STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155153	A. BUILDING 00 B. WING	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHWIN HEALTH & REHABILITATION	20531 DARDEN RD SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00451204, IN00451542, IN00451284, IN00451283, IN00451290, IN00452306, IN00451914, IN00451952, IN00452177 and IN00451978. Complaint IN00451204 - No deficiencies related to the allegation are cited. Complaint IN00451542 - No deficiencies related to the allegation are cited. Complaint IN00451284 - Federal deficiencies related to the allegations are cited at F755. Complaint IN00451283 - No deficiencies related to the allegations are cited. Complaint IN00451290 - No deficiencies related to the allegations are cited. Complaint IN00452306 - No deficiencies related to the allegations are cited. Complaint IN00451914 - Federal deficiencies related to the allegations are cited at F677 and F755. Complaint IN00451952 - Federal deficiencies related to the allegations are cited at F677 and F755. Complaint IN00452177 - Federal deficiencies related to the allegations are cited at F677 and F755.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bud Johnson	Administrator	03/15/2025

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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	Complaint IN00451978 - Federal deficiencies related to the allegations are cited at F677 and F755. Survey dates: February 11, 12, 13, 14, 17, 18, and 19, 2025. Facility number: 000073 Provider number: 155153 AIM number: 100288820 Census Bed Type: SNF/NF: 93 Total: 97 Census Payor Type: Medicare: 5 Medicaid: 68 Other: 5 Total: 97 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/2/2025			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on observation, interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 1 residents reviewed. (Resident 51) Finding includes: During an observation and interview, on 2/12/2025 at 11:17 A.M., Resident 51 indicated there was an agency nurse on the evening shift that had yelled at her during her shifts at the facility. The	F 0600	**F600** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following	03/25/2025

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	resident was unable to recall the staff member's name. Resident 51 indicated the last incident where this staff yelled at her happened approximately two to three weeks ago. Resident 51 indicated the last incident had occurred when she was lying in bed, felt unwell and did not want to attend meal service in the dining room. The resident indicated the nurse raised her voice and demanded the resident get out of her bed and go to the dining room for her meal. Resident 51 was tearful during the re-telling of this occurrence. Resident 51 said, "I feel like I'm going to die here." Resident 51 indicated she had reported the incident to the Director of Nursing (DON) the day after the incident had occurred. The resident indicated she was told by the DON the nurse was talking loudly to the resident because she was from a different culture. During an interview, on 2/12/2025 at 11:55 A.M., the DON indicated she recalled an incident several weeks ago reported to her by Resident 51 but was unable to recall the specific date. She indicated it involved a staff nurse not an agency nurse. The DON indicated the resident had presented the interaction as a cultural difference between herself and the nurse. The DON indicated the resident had reported to her the nurse had "talked loudly" to her. The Director of Nursing indicated she did not report it to the Indiana Department of Health (IDOH) because she did not believe it was abuse. During an interview, on 2/13/2025 at 10:10 A.M., the DON indicated after discussing the allegation further with the surveyor, on 2/12/2025, she had begun investigating the resident's claims of abuse and had reported it to the IDOH. The clinical record of Resident 51 was reviewed on 2/14/2025 at 10:11 A.M. The resident's		CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Resident 51 was assessed for emotional well-being and provided counseling by Social Services 2/12/2025. The alleged staff member was removed from the schedule pending an investigation. A full investigation was conducted, including staff and resident interviews. The allegation was reported to the **Indiana Department of Health (IDOH)** on 2/12/2025. **#2** All residents have the potential to be affected by the alleged deficient practice. Residents were interviewed to determine if they had any concerns related to abuse or neglect. Any identified issues were immediately addressed and reported to the appropriate regulatory agencies.	

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	diagnoses included, but were no limited to: Parkinson's without dyskinesia, unilateral primary osteoarthritis of the left hip, depression, anxiety, post-traumatic stress disorder, personal history of transient ischemic attack and cerebral vascular accident and hypertension. A Quarterly Minimum Data Set (MDS) assessment, dated 1/10/2025, indicated the resident was cognitively intact, was independent with eating and personal hygiene, required partial assistance with oral hygiene, toileting, bathing and/or showering, upper and lower body dressing and footwear. A current Care Plan, revised on 2/4/2025, indicated Resident 51 had diagnoses of post-traumatic stress disorder and depression. Interventions included,, but were not limited to: increase the resident's control by giving her all the choices she can make and let the resident know staff is empathetic. The investigation completed by the Director of Nursing indicated the nurse indicated she had not raised her voice towards Resident 51 at the time of the incident. The investigation indicated Resident 51 initially felt the nurse yelled at her but after speaking to the DON, Resident 51 indicated she no longer felt the nurse had yelled at her. On 2/14/2025 at 2:05 P.M., the DON provided a policy titled,"Abuse," dated 10/20/2022 and indicated the policy was the one currently used by the facility. The policy indicated "...abuse is the willful infliction of...intimidation...includes verbal abuse...mental abuse...willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm..."		**#3** All staff, including agency nurses, were re-educated on the **Abuse Prevention Policy & Reporting Requirements**and **Resident Rights and Recognizing Verbal Abuse.** Staff and residents were re-educated on the grievance process. This education will be completed on or before 3/25/2025 by the DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure the grievance logs include proper documentation and follow-up. Weekly resident interviews will be conducted for three months to monitor staff interactions. Random audits of staff-resident interactions will be completed to ensure compliance. Findings will be reviewed in monthly QAPI meetings. The **QAPI committee** will review audit results monthly for three months. If no concerns arise, monitoring will continue quarterly. If issues persist, additional training and corrective actions will be implemented.	

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F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints Based on observation, interview and record review, the facility failed to ensure a resident from free from a physical restraint for 1 of 1 residents reviewed for restraints. (Resident 67) Finding includes: During an observation on 2/11/2025 at 10:52 A.M., Resident 67 was seated in the dining room in a wheelchair being fed his breakfast by the CNA 11. There was a fastened seat belt noted to be across the resident's lap. During an observation and interview on 2/11/2025 at 11:00 A.M., Resident 67 was had finished his breakfast and w the resident was asked to release his button seat belt. Resident 67 was unable to release the button clasp. During an observation on 2/12/2025 at 11:29 A.M., Resident 67 was seated in his wheelchair in the hallway with the seat belt fastened. During an observation on 2/17/2025 at 3:12 P.M., Resident 67 was seated in his wheelchair with the seat belt fastened. A record review was completed on 2/11/2025 at 2:00 P.M. for Resident 67. Diagnoses included but not limited to: osteoarthritis of right hand, localized swelling, mass and lump right upper limb, dementia unspecified with other behavioral disturbance, unspecified psychotic disorder with hallucinations due to known physiological condition and metabolic encephalopathy. A Significant Change Minimum Data Set (MDS)	F 0604	**F604** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. Th is prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Resident 67 was reassessed for emotional well-being and safety. The seat belt restraint was immediately reviewed for appropriateness, and unnecessary use and was discontinued. The Indiana Department of Health (IDOH) was notified of the restraint	03/25/2025

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	assessment, dated 2/3/2025, indicated Resident 67 was severely cognitively impaired, required extensive assistance for eating, bed mobility and toilet use and required was totally dependent for transfers. A Physician's Order, dated 1/16/2023, indicated every shift the staff were to command the resident to remove the seat belt and check for placement for positioning and safety. The therapy department was to be notified of failed attempts (of resident removing the seatbelt). A fall care plan, initiated on 1/17/2023 and reviewed as current, included an intervention for staff to ensure the resident was able to independently remove the seat belt upon command. Review of a Treatment Administration Record (TAR), from 1/1/2025-1/31/2025, indicated Resident 67 was unable to release the seat belt on 1/28/2025 on evening shift and 1/31/2025 on day shift. Review of a TAR, from 2/1/2025-2/28/2025, indicated Resident 67 was unable to release the seat belt on 2/5/2025 on the day shift. During an interview on 2/17/2025 at 3:10 P.M., CNA 5 indicated Resident 67 had worn a seat belt and was not able to take it off. He indicated that the resident could not take it off because his fingers were unable to do it. CNA 5 did not know why the resident had the belt because he had not fallen. During an interview on 2/18/2025 at 8:53 A.M., CNA 4 indicated Resident 67 had the belt to prevent him from sliding out of the wheelchair.		use and the investigation results. Documentation review completed for resident 67 and corrective actions taken, including the reevaluation of the care plan and restraint practices. **#2** All residents using seat belts have the potential to be affected by the alleged deficient practice. All residents with seat belts were reviewed for appropriateness and unnecessary use, with immediate corrective action taken upon discovery. **#3** All staff members were re-educated on the proper use of restraints and the importance of utilizing the least restrictive alternatives to ensure that residents are not unnecessarily restrained. Training included recognizing when a device, such as a seat belt, may be considered a restraint and the importance of ongoing reassessment of devices used on residents. Staff were educated on the facility's policies regarding the ongoing monitoring of restraint use, including the need to reassess all devices every shift to ensure they are not unnecessarily limiting resident mobility. This education will be completed on or before 3/25/2025 by the DON/designee.	

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	The CNA indicated Resident 67 was not always able to undo the belt or able to use his hands to feed himself and needed assistance for both activities. During an interview on 2/28/2025 at 9:28 A.M., CNA 6 indicated Resident 67 did not stand up on his own but scooted his wheelchair forward, and could not unbuckle due to his dementia. During an interview on 2/28/2025 at 9:41 A.M., RN 3 indicated the seat belt was used so Resident 67 did not get up and fall down. She indicated Resident 67 could not remove the belt when asked to unfasten the restraint. During an observation on 2/28/2025 at 9:43 A.M., Resident 67 was awake, alert and seated in his wheelchair in his room. RN 3 asked Resident 67 several times to remove his seat belt but Resident 67 made no attempt. Both of his hands remained on his lap in a fisted position. He was asked to open his left hand and he picked up his hand and opened it. Then he was asked to open his right hand, but although he raised it, he was unable to open it. The resident's right hand was red and swollen. During an interview on 2/28/2025 at 9:57 A.M., the DON indicated the medical condition that the seat belt was used for was positioning and safety. The DON indicated it was for fall prevention and the interventions attempted prior to the seat belt were: reacher, offer toilet, incontinence check and changes every 2 hours, assisting him to get up at midnight as he preferred, making sure his clothing fit and did not drag on the floor, maintaining room and pathways to ensure they were free of clutter, ensuring the resident wore proper foot wear, ensuring the call light was within reach and		**#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure all residents are free from inappropriate restraints, with specific checks for any devices that limit mobility. Residents will be interviewed regularly to ensure that no resident is being improperly restrained or limited in movement. The QAPI committee will review audit results monthly for three months. If no concerns arise, monitoring will continue quarterly. If issues persist, additional training and corrective actions will be implemented.	

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	installing antiroll back brakes for his wheelchair. The DON indicated the seat belt was not a restraint because Resident 67 could remove it. The DON indicated the facility did not do an on-going evaluation quarterly of the seat belt because it was not a restraint. In addition, the DON indicated the nurses had an order for the resident to be checked every shift to see if he could release the seat belt by himself. She indicated the resident never attempted to release the seatbelt, except when asked to release it by the nursing staff. During an interview on 2/18/2025 at 10:12 A.M., the Director of Therapy indicated the positional device of the seat belt was necessary to prevent the resident from rising unassisted due to Resident 67's impaired recall. The Director of Thereapy indicated the seat belt was not to be used if the resident was not able to remove the belt upon command. She indicated nursing staff assessed the resident's ability to remove the seat belt every shift the resident was awake. Finally she indicated the therapy department re-evaluated the use of restraints and positioning devices when there was a change in the resident's condition, decline in mental status and function and if the resident was unable to release the seat belt for the nursing staff. On 3/18/2025 at 8:54 A.M., the DON provided a policy titled, "Physical Restraint," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms(s) and never for discipline or staff convenience, or for the prevention of falls. When			

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	the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. Specific Procedures/Guidance 1. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition and this restricts his/her typical ability to change position or place, that device is considered a restraint. 3. Practices that inappropriately utilize equipment to prevent resident mobility are considered a restraints and are not permitted, including: c. Placing a resident in a chair that prevents the resident from rising 13. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reeducation, less restrictive methods of restraints, or total restraint elimination....." 3.1-3(w)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on observation, interview, and record review, the facility failed to ensure a resident's allegation of verbal abuse was reported timely after an allegation was made to the Indiana Department of Health for 1 of 1 resident reviewed for abuse. (Resident 51) Finding included: During an observation and interview, on 2/12/2025 at 11:17 A.M., Resident 51 indicated there was an agency nurse on the evening shift that had yelled at her during her shifts at the facility. The	F 0609	**F609** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction.	03/25/2025

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	resident was unable to recall the staff member's name. Resident 51 indicated the last incident where this staff yelled at her had occurred approximately two to three weeks ago. Resident 51 indicated this last incident occurred when she was lying in bed, felt unwell and did not want to attend meal service in the dining room. The resident indicated the nurse raised her voice and demanded the resident get out of her bed and go to the dining room for her meal. Resident 51 was tearful during the re-telling of this occurrence. Resident 51 said, "I feel like I'm going to die here." Resident 51 indicated she reported the incident to the Director of Nursing (DON) the day after the incident occurred. The resident indicated she was told by the DON that the nurse was talking loudly to her because she (the nurse) was from a different culture. During an interview, on 2/12/2025 at 11:55 A.M., the DON indicated she recalled an incident several weeks ago reported to her by Resident 51 but was unable to recall the specific date. She indicated it involved a staff nurse not an agency nurse. The DON indicated the nurse involved was from another culture and was the incident had been presented by the resident as a "cultural difference." The DON indicated she did not report it to the Indiana Department of Health (IDOH) because she did not believe it was an allegation of abuse. During an interview, on 2/13/2025 at 10:10 A.M., after the discussion with the surveyor on 2/12/2025, the DON indicated she had begun investigating the Resident 51s claims of abuse and had reported the allegation to the IDOH. The clinical record of Resident 51 was reviewed on 2/14/2025 at 10:11 A.M. The resident's		Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Resident 51 was assessed for emotional well-being and provided counseling by Social Services. The alleged staff member was removed from the schedule pending an investigation. A full investigation was conducted, including staff and resident interviews. The allegation was reported to the **Indiana Department of Health (IDOH)** on 2/12/2025. **#2** All residents have the potential to be affected by the alleged deficient practice. Residents were interviewed to determine if they had any concerns related to abuse or neglect. Any identified issues were immediately addressed and reported to the appropriate regulatory agencies. **#3** All staff, including agency nurses,	

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	diagnoses included, but were no limited to: Parkinson's without dyskinesia, unilateral primary osteoarthritis of the left hip, depression, anxiety, post-traumatic stress disorder, personal history of transient ischemic attack and cerebral vascular accident and hypertension. A Quarterly Minimum Data Set (MDS) assessment, dated 1/10/2025, indicated the resident was cognitively intact. A current Care Plan, revised on 2/4/2025, indicated Resident 51 had diagnoses of post-traumatic stress disorder and depression. Interventions included, but were not limited to: increase the resident's control by giving her all the choices she can make and let the resident know staff is empathetic. The investigation completed by the Director of Nursing indicated the nurse indicated she had not raised her voice towards Resident 51 at the time of the incident. The investigation indicated Resident 51 felt the nurse yelled at her but after speaking to the DON, Resident 51 indicated she no longer felt the nurse had yelled at her An Incident Report was sent to the IDOH by the Director of Nursing on 2/12/2025. However, the allegation had been reported to the DON a few weeks prior to 2/12/2025. On 2/14/2025 at 2:05 P.M., the DON provided a policy titled,"Abuse," dated 10/20/2022 and indicated the policy was the one currently used by the facility. The policy indicated "...designated staff will immediately review and investigate all allegations...of abuse...each covered individual/mandated reporter shall report...not later than 24 hours if the events that cause the		were re-educated on the **Abuse Prevention Policy & Reporting Requirements**and **Resident Rights and Recognizing Verbal Abuse.** Staff and residents were re-educated on the grievance process and how to file a grievance. This education will be completed on or before 3/25/2025 by the DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure audits of grievance logs to ensure proper documentation and required reporting. Weekly resident interviews will be conducted for three months to monitor staff interactions. Random audits of staff-resident interactions will be completed to ensure compliance. Findings will be reviewed in monthly QAPI meetings. The **QAPI committee** will review audit results monthly for three months. If no concerns arise, monitoring will continue quarterly. If issues persist, additional training and corrective actions will be implemented.	

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HEALTHWIN HEALTH & REHABILITATION	20531 DARDEN RD SOUTH BEND, IN 46637

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	suspicion do not result in serious bodily injury...the organization will report all alleged violations involving...abuse..." 3.1-28(c)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to ensure a comprehensive plan of care included a plan to address an osteomyelitis diagnosis and the use of an indwelling catheter for 1 of 24 residents reviewed for comprehensive care plans. (Resident Q) Findings include: A record review for Resident Q was completed on 2/18/2025 at 9:00 A.M. Diagnosis included, but were not limited to osteomyelitis right foot/ankle, diabetes mellitus type 2, anxiety, depression, hypertension, and chronic kidney disease stage 3. A Physician's order dated 2/7/2025 indicated, an order for the medication, ceftazidime 1.25 grams (gm) intravenously (IV) for osteomyelitis, A History and Physical evaluation, dated 1/3/2025 by the attending Physician, indicated an X-ray of Resident Q's foot had shown chronic osteomyelitis and the resident was started on IV antibiotics. A Nursing Progress note, dated 2/7/2025, indicated Resident Q was admitted from the hospital due to a diagnosis of osteomyelitis. Resident Q's record did not include a plan of care for osteomyelitis.	F 0656	**F656** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** The facility has immediately addressed this by updating	03/25/2025

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	In addition, there was a Physician's order dated 2/7/2025 for a Foley (urinary) catheter, size 18 french, 10 milliliter balloon. A hospital transfer summary dated 2/7/2025, indicated the need for the continued use of a catheter. Resident Q's record did not include a plan of care for the Foley (urinary) catheter use. During an interview with the DON on 02/18/25 at 12:00PM, she indicated care plans would be updated with new orders identified during the morning clinical meeting. She indicated the care plan in the record should be current and she did not know why Resident Q did not have a care plan for osteomyelitis or the Foley (urinary) catheter. A current facility policy was provided by the DON on 2/28/2025 at 2:02 P.M. The policy titled, "Care Planning-Comprehensive Person Centered" indicated the Interdisciplinary team was responsible for reviewing and updating the care plans with a significant change in resident condition, when needs change and when returning from hospital stay. 3.1-35(a)		Resident Q's care plan to include specific interventions for both the osteomyelitis diagnosis and the continued use of the Foley catheter. The updated care plan now reflects detailed actions, including wound care management for osteomyelitis, medication orders for IV antibiotics, and monitoring and management of the Foley catheter. **#2** All residents with significant changes in condition, such as new diagnoses or treatments, have the potential to be affected by the alleged deficient practice. As a result, all care plans for residents currently undergoing treatment for osteomyelitis or using an indwelling catheter were reviewed and updated immediately. **#3** All staff members, including those in nursing and interdisciplinary team roles, were re-educated on the importance of timely and accurate updates to the comprehensive care plans. The team was also educated on the facility's **policy for care planning** and the requirement to update care plans when a resident is admitted to the facility from the hospital, when there are changes in the resident's health status, or when a new physician's order is received. This education will be completed on or before 3/25/2025 by the DON/designee.	

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			#4 Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure the continued accuracy of care plans. These audits will verify that all significant changes in resident condition are reflected in the care plans, including the inclusion of updated orders for diagnoses such as osteomyelitis and catheter use. Any discrepancies will be addressed immediately with corrective action taken as needed. The **QAPI committee** will review audit results monthly for the next three months. If no further concerns are identified, the monitoring process will transition to quarterly audits. If issues persist, additional staff training and corrective actions will be implemented promptly.	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on interview, observation and record review, the facility failed to ensure dependent residents received showers or complete bed baths as scheduled for 5 of 8 residents who were reviewed for showers or complete bed baths. (Residents B, M, D, E, and 55) Findings include: 1. During an interview on 2/11/2025 at 9:48 A.M.,	F 0677	**F677** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the	03/25/2025

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	Resident B indicated she was scheduled to receive three showers a week, but had not received a shower for over two weeks. She indicated there was not enough staff to give her a shower, but she had had a couple of bed baths over the last two weeks. During an interview on 2/12/2025 at 9:55 A.M., Resident B's family member indicated the resident had not had a shower in over two weeks and she had called and left multiple messages for the Administrator, but had not received a call back. During an interview on 2/12/2025 at 10:05 A.M., Resident B's family member indicated the resident was alert and oriented and the resident had been upset about not receiving any showers for over two weeks. Resident B's record review was completed on 2/12/2025 at 11:13 A.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis affecting left non-dominant side, atrial fibrillation, depression and hypertension. An Annual Minimum Data Set (MDS) assessment dated, 12/13/2024, indicated Resident B had intact cognition, required maximal assistance for showering and her preference indicated it was very important for her to choose between a shower or bed bath. A current Care Plan dated, 1/26/2023, indicated Resident B had a self care deficit and required assistance with bathing. The goal of the Care Plan was for the resident to make her own decisions regarding daily care. An intervention of the Care Plan included, but was not limited to: resident to receive a shower on Monday, Wednesday and Friday.		deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** All identified resident shower schedules were thoroughly reviewed, and immediate corrective action was taken to ensure that each resident received the care they desired. Each resident was provided with either a shower or a complete bed bath according to their preferences, and any missed services were promptly rescheduled. **#2** All residents have the potential to be affected by the alleged deficient practice. A thorough review of each resident's bathing schedule was conducted, and any missed showers or bed baths have been rescheduled promptly. **#3** All staff responsible for bathing and showering residents have	

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	A January 2025 Treatment Administration Record (TAR) indicated Resident B had not received a shower on 1/8, 1/10, 1/13, 1/15, 1/20, 1/24, 1/27, 1/29 or 1/31/2025. A February 2025 TAR indicated Resident B had not received a shower on 2/3, 2/5, 2/7 or 2/10/2025. Resident B's there was no documentation Resident B had refused any showers. During an interview on 2/12/25 at 11:33 A.M., CNA 2 indicated Resident B preferred to take showers, but the lack of staff had resulted in the resident not receiving three showers a week. He indicated the resident had received a few complete bed baths but she should have been showered every Monday, Wednesday and Friday. 2. During an interview on 2/11/2025 at 2:57 P.M., Resident M indicated she did not get two bed baths or showers a week and was lucky if she received one bath or shower a week. Resident M's record review was completed on 2/14/2025 at 11:23 A.M. Diagnoses included but were not limited to: paraplegia, epilepsy, major depressive disorder and neuromuscular dysfunction of bladder. A Quarterly MDS assessment dated, 2/6/2025, indicated Resident M had intact cognition, had not refused care and was dependent on staff for showering or bathing. A current Care Plan initiated, 7/2/2023, indicated Resident M required assistance with bathing. The goal of the Care Plan was for the resident to make her own decision regarding daily care.		been re-educated on the importance of adhering to residents' preferences and scheduled care. The specific schedule for each resident has been updated to ensure timely and complete assistance with hygiene needs. Documentation of showers and bed baths has been reviewed, and a system for more consistent and accurate tracking has been implemented. This education will be completed on or before 3/25/2025 by the DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure the effectiveness of these corrective actions and to ensure scheduled showers and bed baths will be conducted to ensure that care is provided in a timely manner. The Director of Nursing (DON) or designee will review these audits weekly for the next three months to ensure compliance. The QAPI committee will review the results of these audits monthly for the next three months to ensure that the plan is effective and that no further deficiencies are identified. If no concerns arise, monitoring will continue quarterly. If issues persist, additional training or corrective actions will be implemented as necessary.	

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	Interventions included, but were not limited to: resident to be well groomed, odor free, clean and comfortable on all shifts, and showers would be Monday and Thursday on the 6:00 A.M. to 2:00 P.M. shift. A January 2025 TAR indicated Resident M had not received a shower or complete bed bath on the following dates: 1/9, 1/16 and 1/23/2025. Resident M's record there was no documentation she had refused any showers in January. During an interview on 2/18/2025 at 2:05 P.M., the Director of Nursing indicated Resident M should have received either a shower or a complete bed bath twice a week. 3. During an observation, on 2/11/2025 at 10:36 A.M., Resident 55 was seated in her padded Broda (reclining) chair and her hair was visibly greasy, pulled into a ponytail on top of her head. During an interview, on 2/11/2025 at 12:15 P.M., the Director of Nursing (DON) indicated the facility did not document showers on paper; but only documented showers and bathing in the electronic medical record. During an observation, on 2/12/2025 at 9:48 A.M., Resident 55 had sat in her Broda chair with greasy looking hair pulled into a ponytail at the top of her head. The clinical record of Resident 55 was reviewed on 2/17/2025 at 8:46 A.M. The resident's diagnoses included, but were no limited to: Alzheimer's disease, dementia, peripheral vascular disease, depression, anxiety, unspecified convulsions and insomnia.			

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	A Quarterly Minimum Data Set (MDS) assessment, dated 1/22/2025, indicated the resident was severely cognitively impaired, was dependent in all areas of self-care including but not limited to: eating, oral and personal hygiene, upper and lower body dressing, toileting, bathing and/or showering, and footwear. A current Care Plan, revised 11/7/2024, indicated Resident 55 required assistance with bathing. Interventions included but were not limited to: showers scheduled for Mondays and Wednesdays. Resident 55's medical record lacked documentation of a bath or a shower from 1/15/2025 through 1/28/2025. During an interview, on 2/17/2025 at 1:30 P.M., CNA 20 indicated all the residents were supposed to be bathed or showered three times per week. During an interview, on 2/17/2025 at 8:33 P.M., CNA 21 indicated residents' hair was to be shampooed when they were given a shower or bed bath. During an interview, on 2/18/2025 at 9:44 A.M., CNA 22 indicated residents were showered or given bed baths according to the resident's preferences. CNA 22 indicated some residents preferred bed baths, some preferred showers. Residents hair was to be shampooed during their bed bath or shower. During an interview, on 2/19/2025 at 10:24 A.M., CNA 22 indicated Resident 55 had never demonstrated any behaviors towards facility staff or others that prevented staff from providing her any Activities of Daily Living (ADL) cares.			

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	4. During a family interview on 2/12/2025 at 9:55 A.M., the family member for Resident D indicated she had not been receiving her showers and after two and half weeks, she had finally received a shower. The family member indicated showers had not been completed routinely at the facility. A record review was completed on 2/13/2025 at 10:00 A.M. for Resident D. Diagnoses included but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and unspecified osteoarthritis. A Quarterly Minimum Data Set (MDS) assessment, dated 1/15/2025 indicated Resident D could not use one upper extremity and was total dependent for all activities of daily living with the exception of set up assistance for eating. A self-care deficit care plan, dated 7/6/2018, indicated Resident D requires assistance with bathing, dressing and hygiene. An intervention, dated 10/6/2022, indicated "will shower every Monday, Wednesday and Friday as the resident desires." A review of the Documentation Survey Report for bathing. dated January of 2025, indicated Resident D received a bed bath on 1/20/2025 and 1/27/2025. There was no documentation of any bathing from 1/7/2025 through 1/16/2025. A review of the Documentation of Survey Report for bathing, dated February of 2025 indicated Resident D received one shower on 2/12/2025 and one bed bath 2/15/2025. There was no other documentation of any bathing opportunities in February, from 2/1 through 2/15/2025.			

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	During an interview on 2/14/2025 at 10:33 A.M., CNA 6 indicated she had not given Resident D a shower, even though it was her shower day because she was waiting to see if a shower aide was going to come in later in the day. She indicated if the facility did not have a shower aide working, she could not give the scheduled showers/baths because she did not have time to complete them. During an interview on 2/14/2025 at 10:40 A.M., CNA 10 indicated if the facility did not have a shower aide scheduled and working, she did not have the time to complete the scheduled showers. She indicated the facility only had a shower aide scheduled a couple days of the week. During an interview on 2/17/2025 at 9:35 A.M., CNA 6, indicated the previous Friday, the shower aide did not show up to work so Resident D did not receive her scheduled shower. CNA 6 confirmed Resident D not had not always received her scheduled showers. 5. During a family interview on 2/11/2025 at 11:23 A.M., the family member indicated they took care of Resident E's fingernails and facial hair, but the resident had not gotten her scheduled showers. The family member indicated staff had told them they would try to get to it, but they did not get around to giving the shower or bath. The family member indicated Resident E had developed a yeast infection under her abdominal folds/groin area that the family member felt was due to not receiving proper cleaning and showering. The family member indicated the resident had not had this infection when she had received her scheduled showers. During an observation on 2/18/2025 at 10:00 A.M.,			

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	and 2/19/2025 at 9:01 A.M., Resident E's hair looked greasy. During a family interview on 2/19/2025 at 1:43 P.M., the family member for Resident E indicated her hair smelled and looked dirty. The facility had informed the family member that Resident E's shower schedule had been changed to every Sunday and Wednesday, but the family member indicated it did not look like the resident had received a shower on 2/16/2025. A record review was completed for Resident E on 2/14/2025 at 10:00 A.M. Diagnoses included but not limited to: Alzheimer's Disease, dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbances and anxiety. A Quarterly Minimum Data Set (MDS) assessment, dated 11/7/2024, indicated Resident E was severely cognitively impaired and required extensive assistance for transfer, bed mobility, and toileting. A self- care deficit care plan, initiated 9/11/2024, indicated Resident E required assistance with bathing, dressing and hygiene. An intervention dated 9/11/2024 indicated she would be bathed at times and days of her choosing on Sunday and Wednesday. A Progress note, dated 1/28/2025 from the Nurse Practioner (NP) indicated the following: "the chief complaint was redness to the groin. She was seen for the redness to the groin skin folds." The NP ordered Nystatin powder twice a day for 14 days, washed daily with soap and water, dry and apply the powder.			

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	A review of the electronic charting system for documenting bathing for Resident E indicated there was no bathing or showers documented from 1/1/2025 through 1/14/2025. A review of the electronic charting system for documenting bathing for Resident E dated February of 2025, indicated there was no documentation for bathing from 2/1/2025 through 2/11/2025. During an interview on 2/19/2025 at 9:05 A.M., CNA 8 indicated Resident E's groin was still red this and she had washed the resident's groin area and applied a cream. On 2/18/2025 at 2:02 P.M., the DON provided a policy titled, "Activities of Daily Living," undated, and indicated the policy was the one currently used by the facility. The policy indicated, "... Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Each resident shall be given proper daily personal attention and care including skin, nail, hair, and oral hygiene, in addition to any specific care ordered by the attending physician. 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); i. Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly or as required by state law. Residents			

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	preference and/or whose medical conditions prohibit tub or shower baths shall have a sponge bath daily....." This Federal tag relates to Complaint IN00451914, IN00451952, IN00452177, and IN00451978. 3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview and record review, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, psychosocial well-being for 2 of 2 resident reviewed for activities. (Resident 55 and 83) Findings include: 1. During an observation, on 2/12/2025 at 2:37 P.M., Resident 55 was observed seated in her room while reclined in a Broda chair with a television playing. During an observation, on 2/13/2025 at 11:03 A.M., Resident 55 was observed in a Broda chair in her room with her eyes open and looking at the floor. The television was tuned to a game show. During an observation, on 2/14/2025 at 2:04 P.M., Resident 55 was observed lying in her bed on her right side with her eyes closed. The February activity calendar indicated Valentine Bingo was scheduled at this time. The clinical record of Resident 55 was reviewed on 2/17/2025 at 8:46 A.M. The resident's diagnoses included, but were not limited to:	F 0679	**F679** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1**	03/25/2025

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	155153	A. BUILDING 00 B. WING	02/19/2025

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	Alzheimer's disease, dementia, peripheral vascular disease, depression, anxiety, unspecified convulsions and insomnia. A Quarterly Minimum Data Set (MDS) assessment, dated 1/22/2025, indicated Resident 55 was severely cognitively impaired. An Annual MDS assessment, dated 10/22/2024, indicated a staff assessment of Resident 55's preferences for activities included visiting with pets, listening to music, being around groups of people and participating in religious activities. Current Physician Orders included but were not limited to: an order for the facility to provide Activities Per Plan, dated 10/27/2023. A current Care Plan for activities, revised 10/22/2024, indicated Resident 55 was unable to initiate activities. Interventions included, but were not limited to: provide 1 to 1 activity visits twice weekly and monitor Resident 55's activity involvement. The record lacked documentation Resident 55 had attended any group activities or received any 1 to 1 visits from 2/3/2025 through 2/10/2025. 2. During an observation, on 2/11/2025 at 10:42 A.M., Resident 83 was seated in her Broda chair at the bedside and was looking out into the hallway while her television was playing. The Activity Calendar listed exercise and trivia as the scheduled activity. During an observation, 2/13/2025 at 11:07 A.M., Resident 83 was seated in her reclining Broda chair in her room. The resident was not looking at her television, which was playing, but was staring out into hallway.		Resident 55 and Resident 83 were both immediately reassessed for their activity needs and preferences. Their care plans were updated to ensure activities tailored to their individual interests are implemented. Documentation practices were reviewed to ensure that activities for all residents are properly documented. **#2** All residents have the potential to be affected by the alleged deficient practice. The facility will review and update the activity preferences of all residents, ensuring that their activities meet their individual interests and needs. A schedule for regular one-to-one activity visits will be maintained for all residents requiring assistance, and these visits will be maintained for all residents requiring assistance, and these visits will be documented accordingly. **#3** Activities staff will receive additional training on documentation and ensuring that all scheduled activities are offered and properly recorded. The Activities Director will be responsible for monitoring resident participation in both group and individual activities and will ensure residents' preferences are incorporated into activity planning. This education will be completed on or before 3/25/2025 by the	

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	During an observation, on 2/14/2025 2:05 P.M., Resident 83 was lying in her bed, awake. Both the television and the radio were playing in her room. The resident was not watching television. The scheduled activity was Valentine Bingo. The clinical record for Resident 83 was reviewed on 2/13/2025 at 11:08 A.M. The resident's, diagnoses included, but were no limited to: senile degeneration of brain, unspecified dementia, bipolar disorder, chronic kidney disease, diabetes mellitus, depression and non-rheumatic mitral valve insufficiency A Quarterly Minimum Data Set (MDS) assessment, dated 1/15/2025, indicated the resident had severely impaired cognitive skills for daily decision making. An Annual MDS assessment, dated 12/11/2024, indicated it was very important for the resident to go outside during nice weather and listen to music and somewhat important to be around pets, do things with groups of people and do activities she enjoys; it was not very important for the resident to read or keep up with the news. Current Physician Orders included but were not limited to: Activities Per Plan, dated 5/16/2023. A current Care Plan, revised 1/23/2025, indicated Resident 83's goal was to participate in one to two group or individual activities weekly. Interventions included but were not limited to: invite Resident 83 to activities of interest and monitor resident's activity involvement. The record lacked documentation Resident 83 had attended any group activities or received any 1 to 1 visits from 2/2/2025 through 2/10/2025.		DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to verify that residents are provided with their desired activities, and their participation in activities will be recorded in the electronic medical record. The QAPI committee will review audit results monthly for three months to ensure compliance. If no concerns arise, monitoring will continue quarterly. If issues persist, additional corrective actions, including further staff education and activity program revisions, will be implemented.	

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	During an interview, on 2/17/2025 at 9:13 A.M., the Activities Director indicated Resident 55 had always attended mass at the request of her family. These activities were documented in the electronic medical record (EMR). The Activities Director indicated she had completed a 1 to 1 visit with both Resident 55 and Resident 83 on 2/11/2025 and 2/13/2025. The Activities Director indicated the 1 to 1 visits consisted of sitting and talking to the residents. On 2/19/2025 at 11:30 A.M., the Director of Nursing provided a policy titled, "Activities Evaluation," dated 10/1/2021 and indicated the policy was the one currently used by the facility. The policy indicated "...Activities: refers to any endeavor...intended to enhance his/her sense of well-being...identify if a resident is capable of pursuing activities independently, or if supervision and assistance are needed..." 3.1-33(a)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review the facility failed to follow Physician orders related to tubi grips, and to failed to assess and treat an area of impaired skin for 2 of 12 residents reviewed for quality of care. (Residents J & 67) 1. During an interview on 2/11/2025 at 10:41 A.M., Resident J indicated she wore Tubi-grips to help with the swelling in her lower legs and feet. She indicated she could not put the Tubi-grips on by herself and staff had not regularly placed the Tubi-grips on her legs.	F 0684	**F684** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction.	03/25/2025

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	During observations of Resident J, the resident was not wearing Tubi-grips (compression socks) on either leg and her right lower leg and foot were swollen: -2/11/2025 10:41 A.M. -2/12/2025 at 9:05 A.M. -2/13/2025 at 3:37 P.M. -2/14/2025 at 12:05 P.M. -2/17/2025 09:06 A.M. -2/17/25 2:01 P.M. Resident J's record review was completed on 2/17/2025 at 9:34 A.M. Diagnoses included, but were not limited to: post polio syndrome, hemiplegia and hemiparesis, Parkinson's disease and anxiety. A Quarterly Minimum Data Set (MDS) assessment, dated 1/24/2025, indicated Resident J had intact cognition, had not rejected care, had impairment of one side, was dependent on staff for dressing her lower body and putting on and taking off her socks and shoes. A current Physician's order dated, 10/16/2024, indicated Resident J was to wear Tubi-grips on both of her legs and feet at all times. Resident J's record lacked the documentation she had refused wearing the Tubi-grips. During an interview on 2/18/2025 at 2:10 P.M., the Director of Nursing indicated Resident J should have been wearing Tubi-grips at all times. On 2/18/2025 at 2:10 P.M., a policy for following Physician's orders was requested, but one was not received before the exit of the survey. 2. During an observation on 2/11/2025 at 10:52 A.M. and on 2/23/2025 at 11:30 A.M., Resident 67		Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Resident J was reassessed, and Tubi-grips were applied as ordered. Resident 67's dressings were replaced with properly dated treatment, and the impaired skin area was documented. The wound was reported to the physician for further evaluation and treatment. **#2** All residents have the potential to be affected by the alleged deficient practice. The facility will ensure that all residents with physician orders for Tubi-grips or similar devices are properly assessed and that these devices are applied as directed. Additionally, all residents receiving treatment for skin conditions have had their care reviewed to ensure that dressings are properly dated, initialed, and that any areas of impaired skin are immediately reported for evaluation and treatment. **#3**	

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	had two dressings noted on his right arm that were undated. During an observation on 2/17/2025 at 3:13 P.M., Resident 67 had just received a shower from the Hospice CNA's and two undated bandages remained on the resident's right arm. During an interview with the Hospice CNA's, on 2/17/2025, they indicated they were not allowed to remove dressings prior to showering. During an observation and interview on 2/17/2025 at 3:15 P.M., RN 9 indicated she did not know what was under the dressings. RN 9 proceeded to pulled the dressings back and there was bloody drainage and scabs attached to the dressing, a crescent shaped skin tear and discolored skin under the bandage. RN 9 indicated the dressing should have been dated and initialed. RN 9 indicated there was no documentation of Resident 67's impaired skin integrity to the right arm. She indicated when a new area was found, nursing staff were to fill out a skin packet, notify the doctor and document the wound care and obtain a treatment. A record review was completed on 2/11/2025 at 2:00 P.M. for Resident 67. Diagnoses included but not limited to: osteoarthritis of right hand, localized swelling, mass and lump right upper limb, dementia unspecified with other behavioral disturbance, unspecified psychotic disorder with hallucinations due to known physiological condition and metabolic encephalopathy. A Physician's Order, dated 8/19/2024, indicated a skin assessment was to be completed every Thursday on night shift. Review of weekly skin assessments for Resident		All nursing staff will be educated on following physician orders and documenting the application of prescribed treatments. Additionally, staff will be trained to ensure all dressings are properly dated, initialed, and that impaired skin areas are reported immediately for evaluation and treatment. This education will be completed on or before 3/25/2025 by the DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure Tubi-grips are being applied correctly and dressings are dated. The Director of Nursing will review the audits, and any deviations will be addressed with immediate retraining. The QAPI committee will review audit results monthly for three months to ensure compliance. If no concerns arise, monitoring will continue quarterly. If issues persist, additional corrective actions, including further staff education and activity program revisions, will be implemented.	

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	67, completed on 1/30/2023, 2/6/2025 and on 2/13/2025 indicated the resident did not have any new skin issues. A care plan related to skin, dated 7/14/2022, indicated the facility was to complete weekly skin assessments. On 2/18/2025 at 2:02 P.M., the DON provided a policy titled, "Non-Pressure Injury/Ulcer Management," undated, and indicted that the policy was the one currently used by the facility. The policy indicated "...The nursing facility will ensure systems and processes to assist in the identification, investigation, treatment and care of residents with non-pressure injury related to wounds. Skin wounds affect quality of life for resident's because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes. Specific Procedures/ Guidance: 2. Weekly skin observations will be conducted by a licensed nurse and findings will be documented in the resident's medical record. 3. Observations of new areas of impaired skin integrity will be reported to the physician/practitioner for further evaluation and treatment. Treatment Protocols: 1. Treatment will be ordered by the physician/practitioner. Care Plans: 1. A resident centered care plan will be developed and implemented to address the resident's wound including interventions to promote healing and to minimize worsening or wound or development of additional wounds....." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility	F 0690	**F690**	03/25/2025

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	failed to ensure there were clinical indications to support the continued use of an indwelling catheter for 1 of 3 residents reviewed for catheters. (Resident Q) Findings include: A record review for Resident Q was completed on 2/18/2025 at 9:00 A.M. Diagnosis included, but were not limited to osteomyelitis right foot/ankle, diabetes mellitus type 2, anxiety, depression, hypertension, and chronic kidney disease stage 3. A Physician's order, dated 2/7/2025, included the following: Foley (urinary) catheter, size 18 french, 10 milliliter balloon. A Physician's progress note,dated 2/8/2025, indicated Resident Q had a Foley (urinary) catheter. There was no documentation of why the resident required the use of an indwelling urinary catheter. A Nurse Practitioner (NP) note, dated 2/20/2025, indicated Resident Q had redness to her buttocks and a Foley urinary catheter was in place for wound healing. However, there was no documentation of any current open wounds for Resident Q that could have been contaminated by urine. During an interview with the Director of Nursing (DON) on 2/18/2025 at 12:00 P.M., she indicated she did not know why Resident Q had a Foley catheter. A current facility policy was provided by the DON on 2/28/2025 at 2:02 P.M. The policy titled, "Urinary Catheter Care" did not include any type of assessment or required documentation to		We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Upon identification of the issue regarding the lack of clinical indications for the continued use of an indwelling catheter for Resident Q, the facility immediately reassessed the resident's need for the catheter. The Foley catheter was removed, and the resident was monitored for any changes in condition. Staff were educated on proper documentation requirements and clinical indications for the use of	

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	support the continued use of an indwelling urinary catheter. 3.1-41(a)(1)		indwelling catheters. **#2** All residents have the potential to be affected by the alleged deficient practice. All residents with indwelling catheters have been assessed to ensure that clinical indications for continued catheter use are clearly documented. Any resident found to have an indwelling catheter without appropriate clinical indications will be reassessed, and necessary actions will be taken to address and correct any issues. This includes removing the catheter if it is no longer clinically required and ensuring that proper documentation is in place for residents who continue to need a catheter. **#3** Staff will receive education on the facility's policies and procedures related to catheter care and the proper usage of indwelling catheters. For any resident requiring a catheter, the physician will provide clear documentation justifying its continued use. This education will be completed on or before 3/25/2025 by the DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts, to ensure	

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			adherence to updated catheter care policies, including the documentation of clinical indications for catheter use. The Director of Nursing (DON) or designee will review audit results regularly, and any instances of non-compliance will prompt immediate retraining for the involved staff. QAPI committee will review audit results monthly for three months to ensure compliance. If no concerns arise, monitoring will continue quarterly. If issues persist, additional corrective actions, including further staff education and activity program revisions, will be implemented.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview and record review, the facility failed to follow Physician's orders related to enteral feedings for 1 of 1 resident reviewed for a gastronomy tube (G-tube) (Resident 46). Finding includes: During an observation on 2/11/2025 at 2:53 P.M., a bottle of Osmolite 1.5 (enteral tube feeding) was disconnected from Resident 46 and hanging on an intravenous line (IV) pole. The bottle of Osmolite was not dated and had approximately 200 milliliters (mLs) left in the bottle. During an observation on 2/12/2025 at 10:40 A.M., a bottle of Osmolite 1.5 was disconnected from	F 0693	**F693** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts	03/25/2025

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	Resident 46 and hanging on an IV pole. The bottle of Osmolite was dated 2/11/2024 and had approximately 300 mLs remaining in the bottle. During an observations on 2/13/2025 at 1:36 P.M., a bottle of Osmolite 1.5 was disconnected from Resident 46 and was hanging on an IV pole with approximately 200 mLs still remaining in the bottle. The date on the bottle was 2/12/2024. Resident 46's record review was completed on 2/13/2025 at 3:00 P.M. Diagnoses included, but were not limited to: spinal cord compression, epilepsy, nontraumatic intracerebral hemorrhage of subcortical, neuromuscular dysfunction of bladder and spinal stenosis. An Admission Minimum Data (MDS) assessment dated 11/10/2024, indicated Resident 46 was severely cognitively impaired, had a feeding tube and received more than 51% of his calories from his feeding tube. A current Physicians order, dated 11/19/2024, indicated Resident 46 was to receive an enteral feeding of Osmolite 1.5. The enteral feeding was to run at 75 mLs per hour for sixteen hours for a total of 1200 mLs. One bottle of Osmolite 1.5 was 1000 mLs. Thus, the resident would have required one whole bottle and 1/5 of a new bottle of tube feeding per night. During an interview on 2/13/2025 at 1:38 P.M., the Infection Prevention (IP) Nurse indicated Resident 46 had not received his full enteral feeding, but should have. The IP Nurse indicated any time a resident did not receive their entire enteral feeding, the Physician should be notified. Resident 46's record lacked the documentation		alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Immediate corrective action was taken to replace the bottles and ensure proper documentation for Resident 46. The nurse was educated on the proper procedure for administering and documenting enteral feedings, including notifying the physician if the full feeding was not provided. **#2** All residents have the potential to be affected by the alleged deficient practice. A review of all residents receiving enteral feedings will be conducted to identify any other residents at risk of similar issues. Any discrepancies found will be immediately corrected. **#3** All nursing staff will be retrained on proper enteral feeding administration, including documentation procedures such as dating and initialing feeding bottles. The staff will be trained to notify the physician immediately if a resident does not receive the full amount of enteral feeding as prescribed. This education will be	

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	that the Physician had been notified on 2/11, 2/12 or 2/13/2024 indicating he had not received the amount of Osmolite 1.5 enteral feeding that was ordered. On 2/13/2024 at 3:00 P.M., the Director of Nursing (DON) provided undated policy titled, "Enteral Feedings", and identified the policy as the one currently used by the facility. The policy indicated, "... 1. Enteral feedings will be administered in accordance with the physician/practitioner order... Preventing Errors in Administration... 2. On the formula container document initials, date, and time the formula was hung... Documentation... 2. Document the administration of the enteral feeding, including name of formula, time administered, and amount administered...." 3.1-44 (a)(2)		completed on or before 3/25/2025 by the DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure proper administration and documentation of enteral feedings. The Director of Nursing (DON) or designee will review the audits weekly, and any non-compliance will be addressed immediately with retraining. The QAPI committee will review the results monthly for three months to ensure ongoing compliance and continuous improvement. If no concerns arise, monitoring will continue quarterly. If issues persist, additional corrective actions, including further staff education and activity program revisions, will be implemented	
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 assist a resident with a fractured arm apply her continuous positive airway pressure (CPAP) and clean the equipment after use for 1 of 1 residents reviewed for respiratory care. (Resident 23) Finding includes: During an observation and interview on 2/11/2025 at 10:49 A.M., Resident 23's CPAP mask and	F 0695	**F695** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following	03/25/2025

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	tubing were lying uncovered on an opened SoClean machine on the right side of the resident's bed. Resident 23 had a splinted right arm propped up on a pillow. During an observation and interview on 2/11/2025 at 2:40 P.M., Resident 23 indicated no one ever cleaned her CPAP, and she did not always wear her CPAP because it was too hard for her to put on by herself with a broken arm. Resident 23 indicated no one had helped her the previous night. During an observation on 2/12/2025 at 2:22 P.M., Resident 23's CPAP mask and tubing was still lying uncovered on an opened SoClean machine. During an observation and interview on 2/13/2025 at 11:15 A.M., Resident 23 indicated she did not wear her CPAP the previous night because no one had assisted her with the equipment The mask continued to lie uncovered on an opened SoClean machine. The machine was filled with supplies. During an observation and interview on 2/14/2025 at 9:23 A.M., Resident 23 indicated she had not worn her CPAP the previous night because no one had assisted her with putting it on. The equipment continued to lie uncovered on an opened SoClean machine. During an observation on 2/17/2025 at 3:09 P.M., Resident 23's CPAP equipment was lying on uncovered on top of the SoClean machine. A record review was completed for Resident 23 on 2/13/2025 at 9:30 A.M. Diagnoses included but was not limited to: chronic obstructive pulmonary disease, obstructive sleep apnea, and fracture of shaft of radius, right arm.		CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** Resident 23 was immediately assisted with applying her CPAP at bedtime, and staff ensured the equipment was placed in the SoClean machine for proper cleaning after use. The resident's care plan was reviewed, and nursing staff were re-educated on assisting residents with CPAP use, especially those with mobility limitations. Staff also verified that the CPAP machine was properly documented in the Treatment Administration Record (TAR). **#2** All residents have the potential to be affected by the alleged deficient practice. A facility-wide review was conducted to identify any other residents using CPAP or BiPAP devices who may require assistance. All residents with CPAP/BiPAP orders were	

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	A Physician Order, dated 4/13/2021, CPAP apply at bedtime and remove upon rising with settings of 11 cm H20, fill with distilled water and apply. A Physician's Order, dated 4/8/2024, to place the mask in SoClean machine with tubing intact after removing the mask from the resident in the morning. A current respiratory care plan, dated 1/19/2023, indicated CPAP settings as ordered A Treatment Administration Record (TAR), dated 1/1/2025 - 1/31/2025 indicated the device had been applied and cleaned as ordered. A TAR dated, 2/1/2025 - 2/28/2025, indicated she had refused to wear the machine on 2/10/2025 and that it was in the SoClean every day, except on 2/6/2025 which was not signed off. During an interview on 2/17/2025 at 3:22 P.M., RN 9 indicated Resident 23 does not always wear the CPAP, when it was not in use it should have been in the CPAP sanitizer, and it currently was not in the machine and should have been. On 2/18/2025 at 8:54 A.M., the DON provided a policy titled "CPAP/BIPAP Guidance," undated, indicated the policy was the one currently used by the facility. The policy indicated "... The facility will implement procedures to ensure that each resident receives necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan, and the resident's choice....." 3.1-47(a)(6)		assessed to ensure they were receiving proper respiratory care, and their equipment was being cleaned according to physician orders. Any issues identified were corrected immediately. **#3** All nursing staff will be educated on CPAP and BiPAP assistance, including proper application, documentation, and cleaning procedures. The facility's policy on CPAP/BiPAP use and cleaning will be reviewed to reinforce compliance with professional standards of care. This education will be completed on or before 3/25/2025 by the DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure CPAP and BiPAP devices are being properly used, cleaned, and documented in accordance with physician orders. The Director of Nursing (DON) or designee will review audit results, and any non-compliance will result in immediate retraining. The QAPI committee will review the results monthly for three months to ensure ongoing compliance and continuous improvement. If no concerns arise, monitoring will continue quarterly. If issues persist, additional corrective actions, including further staff	

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			education and activity program revisions, will be implemented	
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on observation, interview, and record review, the facility failed to ensure there was a sufficient number of nursing staff to provide care to residents on all nursing units. This deficient practice had the potential to affect of residents. See F677 for additional information regarding Residents B, M, D, E, and 55 Findings include: During a Resident/surveyor group meeting, conducted on 2/13/2025 at 1:41 P.M., 22 of 22 residents attending complained about untimely response to call lights, not receiving at least two showers a week and not receiving medications timely and/or not receiving all of their medications. During a Family meeting with the new corporate representatives and the Director of Nursing, conducted on 2/12/2024 at 2 PM, several resident representatives complained about the lack of staffing to provide care, especially at night and residents not receiving timely showers or medications. The family representatives queried the new corporate staff and DON about reducing the number of staff and "firing" the QMAs (Qualified Medication Aides) and shower aides. The Director of Nursing informed the family members that the staff were not "fired" but were just not given as many work hours. The corporate representative informed the family members that the facility was staffed at a 3.5 PPD (hours of	F 0725	**F725** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. Th is prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** The facility immediately reviewed the staffing levels and adjusted to ensure adequate coverage on all shifts. Additional agency staff were brought in to support direct care needs, and internal staff were	03/25/2025

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	direct nursing care per resident per day) which was above the national average. The meeting ended abruptly when family members became emotional and loud after being told individual concerns would not be directly addressed during the meeting. During an interview on 2/17/2025 at 11:18 A.M., the DON indicated the facility determined the staffing levels needed to meet each residents' needs each day based on acuity. The DON indicated in addition, during emergencies they used nursing staffing agencies and staff were allowed to pick up hours through their messaging service. She indicated the facility was staffed with a nursing supervisors every shift, 7 days a week. She indicated she had not received any staffing concerns from the families or residents until the newscasters had came to the facility. She did concede the nursing staff had voiced their concerns and the facility was trying to adjust to the new corporations staffing patterns. Review of the Facility Assessment, provided on 2/17/2025 at 10:30 A.M. by the DON, regarding nursing staffing needs, dated 1/16/2025, indicated the following staffing needs: RN 14.8 (hours scheduled per day) LPN 18.6 (hours scheduled per day), CNA 63.5 per day (hours scheduled per day). Using this ratio for a census of 107 residents, the required, facility assessed PPD would be 6.79. However, after a discussion with the DON, on 2/17/2025 at 1:38 P.M., a corrected facility assessment was provided which indicated the following nursing staff requirements: RN 5.38 (hours per day), LPN 12.55 (hours scheduled per day) and CNA 26.88 (hours scheduled per patient per day). This ratio, utilizing the current facility census of 98 residents equaled 3.42 PPD of nursing staff. It was unclear if any adjustments		offered incentives to pick up extra shifts. Residents who reported delays in care were assessed to ensure all immediate care needs were met. **#2** All residents have the potential to be affected by the alleged deficient practice. A facility-wide review was conducted to determine the impact of staffing levels on resident care. All residents were assessed for missed or delayed care, including showers, medication administration, toileting, and call light response times. Any identified concerns were addressed, and care plans were updated as needed. **#3** The facility will ensure staffing levels are sufficient to meet resident needs by implementing a daily staffing review based on acuity and census. A recruitment and retention plan will be developed to address staffing shortages, including targeted hiring efforts and staff retention incentives. Nursing staff will be educated on prioritizing resident needs and documenting any missed care to ensure follow-up. Daily staffing meetings will be conducted for 60 days to ensure the facility meets or exceeds the required staffing PPD. This education will be completed on or before 3/25/2025 by the DON/designee.	

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	had been made to the PPD requirements due to resident acuity. On 2/17/2025 at 1:30 P.M., the DON provided documentation of current resident needs. The form indicated the following: 40 residents required the use of a mechanical lift to transfer, 21 residents required extensive assistance with personal hygiene and toileting needs and 17 residents required feeding assistance with their meals. Review of the nursing schedules as worked from 1/20/2025 through 2/20/2025 indicated the facility failed to provide the assessed required staffing levels of 3.42 PPD on the following dates: 1/20, 1/21, 1/26, 2/1, 2/15 and 2/16/2025. Although the staffing PPD scheduled was much higher than the 3.42 required staffing levels, the actual PPD for staff that had worked was much lower. During an interview on 2/11/2025 at 2:21 P.M., CNA 5 indicated the facility used to have 3 CNA's on each unit, a nurse, a QMA that worked from 10:00 A.M. until 6:00 P.M., a shower aide and a restorative aide for the day and evening shift, minus a shower aide on the evening shifts. He indicated now the facility only had two aides on the floor per unit and shower aide that worked a couple times a week, a restorative aide and a nurse for the day and evening shift He indicated the night shift had one CNA on all units. He indicated the residents had been complaining they had to wait longer for their call lights to be answered. He indicated they were understaffed and had to hurry and rush to provided the needed care. He indicated it was difficult to complete the scheduled showers.		**#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts completing resident satisfaction surveys to monitor concerns related to staffing and care delivery. Audit results will be reviewed weekly by the Director of Nursing (DON) or designee. The results of these meetings will be reviewed monthly by the Administrator during the QAPI meeting. The QAPI committee will analyze trends, identify areas for improvement, and implement necessary adjustments. If ongoing concerns are identified, additional corrective actions will be taken to ensure compliance and improve resident care.	

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	During an interview on 2/17/2025 at 9:28 A. M., CNA 6 indicated she was assigned ten residents to get up and ready for breakfast by 8:30 A.M.. She indicated she did not have enough time to do extra things like nails, hair, showers and charting. She indicated the residents did not get showered unless there was a shower aide scheduled. She indicated she had only been able to pass ice water to four residents this morning. She indicated the weekends were worse because there were many staff that called off and did not show up for work. She indicated due to the lack of staffing, she had noticed there were now odors in the hallways. She was indicated she was often asked to pick up hours on her day off and asked stay over late. She indicated she was suffering from burn out. During an interview on 2/17/2025 at 12:05 P.M., CNA 17 indicated she was a shower aide 1-2 times a week. She indicated when she worked on the floor and there were only two CNAs, she was assigned 10-11 residents. She indicated she had to work at a faster pace, and could not complete tasks such as nail care, showers and charting. During an interview on 2/17/2025 at 1:56 P.M., CNA 15 indicated staffing the previous weekend did not go well. Sunday, he had worked on the a nursing unit by himself and had been assigned 14 residents. He indicated three of the 14 required feeding assistance in their rooms and by the tine he got done with breakfast trays, the lunch trays had arrived to the unit. The residents were so upset with him because their call lights were also not answered timely. He indicated he had only had time to check and change some residents and make sure they were comfortable. He indicated he had not had time to complete the four scheduled showers and had only completed half of his			

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	charting. He indicated residents that were usually continent had ended up wetting themselves because he could not assist them timely and they were very upset. CNA 15 indicated there was no time to wash everyone, do nail care, shave residents or provide oral care. During an interview on 2/17/2025 at 2:40 P.M., CNA 14 indicated this past weekend, staffing was horrible. She indicated she had only had time to provide one out of four scheduled showers on Saturday and none of the scheduled showers on Sunday. She had been assigned fourteen residents. She indicated she was unable to complete the entire required assignment every day such as showers, charting and the little things that residents had requested. During an interview on 2/18/2025 at 10:48 A.M., CNA 2 indicated that he was assigned to care for 11 residents. He indicated he was unable to complete the following tasks:: showers, nail care, charting. He indicated he attempted to get everyone changed or toileted before he went home, but could not always accomplish it. During an interview on 2/18/2025 at 11:00 A.M., CNA 7 indicated she was assigned to care for 11-12 residents and had problems getting the following tasks done: showers and charting. During an interview on 2/17/2025 at 2:10 P.M., Resident K indicated she had to wait this past Sunday to use the toilet. She indicated her back hurts when she had to hold it for too long. She indicated she had hardly seen the CNA working. She indicated she had ended up wetting the bed, which made her feel terrible. She had to ask her husband to help her with the bed pan because no staff had answered her call light. She indicated			

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	her husband had tried to help her but when he took her off the bedpan, it had spilled onto the bed and soiled the linens. During an interview on 2/17/2025 at 2:21 P.M., Resident L indicated his care this past weekend was non-existent. He indicated it was like that every weekend. He indicated he had gone without fresh ice water all weekend, even though he had asked for it but no one had answered his call. When the aide had arrived, the resident was informed the aide was the only one working and so the resident was unable to get out of bed, be washed up or dressed. He laid in his bed, in a gown, all weekend. Resident L indicated he had really wanted to get up on Sunday because he needed to have a BM. He indicated he had tried to hold it, for over an hour but when help had finally arrived, he had an explosion in his brief and on the floor. He indicated he was so embarrassed about the accident. During a interview on 2/17/2025 at 7:21 P.M., Resident C indicated that she had been at the facility for 5 weeks and had only received one shower. She indicated she was never offered a shower by the staff. On 2/13/2025 at 9:00 A.M., a policy was requested for staffing and the DON provided a policy titled, "Nursing Staffing Information Policy," undated and indicated the policy was the one currently used in the facility. The policy indicated "...The facility will post nursing staffing information daily in a prominent place readily assessable to residents and visitors....." There was no specific information in the policy regarding actual staffing requirements or adjustments to be made based on resident acuity levels.			

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F 0755 SS=F Bldg. 00	3.1-17(a)(b) 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review, interview and observation, the facility failed to ensure physician ordered medications were available for 6 of 13 residents whose medications were reviewed (Resident 86, L, M, N, O and Q) and failed to ensure medications were administered as ordered for 4 of 9 residents reviewed for quality of care. (Resident M, N, 47, 71) Findings include: 1. During an observation, on 2/14/2025 at 10:30 A.M., Resident 86's resident representative was at the nursing station and asked RN 23 about the resident's Vancomycin (antibiotic). RN 23 informed the resident's representative that the pharmacy had not delivered the antibiotic yet. During an observation, on 2/14/2025 at 11:10 A.M., RN 23 notified the nursing supervisor that the oral Vancomycin was not available for Resident 86. During an interview, on 2/14/2025 at 1:54 P.M., RN 23 indicated the antibiotic (Vancomycin) for Resident 86 was ordered on the morning of 2/12/2025 and the pharmacy had not delivered it. RN 23 indicated she had called the pharmacy and the pharmacy indicated the antibiotic would be delivered on 2/14/2025. During an interview, on 2/14/2025 at 2:10 P.M., RN 19 indicated the facility had an emergency drug kit (EDK) to pull medications, if needed, but oral Vancomycin was not included in the kit.	F 0755	**F755** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** All affected residents had their medications reviewed to ensure they were available and administered as prescribed. Any outstanding missed medications were obtained immediately and administered as appropriate.	03/25/2025

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	The clinical record of Resident 86 was reviewed on 2/18/2025 at 11:51 A.M. The resident's diagnoses included, but were no limited to: cerebral infarction, metabolic encephalopathy, diabetes mellitus, gastrointestinal hemorrhage, osteomyelitis, peripheral vascular disease, paroxysmal atrial fibrillation, morbid obesity, hypertension, heart failure, chronic kidney disease, neuromuscular dysfunction of bladder and osteomyelitis. A 5-Day Minimum Data Set (MDS) assessment, dated 2/7/2025, indicated the resident was moderately cognitively impaired and was always incontinent of his bowels. Current Physician Orders included but were not limited to: -Clostridium difficile (C-diff) collection (stool sample) on 2/7/2025 -Vancomycin Hydrochloride oral capsule 125 milligrams (mg) (antibiotic) give one capsule by mouth every six hours for C-diff colitis for ten days, ordered on 2/12/2025. A Lab Report, dated 2/12/2025, indicated a positive C-difficile Toxin Gene for Resident 86. Review of the lab report completed from the stool sample ordered on 2/7/2025 indicated the resident tested positive for a bowel infection, Clostridium difficile (C-Diff) The test results were dated 2/12/2025. Nursing Progress notes completed on the following dates and times indicated the resident's Vancomycin (antibiotic) had not yet been delivered from the pharmacy and could not be administered: -2/13/2025 at 5:37 A.M.,		Physicians were notified of any delays in medication administration and consulted for further instructions. Documentation was updated to reflect physician notifications and interventions. **#2** All residents have the potential to be affected by the alleged deficient practice. A facility-wide audit of all residents receiving scheduled medications, antibiotics, insulin, and critical medications was conducted on 2/18/2025 to identify any additional residents who may have experienced delays in medication administration, missed doses, or lack of provider notification. The audit included a review of all Medication Administration Records (MARs) for the past 30 days to detect any missed doses, documentation gaps, or delays in obtaining medications from the pharmacy with corrective action upon discovery. **#3** All licensed nurses received re-education on medication administration policies, including the proper procedures for identifying missing medications, utilizing the Emergency Drug Kit (EDK), notifying providers, and documenting missed doses. This education will be completed on or before 3/25/2025 by the	

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	-2/13/2025 at 12:11 P.M, -2/13/2025 at 5:04 P.M., -2/14/2025 at 1:59 P.M., and -2/14/2025 at 6:03 P.M. There was no notation the physician had been notified of the delay in treatment, nor was there any documentation the pharmacy had been contacted regarding the need for the medication The February 2025 Medication Administration Record (MAR) indicated Resident 86 did not receive his first dose of the Vancomycin (antibiotic) until 2/14/2025 at 11:00 P.M. An Advanced Practice Provider Note, dated 2/13/2025, indicated the Nurse Practitioner had noted the resident was positive for C-Diff (bowel infection) and she had indicated the treatment had begun on 2/12/2025. During an interview, on 2/19/2025 at 11:39 A.M., RN 3 indicated if an antibiotic was unavailable, then she would notify the pharmacy. If the pharmacy was unable to deliver the ordered medication, she would have tried to get the medication out of the EDK. If the EDK did not have the medication the resident needed, RN 3 indicated she would have notified the nursing supervisor of the missing dose of antibiotic. During an interview, on 2/19/2025 at 1:59 P.M., LPN 24 indicated if there was a missing medication for a resident, she would have called the nursing supervisor to see if it was in the EDK. LPN 24 indicated if the medication was not in the Emergency Drug Kit, then she would have contacted the pharmacy. Lastly, LPN 24 indicated she would have notified the supervisor and updated the provider regarding the missing		DON/designee. **#4** The Director of Nursing (DON) or designee will conduct daily review of the missing medication audits for one month to ensure all prescribed medications are available and administered as ordered. Any missing doses will be addressed immediately, and providers will be notified as required. Audits will be completed 3 times per week for 2 weeks, 2 times per week for 2 weeks, weekly for 4 weeks on varying shifts to ensure all prescribed medications are available and administered as ordered. The QAPI committee will review the results monthly for three months to ensure ongoing compliance and continuous improvement. If no concerns arise, monitoring will continue quarterly. If issues persist, additional corrective actions, including further staff education and activity program revisions, will be implemented.	

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	medication.2. Resident M's record review was completed on 2/18/2025 at 11:13 A.M. Diagnoses included, but were not limited to: paraplegia, sacral osteomyelitis, neuromuscular dysfunction of bladder and epilepsy. A current Physician's order dated, 2/11/2025, indicated Resident M was to receive one gram ertapeneum (antibiotic) intravenously one time a day for sacral osteomyelitis from 2/11/2025 to 2/17/2025. A February 2025 Medication Administration Record (MAR) indicated Resident M had not received her dose of ertapeneum on 2/13 and 2/16/2025. Resident M's record lacked the documentation she had refused her medication or a Physician had been notified that she had missed two doses of her medication. During an interview on 2/18/2025 at 2:15 P.M., the Director of Nursing indicated she was not sure why Resident M had missed two doses of ertapeneum, but Resident M should have received a dose of ertapeneum on 2/13 and 2/16/2025. 3. Resident L's record review was completed on 2/18/2025 at 1:05 P.M. Diagnoses included but were not limited to: spinal stenosis, chronic obstructive pulmonary disease, heart failure and influenza type A. A current Physician's order dated, 2/11/2025, indicated Resident L was to receive 75 milligrams of Tamiflu (antiviral) twice a day for 5 days due to the Influenza type A (flu) infection. A February 2025 MAR indicated Resident L had			

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	not received either dose of the Tamiflu medication on 2/12/2025. Resident L's record lacked the documentation he had refused his medication or a Physician had been notified that he had missed two doses of his medication. 4. Resident N's record review was completed on 2/19/2025 at 9:05 A.M. Diagnoses included, but were not limited to: neurogenic bowel, osteomyelitis of vertebra, urinary tract infection. A current Physician's order dated, 2/10/2025, indicated Resident N was to receive 500 mg capsule of cephalexin (antibiotic) by mouth every eight hours for seven days for a urinary tract infection. A February 2025 MAR indicated Resident N had not received his 1:00 P.M. dose of cephalexin on 2/10, 2/11 and 2/13/2025. Nursing Progress notes, on 2/10 and 2/11 at 1:00 P.M. indicated the medication was not available to administer. Resident N's record lacked the documentation a Physician had been notified that he had missed two doses of his cephalexin. 5. Resident O's record review was completed on 2/19/2025 at 10:15 A.M. Diagnoses included, but were not limited to: osteomyelitis, type two diabetes mellitus, hyperlipidemia and hypertension. The current Physician's orders included the following medication orders: -Admelog SoloStar Solution (Insulin pen) 1 unit at			

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	bedtime ordered on 2/4/2025 - daptomycin (antibiotic) one time a day IV ordered on 2/5/2024 - ergocalciferol (Vitamin D 2) one time a day orally ordered on 2/5/2024 - metformin (oral antidiabetic) one time a day orally ordered on 2/5/2024 The February 2025 Medication Administration Record (MAR) indicated Resident O had not received a scheduled dose of Admelog SoloStar Solution on 2/4, 2/5 or 2/6/2025. Resident O had not received 500 mg of daptomycin intravenously on 2/5 or 2/13/2025. He also had not received 50000 units of ergocalciferol on 2/5, 2/7, 2/8 or 2/9/2025 or his scheduled metformin on 2/4 or 2/18/2025. Resident O's record lacked the documentation he had refused his medications, or a Physician had been notified that he had missed a dose of his medications or the reason for the missed meditation. During an interview on 2/19/2024 at 9:50 A.M., the Nursing Supervisor indicated the facility had been having difficulties obtaining prescriptions since the facility had switched pharmacies. She indicated if a medication was not available, the nurse was supposed to let the Nursing Supervisor know and the medication would have been obtained from the Emergency Drug Kit, if it was available. If the medication was not available, an order was sent to the pharmacy. The order would be sent as stat if the medication was anything other than a vitamin. The facility had a back-up pharmacy, but the Nursing Supervisor was unaware what the back up pharmacy's name was or how to contact the back-up pharmacy. She indicated if the main pharmacy was not able to fill			

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	the prescription timely, the main pharmacy contacted the back-up pharmacy. She indicated the back-up pharmacy was located in Indianapolis and it took several hours for prescriptions to be delivered even if they were ordered "stat." . In addition, she indicated if the resident misseds a dose of any medication, the provider should have been notified. During an interview on 2/19/2024 at 2:00 P.M., the Director of Nursing indicated the facility had had problems with their pharmacy supplying medications timely. She indicated residents should have received their medications as ordered and the provider should have been notified of any missed medications.6. A record review for Resident Q was completed on 2/18/2025 at 9:00 A.M. Diagnosis included but were not limited to osteomyelitis right foot/ankle, diabetes mellitus type 2, anxiety, depression, hypertension, and chronic kidney disease stage 3. Physician orders included but were not limited to: ceftazidime 1.25 grams (gm) intravenously (IV) every 8 hours for osteomyelitis and tamiflu 75mg two times daily for 7 days for influenza. A current care plan indicated Resident Q had Influenza A and interventions included but were not limited to administer oxygen as ordered, droplet isolation precautions, and check oxygen saturation as needed. Resident Q's Medication Administration Record (MAR) for February 2025 indicated Tamiflu doses on 2/14/2025 were not administered and the order was not adjusted to account for the missed doses. In addition, it also indicated the ceftazidime 2.5mg, ordered on 2/7/2025 at 9:00 P.M., was not administerd 2/7/2025 through 2/10/2025.			

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A nursing medication note regarding the Tamiflu medication dated 2/14/2025 at 12:52 P.M. indicated the facility was still waiting for medication to arrive from pharmacy.

A nursing medication note for ceftazidime dated 2/08/2025 at 9:12 A.M., indicated the nurse had called pharmacy regarding the antibiotic and the pharmacist the medication would be delivered later the same night.

However, nursing medication notes on 2/9/2025 at 5:22 A.M., 2/10/2025 at 6:11 A.M., and 2/11/2025 at 8;23 A.M., all indicated the medication had not yet been delivered from pharmacy.

During an interview, on 2/19/2025 at 11:00 A.M., RN 4 indicated the facility could request the medication stat and the pharmacy would decide if they would send the medication from backup pharmacy. She indicated the back up pharmacy was located in Indianapolis and it took several hours to obtain the medication from the back up pharmacy. She indicated the facility had not had pharmacy problems before the facility had switched over to the new pharmacy, the change has not been ideal and the new pharmacy was not on top of delivering ordered medications timely.

On 2/19/2025 at 1:50 P.M., the Director of Nursing indicated the pharmacy and backup pharmacy were both located in Indianapolis and orders took several hours to receive. She was not aware how to use the backup pharmacy but had been in contact with the main pharmacy and had been trying to switch the backup pharmacy to a local pharmacy.

7. A record review for Resident 47 was conducted

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	on 2/17/2025 at 8:24 A.M. Diagnoses included but were not limited to: cerebral infarction, Alzheimer's, diabetes mellitis type 2, depression, and anxiety. Physician orders included but were not limited to Insulin lispro (a fast acting diabetic medication) 100units/milliliter(ml)before meals, if 0 - 60 milligrams per deciliter (mg/dL) Administer nasal Baqsimi (a medication to increase blood sugar levels) and recheck BS in 15 mins; 61 - 149 = 0; 150- 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401+ = 10 notify MD/NP, Baqsimi nasal powder 3 milligrams/dose for hypoglycemia (low blood sugar). A current care plan indicated Resident 47 had Diabetes. The interventions included but were not limited to diabetes medications as ordered, check blood sugar at 4:00 A.M. and offer snack if below 150, and consult doctor regarding any changes in diabetic medications. The Medication Administration Record for December 2024 indicated Resident 47 had the following blood sugar readings: 12/6/2024 of 60 mg/dL, there was no documentation baqsimi was administered. The Medication Administration Record for January 2025 indicated Resident 47 had the following blood sugar readings: 1/22/2025 of 60 mg/dL and 1/12/2025 of 57 mg/dL, there was no documentation baqsimi was administered for either of these readings. The Medication Administration Record for February 2025 indicated Resident 47 had the following blood sugar readings: 2/15/2025 of 60 mg/dL, there was no documentation baqsimi was			

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	administered. During an interview with LPN 19 on 2/18/2025 at 11:44 A.M., he indicated with a blood sugar reading equal to 60 mg/dL or less the facility was to administer baqsimi. During an interview with the DON on 2/18/2025 at 12:00 P.M., she indicated with a blood sugar reading equal to or less than 60 mg/dL, staff should have administered baqsimi. 8. A record review for Resident 71 was conducted on 2/13/2025 at 3:36 P.M. Diagnoses included but were not limited to: cancer head/face/neck, diabetes mellitus, depression, dysphagia, and heart disease. Physician Orders included, but were not limited to: sotalol (medication for hypertension) 20 milligrams (mg) twice a day (BID) hold for systolic blood pressure (SBP) <110 and midodrine (medication for hypotension) 10 mg as needed (PRN) for SBP<110. Resident 71's current care plan indicated he had hypertension. Interventions, included but were not limited to: Check blood pressure per order, give medications as ordered, and observe for side effects such as orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness. The medication administration record (MAR) for January 2025 indicated Resident 71's systolic blood pressure was below 110 on 48 occasions. The same MAR indicated the residents Sotolol was held as ordered, but did not indicate the resident received Midodrine as ordered.			

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	The MAR for February 2025 indicated Resident 71's systolic blood pressure was below 110 on 16 occasions. The same MAR indicated the residents Sotolol was held as ordered, but did not indicate the resident received Midodrine as ordered. During an interview with LPN19 on 2/18/2025 at 11:44 A.M., he indicated if Resident 71 had a blood pressure reading under 110, the facility nurses should have administered midodrine. During an interview with the DON on 2/18/2015, at 12:00 P.M., she indicated staff should have administered midodrine when the resident's systolic blood pressure reading was below 110. A policy for pharmacy services was requested but one was not received before the exit of the survey. This Federal tag relates to Complaint IN00451914, IN00451952, IN00452177, IN00451978, and IN00451284. 3.1-25(a) 3.1-25(b)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to follow standards of practice for infection control for 3 of 4 residents who received supplemental oxygen or wore a CPAP (continuous positive airway pressure) machine at night. (Residents 27, 95 and 11) Findings include: 1. During the following observations, Resident	F 0880	**F880** We here at the facility are respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey visit. We are willing to submit any and all documentation as requested to assure our credible compliance with the	03/25/2025

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	27's CPAP mask was in a SoClean (automated CPAP equipment cleaner and sanitizer) machine. The SoClean machine was not on, did not have a lid and the inside of the machine contained dust. -2/11/2025 at 10:25 A.M. -2/12/2025 at 11:56 A.M. -2/14/2025 at 2:10 P.M. -2/18/2025 at 1:54 P.M. Resident 27's record review was completed on 2/17/2025 at 3:30 P.M. Diagnoses included but were not limited to: Parkinson's disease, sleep apnea, anxiety and dysphagia. A current Physician's order dated, 4/9/2024, indicated Resident 27's CPAP mask was to be placed in the SoClean machine with the tubing intact after it was removed from the resident. A current Care Plan dated, 3/17/2023, indicated Resident 27 had altered respiratory status related to sleep apnea. The goal of the Care Plan was for the resident to maintain normal breathing patterns. An intervention to the Care Plan included, but was not limited to: disinfect CPAP as ordered. During an interview with the Unit Manager (UM) on 2/18/2025 at 1:55 P.M., she indicated the SoClean machine did not have a lid, but should, and the inside of the machine was dirty and should not have been. 2. During an interview on 2/11/2025 at 11:21 A.M., Resident 95 indicated she used supplemental oxygen when she was short of breath. She indicated staff had not changed the tubing or the humidification bottle on the oxygen concentrator in over a month. Resident 95's oxygen tubing was laying on the		deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement because deficiencies. This prepared and submitted because of requirements under State and Federal Law. Please accept this plan of correction as our creditable allegation of compliance. We are requesting desk review for compliance. **#1** The SoClean machine was immediately cleaned and disinfected on 2/18/2025by the Unit Manager. A new lid for the SoClean machine was ordered on 2/19/2025, and the machine will be kept covered going forward. The CPAP mask for Resident 27 will be placed in the SoClean machine as per physician orders, and staff will ensure that the machine is operating and properly sanitized in accordance with facility policies. Oxygen tubing and humidifier bottles for Resident 95 and Resident 11 were immediately replaced, and the equipment was labeled with the date of replacement on 2/19/2025. The oxygen tubing was placed in a proper storage bag when not in use for both residents, and staff	

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	oxygen concentrator, unbagged and the tubing and the humidification bottle on the oxygen concentrator were not labeled with a date during the following observations: -2/11/2025 at 11:27 A.M. -2/13/2025 at 1:15 P.M. -2/17/2025 at 2:15 P.M. -2/18/2025 at 1:52 P.M. Resident 95's record review was completed 2/18/2024 at 9:00 A.M. Diagnoses included, but were not limited to: hemiplegia and hemiparesis affecting left side, dysphagia and atrial fibrillation. A current Physician's order dated, 10/16/2024, indicated Resident 95 received oxygen at 0-4 Liters to maintain biox (amount of oxygen in the blood) greater than 90. A current Physician's order dated, 10/16/2024, indicated Resident 95's oxygen tubing and humidifier bottle should have been changed every Wednesday on the night shift. During an interview on 2/18/2025 at 1:55 P.M., the Unit Manager indicated the oxygen tubing and the humidifier bottle on the concentrator should be labeled with the date they had been changed. The oxygen tubing should have been stored in a bag and not hanging over the oxygen concentrator. During an interview on 2/19/2025 at 2:40 P.M., the Director of Nursing indicated she did not have a policy specific to labeling oxygen equipment with dates.3. A record review for Resident 11 was completed on 1/18/2025 at 10:00 A.M. Diagnoses included but were not limited to congestive heart failure, chronic respiratory failure, and diabetes mellitus.		were instructed to consistently bag oxygen equipment when it is not in use to ensure proper infection control practices are followed. **#2** All residents have the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted to review oxygen equipment and CPAP sanitization practices for all residents using supplemental oxygen or CPAP machines. Any identified issues were corrected immediately upon discovery, and necessary corrective actions were implemented to ensure compliance with infection control standards. Audit completed by 3/12/2025 by the DON/designee. **#3** All licensed nursing staff were re-educated on the proper use of the SoClean machine, including ensuring it is turned on, properly sealed, and cleaned regularly. Additionally, nursing staff received education on the proper handling and storage of oxygen equipment, including bagging unused tubing and labeling all equipment with dates. This education will be completed on or before 3/25/2025 by the DON/designee. A weekly audit will be conducted to ensure all oxygen equipment is stored and labeled correctly, and all CPAP devices are sanitized and properly maintained. Supervisors	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHWIN HEALTH & REHABILITATION	20531 DARDEN RD SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Physician orders included but were not limited to replace oxygen tubing, filter and water every Wednesday on night shift. A current care plan indicated Resident 11 had altered respiratory status/difficulty breathing related to chronic hypoxic respiratory failure. His interventions included but were not limited to: administer medications as ordered, provide oxygen as ordered and to elevated head of bed as needed. During an general observation on 2/12/2025 at 10:15 A.M., Resident 11's nebulizer mouthpiece was lying on the nightstand and the oxygen tubing was lying on the floor. Neither item was dated and was not stored in a bag when they were not in use. During an general observation on 2/18/2025 at 1:59 P.M., Resident 11's oxygen tubing was rolled up and placed in the handle of the concentrator and his nebulizer was lying on the nightstand. Both items were not bagged or dated. During an interview with CNA 16 on 2/18/2025 at 2:10 P.M., he indicated when oxygen is not in use it would be stored in a bag. He also indicated the tubing and water should have been dated. During an interview with the Infection Prevention Nurse on 2/19/2025 at 2:26 P.M., she indicated oxygen administration equipment should have been stored in bags when not in use. A current facility policy was provided by the Director of Nursing on 2/18/2025 at 2:02 P.M. The policy titled "Oxygen Administration", did not indicate how to store oxygen equipment when it		and Unit Managers will perform these weekly checks to verify that all equipment is stored and maintained properly, with documentation provided during morning meetings to ensure ongoing compliance. This education will be completed on or before 3/25/2025 by the DON/designee. **#4** Audits will be completed by the Director of Nursing (DON) or designee 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly for 4 weeks on varying shifts to ensure oxygen administration and storage process is being completed per policy and procedure. The QAPI committee will review the results of the audits monthly for three months to ensure ongoing compliance and continuous improvement. If no concerns arise, monitoring will continue quarterly. If issues persist, additional corrective actions, including further staff education and activity program revisions, will be implemented.	

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	was not in use. 3.1-18(a)			