STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155233	A. BUILDING 00 B. WING	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 4, 5, 6, 7, and 10, 2025. Facility number: 000138 Provider number: 155233 AIM number: 100266500 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 3 Medicaid: 43 Other: 8 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 14, 2025.	F 0000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction is prepared and executed solely because federal and state law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the plan of correction. Failure to dispute or challenge the alleged deficiency below is not an admission that the alleged facts occurred as presented in the statements. This report in its entirety has been reviewed by our quality Assurance Committee.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify the physician when a resident's blood glucose levels were out of range for 1 of 21 residents reviewed for notification of change. (Resident 29) Findings include: The clinical record for Resident 29 was reviewed on 02/05/25 at 10:44 A.M. An Annual MDS	F 0580	F580 Notify of Changes (Injury/Decline/Room, etc.) It is the policy of the facility to notify the physician when a resident's blood glucose levels are out of range. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON/Designee	02/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jalena Ball	Administrator	02/27/2025

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

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	(Minimum Data Set) assessment, dated 01/16/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, anemia, coronary artery disease, heart failure, hypertension, anxiety, and depression. The resident's current MD orders included an open-ended order, with a start date of 04/25/24, to administer 3 units of Humalog insulin, three times a day at 7:00 A.M., 12:00 P.M., and 5:00 P.M. The resident also had an additional open-ended order, with a start date of 04/25/24, to check the blood glucose and administer an additional dose of Humalog based on a sliding scale (the amount of insulin administered would depend on the resident's blood glucose level) three times a day at 7:00 A.M., 12:00 P.M., and 5:00 P.M. The physician was to be notified if the resident's blood glucose was greater than 351. The November and December 2024, and January and February 2025, Electronic Medication Administration Record (EMAR) and Vitals Reports were reviewed. The blood glucose levels documented when the resident received the scheduled dose of insulin were different from the blood glucose levels documented when the sliding scale insulin was administered, even though both doses of insulin would have been administered together and based off the same blood glucose level. - On 11/09/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 430, but the sliding scale blood glucose documented was 350, - On 11/16/24 at 12:00 P.M., the blood glucose documented for the scheduled insulin was 377, but the sliding scale blood glucose documented		notified resident 29's physician of blood glucose levels outside of parameters for last 6 months on DATE 2/11/25. How be identified and what corrective action(s be taken? The DON/Designee completed a 30 day look back of blood glucose results and notified of any blood glucose results out of range on 2/11/25 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? At an in-service held on 2/19/25 held by the DON/Designee the following was reviewed with the nursing staff. Change of condition policy and procedure Notification of resident's physician of blood glucose levels outside of range Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The DON/Designee will monitor blood glucose levels 5 times a week for 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 months for levels out of range and physician notification. If the facility is within 95% compliance after 6 months the monitoring will be stopped. At the	

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	was 350, - On 11/26/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 420, but the sliding scale blood glucose documented was 340, - On 12/06/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 378, but the sliding scale blood glucose documented was 350, - On 12/07/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 358, but the sliding scale blood glucose documented was 350, - On 12/12/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 400, but the sliding scale blood glucose documented was 350, - On 12/14/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 409, but the sliding scale blood glucose documented was 350, - On 12/15/24 at 12:00 P.M., the blood glucose documented for the scheduled insulin was 563, but the sliding scale blood glucose documented was 349, - On 12/17/24 at 8:00 A.M., the blood glucose documented for the scheduled insulin was 379, but the sliding scale blood glucose documented was 350, - On 12/23/24 at 12:00 P.M., the blood glucose documented for the scheduled insulin was 551, but the sliding scale blood glucose documented was 304, - On 12/23/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 337, but the sliding scale blood glucose documented was 373, - On 12/29/24 at 7:00 A.M., the blood glucose documented for the scheduled insulin was 376, but the sliding scale blood glucose documented		monthly QAPI meeting, the monitoring of the DON /Designee will be reviewed. Any concerns will have been corrected as found. Any 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. By what date be completed? Date of Compliance 2/24/25	

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	was 350, - On 01/04/25 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 376, but the sliding scale blood glucose documented was 350, - On 01/23/25 at 12:00 P.M., the blood glucose documented for the scheduled insulin was 435, but the sliding scale blood glucose documented was 248, and - On 02/01/25 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 415. but the sliding scale blood glucose documented was 350. There was no indication the physician was notified when the blood glucose levels were greater than 350. During an interview on 02/07/25 at 11:26 A.M., LPN 6 (Licensed Practical Nurse) indicated if a resident received sliding scale insulin with a routine insulin and the blood sugar needed to be reported to the physician due to the call parameters then she would call the physician and document in the EMAR and a progress note that the physician was notified. During an interview on 02/10/25 at 10:21 A.M., the DON (Director of Nursing) indicated if a resident had two insulin orders and one of them had parameters to call the physician then the orders should have the same blood glucose levels documented and the physician should be notified if they were outside the call parameters. The current, undated, facility policy titled, "Change in Resident's Condition or Status", was provided by the DON on 02/06/25 at 9:51 A.M. The policy indicated, "...It is the policy of the facility to ensure that the resident's attending			

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	physician and Representative are notified of changes in the resident's condition or status..." 3.1-5(a)(3)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation, interview, and record review, the facility failed to maintain resident records in a private manner related to personal information posted in a public setting for 1 of 54 residents who resided in the building. (Resident 59) Findings include: Resident 59's room was observed on 02/04/25 at 1:17 P.M. Signage on the resident's door indicated he was in contact isolation and enhanced barrier precautions. Posted on the wall next to the door directly above the resident's name and room number was a document titled, "Guidelines for addressing Candida auris". The resident's room was observed on 02/05/25 at 9:20 A.M., The signage remained, including the "Guidelines for addressing Candida auris" documents posted on the wall above the resident's name and room number. During an interview on 02/05/25 at 9:22 A.M., Licensed Practical Nurse 5 indicated resident information, including resident profile information, medication lists, and diagnoses information was private and confidential, and should not be out for public viewing. During an interview on 02/05/25 at 9:30 A.M., the Director of Nursing (DON) and the Regional	F 0583	F-583 Personal Privacy/Confidentiality of Records It is the policy of this facility to maintain resident records in a private manner related to personal information posted in a public setting. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #59 had the information removed from his door immediately on 2/5/25, by the DON/Designee. How will the facility identify other residents having the potential to be affected by the same deficient practice? The DON/Designee completed an audit of all resident doors in the facility on 2/5/25 to ensure no other personal information was posted. Any issues found were addressed accordingly. What measures will be put in place or systemic measures to	02/24/2025

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	Nurse Consultant indicated they were unaware of any documentation posted in public related to the resident's diagnosis. It should not be there and would be removed. The resident's clinical record was reviewed on 02/05/25 at 10:00 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/01/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, cancer, hypertension, and depression. The resident's current MD orders included a current open-ended order, with a start date of 02/04/25, that indicated the resident was in contact isolation for a Candida auris infection. The current, undated facility policy, titled "What is HIPAA?" was provided by the DON on 02/06/25 at 9:52 A.M. The policy indicated, "...PROTECTED HEALTH INFORMATION...any and all health information on a resident or employee that identifies an individual..." 3.1-3(o)		ensure the deficient practice will not recur? At an in-service held by the DON/Designee on 2/19/25 with nursing staff the following was reviewed. -HIPAA compliance and displaying resident information - Not to post resident personal information on the doors Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The Director of Nursing or designee will complete an audit of entryways to resident rooms to ensure no personal health information is displayed without the resident’s consent 5 days weekly for 4 week, 3 days weekly for 4 weeks and then 1 day weekly for 4 months. If the facility is within 95% compliance at the end of 6	

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			months the monitoring can be stopped. At the monthly QAPI meeting, the monitoring of the DON /Designee will be reviewed. Any concerns will have been corrected as found. Any 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. By what date be completed? Date of Compliance 2/24/25	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to prime an insulin pen appropriately prior to administration, monitor blood glucose appropriately, and follow physician's orders related to medication hold parameters for 4 of 21 residents reviewed for Quality of Care. (Residents 37, 29, 22, and 43) Findings include: 1. During a medication administration observation and interview, on 02/06/25 at 10:54 A.M., Licensed Practical Nurse (LPN) 4 removed a Fiasp insulin pen from the 39 Back Medication Cart. LPN 4	F 0684	F- 684 Quality of Care It is the policy of this facility to ensure insulin pens are primed prior to administering, to monitor blood glucose appropriately and to follow physician orders related to medication hold parameters. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents 37, 29, 22 and 43 were	02/24/2025

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	indicated the pen had been opened and was for Resident 37 because they were the only resident who used that type of insulin and proceeded to write the resident's name on the pen. The resident required eight units of insulin based on the resident's blood glucose check the nurse had performed. The LPN applied the needle to the insulin pen and turned the dose knob at the end of the pen to 10 units. The LPN indicated she had done that so she could prime the pen with two units. The LPN aimed the insulin pen downwards into a plastic cup and squirted out 2 units. She donned gloves and proceeded to administer the insulin into the resident's abdomen with the door open to the room. During an interview following the procedure, LPN 4 indicated the purpose of priming the insulin pen was to ensure there was no air in the pen and she should have held the insulin pen upwards when priming the pen. The Fiasp insulin package insert was provided by the Regional Nurse Consultant on 02/10/25 at 2:00 P.M. The record indicated, "...Priming your FIASP...Pen...Turn the dose selector to select 2 units...Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top...Hold the Pen with the needle pointing up. Press and hold the dose button until the dose counter shows "0"...A drop of insulin should be seen at the needle tip..." 2. The clinical record for Resident 29 was reviewed on 02/05/25 at 10:44 A.M. An Annual MDS assessment, dated 01/16/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, anemia, coronary artery disease, heart failure, hypertension, anxiety, and depression.		assessed by the DON/Designee on 2/11/25 and no negative outcome related to the cited practice and the physician was notified of medications given outside of parameters on 2/11/25. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. The DON/Designee completed an audit of residents with parameters for diabetic medications on 2/11/25, and MD notified of any medications given outside of parameters on 2/11/25. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. An in-service held on 2/19/25 held by DON/Designee the following was reviewed with the nursing staff. following physician orders related to medications with parameters and priming insulin pens prior to administering insulin. 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 the corrective action will be	

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	A current, open-ended physician's order, with a start date of 12/28/24, indicated the resident was to receive Metoprolol (a blood pressure medication) 25 mg, once a day. The staff were to hold the medication if the resident's heart rate was less than 60 or the blood pressure was less than 110/60. The December 2024, January and February 2025 EMAR indicated the resident received the medication when the vital signs were not documented for the following dates and times: - 12/28/24 through 12/31/24, no vital signs were documented, - 01/02/25 through 01/17/24, no vital signs were documented, and - 02/01/25 through 02/10/25, no vital signs were documented. The residents clinical record lacked any vital signs for the above dates. 3. The clinical record for Resident 22 was reviewed on 02/06/25 at 12:52 P.M. A Quarterly MDS assessment, dated 12/07/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, anemia, hypertension, diabetes, non-Alzheimer's dementia, depression, psychotic disorder, and respiratory failure. The current open-ended physician's order, with a start date of 04/27/23, indicated the resident was to receive Carvedilol (a blood pressure medication) 3.125 mg, twice a day. The staff were to hold the medication when the blood pressure was less than 120/70 or the heart rate was less than 60.		monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. DON/designee audit the Medication Administration Record 5 times a week for 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 months for medication with parameters and following physician orders. The DON/Designee will monitor 10 random staff members administering insulin for priming of insulin pen prior to administering dose weekly x 4 weeks, then 5 random staff weekly x 4 weeks, then 3 random staff members monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months, then monitoring can 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 Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed.	

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	The November and December 2024 and January, February 2025 EMAR indicated the resident had received the medication when the blood pressure was less than 120/70 or the heart rate was less than 60 on the following dates and times: - On 11/04/24 at 8:00 A.M., when the heart rate was 58 and at 8:00 P.M., when the heart rate was 58, - On 11/11/24 at 8:00 A.M., when the heart rate was 56, - On 11/19/24 at 8:00 P.M., when the blood pressure was 100/56, - On 11/20/24 at 8:00 A.M., when the blood pressure was 116/62, - On 12/09/24 at 8:00 P.M., when the blood pressure was 108/60, - On 12/14/24 at 8:00 P.M., when the blood pressure was 102/68, - On 12/16/24 at 8:00 P.M., when the blood pressure was 105/62, - On 12/17/24 at 8:00 A.M., when the blood pressure was 110/66, - On 01/15/25 at 8:00 P.M., when the blood pressure was 111/64, - On 01/20/25 at 8:00 P.M., when the blood pressure was 103/63, - On 01/21/25 at 8:00 A.M., when the blood pressure was 116/67, - On 01/26/25 at 8:00 A.M., when the blood pressure was 108/59, and - On 02/04/25 at 8:00 P.M., when the blood pressure was 114/59. 4. The clinical record for Resident 43 was reviewed on 02/06/25 at 1:37 P.M. A Quarterly MDS assessment, dated 12/26/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stroke, hypertension, Non-Alzheimer's dementia, seizure		By what date be completed? Date of Compliance 2/24/25	

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	disorder, malnutrition, anxiety, and depression. The current open-ended physician's order, with a start date of 11/24/23, indicated the resident was to be administered Midodrine 15 mg, three times a day for hypotension. The staff were to hold the medication if the systolic blood pressure was greater than 120. The November and December 2024 and January, February 2025 EMAR indicated the resident had received the Midodrine medication when their systolic blood pressure was greater than 120 on the following dates and times: - On 11/11/24 at 7:00 A.M., when the blood pressure was 133/70, - On 11/23/24 at 7:00 A.M., when the blood pressure was 124/68 and at 5:00 P.M. when the blood pressure was 126/86, - On 11/25/24 at 7:00 A.M., when the blood pressure was 132/80 at 12:00 P.M., when the blood pressure was 122/68, and 5:00 P.M., when the blood pressure was 136/76, - On 11/27/24 at 7:00 P.M., when the blood pressure was 122/76, at 12:00 P.M., when the blood pressure was 138/77, and 5:00 P.M., when the blood pressure was 122/74, - On 11/29/24 at 12:00 P.M., when the blood pressure was 123/67 and 5:00 P.M., when the blood pressure was 128/78, - On 12/02/24 at 7:00 A.M., when the blood pressure was 134/92 and at 12:00 P.M., when the blood pressure was 126/88, - On 12/03/24 at 12:00 P.M., when the blood pressure was 122/66, - On 12/05/24 at 7:00 A.M., when the blood pressure was 122/88 and 12:00 P.M., when the blood pressure was 134/74, - On 12/09/24 at 7:00 A.M., when the blood			

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	pressure was 142/76, at 12:00 P.M., when the blood pressure was 128/76, and 5:00 P.M., when the blood pressure was 134/88, - On 12/10/24 at 7:00 A.M., when the blood pressure was 135/84 and 12:00 P.M., when the blood pressure was 123/72, - On 12/11/24 at 12:00 P.M. when the blood pressure was 138/86, - On 12/13/24 at 7:00 A.M., when the blood pressure was 121/97, at 12:00 P.M., when the blood pressure was 134/86, and at 5:00 P.M., when the blood pressure was 124/82, - On 12/19/24 at 7:00 A.M., when the blood pressure was 122/84, at 12:00 P.M., when the blood pressure was 134/77, and at 5:00 P.M., when the blood pressure was 128/82, - On 12/22/24 at 5:00 P.M., when the blood pressure was 124/72, - On 12/23/24 at 7:00 A.M., when the blood pressure was 142/86, at 12:00 P.M., when the blood pressure was 132/74, and at 5:00 P.M., when the blood pressure was 132/76, - On 12/24/24 at 7:00 A.M., when the blood pressure was 128/78, - On 12/29/24 at 12:00 P.M., when the blood pressure was 123/73, - On 12/30/24 at 7:00 A.M., when the blood pressure was 142/89, at 12:00 P.M., when the blood pressure was 138/72, and 5:00 P.M., when the blood pressure was 122/84, - On 01/01/25 at 5:00 P.M. when the blood pressure was 123/78, - On 01/02/25 at 7:00 A.M., when the blood pressure was 147/106, at 12:00 P.M., when the blood pressure was 130/88, and at 5:00 P.M., when the blood pressure was 138/87, - On 01/06/25 at 5:00 P.M., when the blood pressure was 129/79, - On 01/08/25 at 7:00 A.M., when the blood pressure was 139/96, at 12:00 P.M., when the			

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	155233	A. BUILDING 00 B. WING	02/10/2025

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	blood pressure was less than 134/88, and 5:00 P.M., when the blood pressure was 132/77, - On 01/13/25 at 7:00 A.M., when the blood pressure was 151/54, at 12:00 P.M., when the blood pressure was 136/68, and 5:00 P.M., when the blood pressure was 142/88, - On 01/15/25 at 7:00 A.M., when the blood pressure was 132/80, - On 01/16/25 at 7:00 A.M., when the blood pressure was 132/80, at 12:00 P.M., when the blood pressure was 128/74, and 5:00 P.M., when the blood pressure was 132/88, - On 01/20/25 at 7:00 A.M., when the blood pressure was 150/84, at 12:00 P.M., when the blood pressure was 138/77, and 5:00 P.M., when the blood pressure was 130/84, - On 01/22/25 at 7:00 A.M., when the blood pressure was 144/88, at 12:00 P.M., when the blood pressure was 147/83, and 5:00 P.M., when the blood pressure was 132/87, - On 01/24/25 at 12:00 P.M., when the blood pressure was 128/80, - On 01/26/25 at 7:00 A.M., when the blood pressure was 142/88, - On 01/27/25 at 7:00 A.M., when the blood pressure was 134/82, at 12:00 P.M., when the blood pressure was 122/77, and 5:00 P.M., when the blood pressure was 136/89, - On 02/03/25 at 7:00 A.M., when the blood pressure was 122/77, at 12:00 P.M., when the blood pressure was 138/80 and 5:00 P.M., when the blood pressure was 126/88, - On 02/04/25 at 7:00 A.M., when the blood pressure was 121/73, at 12:00 P.M., when the blood pressure was 132/87, and at 5:00 P.M., when the blood pressure was 127/84, - On 02/05/25 at 7:00 A.M., when the blood pressure was 134/79, at 12:00 P.M., when the blood pressure was 128/90, and at 5:00 P.M., when the blood pressure was 132/80, and			

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	- On 02/06/25 at 12:00 P.M., when the blood pressure was 128/78. During an interview on 02/07/25 at 11:26 A.M., LPN 6 indicated when a resident had hold parameters on medications, she would check the resident's vital signs prior to administering the medication. If the medication was to be held then she would not administer the medication and mark it on the EMAR that the medication was not administered with what the resident's vitals were. During an interview on 02/10/25 at 10:21 A.M., the DON indicated if a blood pressure medication had hold parameters, then the nurse should check the vitals and hold the medication based on the parameters. If there was a check mark on the EMAR, then that would mean that the medication was administered to the resident. If there was a number, then that determined the medication was not administered. The current, undated, facility policy titled, "PHYSICIAN-ORDERS--(FOLLOWING PHYSICIAN ORDERS)" was provided by the Regional Nurse Consultant on 02/07/25 at 12:15 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." The current facility policy titled, "MEDICATION ADMINISTRATION", dated February 2017, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "...To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis..." 3.1-37(a)			

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to follow a acquired a resident's weight related to daily weights for 1 of 4 residents reviewed for nutrition. (Resident 29) Findings include: The clinical record for Resident 29 was reviewed on 02/05/25 at 10:44 A.M. An Annual Minimum Data Set (MDS) assessment, dated 01/16/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, anemia, coronary artery disease, heart failure, hypertension, anxiety, and depression. A current, open-ended physician's order, with a start date of 12/28/24, indicated the resident was to be weighed daily. The physician was to be notified if the resident had a weight gain greater than 3 pounds in a day or greater than 5 pounds in a week. The clinical record lacked daily weights on the following dates: - 12/30/24 through 01/02/25, - 01/04/25, - 01/06/25 through 01/07/25, - 01/09/25 through 01/11/25, - 01/13/25 through 01/15/25, - 01/17/25, - 01/20/25, - 01/21/25, - 01/23/25 through 02/02/25, and - 02/04/25.	F 0692	F-692 Nutrition/Hydration Status Maintenance It is the policy of the facility to obtain weights in accordance with physician orders. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON/Designee assessed resident 29 on 2/11/25 and notified the MD of missed daily weights on DATE, no negative outcome and no new orders. How be identified and what corrective action(s be taken? An audit was completed by DON/Designee on 2/18/25 for all residents with daily weights to ensure all weights were inputted. Any changes or corrections were addressed and changed as indicated and physician notified on any missing weights on DATE, What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? At an in-service held by the Director of Nursing on 2/19/25 for nurses the following was reviewed:	02/24/2025

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	During an interview on 02/10/25 at 11:02 A.M., Licensed Practical Nurse (LPN) 3 indicated the resident was a daily weight. The CNAs (Certified Nurse Aides) would get the resident's weight and let the nurse know. The nurse would document the weight and call the physician if the resident was greater than a certain amount in a day. The current facility policy titled, "GUIDELINES FOR OBTAINING RESIDENTS' WEIGHTS", dated 07/24/23, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "...Accuracy with weight measurement is essential for residents in the long-term-care setting. Weight measurement is used to calculate energy, protein, and fluid needs. Further, weight is an indicator of nutritional and health status and changes in weight can often indicate other medical changes. Inaccurate weight measurements can result in an increased number of "unplanned" weight changes in the facility-and can affect the plans of care for the residents...Weigh residents at the same time of the day as possible, on the same weight clothing as much as possible-each time they are weighed..." 3.1-46(a)(1)		1 Guidelines for Obtaining Resident's Weights 2 Entering weights into MAR/TAR and following physician orders. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Director of Nursing/Designee will monitor residents with daily weights for weight being obtained and physician notification 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a month x 4 months. If the facility is within 95% compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any 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.	

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			By what date be completed? By what date be completed? Date of Compliance 2/24/25	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on record review and interview, the facility failed to provide Parenteral/IV (Intravenous) site maintenance for 2 of 3 residents reviewed for vascular access sites. (Residents 4 and 38) Findings include: 1. The clinical record for Resident 4 was reviewed on 02/05/25 at 2:36 P.M. An Admission Minimum Data Set (MDS) assessment, dated 01/20/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, acute osteomyelitis (infection in the bone or bone marrow) of the right ankle and foot. During an interview on 02/10/25 at 8:38 A.M., the Director of Nursing (DON) indicated the resident was admitted to the facility from the hospital and had an infected heel wound with osteomyelitis. The resident had been on IV antibiotics for his wound infection since he was admitted to the facility. During an interview on 02/10/25 at 2:25 P.M., Licensed Practical Nurse (LPN) LPN 2 indicated the resident had a Midline vascular access site in his right arm. He came from the hospital with an	F 0694	F-694 Parenteral/IV fluids It is the practice of the facility to provide sight maintenance for residents with intravenous access sites. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 4 no longer resides in the facility. Resident 38's PICC IV line was discontinued on 1/10/2025. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. On 2/11/25 DON/Designee completed an audit on all residents who have IV access to	02/24/2025

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	access site but then had to have it replaced because it would not flush. Residents with a Peripherally Inserted Central Catheter (PICC) line or a Midline Catheter should have physician's orders to flush the line regularly. The "PICC/MIDLINE INSERTION DOCUMENTATION" record, dated 01/24/25, was provided by the Regional Nurse Consultant on 02/10/25 at 3:18 P.M. The record indicated a dual lumen PICC line had been removed, and a Midline had been inserted. The Midline was cleared for use. The clinical record indicated the resident did not receive IV medications on January 19, or 20, 2025, due to a lack of supplies. The resident did not receive IV medications on January 22, 23, or 24, 2025, due to the resident's venous access site not flushing. The clinical record lacked documentation the resident's venous access sites had been flushed on a regular basis or flushed before and after medication administration. The Electronic Medication Administration Record/Treatment Administration Record (EMAR/ETAR) for January and February 2025, was provided by the DON on 02/10/25 at 9:19 A.M. The record lacked a physician's order to flush the resident's vascular access sites to maintain patency (open and unblocked) and there was no order to flush the sites before or following the IV medication administration. 2a. The clinical record for Resident 38 was reviewed on 02/06/25 at 10:05 A.M. A Quarterly MDS assessment, dated 12/17/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, amputation, anemia, hypertension, PVD, diabetes, anxiety, depression, infection of amputation.		ensure medication orders and flush orders are in correctly and completed as ordered. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. On 2/19/25 an in-service was completed by the DON for all licensed staff to include: 1. Documentation of assessment of the PICC line, including assessment of the insertion site, and monitoring for bleeding or signs of infection at a minimum upon insertion, admission and during dressing changes for the duration of the IV access placement. 2. Maintenance flush orders. And following physician orders for scheduling residents to have an IV line inserted at an outside vendor. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.	

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	A Progress Noted, dated 12/07/24 at 9:24 P.M., indicated the resident admitted to the facility for a right stump infection and had a PICC line in her right upper arm. A physician's order, dated 12/08/24 through 12/22/24, indicated the resident was to receive Vancomycin (an antibiotic) 1 gram, once a day for a right stump infection. A physician's order, dated 12/08/24 through 01/10/25, indicated the resident was to receive Cefepime (an antibiotic) 2 grams intravenously, twice a day for a right stump infection. A physician's order, dated 12/08/24 at 10:20 A.M., indicated the staff were to flush the IV-midline with 10 mls normal saline before and after infusions. The order had no scheduling details or assigned times to be completed. The clinical record indicated the resident did not receive the Vancomycin on the following dates: - 12/08/24 due to the medication being unavailable, - 12/09/24 due to the resident needing a new PICC line placed, and - 12/10/24 due to waiting on the PICC line verification. The clinical record indicated the resident did not receive the Cefepime medication on the following dates and times: - 12/08/24 at 8:00 P.M., due to the medication being unavailable, - 12/09/24 at 8:00 A.M., and 8:00 P.M., due to new PICC needing placed, and		DON/Designee will audit residents with intravenous lines for flush orders and physician orders for flushing and maintaining IV line 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a month x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Results of the monitoring will be presented to the QAPI committee weekly, then monthly when appropriate. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored weekly by the Administrator until resolved. Orders for a PICC/IV will be reviewed daily M-F at the CQI (Clinical Quality Indicator) meeting, to ensure orders are correct and being implemented per policy and procedure. By what date be completed? Date of Compliance 2/24/25	

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	- 12/10/24 at 8:00 A.M., due to waiting on PICC line verification. A Vascular Access And Consultation Reports indicated the resident had a PICC/midline placed on the following dates: - 12/09/24 at 11:25 P.M., - 12/14/24 at 4:10 P.M., - 12/14/24 at 8:00 P.M., and - 01/04/25 at 3:50 P.M. The resident's PICC/midline was discontinued on 01/10/25. The clinical record lacked documentation that the resident's PICC/midline was flushed from 12/07/24 through 01/10/25. 2b. An Infectious Disease Progress Note, dated 12/20/2024 at 5:05 P.M., indicated it was recommended a referral was to be sent for the resident to get a central line (an intravenous line that is longer than a regular IV and goes all the way up to a vein near the heart or just inside the heart.) A physician's order, with a start date of 12/24/24, indicated the staff were to contact the local hospital about getting a central line placed due to difficulty with midline placement, for 5 days. A physician's order, with start date 12/26/24 and end date 12/30/24, indicated the staff were to schedule an appointment with the general surgeon for a central line for 4 days. The December 2024 EMAR and clinical record indicated the following related to the central line:			

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	- 12/24/24, the EMAR indicated to see nurse note. There was no nurse note related to the appointment, - 12/25/24 and 12/26/24, EMAR was left blank, - 12/27/24 the EMAR indicated to see a nurse note. The nurse note indicated the physician's office was closed that day, and - 12/28/24 through 12/30/24, the EMAR was left blank. The clinical record lacked any other documentation related to the central line. During an interview on 02/07/25 at 1:30 P.M., LPN 2 indicated if a resident was admitted to the facility with a PICC/Midline the medications would be delivered by pharmacy. They ran three times a day, and the nurse would need to input orders for it to be flushed. There was no reason anyone would have a PICC/Midline without flush orders. To schedule appointments, she would put it on the EMAR, and the nurse would have to check it off like a medication when it was done. If it didn't get done, then the DON would need to follow-up to make sure it was completed. During an interview on 02/10/25 at 10:03 A.M., the DON and the Regional Nurse Consultant indicated when a resident admitted to a facility with a PICC/Midline the nurse would input order for the resident to get flushes to the line. Resident 38 had an order for flushes, but the nurse didn't put in any scheduling details, so it didn't show up on the EMAR to be completed. If the physician gave orders for the pharmacy to dose a resident's medications, then the facility would follow the orders from the pharmacy. The nurse that took the order to increase the Vancomycin to 1.25 grams should have changed the order in the clinical record. Since the infectious disease NP made a			

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	recommendation for a central line the facility should have followed up with the physician to get the line placed. The current facility policy titled, "Flushing a Peripheral Intravenous Catheter", dated January 2016, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "...Specific flush orders must be documented...Flushing is performed to ensure and maintain catheter patency, and to prevent the mixing of incompatible medications/solutions...A physician order is required for flushing of a peripheral IV catheter. The order must include:...Flushing agent...Volume...Frequency..." The current facility policy titled, "Flushing a Midline Catheter", dated January 2016, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "...Specific flush orders must be documented...Flushing is performed to ensure and maintain catheter patency, and to prevent the mixing of incompatible medications/solutions...A physician order is required for flushing of a peripheral IV catheter. The order must include:...Flushing agent...Strength/concentration...Volume...Frequency..." The current, undated, facility policy titled, "PHYSICIAN-ORDERS--(FOLLOWING PHYSICIAN ORDERS)" was provided by the Regional Nurse Consultant on 02/07/25 at 12:15 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-47(a)(2)			
F 0698 SS=D	483.25(l) Dialysis			

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Bldg. 00	Based on interview and record review, the facility failed to completed assessments before and following a resident's dialysis treatments for 1 of 2 residents reviewed for dialysis. (Resident 24) Findings include: During an interview on 02/04/25 at 11:25 A.M., Resident 24 indicated she left the facility for dialysis treatments on Monday, Wednesday, and Friday. During an interview while at the Resident Council Meeting, on 02/06/25 at 2:15 P.M., the resident indicated sometimes when she got back from dialysis, she had to sit in her wheelchair with her coat on for a half an hour before staff helped her. The clinical record for Resident 24 was reviewed on 02/06/25 at 2:41 P.M. A Quarterly Minimum Data Set assessment, dated 12/15/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, hypertension, renal insufficiency, and diabetes. The resident received dialysis treatments. During an interview on 02/06/25 at 3:20 P.M., the Director of Nursing (DON) indicated the facility staff were supposed to complete an assessment on the "DIALYSIS/OBSERVATION COMMUNICATION FORM" in the resident's dialysis binder each time the resident went to the dialysis facility for treatment. The "DIALYSIS/OBSERVATION COMMUNICATION FORM" records were provided by the DON on 02/06/25 at 3:55 P.M. The DON indicated the resident refuse to go to	F 0698	F-698 Dialysis It is the policy of the facility to complete an assessment before and after a resident's dialysis treatment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON/Designee assessed Resident 24 has had no negative outcomes from the cited practice. How be identified and what corrective action(s be taken? An audit was completed by the DON/Designee for all residents on dialysis for assessment before and following dialysis treatment, any concerns were immediately addressed and physician notified on 2/11/25 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? At an in-service held by the Director of Nursing on 2/19/25 for nurses the following was reviewed: Dialysis communication form to be completed before and following a	02/24/2025

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	dialysis sometimes but had been to dialysis a few times in January and February. The dialysis binder only contained records for 12/13/24, 12/20/24, and 12/31/24. The dialysis provider had completed their portion of the forms. The facility failed to complete their portion of the forms which included signed assessments before and after dialysis treatments. The current "Dialysis Guideline" policy, with a reviewed date of 04/04/16, was provided during the Entrance Conference. The policy indicated, "...Care required when a resident's disease trajectory requires hemodialysis may exceed the usual interventions provided to residents in long-term care setting...Communication between the dialysis provider and center staff should include: Written communication including review of daily weights, changes in condition or mood, response to the treatment, and evaluation of the vascular access site..." 3.1-37(a)		dialysis treatment. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Director of Nursing/Designee will monitor dialysis communication forms 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 months. If the facility is within 95% compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any 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. By what date be completed?	

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			By what date be completed? Date of Compliance 2/24/25	
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to provide the required RN coverage on duty for eight hours a day for 16 of the 21 days reviewed. Findings include: The "as worked" nursing schedule indicated there had not been an RN on duty for eight consecutive hours on the following dates: - Saturday 07/13/24, - Sunday 07/14/24, - Saturday 07/20/24, - Sunday 07/21/24, - Saturday 08/10/24, - Sunday 08/11/24, - Saturday 08/24/24, - Sunday 08/25/24, - Saturday 09/07/24, - Sunday 09/08/24, - Saturday 09/21/24, - Sunday 09/22/24, - Saturday 12/14/24, - Sunday 12/15/24, - Saturday 02/08/25, and - Sunday 02/09/25. During an interview on 02/10/25 at 09:52 A.M., The Director of Nursing (DON) indicated they did	F 0727	F-727 RN 8 hours/7 days/, Full Time DON It is the policy of the facility to ensure RN coverage on duty for eight hours day. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No resident has been negatively impacted by this finding. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. All residents that reside in the facility have the potential to be affected by the alleged cited practice, therefore, this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic changes will be made to ensure that the	02/24/2025

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	have issues with staffing in the previous months. The current, undated facility policy, titled "Registered Nurse Coverage" was provided by the DON on 02/10/25 at 9:19 A.M. The policy indicated, "...It is the policy of the facility to provide the services of an RN for at least 8 consecutive hours per 24 hour day, 7days weekly..." 3.1-17(b)(3)		deficient practice does not recur? At an in-service held by the Administrator/Designee on 2/19/25for the DON, ADON and Staffing Coordinator the following was reviewed: 1. Federal regulation related to RN staffing requirements 2. Scheduling strategy to ensure 8hrs of consecutive RN coverage is present daily. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. DON/Designee will audit staffing for RN 8 consecutive hours 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 months. If the facility is within 95% compliance at the end of 6 months, then monitoring can be stopped. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any	

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			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. By what date be completed? Date of Compliance 2/24/25	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to provide IV (Intravenous) antibiotics in a timely manner for 2 of 3 residents reviewed for IV antibiotics. (Residents 4 and 29) Findings include: 1. The clinical record for Resident 4 was reviewed on 02/05/25 at 2:36 P.M. An Admission Minimum Data Set (MDS) assessment, dated 01/20/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, acute osteomyelitis (infection in the bone or bone marrow) of the right ankle and foot. The resident was admitted to the facility on 01/13/25. During an interview on 02/10/25 at 8:38 A.M., the Director of Nursing (DON) indicated the resident was admitted to the facility from the hospital and had an infected heel wound with osteomyelitis. From admission he was on IV antibiotics. The facility had run out of IV tubing. They were out of tubing for two days. The resident was on two different IV antibiotics and missed several doses,	F 0755	F-755 Pharmacy /Procedures/ Pharmacist/ Records It is the policy of this facility to provide IV medications in a timely manner. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 4 no longer resides in the facility resident 29's was assessed by the DON on 2/11/25 no negative outcome related to the cited practice. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. DON/Designee completed an audit of all residents who were receiving	02/24/2025

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	6 doses altogether. The pharmacy did not send tubing with the IV medications. The facility had ordered some IV tubing from a supplier who no longer carried tubing. As soon as they discovered that the supplier no longer carried tubing, they notified the pharmacy, and they delivered a box. The pharmacy delivered once early in the morning, between 2:00 A.M., and 7:00 A.M., and again, later in the afternoon, usually around 5:00 P.M., or 6:00 P.M. If staff ordered something by 3:00 P.M., they would usually have it by 7:00 A.M. the next day. They had two local pharmacies they could get supplies from in an emergency. The Electronic Medication Administration Record/Treatment Administration Record (EMAR/ETAR) for January 2025, was provided by the DON on 02/10/25 at 9:19 A.M. The record indicated the resident was to receive the following IV antibiotics daily for the acute infection in his foot: - Daptomycin 500 milligrams (mg) one time a day, at 2:00 P.M., with a start date of 01/15/25, and an end date of 02/20/25, and - Cefepime 2 grams, two times a day, at 8:00 A.M., and 8:00 P.M., with a start date of 01/16/25, and an end date of 02/21/25. The record indicated the resident did not receive the antibiotics on the following dates and times due to supplies not being available: - Daptomycin on 01/19/25, 01/20/25, at 2:00 P.M., and - Cefepime on 01/19/25 at 8:00 A.M. and 8:00 P.M., and 01/20/25 at 8:00 A.M. 2. The clinical record for Resident 29 was reviewed		intravenous antibiotics for availability of medications on 2/11/25, any concerns were immediately addressed. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? . An in-service held on 2/19/25 held by DON/Designee the following was reviewed the nursing staff. Medication Administration and Ordering Medications Following physician orders. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. DON/designee will audit residents receiving IV antibiotics for timely administration 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped Results of the monitoring will be	

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	on 02/05/25 at 10:44 A.M. An Annual MDS assessment, dated 01/16/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, anemia, coronary artery disease, heart failure, hypertension, anxiety, and depression. A Progress Note, dated 11/19/24 at 9:40 A.M., indicated the resident was positive for a UTI (Urinary Tract Infection). A new order was obtained to place a PICC line for IV Merrem (an antibiotic). A vascular access nurse was to come to the facility and place the PICC line. A physician's order, dated 11/19/24 through 11/26/24, indicated the resident was to receive Merrem, 1 gram every 8 hours for a UTI for 7 days. The November 2024 EMAR indicated the resident did not receive the antibiotics on the following dates and times: - 11/19/24 from 8:00 P.M. to 10:00 P.M., - 11/20/24 from 6:00 A.M. to 10:00 A.M., 4:00 P.M. to 6:00 P.M., and 8:00 P.M. to 10:00 P.M., - 11/21/24 from 6:00 A.M. to 10:00 A.M., 4:00 P.M. to 6:00 P.M. (there was a blank in the EMAR), and - 11/23/24 from 4:00 P.M. to 6:00 P.M. (there was a blank in the EMAR). A Progress Note, dated 11/19/24 at 11:08 P.M., indicated the Merrem medication was not administered due to waiting on the pharmacy to deliver. A Progress Note, dated 11/20/24 at 5:19 P.M., indicated the Merrem medication was not administered due to the medication being unavailable. The pharmacy stated the medication would be there that night.		reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date be completed? Date of Compliance 2/24/25	

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A Progress Note, dated 11/20/24 at 5:26 P.M., indicated the Merrem medication was not administered due to the medication being unavailable. The pharmacy stated the medication would be there that night.

A Progress Note, dated 11/20/24 at 11:41 P.M., indicated the Merrem medication was not administered. The pharmacy was called and clarified that the medication had not been delivered to the facility.

A Progress Note, dated 11/21/24 at 2:33 P.M., indicated the Merrem medication was not administered due to the medication being absent from the facility.

During an interview on 02/07/25 at 1:30 P.M., LPN 2 indicated when a resident started on IV medication the pharmacy would send the medications. The pharmacy delivered medications three times a day.

During an interview on 02/10/25 at 2:37 P.M., the ADON indicated to ensure residents received all their antibiotics the EMAR would be monitored to ensure the nurse was signing off the medication. If a physician ordered IV antibiotics, they should be delivered the next day to start the medication.

During an interview on 02/10/25 at 3:11 P.M., the DON indicated the pharmacy had cut off times for ordering medications. If the staff ordered medications before 6:00 A.M., they would get there by 6:00 P.M. and vice versa.

3. The clinical record for Resident 38 was reviewed on 02/06/25 at 10:05 A.M. A Quarterly MDS assessment, dated 12/17/24, indicated the resident

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	was cognitively intact. The resident's diagnoses included, but were not limited to, amputation, anemia, hypertension, PVD, diabetes, anxiety, depression, infection of amputation. A Progress Note, dated 12/16/24 at 10:01 A.M., indicated the pharmacy was informed of the resident's trough level for the Vancomycin. The pharmacy was increasing the dose from 1 gram to 1.25 grams. The medication was not available in the emergency drug kit and would be started when it arrived from the pharmacy. The residents December 2024 EMAR indicated the resident had received Vancomycin 1 gram on 12/17/24 and 12/18/24 and was on hold from 12/19/24 through 12/21/24. The clinical record lacked an order for the medication to be increased to 1.25 grams. The current facility policy titled, "PHARMACY HOURS AND DELIVERY SCHEDULE", dated February 2017, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "...is open 24 hours/365 days a year. New orders and refill requests may be faxed or sent electronically at any time..." The current, undated, facility policy titled, "PHYSICIAN-ORDERS--(FOLLOWING PHYSICIAN ORDERS)" was provided by the Regional Nurse Consultant on 02/07/25 at 12:15 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-25(a)			
F 0761 SS=E	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	Based on observation, interview, and record review, the facility failed to store medications appropriately for 3 of 3 medication carts reviewed and 1 of 1 medication rooms reviewed. (39 Back Medication Cart, Front Medication Cart, Rehab Medication Cart, and the 39 Hall Medication Room) Findings include: 1. During a medication administration observation on 02/06/25 at 10:54 A.M., Licensed Practical Nurse (LPN) 4 removed a Fiasp insulin pen from the 39 Back Medication Cart. The pen was laying loosely in the drawer of the medication cart and not in a plastic bag. The pen was labeled with an opened date of "2/1". The pen was not labeled with a resident's name or anything that would identify who the pen belonged to. LPN 4 indicated the pen had been opened and was for Resident 37 because they were the only resident who used that type of insulin. The LPN proceeded to write the resident's name on the pen and administer the insulin to Resident 37. 2. The Front Medication Cart was observed on 02/10/25 at 9:37 A.M., with LPN 3 and contained the following loose pills: - one small oval peach tablet, - one medium round gray tablet, - one medium round white tablet, - one small oval white tablet, - one small oval blue tablet, - one small oval red tablet, - one small round pink tablet, - one small round white tablet, - one medium round blue tablet, - one large oval white tablet, and	F 0761	F-761 Label/Store Drugs and Biologicals It is the intent of this facility to ensure that medication stored properly. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee disposed of the loose pills in the Med Cart on Rehab Medication Cart and disposed of insulin with no name on 2/11/25 The DON/Designee disposed of the outdated and undated Tuberculin on 39 Hall Medication room on 2/11/25 The DON/Designee placed resident 37’s insulin in a bag with the resident’s name, dispose of loose pill and clean cart of loose paper bites and spilled substance on 2/11/25 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The DON/Designee completed medication carts and medication room audits for undated and unlabeled tuberculin serum,	02/24/2025

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	- one medium orange capsule. The medication cart had a section of a drawer covered in a spilled substance and several bits of paper were scattered heavily throughout the cart. LPN 3 indicated the pharmacy occasionally came into and audited the medication carts. In-house staff usually kept the carts clean. The LPN was observed destroying the medications with a second nurse. 3. The Rehab Medication Cart was observed on 02/10/25 at 9:53 A.M., with LPN 2 and contained the following loose pills: - one small round white tablet, - one small round pink tablet, and - one large round half of a white tablet. LPN 2 indicated all insulin pens should have a resident's name on them. Per their facility policy, she had to throw the insulin pen away and she proceeded to do so. 4. The 39 Hall Medication Room was observed on 02/10/25 at 10:07 A.M. with LPN 3. The medication refrigerator contained two opened vials of Tuberculin (TB) serum, one with an opened dated of 11/07/24 that was half full and one that was undated that was half full. LPN 3 indicated the TB serum should be dated when opened. It should be discarded after 30 days. The one dated 11/07/24 should have been disposed of. LPN 3 disposed of the outdated serum vial immediately. There were no delivery dates on the serum bottles. During an interview and observation on 02/10/25 at 10:41 A.M., the Director of Nursing (DON) indicated the nurses on the floor administered the		insulins, disposed of loose pills on 2/11/25 What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. An in-service held 2/19/25 by the DON/designee the following was reviewed: Medication storage, dating vials when opened date, storing insulin pulled from the in a bag with resident's names, cleanliness of medication carts and disposing of loose pills in medication cart. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The DON/Designee will audit medication carts and medication rooms for loose pills in cart, insulin dated and store in bag, and undated Tuberculin five times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a week 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring	

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	TB tests to the new admission residents. They had several new admissions in the last 30 days. This refrigerator was the only refrigerator where they kept the TB serum. The TB serum package insert was provided by the DON on 02/10/25 at 10:49 A.M. The record indicated, "...A vial of TUBERSOL (TB serum) which has been entered and in use for 30 days should be discarded...Do not use after expiration date..." The current "MEDICATION STORAGE IN THE FACILITY" policy, dated February 2017, was provided by the DON on 02/10/25 at 1:08 P.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations..." 3.1-25(j) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(o)		can 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 Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. By what date be completed? Date of Compliance 2/24/25	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on interview and record review, the facility failed to obtain blood tests for 1 of 5 residents reviewed for laboratory services. (Resident 27) Findings include: Resident 27's clinical record was reviewed on 02/06/25 at 11:00 A.M. A Quarterly Minimum Data Set assessment, dated 01/13/25, indicated the resident was moderately cognitively impaired. The	F 0770	F-770 Laboratory Services It is the policy of this facility to obtain blood tests for residents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The DON/Designee notified	02/24/2025

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	resident's diagnoses included, but were not limited to, diabetes, anxiety, and hypertension. The resident's current MD orders included, but were not limited to, an open-ended order, with a start date of 06/07/23, to check the resident's A1C (a blood test that measures the average blood glucose level over the past 2 to 3 months) every 3 month(s). Based on the physician's orders, the A1C blood tests should have been obtained in March, June, September, and December of 2024. The resident's A1C lab (laboratory) results for 2024 were provided by the Director of Nursing (DON). The resident's A1C was checked in March and December of 2024. During an interview on 02/07/25 at 2:24 P.M., the DON indicated the copies of the A1C labs she provided were all that were located in the resident's record. The facility missed some of the resident's required labs. The current, undated facility policy, titled "LAB SCHEDULING/TRACKING", was provided by the DON on 02/10/25 at 9:19 A.M. The policy indicated, "...It is the policy of the facility to ensure that laboratory tests ordered by the physician are systematically scheduled and tracked so that lab work is obtained and results are received and reported timely..." 3.1-49(a)		resident 27's physician of the missing lab on 2/11/25, new order to complete How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. The DON/Designee completed a 90 day look back of lab orders to verify completion of test on 02/11/2025, any concerns were addressed with the physician. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? The DON/Designee completed an in-service with the nursing staff on 2/19/25 on laboratory services and monitoring lab results. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. DON/Designee will implement an audit tool to monitor compliance	

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			with laboratory orders to ensure orders are completed. This audit will be completed 5x a week x4 weeks, then 3 x a week x 4 weeks, then one time a week x 4 weeks, then once a month x 3 months. ¿If the facility is within 95% compliance at the end of the 6 months, then monitoring can 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 Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date be completed? Date of Compliance 2/24/25	
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 maintain a kitchen exterior door in good working order related to food safety for 3 of 3 kitchen observations. This deficient practice had the potential to affect 52 of 54 resident who received food from the kitchen. Findings include: During an initial kitchen observation on 02/04/25	F 0812	F-812 Food Procurement, Store/Prepare/Serve Sanitary It is the intent of this facility of maintain a kitchen door in good working order. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	02/24/2025

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	at 10:30 A.M., an exterior kitchen door was cracked open about 1/2 to 1 inch that the outside was visible. The Dietary Manager closed the door. The bottom of the door contained a door draft stopper that was broken on the right side where the door opened to the outside. The part that was broken left an approximately 2-inch gap at the bottom of the door. During an observation on 02/04/25 at 11:01 A.M., an exterior kitchen door was cracked open about 1/2 to 1 inch that the outside was visible. The bottom of the door contained a door draft stopper that was broken on the right side where the door opens to the outside. The part that was broken left an approximately 2-inch gap at the bottom of the door. During an observation and interview on 02/10/25 at 10:44 A.M., an exterior kitchen door was cracked open about 1/2 to 1 inch that the outside was visible. The bottom of the door contained a door draft stopper that was broken on the right side where the door opens to the outside. The part that was broken left an approximately 2-inch gap at the bottom of the door. She indicated the staff knew to keep the door closed as it didn't shut properly. The broken piece in the bottom of the door had been like that for a couple weeks. She had verbally told the Maintenance Director about it. During an interview on 02/10/25 at 10:53 A.M., the Maintenance Director indicated he was notified of the door being broken in the kitchen few weeks ago. The kitchen staff were educated to make sure the door stayed closed. He had no documentation that the door needed to be fixed, and it would be fixed by the end of the day.		No residents were identified How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. All residents have the potential to be affected by this deficient practice, therefore, this plan of correction applied to all the residents that reside in the facility. The Maintenance Director/Designee repaired the kitchen doon on 2/10/25. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? The ADM/Designee educated the maintenance director on repairing doors when broken and preventative maintenance on 2/19/25 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The Maintenance Director/Designee will audit exterior doors gaps five times a	

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	The current facility policy titled, "OTHER INFORMATION", dated 12/05/23, was provided by the Regional Director of Operations on 02/10/25 at 3:04 P.M. The policy indicated, "...Maintenance Request Log...Maintenance staff will check all nurses' stations and housekeeping carts during morning rounds to pick up the Maintenance request Logs and take care of the requests as time allows. If an issue is urgent in nature, it will be addressed immediately...Work orders needed to be completed in a timely fashion...Door Inspections...Check for holes/gaps and repair as needed..." 3.1-21(i)(3)		week x 4 weeks, then 3 times a week x 4 weeks, then once a month x 4 months. If the facility is within 95% compliance at the end of the 6 months, then monitoring can 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 Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date be completed? Date of Compliance 2/24/25	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to notify the physician when a resident's blood glucose levels were out of range for 1 of 21 residents reviewed for notification of change. (Resident 29) Findings include: The clinical record for Resident 29 was reviewed on 02/05/25 at 10:44 A.M. An Annual MDS (Minimum Data Set) assessment, dated 01/16/25, indicated the resident was cognitively intact. The	F 0842	F- 842 Resident Records-Identifiable Information It is the policy of this facility to notify the resident's physician of out-of-range blood glucose levels. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee notified	02/24/2025

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	resident's diagnoses included, but were not limited to, diabetes, anemia, coronary artery disease, heart failure, hypertension, anxiety, and depression. The resident's current MD orders included an open-ended order, with a start date of 04/25/24, to administer 3 units of Humalog insulin, three times a day at 7:00 A.M., 12:00 P.M., and 5:00 P.M. The resident also had an additional open-ended order, with a start date of 04/25/24, to check the blood glucose and administer an additional dose of Humalog based on a sliding scale (the amount of insulin administered would depend on the resident's blood glucose level) three times a day at 7:00 A.M., 12:00 P.M., and 5:00 P.M. The physician was to be notified if the resident's blood glucose level was greater than 351. The November and December 2024, and January, February 2025, Electronic Medication Administration Record (EMAR) and Vitals Reports were reviewed. The blood glucose levels documented when the resident received the scheduled dose of insulin were different from the blood glucose levels documented when the sliding scale insulin was administered, even though both doses of insulin would have been administered together and based off the same blood glucose level. - On 11/09/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 430, but the sliding scale blood glucose documented was 350, - On 11/16/24 at 12:00 P.M., the blood glucose documented for the scheduled insulin was 377, but the sliding scale blood glucose documented was 350, - On 11/26/24 at 5:00 P.M., the blood glucose		resident 29's out of range blood sugars on 2/11/25. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. The DON/Designee completed a 30 day look back of blood glucose levels and notified the resident's physician of any concerns. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. An in-service held on 2/19/25 held by DON/Designee the following was reviewed: Notifying the physician of out-of-range blood sugars and following physician orders. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. DON/designee will monitor blood glucose levels 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 months. If the facility is within	

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	documented for the scheduled insulin was 420, but the sliding scale blood glucose documented was 340, - On 12/06/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 378, but the sliding scale blood glucose documented was 350, - On 12/07/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 358, but the sliding scale blood glucose documented was 350, - On 12/12/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 400, but the sliding scale blood glucose documented was 350, - On 12/14/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 409, but the sliding scale blood glucose documented was 350, - On 12/15/24 at 12:00 P.M., the blood glucose documented for the scheduled insulin was 563, but the sliding scale blood glucose documented was 349, - On 12/17/24 at 8:00 A.M., the blood glucose documented for the scheduled insulin was 379, but the sliding scale blood glucose documented was 350, - On 12/23/24 at 12:00 P.M., the blood glucose documented for the scheduled insulin was 551, but the sliding scale blood glucose documented was 304, - On 12/23/24 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 337, but the sliding scale blood glucose documented was 373, - On 12/29/24 at 7:00 A.M., the blood glucose documented for the scheduled insulin was 376, but the sliding scale blood glucose documented was 350, - On 01/04/25 at 5:00 P.M., the blood glucose		95% compliance at the end of the 6 months; then monitoring can 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 Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date be completed? Date of Compliance 2/24/25	

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	documented for the scheduled insulin was 376, but the sliding scale blood glucose documented was 350, - On 01/23/25 at 12:00 P.M., the blood glucose documented for the scheduled insulin was 435, but the sliding scale blood glucose documented was 248, and - On 02/01/25 at 5:00 P.M., the blood glucose documented for the scheduled insulin was 415. but the sliding scale blood glucose documented was 350. There was no indication the physician was notified when the blood glucose levels were greater than 350. During an interview on 02/07/25 at 11:26 A.M., LPN 6 (Licensed Practical Nurse) indicated if a resident received sliding scale insulin with a routine insulin and the blood sugar needed to be reported to the physician due to the call parameters then she would call the physician and document in the EMAR and a progress note that the physician was notified. During an interview on 02/10/25 at 10:21 A.M., the DON (Director of Nursing) indicated if a resident had two insulin orders and one of them had parameters to call the physician then the orders should have the same blood glucose levels documented and the physician should be notified if they were outside the call parameters. The current, undated, facility policy titled, "Change in Resident's Condition or Status", was provided by the DON on 02/06/25 at 9:51 A.M. The policy indicated, "...It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status..."			

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	3.1-50(a)(2)			