STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(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 IN00436384 and IN00442512. Complaint IN00436384 - Federal deficiencies related to the allegations are cited at F677, F755, F757 and F758. Complaint IN00442512 - Federal deficiencies related to the allegations are cited at F677, F755, F757 and F758. Survey dates: October 21, 22, 23, 24 and 25, 2024 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 5 Medicaid: 66 Other: 12 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 11/14/2024	F 0000		
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Matthews	Administrator	11/27/2024

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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	Based on observation, record review and interview, the facility failed to ensure care plans related to respiratory status were revised for 1 of 25 residents reviewed. (Resident 7) Finding includes: During an observation, on 10/21/2024 at 10:54 A.M., Resident 7 was receiving 2 liters (L) of oxygen via a nasal cannula (NC). During an observation, on 10/22/24 at 9:54 A.M., Resident 7 was receiving 2L of oxygen via a NC. During an observation, on 10/23/2024 at 1:57 P.M., Resident 7 was receiving 2L of oxygen via a NC. The medical record for Resident 7 was reviewed on 10/23/2024 at 11:55 A.M. Diagnoses included, but were not limited to: delusional disorder, diabetes mellitus, peripheral vascular disease, obstructive sleep apnea, heart failure, acquired absence of left leg below knee, hypertension, depression, anxiety, chronic obstructive pulmonary disease and history of transient ischemic accident and cerebrovascular accident. There was no physician's order for the use of oxygen for Resident 7. During an interview, on 10/24/2024 at 9:51 A.M. with the Director of Nursing, she indicated a physician's order was not required because the oxygen use was a nursing measure. She indicated she was unaware of Resident 7's oxygen use and did not know how long the resident had been receiving oxygen. A Quarterly Minimum Data Set (MDS) assessment, dated 8/5/2024, indicated Resident 7 had a diagnosis of chronic obstructive pulmonary disease and had not received oxygen therapy.	F 0657	**F657 Care Plan Timing and Revision** **This facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #7 care plan for oxygen was updated to include oxygen therapy. Resident #7 was assessed, and comprehensive care plan was revised to reflect residents' oxygen order. **2) How the facility identified other residents:** Audit was conducted to determine that those residents that require oxygen therapy or receive oxygen have current and updated care plans. Any issues identified were immediately addressed. **3) Measures put into place/**	11/20/2024

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	Resident 7's current Care Plan, dated 8/5/2024, lacked documentation including oxygen therapy as a current intervention for the resident. During an interview, on 10/25/2024 at 9:44 A.M., LPN 4 indicated Resident 7's care plan should have been updated to include oxygen therapy. On 10/25/2024 at 2:55 P.M., the Director of Nursing provided a policy titled, "Comprehensive Care Plan," dated 11/17/2017 and indicated the policy was the one currently used by the facility. The policy indicated, " ...the care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving ..." 3.1-35(d)(2)(B)		**System changes:** The Director of Nursing conducted an in-service for the interdisciplinary team to review procedures for development of a comprehensive care plan. The MDS coordinator \Director of Nursing will review care plans within 24-48 hours of admission, quarterly, annually and with significant changes.to ensure timely revisions have occurred. Identified areas of concern will be addressed immediately. During weekly Comprehensive Clinical Review, MDS Coord/Director of nursing will ensure timely care plan revisions. **4) How the corrective actions will be monitored:** The Director of Nursing or designee will randomly review five residents' records weekly to ensure that care plans have been revised to reflect current status. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** **11/20/24**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review and interview, the facility failed to provide showering,	F 0677	**F677 - ADL Dependent Resident** **The facility requests paper**	11/20/2024

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	shaving and nail care services related to ADL's (activities of daily living) for 2 of 8 residents reviewed for ADL's. (Resident D and 4) Findings include: 1. During an observation, on 10/21/2024 at 9:58 A.M., Resident D was observed to have facial hair. During an observation, on 10/22/2024 at 9:11 A.M., Resident D was observed to have facial hair and disheveled hair. At 1:30 P.M., Resident C was observed to have a baseball hat on and continued have facial hair. During an observation, on 10/23/2024 at 9:13 A.M., Resident D was observed with more than a days growth of facial hair and his hair was disheveled. At 1:29 P.M., Resident D's face continued to be unshaven and his hair disheveled. During an observation, on 10/24/2024 at 10:03 A.M., Resident D was observed to be wearing a baseball hat on top of unbrushed, greasy hai. His facial hair continued to be unshaven. During an observation, on 10/25/2024 at 10:22 A.M., Resident D was observed with an unshaven beard and wearing a baseball cap over greasy hair. A record review for Resident D was completed, on 10/23/2024 at 10:01 A.M. Diagnoses included, but were not limited to: dementia and illiteracy. An Admission Minimum Data Set (MDS) assessment, dated 9/25/2024, indicated it was very important for Resident D to choose between a tub bath, shower, bed bath, or sponge bath.		**compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1 Immediate actions taken for those residents identified:** Resident D- rounds completed to ensure residents facial hair had been shaved, shower had been given and nail care provided. Resident 4- rounds completed to ensure shower had been given and nail care provided. Rounds also completed on all dependent residents to ensure showers, nail care and facial grooming was provided. **2 How the facility identified other residents:** Audit completed and determined residents requiring assistance with ADL's have the potential to be affected. Any issues identified were immediately addressed. **3 Measures put into place/**	

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	A Quarterly MDS assessment, dated 10/11/2024, indicated Resident D had moderate cognitive impairment and required partial/moderate assistance with hygiene and showering. Resident D had behaviors of, but not limited to: -Delusions -Verbal behavioral symptoms directed towards others for 1-3 days of the 14-day assessment period. -Wandering for 1-3 days of the 14-day assessment period. Resident D had mood indicators of, but not limited to: -Little interest or pleasure in doing things for 12-14 days of the 14-day assessment period. -Feeling down, depressed, or hopeless for 12-14 days of the 14-day assessment period. -Trouble concentrating on things, such as reading the newspaper or watching television for 12-14 days of the 14-day assessment period. A review of the CNA's (Certified Nursing Assistant) tasks tab in the electronic medical record, indicated Resident D preferred showers or bed baths. Resident D was to receive showers on Tuesday and Friday evenings. Showers recorded for Resident D from 9/26/2024 through 10/22/2024 indicated he only received showers on the following dates: -9/26/2024 -10/1/2024 -10/8/2024. A Care Plan, dated 9/20/2024, indicated Resident D had an ADL self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day related to dementia, vitamin D deficiency, benign prostatic		**System changes:** Staff will be re-educated on providing assistance with all ADL's as needed, including showers, nail care, and facial grooming. **4 How the corrective actions will be monitored:** The Director of Nursing or designee will complete care rounds on at least 5 dependent residents per week at varied times/shifts to ensure ADL assistance is provided per plan of care to include facial grooming, nail care and showers. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 **Date of compliance**: 11/20/24	

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	hypertrophy, smoker, infrarenal aneurism, weakness and impaired cognitive deficiency. The goal included to maintain Resident D's existing ADL self-care/mobility performance. Interventions included, but were not limited to: -If Resident D was resistive to ADL's, reassure Resident D and leave him alone, return 5-10 minutes later and try again. -Resident D will take a bath and his usual performance of supervision to physical assistance as needed. During an interview, on 10/24/2024 at 2:27 P.M., CNA 9 indicated that showers were documented in the electronic medical record, and the dementia unit did not use shower sheets for supplemental documentation. She indicated all residents received a shower twice a week. When CNA 9 reviewed the shower documentation of only 3 showers in 30 days, she indicated maybe someone did not document Resident D's showers. She indicated Resident D does get shaved, but he was difficult to shave since he cursed and yelled. 2. During an observation and interview, on 10/21/2024 at 11:41 A.M., Resident 4 had long fingernails with a brown substance underneath all his fingernails and indicated he only got an occasional shower. During an observation and interview, on 10/22/2024 at 2:25 P.M., Resident 4 still had a brown substance under all of his long fingernails and more than a days growth of facial hair was present. Resident 4 indicated he liked a clean-shaven face and it had been quite a few days since his last shower. During an interview, on 10/22/2024 at 2:30 P.M., CNA 2 indicated resident showers were completed			

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	at least twice a week and sometimes three times a week, if needed. During an interview, on 10/23/2024 at 11:40 A.M., CNA 1 indicated showers were documented in the electronic medical record (EMR). During an interview, on 10/23/2024 at 1:58 P.M., CNA 2 indicated nail care was done two times per week during the resident's scheduled showers. During an interview, on 10/24/2024 at 2:00 P.M., the Director of Nursing (DON) indicated there was no documentation of showers completed for Resident 4 due to agency staffing and facility staff "call-ins". The DON indicated the resident's behavioral care plan regarding his ADL refusal history, should count as his refusals of showers. The DON indicated the ADL refusal history was to be documented in the behavioral care plan. The DON indicated residents should receive showers twice a week and refusals of showers should be documented in the EMR. The medical record for Resident 4 was reviewed on 10/23/2024 at 9:20 A.M. Diagnoses included but were not limited to: Parkinson's disease with dyskinesia, unspecified psychosis, diabetes mellitus, anorexia, depression, hypertension, heart failure, chronic kidney disease, dementia, peripheral vascular disease, bipolar disease and myoneural disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 9/18/2024, indicated the Resident 4 was severely cognitively impaired, displayed no delusions or hallucinations, required substantial assistance with personal hygiene and was dependent for showering and bathing needs.			

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	A current Care Plan, dated 5/10/2024, indicated Resident 4 had an ADL self-care performance deficit. Interventions included, but were not limited to: if resident resists with ADLs, reassure resident, leave and return five to ten minutes later and try again; monitor and document resident's abilities for ADLs and assist resident as needed. The Care Plan indicated Resident 4's usual performance for showering and/or bathing was total assist or dependent. The October 2024 Documentation Survey Report for bathing indicated Resident 4 received a shower on 10/2/2024, 10/12/2024 and 10/16/2024 and Resident 4 had refused a shower on 10/10/2024. There was no documentation Resident 4 received showers for the dates of 10/3/2024 through 10/9/2024 and 10/17/2024 through 10/23/2024. Resident 4's medical record lacked documentation of nail care for the month of October 2024. On 10/25/2024 at 10:54 A.M., the Regional Director of Nursing Services (RDNS) provided a policy titled, "Bathing: Shower and Tub Bath," dated 1/31/2018 and indicated the policy was the one currently used by the facility. The policy indicated, " ...a shower will be offered according to resident's preference two times per week ..." A policy titled, "Shower and Tub Bath", was provided by the Regional Director of Nursing Services on 10/25/2024 at 10:54 A.M. The policy indicated, " ...To ensure resident's cleanliness to maintain proper hygiene and dignity ...A shower, tub bath or bed/sponge bath will be offered according to resident's preference two times per week or according to the resident's preferred			

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	frequency and as needed or requested ...Document bathing task and assistance provided in the electronic record, including pertinent observations ...." This citation relates to complaint IN00442512. 3.1-38(a)(3) 3.1-38 (a)(3)(B) 3.1-38(a)(3)(D) 3. 1-38(a)(3)(E) 3.1-38(b)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, record review and interview, the facility failed to provide splinting to prevent further contractures of a resident's upper extremity for 1 of 3 residents reviewed for mobility. (Resident 18) Finding includes: During an observation, on 10/21/2024 at 11:06 A.M., Resident 18 was unable to move her right hand, which was partially closed with contractures (shortening of muscles, tendons, skin and nearby soft tissues that causes the joints to shorten and become very stiff preventing normal movement). During an interview, on 10/21/2024 at 11:07 A.M., Resident 18 indicated the staff were supposed to stretch her hand, but they did not do it. A record review for Resident 18 was completed on 10/23/2024 at 10:23 A.M. Diagnoses include but were not limited to: Hemiplegia and hemiparesis, Lung and Brain Cancer, depression and anxiety.	F 0688	**F 688 Increase/Prevent in ROM/Mobility** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1 Immediate actions taken for those residents identified:**	11/20/2024

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	An Admission Restorative Observation Form, dated 7/30/2023, indicated Resident 18 had no existing contractures or limited Range of Motion (ROM). A Care Plan, initiated 7/31/2023 and revised on 6/28/2024, indicated Resident 18 had an ADL (activity of daily living) self-care performance and functional mobility deficit related to flaccid (limp) right side due to an old stroke. Interventions initiated on 7/31/24 included: The resident has a contracture of the right hand and wrist: Provide skin care daily as ordered to keep clean and prevent skin breakdown; keep hand roll in palm of hand. A Restorative Observation Form, dated 10/31/2023, indicated Resident 18 had an existing contracture or limited ROM of the right wrist at 75 percent of normal mobility and the right hand/fingers at 75 percent of normal mobility. A Restorative Observation Form, dated 2/2/2024, indicated Resident 18 had no existing contractures or limited ROM. A Restorative Observation Form, dated 5/2/2024, indicated Resident 18 had an existing contracture or limited ROM. The right wrist, hand and fingers were now fixed with no mobility. The form indicated Resident 18 was not receiving any restorative programs. During an interview, on 10/23/2024 at 11:07 A.M., Resident 18 was asked if staff had been stretching or putting anything in her hand. She indicated they had not stretched her hand nor placed anything in her hands. Resident 18 was observed with nothing in her right hand nor was she		Resident 18 had splint placed to her right hand. **2 How the facility identified other residents:** All residents requiring anti-contracture devices were observed for placement. No other concerns noted. **3 Measures put into place/ System changes:** Staff were educated on ensuring anti-contracture devices are applied as ordered. **4 How the corrective actions will be monitored:** An audit tool was created to observe for anti-contracture devices applied as ordered. Audit will be completed by DON or designee at least 5 times per week at various times to ensure devices are in place as ordered. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA	

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	wearing a splint to her right hand. A Hospice Nurse's Visit Note, dated 11/14/2023, indicated the following: "...nurse delivered to patient. The writer placed brace on patient's right hand/wrist. Patient noted brace felt good. Updated facility SN of brace." A Hospice Nurse Visit Note, dated 2/19/2024, indicated the following: "Patient has her sling on her right shoulder and brace on her right wrist. Patient reports these two items are helping her shoulder and wrist to not hurt so much..." The Hospice Social Worker note, dated 12/6/2023, indicated the following: "Patient voicing desire to have a brace that keeps her hand straight with goal of retaining use of right arm. Patient currently has hand piece to prevent further contraction of right hand." A Hospice Care Plan, dated 10/24/24 at 1:56 P.M., indicated: DME/assistive device needs. Interventions included, but were not limited to: 5 hand/wrist brace start 11/14/2023. During an interview, on 10/24/2024 at 2:04 P.M., CNA 14 indicated Resident 18 had a contracture to her right hand and there should have been a hand pillow (small pillow with a strap that goes over the back of her hand) in her right hand. CNA 14 indicated staff completed basic ROM (Range of Motion) while providing routine care. During an observation, on 10/24/2024 at 2:10 P.M., Resident 18 was in bed with no device in her right hand. During an interview, on 10/24/2024 at 2:11 P.M., Resident 18 indicated she did not have a pillow in		Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 11/20/24**	

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	her hand and she did not know where it was but she knew she was supposed to be wearing something in her hand. During an interview, on 10/24/2024 at 2:10 P.M., the Director of Rehabilitation indicated Resident 18 had transitioned into hospice care once she was admitted and therapy had not worked with her. During an interview, on 10/25/2024 at 12:05 P.M., LPN 13 indicated Resident 18 had contractures identified on the Restorative Assessment of minimal impairment completed on 10/31/2023. In addition, the May 2024 assessment had identified the resident's right hand contratures as fixed/no mobility. LPN 13 indicated Resident 13 was on no formal ROM or restorative program and staff completed basic ROM with routine care. During an interview, on 10/25/2024 at 2:10 P.M., the Corporate Nurse indicated the facility did not have a formal restorative program and they did not have a policy speciic to contracure prevention. 3.1-42(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on interview and record review, the facility failed to check gastric residual volumes (GRV) and contact the resident's physician as ordered for 1 of 1 resident reviewed for tube feedings. (Resident 3) Finding includes:	F 0693	**F693 – Tube feeding management.** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of*	11/20/2024

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	155702	A. BUILDING 00 B. WING	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

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	A record review for Resident 3 was completed on 10/22/2024 at 1:30 P.M. Diagnoses included, but were not limited to: Schizoaffective disorder, non-Alzheimer dementia, malnutrition, Bi-polar, autism, and dysphagia. A Quarterly Minimum Data Set (MDS) assessment, dated 9/19/2024, indicated Resident 3 received a mechanically altered diet and had a feeding tube. Resident 3's Physician Order's regarding the feeding tube included: Jevity1.5 of 300 ml (milliliter) bolus (single large dose given at once) four times a day, and a 240 ml bolus at bedtime with 175 mls of water before and after each bolus. Check residuals before beginning the feedings and before medication administration. If the residuals amounts are greater than 100 ml, hold the feedings and recheck in 1 hour. If not resolved, call the physician. A Care Plan, initiated on 8/22/2024, indicated Resident 3 received enteral feeding related to dysphagia, poor oral intake: combine feedings and oral intake for pleasure foods. Interventions included but were not limited to: the resident is dependent with tube feeding and water flushes; check for tube placement and gastric contents/residual volume per facility protocol and record; and hold feedings as ordered. The Medication Administration Record (MAR), dated October 2024, indicated Resident 3's residual checks were only documented twice daily. In addition, there were documented residuals over 100 mls with no documentation to support the feedings had been held and/or the physician had been notified.		*compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 3 residual check was completed with no concerns noted. The order for residual check was clarified to check residual prior to each feeding if residual greater than 100ml hold feeding and notify physician. **2) How the facility identified other residents:** An audit was completed of all residents with tube feeding to ensure all orders for residual checks are accurate. No concerns were identified. **3) Measures put into place/ System changes:** Licensed nurses will be re-educated on policy for tube feeding management.	

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	During an interview, on 10/23/2024 at 2:50 P.M., LPN 5 indicated nursing staff should be checking residuals 5 times a day and if the residual was over 100 mls, they should be holding the feeding, based on the physician orders. The current facility policy, titled "Transcription of Physician Orders-Procedure", dated 11/3/2022, was provided by the Director of Nursing on 10/23/2024 at 3:33 P.M., and indicated the policy was the one currently used by the facility. The policy indicated ..." 2. To document and give clear indication that physician orders have been processed and action taken ...." 3.1-44(a)(2)		**4) How the corrective actions will be monitored:** An audit tool was created to observe g-tube feeding and documentation to ensure accurate procedure and documentation to be completed by DON or designee 3 x per week. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 11/20/24**	
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 ensure proper labeling and storage of respiratory equipment and provide necessary respiratory services according to physician orders for 2 of 2 residents reviewed for respiratory care. (Residents 7 and 238) Findings included: 1. During an observation, on 10/21/2024 at 10:54 A.M., Resident 7 was receiving 2 liters (L) of oxygen via nasal cannula (NC) and the resident's	F 0695	**F695 Respiratory** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set*	11/20/2024

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	oxygen tubing was undated and without a bag. During an observation, on 10/22/24 at 9:54 A.M., Resident 7 was receiving 2L oxygen via NC and oxygen tubing was undated and without a bag. During an observation, on 10/23/2024 at 1:57 P.M., Resident 7 was receiving 2L oxygen via NC and oxygen tubing was undated and without a bag. The medical record for Resident 7 was reviewed on 10/23/2024 at 11:55 A.M. Diagnoses included but were not limited to: delusional disorder, diabetes mellitus, peripheral vascular disease, obstructive sleep apnea, heart failure, acquired absence of left leg below knee, hypertension, depression, anxiety, chronic obstructive pulmonary disease and history of transient ischemic accident and cerebrovascular accident. A Quarterly Minimum Data Set (MDS) assessment, dated 8/5/2024, indicated Resident 7 had a diagnosis of chronic obstructive pulmonary disease and did not receive oxygen therapy. 2. During an observation, on 10/22/2024 at 9:30 A.M., Resident 238's oxygen tubing was without date or bag and the humidification bottle was undated. During an observation, on 10/23/2024 at 9:37 A.M., Resident 238's oxygen tubing was without a bag and the tubing and the humidification bottle were undated. During an observation, on 10/24/2024 at 11:21 A.M., Resident 238's oxygen tubing was without a bag and was undated and there was no date on the humidification bottle.		*forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 7- We called physician and received order for 2 L of O2. Care plan reviewed and updated. Also replaced & dated humidity bottle and tubing. Resident 238- We immediately replaced and dated tubing and humidity bottle. **2) How the facility identified other residents:** All residents who receive oxygen have the potential to be affected by the alleged deficient practice. An audit was completed on all residents who receive oxygen therapy to ensure physician order is followed and equipment changed/replaced and dated at least weekly or as needed. **3) Measures put into place/ System changes:** The licensed nursing staff will be re-educated on ensuring oxygen is administered per physician order, and equipment such as humidity bottle and tubing are replaced and	

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	The medical record for Resident 238 was reviewed on 10/22/2024 at 2:12 P.M. Diagnoses included but were not limited to: fracture of the left fibula, acute and chronic respiratory failure, hemiparesis and hemiplegia following cerebrovascular accident, chronic obstructive pulmonary disease, nontraumatic subdural hemorrhage, morbid obesity, chronic kidney disease, atrioventricular block, bipolar disease, dependence on wheelchair, pacemaker and celiac disease. An Admission MDS assessment, dated 10/10/2024, indicated the resident was receiving oxygen therapy. Resident 238's current Physician Orders included, but were not limited to: change out, date, and label oxygen humidifier 500cc and oxygen tubing every Sunday - every night shift every Sunday when in use. During an interview, on 10/23/2024 at 2:50 P.M., LPN 2 indicated both the oxygen tubing and the humidification bottle should be changed and dated every Sunday night. During an interview, on 10/24/2024 at 9:51 A.M., the Director of Nursing (DON) indicated all oxygen tubing should be stored in a bag that was dated but the humidification bottles did not need to be dated. On 10/24/2024 at 10:25 A.M., the Director of Nursing provided a policy titled, "Oxygen and Respiratory Equipment: Changing/Cleaning," dated 1/17/2019 and indicated the policy was the one currently used by the facility. The policy indicated, " ...nasal cannulas are to be changed once a week and as needed ...a clean plastic bag ...will be provided to store the cannula when it is not in use. It will be dated with the date the		dated at least weekly or as needed. **4) How the corrective actions will be monitored:** The DON/designee will observe residents receiving oxygen on varied shifts at least 3 x weekly for 4 weeks then weekly thereafter to ensure oxygen is administered at the correct flow rate per physician order, as well as observation of equipment to ensure it is changed and dated appropriately. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 10/20/24**	

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	tubing is changed ..." 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review and interview, the facility failed to transcribe and administer ordered comfort medications for 1 of 1 resident reviewed for hospice services. (Resident B) and failed to ensure controlled narcotics were reconciled, counted and documented every shift for 2 of 3 narcotic count log books reviewed. (Touchstone Terrace & Behavioral Unit) Findings include: 1. A record review for Resident B was completed, on 10/22/2024 at 1:44 P.M. Diagnoses included, but were not limited to: pneumonia, chronic obstructive pulmonary disease (COPD), acute respiratory failure and generalized anxiety. A Nursing Progress Note, dated 10/10/2024 at 3:50 P.M., indicated Resident B was admitted to Hospice services with a diagnosis of senile degeneration of the brain. He was prescribed hydrocodone (pain medication) 5-325 milligrams every six hours as needed and lorazepam (antianxiety medication) 0.5 milligrams every six hours as needed for anxiety/agitation. A Nursing Progress Note, dated 10/12/2024 at 4:11 P.M., indicated Resident B had audible gurgling with secretions/mucus. The nurse had attempted multiple attempts to suction Resident B to ensure a clear airway, but Resident B started screaming, "No" and placed his hands over his mouth, not allowing the nurse to perform suctioning.	F 0755	**F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1 Immediate actions taken for those residents identified:** Resident B had no harmful effects from medications not being started. Order was transcribed and medication given to resident. Facility wide narcotic count sheets were reconciled with no	11/20/2024

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	A Nursing Progress Note, dated 10/12/2024 at 2:13 P.M., indicated the nurse called the Hospice company to determine if a Hospice nurse would come to the facility due to Resident B refusing to be suctioned. The Hospice company indicated a nurse would come to the facility later in the day to assess and provide care for Resident B. A Nursing Progress Note, dated 10/12/2024 at 4:05 P.M., indicated the Hospice nurse had arrived at the facility and assessed Resident B. The Hospice nurse ordered hyoscyamine tablets to help with Resident B's secretions. The hospice nurse evaluated Resident B, noting his respirations were increased, labored and had periods of apnea (temporary cessation of breathing). A Hospice Nursing Note, dated 10/12/2024 at 5:46 P.M., indicated LPN 6 was instructed to administer Tylenol and to administer hyoscyamine for excess secretions once the medication was delivered. LPN 6 had voiced understanding. A Nursing Progress Note, dated 10/16/2024 at 12:48 A.M., indicated Resident B required suctioning to remove excess secretions. His respirations were even, but elevated to 28 breaths per minute. A Nursing Progress Note, dated 10/16/2024 at 2:20 A.M., indicated Resident B required suctioning to remove excess secretions. A Nursing Progress Note, dated 10/18/2024 at 12:31 P.M., indicated the Hospice nurse came to the facility and assessed Resident B. The Hospice nurse indicated Resident B's respirations were 32 breaths per minute, his oxygen saturation was 56 percent on room air and Resident B appeared		concerns noted. **2 How the facility identified other residents:** ·All residents receiving medication could be affected. All residents were reviewed for all orders to ensure they were placed on the MAR and started timely. All residents who are on controlled substance of the facility have the potential to be affected by the same alleged deficient practice. Facility wide controlled substance audit completed with no concerns noted. **3 Measures put into place/ System changes:** ·Licensed nurses and QMA's will be educated on the receiving orders for medications, including procedure for re-ordering medications and use of emergency drug kit as appropriate as well as Nursing staff in serviced on Narcotic – controlled counting policy and following and transcribing physician orders. **4 How the corrective actions will be monitored:** The DON/designee will audit hospice binder, notes and orders as well as residents' records to ensure all orders are transcribed on MAR and administered timely	

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	uncomfortable. The Hospice nurse indicated Resident B needed Morphine (a narcotic pain medication). The Hospice nurse left an order for the Morphine and indicated a prescription would be sent to the pharmacy for the Morphine medication, 0.25 milliliters every three hours as needed for dyspnea and pain. A Hospice Nursing Note, dated 10/18/2024 at 4:59 P.M., indicated an order was provided to LPN 6 for Morphine as needed for Resident B and LPN 6 was encouraged to administer the Morphine as soon as possible. LPN 6 had verbalized understanding. A Care Plan, dated 10/10/2024 and revised on 10/22/2024, indicated Resident B has a terminal condition and was under hospice care. The Care Plan goal was to be free from unrelenting pain and discomfort. Interventions included, but were not limited to: -Maintain good communication with hospice. -Notify the physician and hospice if pain or discomfort was not alleviated by current medication or treatment regimen. -Notify the physician and then hospice for a change in condition. -Observe for signs and symptoms of pain or discomfort, such as facial grimacing, complaints of pain, moaning or restless movements and promptly treat per order. A Care Plan, dated 8/9/2024 and revised on 10/24/2024, indicated Resident B was on pain medication therapy related to impaired mobility, frail condition, shortness of breath and pain. The goal was for Resident B to be free of any discomfort or adverse side effects from the pain medication. Interventions included, but were not limited to: -Administer analgesic medications as ordered by the physician. Monitor/document side effects and		at least 5 x per week. As well as DON/Designee will audit all narcotic count records to be completed 2 x per week. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 11/20/24**	

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	effectiveness every shift. -Review for pain medication efficacy. Assess whether pain intensity is acceptable to resident. Review of the October MAR (Medication Administration Record) for October 2024 for Resident B indicated neither the hyoscyamine nor the Morphine had been administered. During an interview, on 10/23/2024 at 2:52 P.M., LPN 6 indicated she did not note the order or administer the recommended hyoscyamine because she needed to confirm the order with the facility's house doctor. She indicated she did not note the order or administer the Morphine pain medication either. LPN 6 indicated she could not give the Morphine until an actual prescription was sent to the pharmacy and she was unsure if or when it had been sent by the Hospice doctor. She indicated she could have called a nurse practitioner to get the script fo the medications sent to the pharmacy so the morphine could be administered, but she had not called. LPN 6 did not indicate a reason why she had not taken the time to confirm the Hospice order for hyoscyamine with the facility's house physician when the order from Hospice had been received on 10/12/2024. In addition, although the 10/18/2024 Nursing Progress Note and the Hospice Progress note both indicated LPN 6 had received an order from Hospice for Morphine for Resident B and LPN 6 had voiced understanding that Hospice has sent the order for the Morphine to the pharmacy, she still indicated she was unsure if the prescription for the Morphine had been sent to the pharmacy. The Regional Director of Nursing Services indicated on 10/25/2024 at 10:54 A.M., the facility does not have a policy for following physician			

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	order, but the facility followed the standard of practice. 2. A Medication Storage observation for the Garden Medication Cart was completed on 10/25/2024 at 10:20 A.M., with RN 18. The narcotic log book lacked signatures for the following dates and times: 9/4 for the night shift signing on. 9/4 for the night shift signing off. 9/5 for the day shift signing on. 9/5 for the day shift shift signing off. 9/5 for the night shift signing on. 9/6 for the night shift signing off. 9/9 for the day shift signing off. 9/16 for the day shift signing on. 9/16 for the night shift signing on. 9/17 for the night shift signing off. 9/18 for the night shift signing off. 9/23 for the night shift signing off. 10/4 for the day shift signing off. 10/5 for the day shift signing off. 10/5 for the night shift signing on. 10/5 for the night shift signing off. 10/6 for the day shift signing on. 10/7 for the night shift signing on. 10/8 for the night shift signing off. 10/13 for the night shift signing on. 10/13 for the night shift signing off. 10/14 for the night shift signing off. 10/18 for the night shift signing off. 10/20 for the day shift signing off. 10/20 for the night shift signing on. 10/21 for the night shift signing off. 10/21 for the day shift signing off. 3. A Medication Storage observation of the Behavior unit medication cart was completed on 10/25/2024 at 10:30 A.M., with Qualified Medication Aide (QMA) 16. The narcotic log			

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	book lacked signatures for the following dates and times: 10/3 for the day/evening shift signing off. 10/4 for the day/evening shift signing off. 10/7 for the day/evening shift signing off. 10/8 for the day/evening shift signing off. 10/11 for the day/evening shift signing off. 10/14 for the day/evening shift signing off 10/15 for the day/evening shift signing off. During an interview, on 10/25/2024 at 10:37 A.M., QMA 16 indicated two licensed nursing staff should have signed the narcotic book between shifts. On 10/25/2024 at 10:54 A.M., the Regional Director of Nursing Services (RDNS) provided the policy titled," Narcotic/Controlled Substance-Counting", with a revised date of 11/26/2017, and indicated the policy was the one currently used by the facility. The policy indicated"... Purpose: 1. To count controlled substances with a partner and to verify the accuracy of the log sheets. 2. Knowledge of correct response should an error be discovered in the control substance count. General Guidelines: 1. Always participate in the counting of the controlled substances at the beginning and ending of your shift. General Procedure for Counting Controlled Substances: 1. Follow your facilities specific guidelines and use their specific log sheet...16. Sign name, time and date of completed count...." This citation relates to complaint IN00442512. 3.1-37(a) 3.1-25(e)(2) 3.1-25(e)(3)			

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F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on observation, record review and observation, the facility failed to ensure the use of an appetite stimulant medication was necessary for 1 of 5 residents reviewed for unnecessary medications. (Resident C) Finding includes: During an observation, on 10/21/2024 at 12:10 P.M., Resident C was observed to be feeding herself a meal of a quesadilla, corn and refried beans. A record review for Resident C was completed on 10/23/2024 at 8:44 A.M. Diagnoses included, but were not limited to: dementia, major depressive disorder, chronic kidney disease and heart failure. A Quarterly Minimum Data Set (MDS) assessment, dated 9/4/2024, indicated Resident C had severe cognitive impairment and had not experienced a significant weight loss (weight loss of five percent in one month or 10 percent in 6 months). A Dietary Quarterly Review note, dated 9/6/2024, indicated the resident's fluid intake were good, their appetite was good and staff were to continue the plan of care. A Dietary Assessment for the MDS assessment, dated 9/6/2024, indicated there had been no significant weight loss of five percent or more in the last month or loss of ten percent in the last six months. A Physician Progress Note, dated 9/9/2024 at 4:12	F 0757	**F 757 Unnecessary Drug** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1 Immediate actions taken for those residents identified:** Physician was contacted regarding unnecessary appetite stimulant for resident C. Order was discontinued. **2 How the facility identified other residents:** Audit completed for those residents receiving appetite stimulant along with residents who have the same last name. Orders reviewed for any issues identified were immediately addressed. **3 Measures put into place/**	11/20/2024

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	155702	A. BUILDING 00 B. WING	10/25/2024

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	P.M., indicated, " ...Patient is having progressive weight loss and it (sic) with loss of more than 20 pounds in a few weeks. Patient had history of recent COVID infection with anorexia. For that reason, patient will be started on Megace ...." A Physician's Order, dated 9/10/2024, indicated Megace Acetate Suspension 400 milligrams per 10 milliliters, give 10 milliliters by mouth one time a day for weight loss. A Physician Progress Note, dated 9/26/2024 at 11:15 A.M., indicated, " ...we will not make any changes as she still continues to be stable and eating better ...." The following weights were recorded in the electronic medical record for Resident C: 10/8/2024 1:44 P.M. 162.0 lbs. (pounds) 9/9/2024 10:54 A.M. 164.8 lbs. 8/6/2024 11:30 A.M. 168.0 lbs. 7/1/2024 11:27 A.M. 171.0 lbs. 6/21/2024 2:45 P.M. 171.5 lbs. 6/7/2024 2:04 P.M. 170.4 lbs. 6/4/2024 3:48 P.M. 169.2 lbs. A Care Plan, dated 6/5/2024, indicated Resident C had a nutritional problem or a potential nutritional problem related to dementia, may not recognize thirst or hunger, hypertension, hyperlipidemia, heart disease, chronic kidney disease, vitamin deficiency, impaired mobility and impaired cognitive status. The goal was to maintain adequate nutritional status as evidenced by no signs or symptoms of malnutrition and consuming at least 75 percent of at least two meals daily. Interventions included, but were not limited to: -Assist with nutritional intake as needed. -Encourage oral intake of meals and snacks. -Monitor/record/report to the physician as needed		**System changes:** Physician was educated on ensuring when charting and giving medication orders he must ensure he is documenting in the correct resident's chart. Specifically focused on resident with the same last name. **4 How the corrective actions will be monitored:** The DON/Designee will audit residents' charts when receiving new orders to ensure it is documented in correct chart and on the correct MAR. 3 X a week. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **11-20-24**	

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	signs and symptoms of malnutrition: emaciation, muscle wasting, significant weight loss of 3 pounds in 1 week, greater than 5 percent in one month, greater than 7.5 percent in three months and greater than ten percent in six months. -Provide and serve diet as ordered. Monitor intake and record every meal. -The registered dietician to evaluate and make diet change recommendations as needed. During an interview, on 10/25/2024 at 10:10 A.M., the Director of Nursing (DON) indicated the resident's medical provider, dietician, medical director or nurse practitioner made the decision regarding the use of an appetite stimulant. She indicated there was usually a collaboration between the medical provider and the dietician. The DON indicated there were no nursing interventions specific to the required documentation when a resident was on an appetite stimulant. On 10/25/2024 at 10:44 A.M., the DON indicated Resident C's husband was supposed to be on Megace for 2 weeks, and not Resident C. On 10/25/2024 at 11:44 A.M., the DON later indicated she was aware that Resident C had an order for Megace, and the medical provider had placed the couple on the medication together. There was no documentation provided to support the need and use of Megace for appetite supplementation. A current policy titled, "Weight Assessment and Intervention", was provided by the Regional Director of Nursing Services, on 10/25/2024 at 10:54 A.M. The policy indicated, " ...Weights are monitored monthly or more as recommended by			

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	the interdisciplinary care team. The goal is to ensure adequate parameters of nutritional status are maintained by preventing unintentional weight loss. Weight data will be used as one step in determining if changes to the nutritional plan of care are needed to prevent or slow unintentional weight loss with the limits of the resident's clinical condition ...4. Any weight change of 5% or more since the previous weight assessment shall be re-taken the next day to confirm. If the weight is verified, nursing will notify the appropriate designated individuals such as the physician, Registered Dietician, Dining Services Manager, or other members of the interdisciplinary team within 24 hours. Verbal notifications must be confirmed in writing. 5. The Registered Dietician will review the weight log each month to follow individual weight trends. Negative trends will be evaluated by the treatment team to determine whether or not significant weight changes has occurred. 6. The threshold for significant unplanned and undesired weight loss shall be based on the following criteria: 1-month significant loss 5%, severe loss greater than 5%; 3 months significant loss 7.5%, severe loss greater than 7.5%; 6 months significant loss 10%, severe loss greater than 10%...." This citation relates to complaint IN00442512. 3.1-48(a)(4)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to limit an as needed (PRN) antianxiety medication to 14 days for 1 of 5 residents reviewed for unnecessary medications. (Resident B)	F 0758	**F758 Unnecessary Psychotropic Medication Use** *This Plan of Correction is the*	11/20/2024

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	Finding includes: A record review for Resident B was completed, on 10/22/2024 at 1:44 P.M. Diagnoses included, but were not limited to: psychosis, adult failure to thrive, alcoholic dementia and generalized anxiety. An Annual Minimum Data Set (MDS) assessment, dated 9/26/2024, indicated Resident B had severe cognitive impairment. The assessment indicated Resident B was on an antipsychotic, antianxiety and opioid medications. He had behaviors including, but not limited to: -Delusions. -Verbal behavioral symptoms directed towards others as threatening others, screaming at others and cursing at others. -Other behavioral symptoms not directed towards others as physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds. A Physician's Order, dated 7/26/2024 through 8/16/2024, indicated lorazepam (antianxiety) medication 0.5 milligrams every eight hours as needed for anxiety. A Consultant Pharmacist Recommendation, dated 8/10/2024, indicated Resident B had an order for lorazepam 0.5 milligrams every eight hours as needed for anxiety with no stop date. The nurse practitioner responded to the recommendation on 8/16/2024 with continuance of the lorazepam for 30 days as the benefit outweighed the risk. A Physician's Order, dated 8/16/2024 through 8/26/2024, indicated lorazepam 0.5 milligrams every		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B physician was notified about the PRN psychotropic medication and gave the clinical rationale for extended use and the expected duration. **2) How the facility identified other residents:** An audit was completed for all residents who receive a PRN psychotropic medication to ensure they are not used beyond 14 days without clinical rationale from physician. No other concerns were found. **3) Measures put into place/ System changes:** An audit tool was created to ensure all PRN psychotropic	

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	eight hours as needed for anxiety. A Physician Progress Note, dated 8/16/2024 at 11:50 A.M., indicated Resident B was seen for a follow-up psychiatric assessment and continued evaluation of psychotropic medications. For generalized anxiety disorder, Resident B was to continue clonazepam 0.5 milligrams twice daily. The nurse practitioner did not mention the use of lorazepam or document a reasoning for the continuance of the as needed lorazepam beyond 14 days. Resident B received lorazepam 0.5 milligrams beyond the 14 days on 8/9/2024 at 7:31 P.M., 8/11/2024 at 9:42 P.M. and on 8/15/2024 at 6:54 P.M. During an interview, on 10/24/2024 at 2:40 P.M., LPN 10 indicated an as needed (IPRN) psychotropic medication could only be ordered for 14 days. A current policy titled, "Psychotropic Medication-Gradual Dose Reduction", was provided by the Regional Director of Nursing Services, on 10/25/2024 at 10:54 A.M. The policy indicated, " ...To ensure that residents are not given psychotropic drugs unless psychotropic drug therapy is necessary to treat a specific or suspected condition as per current standards of practice, and are prescribed at the lowest therapeutic dose to treat such conditions ...PRN [as needed] hypnotic, antianxiety or antidepressant medications shall not be used beyond 14 days unless the prescribing practitioner indicates the clinical rationale for extended use and the expected duration for PRN id of the medication ...."		medications orders have a stop date not exceeding 14 days. **4) How the corrective actions will be monitored:** DON or designee will review orders in clinical meeting at least 3 x's a week to ensure that all PRN psychotropic medications have a stop date not exceeding 14 days. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 11/20/2024**	

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	This citation relates to complaint IN00442512. 3.1-48(a)(2)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to provide sanitary serving of food plates for 1 of 3 dining rooms observed during the lunch meal service. This had the potential to affect 14 residents on the dementia unit. Finding includes: During a continuous observation, on 10/21/2024 from 11:52 A.M. through 12:17 P.M., the activities assistant was observed to serve plates with her thumb over the rim of the plate to 5 of 12 residents in the dining room. During an interview, on 10/21/2024 at 12:02 P.M., the activity assistant indicated she had not been educated on how to properly serve dinnerware. She indicated her thumb should not have been on the top of the plate. A current policy titled, "Resident Tray Delivery", was provided by the Regional Director of Nursing Services, on 10/25/2024 at 10:54 A.M. The policy did not address proper handling of dinnerware when serving the residents. 3.1-21(i)(3)	F 0812	**F 812 Food Procurement, Storage** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1 Immediate actions taken for those residents identified:** Education was provided to the employee on how to serve meal plate with instructions to refrain from touching over the rim area of the plate. **2 How the facility identified other residents:**	11/20/2024

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			All residents receiving an oral diet have the potential to be affected. **3 Measures put into place/ System changes:** All staff were educated on proper serving of meals to residents to refrain from touching the plate over the rim area. **4 How the corrective actions will be monitored:** An audit tool was created to observe meal service to ensure proper handling of the plates while being served. Audit will be completed by Administrator or designee 3-5 x per week at various meals to ensure proper handling of plates. The results of these audits will be reviewed in Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5 Date of compliance: 11/20/24**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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	Based on observation, interview and record review, the facility failed to ensure safe infection control practices were followed regarding obtaining a blood sugar sample and administering insulin for 1 of 2 residents observed administering insulin. (Residents 43) Finding includes: During a medication administration observation, on 10/25/2024 at 8:35 A.M., LPN 17 was observed to donn (apply) gloves and walk to the main dining area. He then placed the glucometer (device to monitor blood glucose levels) on a dirty dining room table. Next, LPN 17 wiped the finger of Resident 43 with an alcohol pad. and then obtained the blood sample from Resident 43's finger. Afterwards, he removed the test strip, placed it in his gloves and removed his gloves. During an interview, on 10/25/2024 at 8:37 A.M., LPN 17 indicated he should not have obtained the blood sugar sample in the dining room and should have used a barrier between the dining room table and the glucometer. On 10/25/2024 at 12:25 P.M., the Corporate Nurse provided the policy titled," Insulin Pen Procedure", dated 8/4/2020, and indicated the policy was the one currently used by the facility. The policy indicated"... Select a clean , dry work area...." 3.1-18(a)	F 0880	**F880 Infection Prevention and Control** **This facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1.) Immediate actions taken for those residents identified:** Resident #43 was assessed. No negative outcomes identified. RN #17 was educated on facility policy regarding insulin pen procedure. **2) How the facility identified other residents:** Any resident who received glucometer/accu check testing by RN#17 had the potential to be affected however no one was identified. **3) Measures put into place/ System changes:** In-service provided on infection	11/20/2024

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			control with a specific focus on ensuring a clean and dry work area when using a glucometer. **4) How the corrective actions will be monitored:** The Director of Nursing Services/designee will observe nursing staff obtaining blood sugars 3 x per week to ensure proper glucometer usage in adherence to the facilities infection control standards. Any variations will be immediately corrected with 1-1 education. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance**: 11-20-24	