STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155573	A. BUILDING 00 B. WING	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(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 IN00448522, IN00441092 and IN00440964. Complaint IN00448522 - No deficiencies related to the allegations are cited. Complaint IN00441092 - Federal/state deficiencies related to the allegations are cited at F812. Complaint IN00440964 - Federal/state deficiencies related to the allegations are cited at F921. Survey dates: December 4, 5, 6, and 9, 2024 Facility number: 000342 Provider number: 155573 AIM number: 100289140 Census Bed Type: SNF/NF: 18 SNF: 1 Total: 19 Census Payor Type: Medicare: 2 Medicaid: 16 Other: 1 Total: 19 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 12, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.¿ Facility's date of alleged compliance is: 12/30/24.¿¿Facility is respectfully requesting paper compliance for all deficiencies in this POC.¿	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Blackmon	HFA	12/26/2024

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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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to ensure a resident was treated with dignity and respect for 1 of 1 resident reviewed for dignity. (Resident 11) Findings include: The clinical record for Resident 11 was reviewed on 12/4/24 at 12:07 p.m. The diagnoses included, but were not limited to, diabetes and depression. A Quarterly Minimum Data Set (MDS) assessment, completed 11/10/24, indicated she was cognitively intact and dependent on staff for toileting. During an interview on 12/4/24 at 12:07 p.m., Resident 11 indicated a staff member had spoken to her disrespectfully while performing incontinent care. Resident 11 had put her call light on, around 10:00 p.m., and the staff member had come into the room to answer the call light. Resident 11 had told the staff member she needed to be cleaned up after having a bowel movement. The staff member asked her if she waited till 10:00 p.m. to (expletive). There was another staff member present when the incident happened. The incident happened the night before and she had informed the management staff that morning. On 12/4/24 at 12:22 p.m., the Executive Director (ED) provided a reportable incident form, dated 12/4/24 at 7:30 a.m., which indicated Resident 11 had notified the ED of a concern related to care involving Qualified Medication Aide (QMA) 6. The immediate action taken was to suspend QMA	F 0550	F550 It is the intent of the facility to ensure that all residents are treated with respect and dignity during incontinent care related interactions. What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice? Resident 11 was interviewed by SSD daily from 12/4 through 12/10 with no negative outcomes related to interactions with staff providing incontinent care. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents have the potential to be impacted by this deficient practice. DON interviewed all alert and oriented residents on 12/4 with no concerns noted related to incontinent care related interactions with staff. All non-alert and orientated residents had skin assessments on 12/4 and 12/5 to ensure proper incontinent care is being provided, as well as on 12/19 for follow up. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?	12/30/2024

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	6 immediately pending an investigation. The physician and Director of Nursing (DON) were notified. During an interview on 12/9/24 at 12:02 p.m., Certified Nursing Assistant (CNA) 7 indicated she had been present during the incident between Resident 11 and QMA 6. QMA 6 had asked Resident 11 why she always turned the call light on, at 10:00 p.m., to be changed. QMA 6 had begun to provide incontinent care and Resident 11 indicated QMA 6 was being too rough. QMA 6 told Resident 11 she had to get the (expletive) off. Resident 11 had made another comment to QMA 6 and QMA 6 asked CNA 7 to finish the incontinent care for Resident 11 and exited the room. Resident 11 asked if she had done something wrong, and if QMA 6 was having a bad night. QMA 6 was unavailable for interview. On 12/9/24 at 3:39 p.m., the Director of Nursing provided the Guidelines for Observing and Implementing Resident Rights, dated 7/12/24, which read, "...Each resident has the right to be treated with dignity and respect. Any interaction between a resident and a staff member...must be conducted in such a way as to enhance the residents' self- esteem and self-worth while meeting the resident's needs. The preferences and goals of the resident should be honored as much as possible and the resident's comfort, safety and overall welfare must be promoted, protected, and enhanced at all times..." 3.1-3(t)		At an in-service held by the DON/Administrator on December 17, 2024 for all staff the following was reviewed: 1. Resident Rights 2. Dignity/Respect during interaction/communication with residents 3. Customer Service Additionally, any staff member that fails to comply with the points of the in-service will be further educated and/or disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place? SSD/Designee will interview 10 random residents weekly related to staff treating residents with dignity during care for 4 weeks, then 5 random residents weekly for 4 weeks, and then 3 random residents monthly for 4 months. If the facility is within 95% compliance after 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be	

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			monitored by the Administrator weekly until resolved. Date corrective action will be completed 12/30/24	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure orthostatic blood pressures were properly obtained and to obtain blood pressure and pulse, as ordered by the physician, prior to administering medication for 1 of 1 resident reviewed for death and 1 of 1 resident reviewed for behaviors. (Resident 17 and Resident 20) Findings include: 1. The clinical record for Resident 17 was reviewed on 12/6/24 at 11:19 a.m. The diagnoses included, but were not limited to, atrial fibrillation (abnormal heartbeat), and hypertension. She died at the facility on 11/28/24. A care plan, last revised 10/10/24, indicated Resident 17 was at risk for falls related to dementia, atrial fibrillation, and history of falls. The goal was for her to have no injuries due to falls. The interventions included, but were not limited to, attempt to keep areas free of clutter and to notify and update physician as needed. A Quarterly Minimum Data Set (MDS) assessment, completed 10/11/24, indicated she was cognitively intact, needed moderate assistance of staff with walking in her room, and had one fall without injury since the prior	F 0684	¿Tag Number 684 It is the intent of the facility to ensure that orthostatic blood pressures, blood pressures and pulse are properly obtained as ordered by the physician and prior to administering medications with parameters. What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice? Resident 17 no longer resides in the facility. Resident 20 was assessed by DON on 12/6/2024, no negative outcome related to the alleged deficient practice. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The DON/Designee completed a 30 day look back audit of residents with hold parameters for blood pressure and pulse for medications, the physician was notified of any medications administered outside the parameters on 12/26/2024.	12/30/2024

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	assessment. An incident note, dated 11/24/24 at 11:29 a.m., indicated a nursing assistant had called the nurse to the shower room because Resident 17 had fallen. Resident 17 was assessed for injuries. Resident 17 indicated she was fine and not hurt. Resident 17 was assisted up and walked back to her room. Resident 17 was sitting in her recliner relaxing. An Interdisciplinary Team (IDT) Post Fall Review, dated 11/25/24, indicated that Resident 17 had become dizzy when reaching for her walker, slipped and fell in the shower room. The IDT recommended orthostatic blood pressures should be completed for 72 hours. A physician's order, dated 11/25/24, indicated to measure orthostatic blood pressure every shift for dizziness for three days. Check blood pressure after laying down for five minutes. A physician's order, dated 11/25/24, indicated to measure orthostatic blood pressure every shift for dizziness for three days. Check blood pressure after standing up for one minute from a lying position. A physician's order, dated 11/25/24, indicated to measure orthostatic blood pressure every shift for dizziness for three days. Check blood pressure after standing up for three minutes from a lying position. The November 2024 Medication Administration Record (MAR) indicated the orthostatic blood pressure, obtained on day shift of 11/26/24 by Registered Nurse (RN) 3, was documented as being 134/78 after lying for five minutes, after		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? At an in-service held by the DON/Administrator on December 17, 2024, for the nursing staff on the following. Medication administration requirements Blood pressure monitoring Pulse monitoring. Physicians Orders Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place? DON/Designee will monitor the MARs of all residents taking blood pressure medications to ensure proper documentation is present of blood pressure and pulse being obtained prior to medication being administered and for new orders for orthostatic blood pressures obtained per order 5 x weekly for 4 weeks, and then 3 times weekly for 4 weeks, and then weekly for 4 months. If the facility is within 95% compliance after the 6	

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	standing from a lying position of one minute, and after standing from a lying position for three minutes. The November MAR did not contain orthostatic blood pressure readings, on 11/27/24, during the day shift. A physician's order, dated 11/26/24, indicated she was to receive metoprolol tartrate (heart medication) tablet 50 milligram (MG) by mouth twice a day for hypertension. Instructions were to hold if systolic blood pressure (upper reading of blood pressure) (SBP) was less than 100 or if heart rate was less than 60. The November 2024 MAR did not contain documentation of a pulse rate being obtained prior to administering the Metoprolol in the evening, on 11/26/24, or prior to the morning and/or evening administrations on 11/27/24. During an interview on 12/6/24 at 1:56 p.m., Registered Nurse (RN) 3 indicated she took the orthostatic blood pressure when the resident was standing, sitting, and lying down. 2. The clinical record for Resident 20 was reviewed on 12/4/24 at 2:15 p.m. The diagnoses included, but were not limited to, hypertension and anemia. A Quarterly MDS assessment, completed 10/22/24, indicated he was moderately cognitively impaired. A care plan, last revised 11/4/24, indicated he was at risk for elevated blood pressure related to hypertension. The goal was for his blood pressure to remain within normal limits. The interventions included, but were not limited to, administer medication as ordered by the physician, check for		months, the monitoring will stop. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date corrective action will be completed? 12/30/24	

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	blood pressure parameters, and monitor blood pressure prior to administering, if indicated. A physician's order, dated 11/26/24, indicated he was to receive metoprolol succinate ER (extended-release heart medication) 25 MG twice daily for hypertension. The instructions were to hold the medication for SBP less than 100 or heart rate less than 60. The November and December MAR did not contain documentation of the blood pressure and/or heart rate readings prior to administering the metoprolol twice daily from 11/26/24 through 12/9/24. During an interview on 12/9/24 at 2:38 p.m., the Director of Nursing indicated the directions for obtaining the orthostatic blood pressures were specified in the physician's order, and if an order contains parameters, the vitals should be taken and documented prior to administration and held as ordered. 3.1-37(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, interview, and record review, the facility failed to timely inform the physician of changes in a resident's pain for 1 of 2 residents reviewed for pain. (Resident 13) Findings include: The clinical record for Resident 13 was reviewed on 12/4/24 at 2:41 p.m. The diagnoses included, but were not limited to, hypertension and heart	F 0697	F697 It is the intent of the facility to ensure the physician is notified timely of changes in a resident's pain and proper pain management prescriptions in place. What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice? Resident 13 was admitted to	12/30/2024

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	failure. A physician's order, dated 6/16/23, indicated he could receive hydrocodone-acetaminophen (narcotic pain medication) 5-325 milligrams (MG); one tablet every six hours as needed for pain. A care plan, last revised on 10/23/24, indicated he was at risk for pain related to weakness and impaired mobility. The goal was for him to be free of pain with interventions as needed. The interventions included, but were not limited to, give medications as ordered, notify physician of uncontrolled pain, observe for effectiveness of interventions, and observe for signs and symptoms of pain. A Quarterly Minimum Data Set (MDS) assessment, completed 11/10/24, indicated he had moderately impaired cognition. He received scheduled and as needed pain medications. He experienced pain occasionally, which did not interfere with sleep or daily activities. His pain was rated as a 5 on a pain scale of 1 to 10 (10 being severe pain). A physician's order, dated 11/12/24, indicated he was to receive acetaminophen extra strength 500 mg: two tablets three times daily for pain. A Nurse Practitioner progress note, dated 11/12/24, indicated Resident 13 had been complaining of "quite a bit more pain lately." His Norco (hydrocodone- acetaminophen) was refilled. He reported pain in his knees. A Nurse Practitioner progress note, dated 11/19/24, indicated Resident 13 had osteoarthritis, managed with Tylenol 1000 MG three times daily and had Norco for as needed (PRN) use. A new		hospice services on 12/5/2024 and new orders for pain medication. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The DON/Designee completed a pain assessment on all residents and the physician was notified of any concerns for pain management on 12/23/24 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? At an in-service held by the DON/Administrator on December 17, 2024, for the nursing staff on the following. Pain assessments Physician notification Clinical documentation Pain Management Re-ordering narcotics Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be	

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	script had been sent recently. The assessment and plan indicated he had pain and to continue Tylenol 1000 mg three times daily and to continue Norco PRN. The clinical record contained Nurse Practitioner Progress notes, dated 11/21/24 and 11/26/24, which did not contain information about increased pain or discomfort. The November and December Medication Administration Records (MAR) indicated Resident 13 had received hydrocodone-acetaminophen 5-325 mg on the following days: 11/1/24 - once for pain level of 7. 11/2/24 - once for pain level of 7, 11/3/24 - twice for pain level of 5 and for pain level of 6, 11/5/24 - twice for pain level of 5 and pain level of 6, 11/6/24 - once for pain level of 5, 11/9/24 - twice for pain level of 5 and pain level of 5, 11/11/24 - twice for pain level of 5 and pain level of 7, 11/12/24 - once for pain level of 6, 11/16/24 - once for pain level of 6, 11/28/24 - twice for pain level of 5 and pain level of 5, 11/29/24 - twice for pain level of 8 and pain level of 6, 11/30/24 - three times for pain level of 6, pain level of 5, and pain level of 4, 12/1/24 - twice for pain level of 8 and pain level of 7, 12/2/24 - three times for pain level of 7, pain level of 8 and pain level of 8, 12/3/24 - twice for pain level of 6 and pain level of 8, and		put into place? DON/Designee will audit residents pain levels five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. The DON/Designee will audit availability of pain medications 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance after the 6 months, the monitoring will be stopped, Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Date corrective action will be completed? 12/30/24	

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	12/4/24- twice for pain level of 5 and pain level of 8. On 12/4/24 at 2:41 p.m., Resident 13 was observed lying in bed in his room. He was grimacing and moaning out. Family Member (FM) 1 was at bedside and indicated Resident 13 was in a lot of pain and was being evaluated by hospice so he could receive stronger pain medications. During an interview on 12/5/24 at 2:25 p.m., FM 1, FM 2, and FM 3 indicated Resident 13 had been in a lot of pain off and on for several weeks. They had just enrolled him in hospice so he could have his pain managed better. During an interview on 12/5/24 at 2:40 p.m., Certified Nursing Assistant (CNA) 12 indicated Resident 13 had been experiencing more pain in the last few weeks. She had informed the nurses of his increased pain. During an interview on 12/5/24 at 2:41 p.m., Registered Nurse (RN) 3 indicated the Nurse Practitioner had been informed Resident 13 was having a lot of pain, and the Norco was not effectively treating the pain. He had been out of Norco for a while, but it had been refilled and the nursing staff were trying to administer it every six hours to assist with his pain control. Resident 13 had been experiencing pain in his groin area. During an interview on 12/6/24 at 10:17 a.m., Registered Pharmacist 15 indicated a refill of 24 tablets of hydrocodone- acetaminophen 5-325 mg had been sent to the facility on 10/27/24. The next refill of hydrocodone- acetaminophen 5-325 mg had been sent on 11/26/24. A controlled drug form, dated 10/27/24, indicated			

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	24 tablets of hydrocodone- acetaminophen had been delivered to the facility on 10/27/24. The last dose had been administered on 11/12/24. A controlled drug form, dated 11/26/24, indicated 30 tablets of hydrocodone- acetaminophen had been delivered to the facility on 11/26/24. The clinical record did not contain any other controlled drug forms indicating any hydrocodone- acetaminophen had been delivered to the facility from 11/12/24 through 11/26/24. The clinical record did not contain documentation that the physician and/or nurse practitioner had been informed of Resident 13 not having any hydrocodone in the facility from 11/12/24 through 11/26/24. The clinical record did not contain documentation the physician and/or nurse practitioner had been informed of Resident 13's increased pain. On 12/6/24 at 10:39 a.m., the Director of Nursing provided the Guidelines for Pain Management policy, dated 9/1/23, which read, "...It is the intent of the facility to promote resident independency, comfort, and to preserve resident dignity in the ongoing effort to promote the highest level of quality for their lives. One aspect of this commitment is to maintain an effective pain management plan... Physician Communication and Involvement Pain will be assessed and managed in a timely manner, to include pain that is 'new' and of a recent onset. The physician will be notified of a resident's onset of 'new' pain and also of pain not being relieved by the interventions ...PRN Pain Medications ...If a resident requests prn pain medications 3-4 times a day for 3-4 days in a row- the physician should be notified for			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MIDDLETOWN SKILLED NURSING FACILITY, THE	981 BEECHWOOD AVE MIDDLETOWN, IN 47356

(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
	directions/ orders to include the possibility of regularly scheduled pain medications or a change in the current order for pain medications...." 3.1-37(a)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food items were closed to air and contaminants, expired food was disposed of timely, and label food containers with the date opened and discard dates with the potential to affect 19 of 19 residents residing at the facility. Findings include: The facility kitchen was observed with the Kitchen Cook (KC) on 12/4/24 at 10:30 a.m. The dry storage area contained a bag of sugar in a box. The bag of sugar was open to air. There was an undated loaf of cinnamon bread, with mold visible through the packaging, present on the bread rack. The KC indicated the bag of sugar should not have been open to air and cinnamon bread had mold present and had been on the rack for around two weeks. The kitchen refrigerator was observed to have a container of cottage cheese with a use by date of 12/2/24, a large plastic bucket of hard-boiled eggs with no open date present, and three large bags of pre-mixed salad. One of the bags of pre-mixed salad was opened and half gone. The bags were dated as best by 12/1/24. A box of prune juice had a date opened of 10/24/24. A pitcher of unsweet tea had a preparation date of "11/20". A box of	F 0812	It is the intent of the facility to ensure that food items are closed to air, expired food is disposed of timely and food containers contain proper date opened and discard dates. What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice? How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The Dietary Manager/Designee completed an audit of the dry storage areas and refrigerators for items that were left open to air and contaminants, mold, and open dates and discarded any items as needed on 12/10/2024. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** The Dietary Manager in-serviced the dietary department 12/17/2024	12/30/2024

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	pasteurized eggs had a best by date of 11/29/24. A bowel of chopped cucumbers was without a lid and no date and/or label. There were two containers of half and half, one was approximately half full, with a package date of 10/24/24 and there was no open date on the containers. A silver serving container covered in plastic wrap was dated "12/1" and discard by "12/3". During an interview on 12/4/24 at 10:50 a.m., the KC indicated the outdated items in the refrigerator should have been discarded. All items should have an open date when put into the refrigerator. All items put into the refrigerator should have lids and/or be sealed from air and dated. The items found to be outdated or undated should be thrown away. On 12/4/24 at 12:22 p.m., the Executive Director provided the Labeling and Dating policy, dated 8/12/23, which read, "...Leftovers and open foods shall be clearly labeled with date food item is to be discarded. Food items to be labeled and dated include items prepared in house and food items that are opened and stored for later use...7-day self-life including date of preparation- label includes: a. Name of food item b. discard date...30-day shelf life, usually applies to items that are shelf stable until opened- label includes: a. name of food item if not clearly identified on container b. Discard date ... Discard date cannot exceed use by date stamped on product by manufacturer...." This citation relates to Complaint IN00441092. 3.1-21(i)(2) 3.1-21(i)(3)		on the following. Labeling and Dating Foods. Storage of food in closed containers. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place?** The Dietary Manager/Designee will audit the dry storge and refrigerator for foods properly closed to air and contaminants, moldy breads, and dates of foods opened 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance after 6 months, the monitoring will be stopped. ,	

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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control was maintained during medication administrations by not utilizing hand hygiene, glove usage, and touching pill medication with bare hands for 5 of 5 residents reviewed for medication administrations. (Residents' 8, 11, 12, D, and 19) Findings include: 1. The clinical record for Resident D was reviewed on 12/4/24 at 2:00 p.m. The diagnoses included, but were not limited to, stroke. An observation was made of Resident D's medication administration with Registered Nurse (RN) 3 on 12/5/24 at 9:00 a.m. RN 3 was observed finishing up with administering medications to another resident. After the administration, RN 3 hugged the resident. She then went back to the medication cart and pulled and prepared Resident D's medication. During that time, RN 3 pulled medication packages from the cart. After review, she then removed the pill medications from the packets and dropped them in two mediation cups. One medication cup was for tablets and the other medication cup was for three capsule pill medications. She then crushed the tablet medications. After, RN 3 using her bare hands, removed the three capsule medications in the other medication cup and emptied two of the three capsules into the crushed medications cup. The third capsule was unable to opened. So, RN 3 grabbed a pair of scissors in the medication cart drawer and cut the capsule using the scissors. RN	F 0880	It is the intent of facility to maintain infection control measures of handwashing, not touching pills with bare hands and hand-hygiene during medication pass administration.**What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice?** The DON/Designee assessed residents 8, 11, 12, D, and 19 on 12/6/2024 and no negative outcome related to the alleged deficient practice.**How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents could be negatively impacted by this practice, therefore, this plan of correction applies to all residents that reside in the facility. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** At an in-service held by the DON/Administrator on December 17, 2024, for all nursing and QMA staff on the following. Hand	12/30/2024

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	3 indicated at that time, she always had to cut the third capsule with scissors. There was no observation of disinfecting the scissors prior to cutting the capsule. After preparing the medications, she went into Resident D's room and administered the medications. RN 3 had picked up a straw and removed the paper covering with her bare hands, touching the mouth portion of the straw, and placed in a cup of water for resident to use. There were no observations of hand hygiene prior, during, or after medication administration of Resident D's medications. 2. The clinical record for Resident 11 was reviewed on 12/4/24 at 2:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus. An observation was conducted of medication administration for Resident 11 with RN 3 on 12/5/24 at 9:15 a.m. RN 3 was observed preparing Resident 11's medications. During that time, she pulled pill medications from medication packets and eye drops. She then entered the resident's room and administered the pill medications. After, she administered the resident's eye drops. RN 3 was not observed utilizing hand hygiene prior or after administering the pill mediations and/or the resident's eye drops. 3. The clinical record for Resident 8 was reviewed on 12/4/24 at 2:45 p.m. The diagnoses included, but were not limited to, depression. A medication administration was observed for Resident 8 with RN 3 on 12/5/24 at 9:25 a.m. RN 3 was observed pulling and preparing the resident's medication. During that time, RN 3 had touched her nose and then utilized hand sanitizer on the wall. After, she returned to the medication cart and continued to pull and prepare Resident 8's pill		Washing Medication administration Infection Control/Glove usage. Administration of eye drops Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place?** DON/Designee will observe 10 random medication administrations on random shifts weekly x 4 weeks, then 5 random medication administrations weekly x 4 weeks, then 5 random medication administrations monthly x 4 months for hand hygiene, usage of gloves, infection control practices with eye drop administration and handling to pills If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any	

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	medications. Prior to entering the resident's room, RN 3 had dropped an empty pill medication packet on the floor. She picked up the empty medication package and discarded it in the trash. She then went into the resident's room and administered the pill medication to Resident 8. There was no observation of hand hygiene after picking up the pill package off the floor. 4. The clinical record for Resident 12 was reviewed on 12/4/24 at 2:55 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). An observation was made of medication administration for Resident 12 with RN 3 on 12/5/24 at 9:36 a.m. After administering Resident 8's medications, RN 3 immediately went to Resident 12's bedside. At that time, she obtained Resident 12's vital signs utilizing a Dinamap machine (a mobile monitor to electronically measure blood pressure, pulse, oxygen saturations and temperature). During that time, she removed the protective sleeve on the thermometer that was in the resident's mouth and discarded it on the Dinamap. After, she then went to the medication cart and pulled and prepared Resident 12's medication. RN 3 was observed pulling apart a capsule pill medication with her bare hands and emptying the contents in a medication cup. After, she then returned to Resident 12's room and administered the medications. There was no hand hygiene after the administration of medications to Resident 8 and/or prior to obtaining vitals for Resident 12. 5. The clinical record for Resident 19 was reviewed on 12/4/24 at 3:10 p.m. The diagnoses included, but were not limited to, stroke.		patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **Date corrective action will be completed? 12/30/2024**	

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	An observation was made of an insulin medication administration for Resident 19 with RN 3 on 12/5/24 at 11:33 a.m. RN 3 was observed gathering supplies that included: glucometer, lancet, insulin flexpen medication, alcohol wipes, needle, and gloves for Resident 19 at the medication cart. After, she entered Resident 19's room and donned on gloves. There was no hand hygiene prior to donning on the gloves. She then obtained the resident's blood sugar reading utilizing the glucometer and administered the insulin in the resident's abdomen. After, she left the room and returned to the medication cart with her gloved hands. There was no observation of hand hygiene prior to donning on the gloves or prior to leaving the resident's room. An interview was conducted with RN 3 on 12/5/24 at 11:35 a.m. She indicated she had washed her hands prior to gathering the resident's supplies in the medication cart. An interview was conducted with Nurse Consultant (NC) 8 on 12/5/24 at 3:05 p.m. She indicated hand hygiene should be utilized between residents. RN 3 should have donned on gloves prior to eye drop administration and should not be touching pill medications with her bare hands. A medication administration policy was provided by the Director of Nursing (DON) on 12/6/24 at 9:57 a.m. It indicated the following, "...Purpose: To administer all medications safely and appropriately to aid residents to over illness, relieve and prevent symptoms, and help in diagnosis...Procedure... 1. Wash hands before beginning, whenever you contaminate your hands, and if contact is made with the medication...."			

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	An eye drops administration policy was provided by the DON on 12/6/24 at 9:57 a.m. It indicated the following, "...Purpose: The appropriate and safe administration of liquid ophthalmic medication (eye drops) as a local anesthesia to facilitate eye examination, for therapeutic treatment, or for help in the production of tears. Procedure: 1. Follow general medication administration policy and procedures. 2. Proper hand washing before and after administration..." 3.1-18(b)(1) 3.1-18(l)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to ensure a homelike environment with residents' rooms that were not in good repair for 3 of 20 residents' rooms observed. (Residents' F, C and B) Findings include: 1. The clinical record for Resident B was reviewed on 12/4/24 at 11:30 a.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 11/10/24, indicated Resident B was cognitively impaired. An observation was made of Resident B's room on 12/5/24 at 12:38 p.m. The windowsill was observed gouged and chipped. An interview was conducted with Resident B's	F 0921	**F921** It is the intent of the facility to ensure a homelike environment for residents, and rooms be kept in good repair. **What corrective action will be accomplished for those resident(s) found to have been affected by the deficient practice?** The Maintenance Director/Designee replaced Resident B's windowsill on 12/11/2024, repaired Resident C's outlet on 12/10/2024, and walls patched and painted on 12/11/2024. Resident F's ceiling was painted and trim replaced on 12/10/2024, as well as attic was reviewed to ensure no leaks were present. Resident F's trim was replaced on 12/11/2024. **How will other residents having the**	12/30/2024

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	Representative on 12/5/24 at 12:40 p.m. He indicated the room needed repairs. The windowsill had a gouge. 2. The clinical record for Resident F was reviewed on 12/4/24 at 3:19 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly MDS assessment, dated 10/14/24, indicated Resident F was cognitively intact. 3. The clinical record for Resident C was reviewed on 12/4/24 at 3:25 p.m. The diagnoses included, but were not limited to, hypertension. An observation was made of Resident C and Resident F's room on 12/4/24 at 3:19 p.m. Resident C's side of room had scrapes and missing paint on back and side wall by an electrical outlet that was pulling away from the wall. Resident F's side of the room had a missing trim piece and a large yellow in color oblong shaped ring on the white ceiling. An environmental tour was conducted with the Executive Director (ED) on 12/9/24 at 1:53 p.m. Resident B's room was observed with gouged windowsill. Resident F and Resident C's room was observed with scrapes and missing paint on back and side walls by the electrical outlet of Resident C's side of the room. Resident F's side of the room was observed with a large oblong shaped yellow in color ring on the white ceiling and the trim was missing on the chair rail. An interview was conducted with Resident F on 12/9/24 at 1:55 p.m. She indicated the yellow ring on the ceiling had been there ever since she had been in the facility. She had been in the facility for approximately a year.		**potential to be affected by the same deficient practice be identified and what corrective action will be taken?** The Maintenance Director/Designee completed an audit of resident rooms and any concerns were addressed by 12/23/2024. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** Administrator educated Maintenance director on 12/16/2024 on ensuring a homelike environment and residents' rooms are in good repair. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **How will the corrective action be monitored to ensure the deficient practice will not reoccur? What quality assurance program will be put into place?** The Administrator/designee will audit 10random resident rooms 5 weekly x 4 weeks, then 5 random resident rooms weekly r 4 weeks, then 5 random resident rooms monthly x 4 months for a homelike environment and rooms in good repair. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be	

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	An interview was conducted with the ED on 12/9/24 at 2:00 p.m. The ED indicated the facility was currently going through remodeling of the building. She had spoken with the maintenance director and Residents' F, B and C's rooms were on his list for repairs, but he had not gotten to them yet. A homelike environment policy was provided by the ED on 12/9/24 2:15 p.m. It indicated the following, "...Policy: It is the policy of the facility to ensure that the environment provided by the facility is safe, sanitary, functional and comfortable...23) All room contents to include clothes, furniture, devices, linens, bedspreads, privacy curtains, window coverings, wall hangings, wall paper and floors should be clean and in good repair." This citation relates to Complaint IN00440964. 3.1-19(f)(5)		stopped Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **Date corrective action will be completed? 12/30/2024**	