, continue to evaluate for weight changes, and update the care plan as appropriate. A 4/3/25, IDT NAR note indicated Resident 42 weighed 265.4 lbs on 3/2/25 and 281.4 lbs on 2/1/25. The recommendation was to discontinue the carbohydrate control portion of the diet to improve intake, continue to evaluate for weight changes, and update the care plan as appropriate. A 4/28/25, IDT NAR note indicated Resident 42 weighed 246.8 lbs on 4/27/25 and previous		being followed. Ongoing audit to be completed by DNS or designee on monitoring weight changes and RD recommendations from NAR. Audit to be completed 3 X weekly x 4 weeks, 1 x weekly x 8 weeks, and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	

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	weights were 265.4 lbs on 3/2/25 and 281.4 lbs on 2/1/25. The resident experienced a significant weight loss of 7% in 30 days. The recommendation was to discontinue the carbohydrate control portion of the diet to improve intake, continue to evaluate for weight changes, and update the care plan as appropriate. Review of the "Registered Dietitian Reports" from 2/3/25- 3/26/25 indicated Resident 42 was not reviewed. The clinical record lacked documentation indicating the physician was notified of the significant weight loss. The clinical record lacked an order to change the resident's diet or that the physician declined the recommendation to change the resident's diet. During an interview, on 5/2/25 at 10:07 a.m., CNA 16 indicated Resident 42 usually consumed 75-100% of her meals and did not require feeding assistance. During an interview, on 5/2/25 at 12:11 p.m., the Director of Nursing (DON) indicated she received electronic mail (e-mails) from the Registered Dietitian. The "Registered Dietitian Report" had recommendations for each resident reviewed. The DON was not aware the IDT NAR notes in the resident electronic medical record (eMar)recommended a change in Resident 42's diet as she went off the e-mailed report. Resident 42 was not in the "Registered Dietitian Report" e-mail. During an interview, 5/2/25 at 1:56 p.m., the DON indicated the physician should have been notified when the resident experienced significant weight			

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	loss. The IDT NAR notes should've included documentation indicating the physician notification. The Registered Dietitian completed the IDT NAR notes in the residents' clinical records. The NAR program was not effective if the recommendations were not communicated and the physician was not notified. A facility policy, dated 2023, titled, "Nutritional Management", provided by the DON on 5/2/25 at 2:31 p.m., indicated the following: "The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition...Nursing staff shall obtain the resident's height and weight upon admission, and subsequently in accordance with facility policy...The dietitian shall use data gathered from the nutritional assessment to estimate the resident's calorie, nutrient, and fluid needs and whether intake is adequate to meet those needs. Current standards of practice/formulas are used in calculating these estimates...Interventions will be individualized to address the specific needs of the resident. Examples include, but are not limited to: Diet liberalization unless the resident's medical condition warrants a therapeutic diet... Monitoring of the resident's condition and care plan interventions will occur on an ongoing basis. Examples of monitoring include...The physician will be notified of: Significant changes in weight, intake, or nutritional status..." 3.1-46(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record	F 0693	F 693	05/25/2025

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	review, the facility failed to check placement and prevent contamination during site care for 1 of 2 residents reviewed for feeding tubes. (Resident 36) Finding includes: Resident 36's clinical record was reviewed on 4/30/25 at 8:27 a.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction (stroke), oropharyngeal phase dysphagia (difficulty swallowing), and unspecified protein-calorie malnutrition. Current orders included check placement of tube prior to medication administration, flush feeding tube with 80 milliliters (ml) of water every shift, and place a split drain sponge with antibiotic ointment for feeding tube maintenance every shift. A 2/13/25, annual, Minimum Data Set assessment indicated Resident 36 had severe cognitive impairment. The resident required moderate assistance with eating. He was dependent on staff for assistance with all other activities of daily living. Nutritional approaches included a mechanically altered diet and a feeding tube. A discontinued care plan, resolved on 4/2/25, indicated the resident received supplemental tube feedings due to inadequate food and beverage intake related to a stroke with right hemiparesis, dysphagia, and malnutrition. Interventions included the following: provide care to the feeding tube site as ordered, water flushes as ordered, report concerns to the physician as needed, and check tube placement every feeding. During a feeding tube site care observation on 4/30/25 at 9:53 a.m., LPN 9 performed hand		-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident CM had g tube care performed again per policy and no adverse effects were noted, with 1:1 education to LPN that originally performed catheter care. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed at random with nursing staff for residents with g-tubes to ensure adherence to g-tube care policy. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nursing staff on gastrostomy site care and verifying tube placement policy. Ongoing audit to be completed by DNS or designee by completing observation rounds on employees providing gastrostomy site care to residents. Audit to be completed 5	

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	hygiene and donned a gown and gloves prior to entering the resident's room. She placed the tube feeding site care supplies on a foldable chair at the bedside. The chair, where she placed the supplies, lacked a barrier. She used her gloved hands and released the bottom of the abdominal binder that covered the feeding tube site. Without hand hygiene or checking placement, the feeding tube was opened with the same gloved hands and a syringe without the plunger was connected to the feeding tube. The feeding tube was flushed with water via gravity and closed with her contaminated gloved hands. The resident's old split drain sponge was removed. There was scant drainage noted on the old dressing. Without completing hand hygiene and a change of gloves, the bottle of normal saline wound wash was picked up from the chair and sprayed onto a clean gauze. Prior to spraying the saline, the gauze was opened with the same dirty gloves. The feeding tube site had minimal redness. The site was cleansed from the insertion site moving in an outward motion. LPN 9 used her contaminated gloved hands to open the resident's dresser drawer, and picked up a tube of zinc oxide cream in her right hand. She returned to the resident's bedside without hand hygiene and a change of gloves, placed the zinc oxide cream on the foldable chair, removed a packet of antibiotic ointment from her pocket, opened the antibiotic ointment, and squeezed the antibiotic ointment onto her right gloved index finger. She used her index finger and applied the antibiotic ointment to the reddened feeding tube insertion site and then applied a new split drain sponge to the site. The abdominal binder was put back in place over the feeding tube. During an interview, on 4/30/25 at 10:22 a.m., LPN 9 indicated during the above feeding tube site		X weekly x 4 weeks, 3 x weekly x 4 weeks, 1 x weekly x 4 weeks and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	

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	care observation, she should have checked placement of the feeding tube prior to flushing the resident's feeding tube. She would have typically performed hand hygiene and changed her gloves after removing the old dressing and prior to cleansing the resident's feeding tube site, but she did not this time. Hand hygiene and a change of gloves should have been completed after touching the resident's drawer, the items in the drawer, and prior to application of the resident's antibiotic ointment to the feeding tube site. The lack of proper infection control practices placed the resident at risk for infection. During an interview on 4/30/25 at 11:40 p.m., the DON indicated staff were required to verify placement of a feeding tube prior to flushing, administration of medication, and administration of feedings. Hand hygiene and glove changes were required after touching potentially contaminated surfaces during feeding tube site care. A lack of proper hand hygiene placed the resident at risk for infection. A current facility policy, undated, titled "Verifying Placement of Feeding Tube," provided by the DON on 4/30/25 at 1:29 p.m., indicated the following: "Policy: It is the practice of this facility to ensure proper placement of feeding tubes prior to beginning a feeding, flushing the tube, or before administering medications via feeding tube. Policy Explanation and Compliance Guidelines: 1. Before beginning a feeding, flushing the tube, or administering a medication via the feeding tube, proper placement and functioning will be verified...." A current facility policy, undated, titled "Gastrostomy Site Care," provided by the DON on 4/30/25 at 1:29 p.m., indicated the following: "It is			

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	the policy of this facility to perform gastrostomy site care as ordered and per current standards of practice. Policy Explanation and Compliance Guidelines: ... 8. Set up supplies using clean technique using over bed table covered with towel or disposable barrier. 9. Wash hands and don gloves. 10. Apply any other PPE [personal protective equipment] as needed to protect staff from any exposure to infectious material and to comply with any isolation precautions ordered. 11. Maintain clean technique. 12. Remove old dressing if applicable and discard in appropriate container. 13. Wash hands and don gloves. 14. ...gently clean the area around the tube and continue in an outward circular fashion... 18. Apply dressing as ordered...." 3.1-44(a)(2) 3.1-18(l)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to follow physician orders regarding oxygen flow rate and humidity for 1 of 2 residents reviewed for oxygen. (Resident 48) Finding includes: Random observations of Resident 48 indicated the following: During an observation on 4/28/25 at 2:57 p.m., Resident 48 was in her bed asleep with oxygen on via nasal cannula at five liters per minute. The humidity bottle attached to the oxygen concentrator was empty and dated 4/24. During	F 0695	F 695 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident TB oxygen settings were corrected to what was ordered and humidification added, MD notified of oxygen setting with no new orders given. -how other residents having the potential to be affected by the same deficient practice will be	05/25/2025

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	an interview with the resident, she indicated she wore oxygen continuous at four liters per minute. She was unable to get out of bed and did not adjust the oxygen flow rate. On 4/29/25 at 9:00 a.m., the resident was asleep in bed with the oxygen on via nasal cannula at five liters per minute. The humidity bottle attached to the oxygen concentrator was empty and dated 4/24. Resident 48's clinical record was reviewed on 4/29/25 at 2:37 p.m. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia (low oxygen), chronic respiratory failure with hypercapnia (high carbon dioxide levels), and dependence on supplemental oxygen. A current order, dated 2/3/25, included oxygen at four liters per minute via nasal cannula. Physician notification was required if oxygen saturations were below 90 percent. A current order, dated 2/6/25, included a humidification bottle change once weekly, on Thursday, and as needed for humidity every shift. A 2/3/25, admission, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident was dependent on staff assistance for toileting, bathing, dressing, and personal hygiene. She required substantial assistance for transfers. Specialized services included continuous oxygen therapy. A current care plan, dated 3/13/23, indicated the resident had a potential for alteration in her respiratory status related to chronic obstructive pulmonary disease and chronic respiratory failure		identified and what corrective actions will be taken Audit completed with all residents receiving oxygen therapy to ensure ordered settings and humidification were correctly applied. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nursing staff on Oxygen Administration policy. Ongoing audit to be completed by DNS or designee by completing observation rounds on oxygen settings/humidification compared to resident orders. Audit to be completed 5 X weekly x 4 weeks, 3 x weekly x 4 weeks, 1 x weekly x 4 weeks and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits	

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	with hypoxia and hypercapnia. Interventions included administer oxygen as needed per physician order (3/13/23) and monitor oxygen flow rate and response (3/13/23). A Nurse's note, dated 4/14/25 at 5:38 p.m., indicated Resident 48 complained of breathing discomfort and restlessness. The oxygen saturation level was 87 percent. The oxygen was increased to five liters per minute via nasal cannula and an as needed inhaler was administered. The nurse remained with the resident for ten minutes. After 10 minutes, the resident's oxygen saturation was 92 percent and the resident verbalized she felt better. The nurse planned to report the information to the next shift. The clinical record lacked a physician notification of the resident's change in respiratory status when the oxygen flow rate was changed to five liters per minute. During an observation on 4/29/25 at 4:04 p.m., Resident 48 was in bed watching television with her oxygen on via nasal cannula at five liters per minute. The humidity bottle attached to the oxygen concentrator was empty and dated 4/24. The oxygen concentrator was turned around backwards and positioned in a manner that the flow rate was difficult to read. During an interview on 4/29/25 at 4:22 p.m., LPN 7 indicated Resident 48 was cooperative with care. The resident did not get up on her own and had not been known to change her own oxygen flow rate. On 4/29/25 at 4:29 p.m., LPN 7 was in Resident 48's room and indicated the resident's oxygen flow rate was set on five liters per minute with an empty		based on QAPI recommendations, otherwise will review on a PRN basis.	

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	humidity canister dated 4/24. The resident's oxygen flow rate was ordered at four liters per minute. Oxygen flow rate should have been followed per physician orders. The oxygen humidification should have been changed as needed to prevent a lack of humidification. She had not received any information in report regarding a change in the resident's respiratory status. The residents oxygen saturation was 94 percent. LPN 7 was unable to find any information in the resident's clinical record where the physician was notified when the oxygen flow rate was changed to five liters per minute on 4/16/25. On 4/29/25 at 4:47 p.m., the DON indicated residents' oxygen flow rates should have been administered according to the physician's orders. The physician should have been notified when a resident required oxygen at five liters per minute when the order indicated to administer oxygen at four liters per minute. Humidity should have been changed as needed to prevent an empty oxygen humidification bottle. On 4/30/25 at 9:34 a.m., CNA 8 indicated she was familiar with the resident and never knew the resident nor her family to change the oxygen flow rate. A current facility policy, undated, titled "Oxygen Administration," provided by the DON on 4/30/25 at 9:47 a.m., indicated the following: "Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences... Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In			

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	such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control... 9. The equipment needed for oxygen administration will depend on the type of delivery system ordered... Types of delivery systems include: a. Nasal Cannula - Oxygen is administered through plastic cannulas in the nostrils. Effective for low oxygen concentrations less than 40 %. Requires humidification at flow rates greater than 4 liters/minute... 12. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen." 3.1-47(a)(6)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to provide individualized interventions for dementia services to reduce or eliminate the need for psychoactive medications for 1 of 4 residents reviewed for dementia care. (Resident 29) Findings include: Resident 29's clinical record was reviewed on 4/29/25 at 2:56 p.m. Current diagnoses included dementia with agitation, diabetes mellitus, insomnia, major depressive disorder, generalized anxiety disorder, and delusional disorder. Current physician's orders included the following psychoactive medications: Risperdal 0.5 mg (an anti-psychotic medication) - one tablet- two times daily for delusional disorder (4/29/25), buspirone	F 0744	F 744 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident JL medications and behavior interventions were reviewed by MD with no new orders given. IDT reviewed all current behavior interventions to ensure appropriateness for behaviors de-escalation specific to resident JL. Psych NP reviewed medications and recent GDR's and Genesight testing to be completed. ¿	05/25/2025

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	HCL 10 mg (an anti-anxiety medication)- one tablet-three times daily for anxiety (3/3/25), Klonopin 0.5 mg (an anti-anxiety medication)- one tablet daily at bedtime (3/5/25), Zoloft 125 mg (an anti-depressant medication)- one tablet daily for depression (10/25/2024), and Remeron 7.5 mg (an anti-depressant used as an appetite stimulant). A 3/20/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, did not have hallucinations or delusions during the assessment period, displayed both verbal and psychical aggressive behaviors and rejected care visit one to three days of the assessment period, received anti-psychotic medication, antidepressant medication, and anti-anxiety medication during the assessment period. A 4/29/25 "Psychiatry Progress Note" indicated the visit was initiated due to increased anxiety and/or increased aggression. The resident had a failed GDR (gradual dose reduction) of Risperdal due to being aggressive towards another resident. The resident did not display delusions or hallucinations. A review of Resident 29's behavior notes from 12/1/24 through 5/1/25 (approximately five months) indicated the following: December 2024: The resident had eight (8) documented behavioral events this month. Two documented events were medical events. Four events were resistance to care. Five of the six non-medical behaviors the resident calmed with non-chemical interventions. A 12/31/24 at 4:03 p.m., note indicated the resident		-how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed with all residents with behaviors from the last 14 days to ensure appropriate non-pharmacological interventions were used for dementia related behaviors. ¿ -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with all staff on Dementia Care policy and non-pharmacological interventions. Ongoing audit to be completed by DNS or by auditing dementia related behavior notes for non-pharmacological interventions. Audit to be completed 5 X weekly x 4 weeks, 3 x weekly x 4 weeks, 1 x weekly x 4 weeks and monthly thereafter. ¿ -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place	

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	had been unclothed in the hall and staff had tried to dress her. The resident fought during attempts to clothe her. A 12/31/24 at 12:36 p.m., note indicated the resident became upset with her surroundings in the dining area and threw chocolate milk. She became calm when removed from the situation and allowed to rest. A 12/28/24 at 11:31 p.m.., late entry note indicated, the resident slapped and scratched when being assisted to change her cloths for bed. Non-chemical intervention were successful and the resident went to bed. A 12/23/24 at 10:59 p.m., note indicated the resident could not remember how to swallow. A 12/23/24 at 10:51 p.m., note indicated the resident was having difficulty remembering how to swallow. A 12/6/24 at 8:31 p.m., note indicated the resident resisted care and spit and pulled the staff's hair. The staff left her alone and she became calm. A 12/6/24 at 4:26 p.m., note indicated the resident resisted toileting and changing. Non-chemical interventions were effective to calm the resident. A 12/6/24 at 7:28 a.m., note indicated the resident took other residents food and threw and orange juice. The resident was calmed when given extra food and taken to a different dining area. January 2025: The resident had one documented event of resisting personal care this one. The one event		The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	

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	was successfully managed by non-chemical interventions. A 1/15/25 at 1:07 p.m., note indicated the resident became upset and yelled and hit at staff during peri-care. Non-chemical intervention were successful and the resident was calmed. February 2025: The resident had four (4) documented behavioral events this month. Three of 4 events were successfully managed by non-chemical interventions. A 2/25/25 at 6:05 a.m., note indicated the resident got out of bed and crawled on the floor. The resident had been in bed prior to the event. The resident was assisted to her wheelchair and she became calm. A 2/20/25 at 12:29 p.m., note indicated the resident grabbed another resident's hair while they were both in the dining room. Redirection and non chemical interventions were effective in calming the resident. Laboratory tests were ordered. A 2/20/25 at 10:16 a.m., note indicated the resident attempted to stab an activity staff member with a colored pencil and also hit and bit at staff. The resident had taken the colored pencils from the activity table and became angry when staff tried to take them away. Non-chemical interventions suck as coffee and snacks were effective to calm the resident. The record did not indicate if the staff members attempted to trade items or snacks for the colored pencils the resident had taken. A 2/12/25 at 5:10 a.m., note indicated the CNA was performing early morning care and bent to fix the			

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	resident's sock and the resident kicked her. The record lacked any indication why morning care needed to occur at 5:00 a.m. All attempts to calm the resident were unsuccessful. March 2025: The resident had two (2) documented behavioral events this month. Two of two events were successfully managed with non-chemical interventions. A 3/30/25 at 11:06 a.m., note indicated the resident grabbed the CNA and hit at her as the CNA attempted to dress her for the day. Non-chemical interventions were successful and the resident was dressed for the day. A 3/12/25 at 10:53 a.m., note indicated the resident grabbed the activity assistant and told her to sit down. Non-chemical interventions were successful in calming the resident. April 2025: The resident had six (6) documented behavioral events this month. One time she was startled and lashed out. Four (4) of 6 events the resisted care, three of which events she had been sleeping before the staff woke her to provide care. Five of six events were successfully managed with non-chemical interventions. A 4/28/25 at 10:58 a.m., note indicated was startled by activity staff and swatted them in the face. Non chemical interventions were successful to calm the resident. A 4/27/25 at 5:54 a.m., note indicated the resident resisted early morning care hitting and slapping.			

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	The resident had been asleep when staff awoke her for care. The staff redirected and switch care givers without success. The record lacked documentation of the reasoning the resident had to be woke from sleep in order to provide care. A 4/26/25 at 9:40 a.m., late entry note indicated the resident had been asleep in bed and was woke by staff for morning care. The resident resisted care and hit, grabbed and slapped at staff. When left alone and provided a different care giver at a later time the resident was co-operative. The record lacked documentation of the reasoning the resident had to be woke from sleep in order to provide care. A 4/26/25 at 7:23 a.m., note indicate the resident was asleep in bed when the staff awoke her for morning care. The resident hit, bit and kicked to resist care. Non-chemical interventions were somewhat effective. The record lacked documentation of the reasoning the resident had to be woke from sleep in order to provide care. A 4/19/25 at 11:12 a.m., late entry, note indicated the resident had been seated in her chair when staff approached her for care. She resisted care hitting and slapping. The staff redirected the resident and were eventually able to provide care. A 4/15/25 at 3:14 p.m., note indicated the resident was tearing up BINGO cards at an activity. She was offered drinks and snacks which were effective in redirecting her behavior. A 4/4/25 at 12:23 p.m., note indicated the resident was eating lunch and a CNA tried to assist her she cursed the CNA and hit her. Non-chemical interventions were successful to calm the resident.			

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	Review of SBAR (Situation, Background, Assessment and Recommendation)- Change of Condition notes from the 12/1/24 to 5/1/25 contained three behavioral events: A 1/26/25 at 11:12 a.m., SBAR note indicated, " Resident attempted to stand without assistance and fell on her face." A 3/10/25 at 5:44 p.m., SBAR note indicated "Two residents [names] both going to the dining room around 1650 hour and both made physical contact with each other." A 4/25/25 at 10:30 a.m., SBAR note indicated "resident was in the activity room. propelled self to other side of table. smacked another resident's hand and pulled her hair. resident states resident was running her mouth." Following pharmacy recommendations for GDRs (gradual dose reductions of psychoactive medications on 3/15/25, the Nurse Practitioner refused recommendations indicating the resident was still having significant behaviors and anxiety. The resident had four documented behaviors in February and two in March 2025. Non-chemical interventions were documented as successful for the majority of the behavioral events. Although behavioral concerns were listed as the reason for maintaining current levels of psychoactive medications, approaches to behavioral care plans were not updated now resolved including, but not limited to, the following: The resident had a care plan problem regarding yelling at staff, attempting to exit, claiming			

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	someone is trying to kill me, throwing food, stating she would burn the place down (5/25/22). There were no new approaches were added since 4/25/23 nor had this problem been identified as resolved. The resident had a care plan problem regarding laying clothes all over the room (6/1/22). There were no new approaches since 6/1/22 nor had this problem been identified as resolved. The resident had a care plan problem regarding racial comments, not wanting others near me, making fun of others (6/3/22). There were no new approaches since 6/3/22 nor had this problem been identified as resolved. The resident had a care plan problem regarding agitation, yelling, running her walker into others, become upset with others, tearfulness, and suicidal comments (5/2/22). There were no new approaches to this problem since 8/29/23 nor had this problem been identified as resolved. The resident had a care plan problem of believing there was a horse in the hallway (3/29/24). There have been no new approaches to this problem since 3/29/24. The resident had a care plan problem regarding believing her clothing was poisoned (5/17/24). There have been no new approaches since 5/17/24. The resident had a care plan problem regarding calling staff fat a####, saying she worked here, knocking staffs glasses off during care, being combative (5/22/24). There were no new approaches to this problem since 5/22/24 nor had this problem been identified as resolved.			

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	The resident had a care plan problem regarding the refusal of care, refusing medication, believing care will cause her to get hurt (6/17/24). There were no new approached to this problem since 6/26/24 nor had this problem been identified as resolved. The residents record lacked an assessment for possible triggers to behaviors and personalized updated approaches to behavioral and dementia care plans. During an interview on 5/2/25 at 2:57 p.m., CNA 10 indicated Resident 29 had behaviors of being resistant to care. She did not have see or hear things that were not there. She liked it when staff talked to her and had a conversation. She could be easily redirected with pop and movies. Sometimes switching care givers helped. She did at times strike out at others "out of the blue." Mostly dementia behavior. During an interview on 5/2/25 at 2:59 p.m., QMA 11 indicated Resident 29 had "random" behaviors. She occasionally had behaviors "you didn't see coming." She did resist care. She did not see or hear things. She was not tearful. She liked movies, food, drinks. She did at time resist care. Snacks and switching care givers helped when she resisted. She had dementia behaviors. During an interview on 5/2/25 at 3:01 p.m. Agency CNA 12 indicated she was familiar with Resident 29. The resident resisted care. She did not see or hear things. She was not tearful. Staff needed to walk away and re-approach if she was resisting. During an interview on 5/2/25 at 3:03 p.m., LPN 13 indicated the resident did have behaviors. She			

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	resisted care. She was overwhelmed in large groups. If staff removed her from stimulating environments it helped. She likes treats and pop. During an interview on 5/2/25 at 12:22 p.m., the Administrator, DON, and Dementia Unit Manager indicated the facility would attempt to provide information about personalized dementia care provided to Resident 29 in order to reduce dementia related behaviors and reduce the need for psychoactive medications. A current, undated, facility policy titled, "Dementia Care", provided by the Administrator on 5/2/25 at 2:25 p.m., indicated : "Care and services will be person centered and reflect each resident's individual goals...Individualized non-pharmacological approaches to care will be utilized..." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure shift to shift narcotic reconciliation was completed for 5 of 6 carts reviewed for medication storage. (C Unit 2 hall cart, C Unit 1 hall cart, Advanced Acute Care Unit cart (AACU), Acute Care Unit (ACU) short hall cart, ACU long hall cart) Finding includes: 1. During a medication storage observation of the C Unit 1 hall cart, accompanied by LPN 3 on 5/1/25 at 11:41 a.m., the "Controlled Drugs- Count Record" was reviewed and the following dates lacked shift to shift reconciliation of controlled	F 0755	F 755 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Controlled Drugs – Count record sheets were observed for holes with 1:1 education provided to individual staff members. -how other residents having the potential to be affected by the	05/25/2025

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	substances: In April 2025- 4/4/25 on evening shift, 4/18/25 on evening shift, 4/20/25 on day and night shifts. During an interview, at the time of the observation, LPN 3 indicated the narcotic count sheet was to be completed at the beginning of every shift. The medication count needed to be completed before the two nurses signed the form verifying the count was correct. 2. During a review of the C Unit 2 hall cart "Controlled Drugs- Count Record", provided by Medical Records on 5/1/25 at 12:50 p.m., the following dates lacked signatures for shift to shift reconciliation of controlled medications: In February 2025- 2/2/25 on night shift, 2/6/25 on night shift, 2/7/25 on evening and night shifts, 2/20/25 on night shifts, 2/21/25 on day shift. 2/28/25 on evening and night shift. In March 2025- 3/1/25 on night shift, 3/2/25 on night shift, 3/8/25 on night shift, 3/12/25 on evening shift, 3/14/25 on evening shift, 3/15/25 on night shift, 3/16/25 on evening and night shifts, 3/25/25 on night shift.		same deficient practice will be identified and what corrective actions will be taken Audit completed on all carts for the month of May to ensure completion of Controlled Drugs – Count Record with 1:1 education given to individual employees. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nurses and QMA's on Controlled Substance Administration and Accountability policy. Ongoing audit to be completed by DNS or designee by auditing carts Controlled Drugs – Count Record for completion of form. Audit to be completed 5 X weekly x 4 weeks, 3 x weekly x 4 weeks, 1 x weekly x 4 weeks and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any	

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	In April 2025- 4/9/25 on evening shift, 4/14/25 on evening shift. 3. During a review of the AACU hall cart "Controlled Drugs- Count Record", provided by Medical Records on 5/1/25 at 12:50 p.m., the following dates lacked signatures for shift to shift reconciliation of controlled medications: In January 2025- 1/4/25 on evening shift, 1/5/25 on evening shift, 1/11/25 on evening shift, 1/12/25 on evening and night shifts, 1/14/25 on day shift, 1/16/25 on evening and night shifts, 1/17/25 on evening and night shifts, 1/18/25 on evening shift, 1/19/25 on evening shift, 1/20/25 on day and evening shift, 1/21/25 on day shift, 1/25/25 on day, evening, and night shifts, 1/26/25 on day, evening, and night shifts, 1/28/25 on evening shift, 1/29/25 on evening shift, 1/30/25 on evening shift. In February 2025- 2/1/25 on day and evening shifts, 2/2/25 on day and night shifts, 2/4/25 on evening and night shifts, 2/8/25 on evening shift, 2/9/25 on evening shift, 2/13/25 on day and evening shifts, 2/14/25 on evening and night shifts, 2/15/25 on evening shift,		identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	

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	155687	A. BUILDING 00 B. WING	05/02/2025

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	2/16/25 on day and evening shifts, 2/22/25 on evening shift, 2/23/25 on evening shift, 2/24/25 on evening shift, 2/27/25 on evening shift. In March 2025- 3/1/25 on night shift, 3/2/25 on night shift, 3/3/25 on night shift, 3/4/25 on night shift, 3/5/25 on night shift. 4. During a review of the ACU short hall cart "Controlled Drugs- Count Record", provided by Medical Records on 5/1/25 at 12:50 p.m., the following dates lacked signatures for shift to shift reconciliation of controlled medications: In January 2025- 1/3/25 on night shift, 1/8/25 on night shift, 1/9/25 on night shift, 1/17/25 on night shift, 1/24/25 on night shift, 1/25/25 on night shift, 1/26/25 on night shift. In February 2025- 2/2/25 on evening shift, 2/13/25 on night shift, 2/16/25 on night shift, 2/28/25 on evening shift. In March 2025- 3/1/25 on day and evening shifts,			

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	3/2/25 on day shift, 3/9/25 on evening shift, 3/15/25 on night shift, 3/29/25 on day shift, 3/30/25 on night shift. In April 2025- 4/4/25 on night shift, 4/27/25 on night shift. 5. During a review of the ACU long hall cart "Controlled Drugs- Count Record", provided by Medical Records on 5/1/25 at 12:50 p.m., the following dates lacked signatures for shift to shift reconciliation of controlled medications: In January 2025- 1/4/25 on day shift, 1/8/25 on night shift, 1/26/25 on day, evening, and night shifts. In February 2025- 2/13/25 on night shift, 2/16/25 on night shift, 2/22/25 on day shift, 2/24/25 on day shift. In March 2025- 3/1/25 on day and evening shifts, 3/2/25 on day shift, 3/11/25 on evening shift, 3/15/25 on night shift, 3/17/25 on evening shift, 3/29/25 on day shift. In April 2025-			

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	4/19/25 on day shift, 4/24/25 on evening shift, 4/26/25 on day shift, 4/17/25 on day and night shifts. During an interview, on 5/2/25 on 2:25 p.m., the Director of Nursing (DON) indicated the expectation for staff was to complete a narcotic count at the start of each shift and exchange of keys. The two nurses sign the log to confirm the count was completed and correct. This process prevents drug diversion. A facility policy, dated 2025, titled, "Controlled Substance Administration & Accountability", provided by the DON on 5/2/25 at 11:00 a.m., indicated the following: " It is the policy of this facility to promote safe, high quality patient cares, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure... All controlled substances (Schedule II, III, IV, V) are accounted for in one of the following ways:... All controlled substances obtained from a non-automatic medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided...The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient information...Inventory Verification...For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift..." 3.1- 25(b)(3)			

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure insulin was dated after opening and discarded when expired for 1 of 3 medication carts reviewed. (ACU Medcart) Finding includes: During an observation on 5/2/25 at 10:48 a.m., the ACU Medcart was reviewed with LPN 13. A Lantus Subcutaneous Solution 100 unit/ml (insulin glargine) vial for resident 59 was opened and dated 3/31/25 and a HumaLOG Injection Solution 100 unit/ml (insulin lispro) vial was opened and undated. A Dulaglutide Subcutaneous Solution (to treat diabetes) Pen-injector 4.5 mg/0.5 ml for resident 12 was opened and undated. An Insulin NPH (neutral protamine hagedorn insulin) Suspension Pen-injector 100 unit/ml for resident 18 was opened and unlabeled. LPN 13 indicated insulin expired 30 days after opening and the pens and vials should have been labeled appropriately and the expired items thrown away. On 5/5/25 at 9:25 a.m. manufacturer recommendations for the Lantus, retrieved from https://products.sanofi.us/lantus/lantus.html indicated in-use (opened) vials may be stored at room temperature or refrigerated for 28 days. On 5/5/25 at 9:28 a.m., manufacturer recommendations for Humalog, retrieved from /https://pi.lilly.com/us/humalog-vial-ifu.pdf indicated store opened vials in the refrigerator or at room temperature up to 86°F (30°C) for up to 28 days.	F 0761	F 761 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice bottle that was not labeled appropriately was destroyed and insulin was reordered from . -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed on all carts to ensure insulin bottles and pens are appropriately labeled after opening. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nurses and QMA's on Labeling of Medications and Biologicals policy. Ongoing audit to be completed by DNS or designee by auditing carts for the insulin bottles and pens to ensure it is	05/25/2025

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	A current, undated facility policy, titled "Insulin Pen", provided by the DON on 5/2/25 at 12:00 p.m. indicated,"...2. Insulin Pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given, frequency, and expiration date. 3. If the label is missing, the pen will not be used;a new pen must be ordered from the pharmacy...9. Insulin pens should be dispose of after 28 days or according to manufacturer's recommendation...." 3.1-25(j) 3.1-25(m) 3.1-25(n)		appropriately labeled. Audit to be completed 5 X weekly x 4 weeks, 3 x weekly x 4 weeks, 1 x weekly x 4 weeks and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on record review and interview, the facility failed to offer and educate residents regarding Pneumococcal vaccines per the Center for Disease and Control (CDC) guidance for 1 of 5 residents reviewed for infection control. (Resident 48) Finding includes: Resident 48's clinical record was reviewed on 4/29/25 at 2:37 p.m. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, and dependence on supplemental oxygen.	F 0883	F 883 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident TB was provided education and offered the PNA Vaccine. MD notified. -how other residents having the potential to be affected by the	05/25/2025

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	An admission Minimum Data Set (MDS) assessment, dated 2/3/25, indicated the resident was cognitively intact. Specialized services included continuous oxygen therapy. Review of the resident's vaccinations included the following: The resident had a historical administration of Pneumovax (pneumococcal) 23 on 3/5/20, prior to admission to the facility. A Pneumococcal Vaccine Consent Form, dated 7/7/23, indicated the resident was provided education and declined administration. The clinical record lacked additional offerings of the Pneumococcal vaccine since 2023. During an interview on 5/1/25 at 11:37 a.m., the Infection Preventionist indicated residents who refused the Pneumococcal vaccines on admission were not offered the vaccines again when they were eligible to receive the next doses per CDC guidance. During an interview on 5/1/25 at 2:58 p.m., the DON indicated the Pneumococcal vaccines should have been offered/administered following the CDC guidance. A current facility policy, undated, titled "General Immunization/Vaccination," provided by the DON on 5/1/25 at 2:57 p.m., indicated the following: "Policy: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from infectious disease by offering our residents, staff members, and volunteer workers immunization/vaccination against such		same deficient practice will be identified and what corrective actions will be taken Audit completed on all resident's vaccination history to ensure residents are offered vaccinations according to CDC guidelines. Education and offered vaccination to any residents noted to be out of compliance with CDC guidelines. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nursing staff on General Immunizations/Vaccination policy. Ongoing audit to be completed by DNS or designee by auditing admissions for their vaccination history/status. Audit to be completed 3 X weekly x 8 weeks, 1 x weekly x 8 weeks, and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to	

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	diseases... Policy Explanation and Compliance Guidelines: 1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against infectious diseases in accordance with national standards of practice. 2. Immunizations will follow current CDC guidance and scheduling based on the specific vaccinations. 3. Residents, staff, and volunteer workers will be offered immunizations against infectious diseases as per current federal, state and local guidance...." 3.1-18(b)(5)		track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization Based on record review and interview, the facility failed to provide education regarding and failed to offer COVID-19 vaccines per the Center for Disease and Control (CDC) guidance for 1 of 5 residents reviewed for infection control. (Resident 48) Finding includes: Resident 48's clinical record was reviewed on 4/29/25 at 2:37 p.m. Diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, and dependence on supplemental oxygen. An admission Minimum Data Set (MDS) assessment, dated 2/3/25, indicated the resident was cognitively intact. A COVID-19 Vaccine Consent/Declination Form, dated 9/13/23, indicated the resident was provided education and declined administration. The	F 0887	F 887 -what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident TB was provided education and offered the COVID Vaccine. MD notified. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken Audit completed on all resident's vaccination history to ensure residents are offered vaccinations according to CDC guidelines. Education and offered vaccination	05/25/2025

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	declination indicated the following information, " I understand that I can change my mind at any time and accept the COVID-19 vaccination at a later time and will receive current education at that time." The clinical record lacked any other offerings of the COVID-19 vaccine since 2023. During an interview on 5/1/25 at 11:37 a.m., the Infection Preventionist indicated residents who refused the COVID-19 vaccines on admission were not offered the vaccines again when they were eligible to receive the next doses per CDC guidance. During an interview on 5/1/25 at 2:58 p.m., the DON indicated the COVID-19 vaccines should have been offered/administered following the CDC guidance. A current facility policy, undated, titled "General Immunization/Vaccination," provided by the DON on 5/1/25 at 2:57 p.m., indicated the following: "Policy: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from infectious disease by offering our residents, staff members, and volunteer workers immunization/vaccination against such diseases... Policy Explanation and Compliance Guidelines: 1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against infectious diseases in accordance with national standards of practice. 2. Immunizations will follow current CDC guidance and scheduling based on the specific vaccinations. 3. Residents, staff, and volunteer workers will be offered immunizations against infectious diseases as per current federal, state and local guidance...."		to any residents noted to be out of compliance with CDC guidelines. -what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Education completed with nursing staff on General Immunizations/Vaccination policy. Ongoing audit to be completed by DNS or designee by auditing admissions for their vaccination history/status. Audit to be completed 3 X weekly x 8 weeks, 1 x weekly x 8 weeks, and monthly thereafter. -how the corrective action will be monitored to ensure that deficient practice will not recur; I.e., what quality assurance program will be put into place The results of these audits be reviewed at QAPI x 6 months to track for any trends. If any identified, will continue audits based on QAPI recommendations, otherwise will review on a PRN basis.	

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	3.1-18(b)(5)			