STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING 00 B. WING	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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 IN00456840, IN00450874, and IN00449780. Complaint IN00456840 - Federal/State deficiencies related to the allegations are cited at F584, F677, and F686 Complaint IN00450874 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00449780 - Federal/State deficiencies related to the allegations are cited at F677, F689, F692, and F804 Survey dates: April 3, 4, 7, 8, and 9, 2025 Facility number: 000443 Provider number: 155820 AIM number: 100289580 Census Bed Type: SNF/NF: 44 Total: 44 Census Payor Type: Medicare: 4 Medicaid: 24 Other: 16 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 17, 2025.	F 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dena kerschenr	RVPO	05/05/2025

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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F 0553 SS=E Bldg. 00	483.10(c)(2)(3) Right to Participate in Planning Care Based on interview and record review, the facility failed to ensure care plan conferences were completed quarterly for 6 of 7 residents reviewed for care plan conferences. (Resident P, Resident S, Resident D, Resident N, Resident B, and Resident F) Findings include: 1. On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy, diabetes mellitus, and major depressive disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/25/25, indicated Resident P was cognitively intact. The most current care plan conference was completed on 10/31/24. 2. On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited, to dementia, repeated falls, and major depressive disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/20/25, indicated that Resident S had severe cognitive impairment. The most current care plan conference was completed on 11/14/24. 3. On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, wedge compression fracture of unspecified lumbar vertebra and unsteadiness on	F 0553	**1) Immediate actions taken for those residents identified:** Resident P has had their individual Care Conference scheduled Resident S has had their individual Care Conference scheduled Resident D has had their individual Care Conference scheduled. Resident N has had their individual Care Conference scheduled Resident B has had their individual Care Conference scheduled Resident F has had their individual Care Conference scheduled . **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. Residents reviewed for missed or New quarterly care conferences. Residents and/or representatives invited to scheduled care conferences. SSD has been educated on ensuring residents have quarterly care conferences scheduled at a minimum and documentation on care conference attendance.	05/06/2025

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	feet. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/18/25, indicated Resident D had severe cognitive impairment. The most current care plan conference was completed on 11/7/24.4. On 4/4/25 at 12:48 P.M., Resident N's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus with diabetic polyneuropathy. The most recent Quarterly MDS assessment, dated 3/20/25, indicated Resident N was cognitively intact. The clinical record lacked a care plan conference since admission. 5. On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, hypertensive encephalopathy. The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact. The clinical record lacked a care plan conference since 10/10/24. 6. On 4/7/25 at 11:57 A.M., Resident F's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension. The most recent Quarterly MDS assessment, dated 2/17/25, indicated Resident F was cognitively intact. The clinical record lacked a care plan conference since admission.		**3) Measures put into place/ System changes:** Residents reviewed for missed or New quarterly care conferences. Residents and/or representatives invited to scheduled care conferences. SSD has been educated on ensuring residents have quarterly care conferences scheduled at a minimum and documentation on care conference attendance. **4) How the corrective actions will be monitored:** The SSD/Designee will audit 5 resident care plans weekly times four weeks, then monthly for 3 months to ensure resident and/or representative invitations have been completed with documentation. The SSD/Designee will audit 5 resident care plans weekly times 4 weeks, then monthly for 3 months to ensure the Care Plan Conferences are being held. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive**	

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	During an interview on 4/8/25 at 1:23 P.M., the Director of Nursing (DON) indicated care plan conferences were held quarterly. On 4/9/25 at 9:19 A.M., care plan conferences held for Resident N, Resident B, and Resident F were requested and not provided. On 4/9/25 at 12:14 P.M., the DON provided a policy titled Comprehensive Care Plans that indicated "The resident and/or representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference (if available) at least quarterly." 3.1-3(n)(3)		**months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination Based on observation, interview, and record review, the facility failed to accommodate a resident's choice of activity for 1 of 2 residents reviewed for choices. A resident's morning care was not completed in time for the resident to attend mass. (Resident P) Finding includes: On 4/4/25 at 9:05 A.M., Resident P indicated she wanted to go to mass, but staff didn't always get her up in time to go. Mass was scheduled daily in the facility at 11:00 A.M. On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy and major depressive disorder.	F 0561	**1) Immediate actions taken for those residents identified:** Resident P has been provided am care and gotten up and attended Mass. Resident P has no signs and/or symptoms of negative outcome. . **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. Nursing staff have been educated on Resident Rights and Choices	05/06/2025

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	The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/24/25, indicated that Resident P was cognitively intact and was dependent on staff (staff does all of the effort) for toileting and bathing. The most current care plan conference was completed on 10/31/24. Care plans were reviewed and updated. A current preferences care plan, initiated 2/12/21, indicated that the resident preferred to get up for the day at 10:00 A.M. or as desired. A current self care deficit care plan, initiated 2/12/21, indicated that the resident required a mechanical lift and the assistance of two staff members for safe transfers. A current activities care plan, initiated 4/15/21, indicated the resident was catholic. On 4/8/25 at 10:14 A.M., CNA 23 indicated that there was never enough staff to get everything done. On 4/8/25 at 11:05 A.M., Resident P was observed in bed in her room. The resident indicated that staff had just completed her shower and she was waiting on staff to get her out of bed with the mechanical lift. On 4/3/25 at 10:05 A.M., the Administrator provided a copy of the Resident Rights, revised 3/15/17, that indicated "You have the right to and the facility must promote and facilitate self-determination through support of resident choice, including: the right to choose activities, schedules...consistent with your interests ... You		Non nursing staff have been educated on Resident Rights and Choices. **3) Measures put into place/ System changes:** Nursing staff have been educated on Resident Rights and Choices Non nursing staff have been educated on Resident Rights and Choices. **4) How the corrective actions will be monitored:** The Interdisciplinary Team will complete 5 resident interviews a week care times four weeks, then 3 times a week for 3 months to ensure resident preferences and/or choices are being followed. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	have a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility". 3.1-3(u)(3)			
F 0572 SS=D Bldg. 00	483.10(g)(1)(16) Notice of Rights and Rules Based on interview and record review, the facility failed to ensure a resident signed admission paperwork and resident rights and was provided a copy for 1 of 3 residents reviewed for new admissions. (Resident L) Finding includes: During an interview on 4/4/25 at 8:36 A.M., Resident L indicated she was unaware of her rights as a resident in the facility, and had not signed or received an admission packet. On 4/7/25 at 8:55 A.M., Resident L's clinical record was reviewed. Resident L was admitted on 3/19/25. Diagnosis included, but was not limited to, malignant neoplasm. The most recent Admission Minimum Data Set (MDS) assessment, dated 3/25/25, indicated Resident L was cognitively intact. An admission packet was signed 3/21/25 by the Social Services Director (SSD) and Resident L. During an interview on 4/8/25 at 1:53 P.M., Resident L stated the signature on the admission packet was not hers.	F 0572	**1) Immediate actions taken for those residents identified:** Resident L has been provided a signed copy of his/her individual resident rights and individual admission paperwork. . **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. The Social Service Director has been educated on providing each Admission paperwork if requested by resident and a copy of the Resident Rights **3) Measures put into place/ System changes:** The Social Service Director has been educated on providing each Admission paperwork if requested by resident and a copy of the Resident Rights. **4) How the corrective actions**	05/06/2025

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	During an interview on 4/9/25 at 9:19 A.M., the SSD indicated residents sign the admission packets electronically and were not provided with a copy unless they request it. On 4/9/25 at 12:14 P.M., the Director of Nursing provided an undated policy titled Documentation Procedures and Guidelines that indicated "Each healthcare professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable." 3.1-4(j)		**will be monitored:** ADM/Designee will complete audits 3 times a week for 4 weeks, then weekly times 8 weeks. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, record review, and interview, the facility failed to provide a safe and sanitary environment for residents, staff, and the public for 11 random observations on 5 of 5 days. Offensive odors were detected in public hallways, alcoves and stairwells (throughout 100-unit hallways, in front of chapel, alcoves on 200 unit, outside of rooms 109 and 113, Holy Family Nurses Station), dirty showers and resident room floors were observed. (Resident P and Resident D) Findings include: 1. On 4/3/25 at 9:30 A.M., during a random observation, the smell of urine was observed on the first floor outside of the chapel. 2. On 4/3/25 at 11:35 A.M., during a random	F 0584	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice.** The urine odor outside the Chapel has been removed. The urine odor outside of room 109 and 113 has been removed. The urine odor throughout the 100 unit. The urine odor was removed in the first floor stairwell.	05/06/2025

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	observation the strong smell of urine was observed outside of room 109 and 113. 3. On 4/4/25 at 10:03 A.M., during a random observation, the strong smell of urine was observed in the hallway outside of the chapel. 4. On 4/7/25 at 8:50 A.M., during a random observation, the strong smell of urine was observed in the hallway in front of the chapel and in the hallways throughout the 100 unit. 5. On 4/8/25 at 9:10 A.M., during a random observation the strong smell of urine was observed in hallways throughout the 100 unit. 6. On 4/9/24 at 8:40 A.M., during a random observation, the strong smell of urine was observed in the first-floor stairwell and coming onto the hallway in front of the chapel. 7. On 4/9/25 at 8:45 A.M., during a random observation, the strong smell of urine was observed in the hallway near Holy Family Nurses Station. 8. On 4/9/25 at 9:06 A.M., during a random observation, the smell of feces was observed in alcoves throughout the second floor.9. In an interview on 4/4/25 at 9:13 A.M., Resident P indicated that staff did not clean her room daily. At that time, brown dried mud was observed on the floor by the bathroom door. On 4/8/25 at 11:05 A.M., Resident P's room was observed to have brown mud stains on the floor by the bathroom door and the shower floor was dirty. 10. In an interview with a family member on 4/3/25		The urine odor was removed from the hallway near Holy Family Nurses Station. The feces odor was removed from the alcoves on the second floor. Resident P's floor in the room and shower room. Resident D's floor in the room and shower room. **How the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have been potential to be affected by this alleged deficient practice. Housekeeping Supervisor has been educated on the Facility's Housekeeping Policy including cleaning floor in the rooms and shower floors. Housekeeping Staff have been educated on the Facility's Housekeeping Policy including cleaning floor in the rooms and shower floors. A Facility wide audit of odors has been completed to determine root cause M**easures the facility will take to ensure that the problem will be corrected and will not recur:** Housekeeping Supervisor has been educated on the Facility's	

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	at 2:30 P.M., it was indicated that Resident D's room was not cleaned enough and they would find food crumbs behind the drawers when visiting. On 4/8/24 at 2:40 P.M., Resident D's room was observed to have food crumbs along the wall. The bathroom floor was sticky by the shower and the shower floor was dirty. On 4/8/25 at 2:45 P.M., Housekeeper 11 indicated that there was not a daily cleaning list. She indicated she was told to clean the resident's sink and toilet, mop the floors if they were dirty, and take the trash out daily. During an interview on 4/9/25 at 3:03 P.M., the Director of Nursing (DON) indicated there should be no offensive smells in the building. On 4/9/25 at 12:14 P.M., the DON provided a current, non-dated policy "Housekeeping Services Policy." The policy indicated "... it was the policy of the facility to maintain a clean, odor free, environment in all health care and public areas, which meet the sanitation needs of the facility for a ...clean...comfortable environment..." On 4/9/24 at 12:14 P.M., the Director of Nursing (DON) provided a current undated Housekeeping Services Policy that indicated "The department shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt and hazards". This citation related to Complaint IN00456840. 3.1-19(f)		Housekeeping Policy including cleaning floor in the rooms and shower floors. Housekeeping Staff have been educated on the Facility's Housekeeping Policy including cleaning floor in the rooms and shower floors. A Facility wide audit of odors has been completed to determine root cause. **Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** Housekeeping Supervisor and or designee will perform 5 observations a week for 12 weeks of resident's rooms, shower floor to assure cleanliness. Housekeeping Supervisor/Designee will perform 5 observations a week for 12 weeks of resident's rooms to ensure floors are clean and shower room floors are clean. Housekeeping Supervisor/Designee will perform 5 observations a week for 12 weeks of showers rooms to ensure cleanliness. IDT will complete 5 interviews a week to ensure resident room floors, shower room floors were maintained in a safe, clean and	

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			sanitary manner. ·The results of the above observations, interviews will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on interview and record review, the facility failed to ensure clinical documentation was sent with a resident during a transfer for 2 of 2 residents reviewed for hospitalizations. (Resident B and Resident D) Findings include: On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, hypertensive encephalopathy. The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact, required partial assistance from staff (staff do half of the work) for toileting and transfers, and required substantial assistance for bathing (staff do more than half of the work). Physician orders included, but were not limited to: Carvedilol oral tablet 12.5 mg (milligrams) give one	F 0622	**How corrective action will be taken for those affected by the alleged deficient practice:** Residents have been interviewed with no negative outcomes noted. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** How the facility identified other residents: All residents who have been transferred or discharged have the potential to be affected by the same alleged deficient practice. Social Service Director and Director of Nursing were in-serviced on requirements of notifying the resident and the resident's representative of the transfer or discharge and the reason for the move in writing, ensure clinical documentation is	05/06/2025

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	tablet by mouth two times a day for hypertension; Start date 2/9/24 Isosorbide Mononitrate ER (extended release) oral tablet 60 mg give one tablet by mouth two times a day for paroxysmal atrial fibrillation; Start date 2/9/24 Lisinopril oral tablet 10 mg give one tablet by mouth two times a day for hypertension; Start date 2/9/24 Resident B was transferred to the hospital on 6/25/24 and 12/8/24. The clinical record lacked documentation of advanced directive information, diagnoses, plan of care, or current medications for the transfer to the hospital on 6/25/24. The clinical record lacked documentation of advanced directive information, diagnoses, plan of care, or current medications for the transfer to the hospital on 12/8/24. A nursing progress note, dated 12/8/24 at 10:04 A.M., indicated the hospital called the facility and requested medication record and advanced directives that were not sent with transfer. During an interview on 4/9/25 at 12:49 P.M. the Director of Nursing (DON) indicated there was no documentation of records sent with the resident during transfers on 6/25/24 or 12/8/24. 2. On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, epileptic seizures, wedge compression fracture of unspecified lumbar vertebra, repeated falls, unsteadiness on feet, and weakness. Resident D was discharged to the		sent with the resident and in a language and manner they understand. And that the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:** Measures put into place/system changes: Social Service Director and Director of Nursing were in-serviced on requirements of notifying the resident and the resident's representative of the transfer or discharge and the reason for the move in writing, ensure clinical documentation is sent with the resident and in a language and manner they understand. And that the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. **Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** How the corrective action will be monitored: DON/Designee will perform 5 random Medical Record reviews a week to ensure the resident and resident representative have been	

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(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
	hospital on 4/4/25 and was anticipated to return. The most recent Quarterly MDS Assessment, dated 2/18/25, indicated Resident D had severe cognitive impairment, required substantial to maximal assistance of staff (staff does more than half of the effort) for toileting, bathing, and transferring, and had 2 or more falls without injury since the prior assessment on 1/6/25. A nursing progress note, dated 4/4/25 at 3:10 P.M., indicated a new order was received to send the resident to the hospital for treatment and evaluation. A nursing progress note, dated 4/4/25 at 3:41 P.M., indicated ambulance staff picked up the resident from the facility and transported him to the hospital for the possibility of "trauma from a fall". A nursing progress note, dated 4/5/25 at 12:52 P.M., indicated that the hospital called the facility to request Resident D's Medication Administration Record (MAR). It was faxed to the hospital at that time. On 4/9/25 at 12:14 P.M., the Director of Nursing (DON) indicated she was unable to find the transfer documents for Resident D's transfer to acute care on 4/4/25. On 4/9/25 at 12:14 P.M., the DON provided a current undated Discharge/Transfer or Resident policy that indicated "Complete Transfer Form accurately and completely including vital signs ... Ensure that resident's current physical and psycho/social assessment, medications and current treatment is completely described and available to the receiving facility upon transfer.		provided written notice of transfer. ADM/Designee will perform 5 random audits to ensure the Ombudsman have been notified monthly of resident transfer. **The results of these interviews will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	Assure required "notices" (DNR, Will, POA) are sent with the resident". 3.1-12(a)(3) 3.1-12(a)(5)(A) 3.1-12(a)(6)(B)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure a notice of transfer was provided to the ombudsman for 1 of 2 residents reviewed for hospital transfers. (Resident B) Finding includes: On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, hypertensive encephalopathy. The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact, required partial assistance from staff (staff do half of the work) for toileting and transfers, and required substantial assistance for bathing (staff do more than half of the work). Resident B was transferred to the hospital on 6/25/24, 9/8/24, and 12/8/24. A list of transfers and discharges for June, September, and December 2024 sent to the ombudsman was requested, but failed to be provided. During an interview on 4/9/25 at 12:49 P.M., the Director of Nursing (DON) indicated there was no notification to ombudsman for June, September, or	F 0623	**How corrective action will be taken for those affected by the alleged deficient practice:** Residents have been interviewed with no negative outcomes noted. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** How the facility identified other residents: All residents who have been transferred or discharged have the potential to be affected by the same alleged deficient practice. Social Service Director and Director of Nursing were in-serviced on requirements of notifying the resident and the resident's representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. And that the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. **The measures the facility will**	05/06/2025

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	December 2024 transfers. On 4/9/25 at 12:14 P.M., the DON provided an undated policy titled Discharge/Transfer of Resident that indicated "Review and adhere to current federal regulations as found in resident rights and transfer and discharge policies.. Inform all departments of anticipated and actual discharge.. Assure required noticies are sent with the resident".		**take or systems the facility will alter to ensure that the problem will be corrected and will not occur:** Measures put into place/system changes: Social Service Director and Director of Nursing were in-serviced on requirements of notifying the resident and the resident's representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. And that the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. **Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** How the corrective action will be monitored: DON/Designee will perform 5 random Medical Record reviews a week to ensure the resident and resident representative have been provided written notice of transfer. ADM/Designee will perform 5 random audits to ensure the Ombudsman have been notified monthly of resident transfer. **The results of these interviews will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is**	

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			achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure a bed hold was provided upon transfer for 2 of 2 residents reviewed for hospitalizations. (Resident B and Resident D) Finding includes: 1. On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, hypertensive encephalopathy. The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact, required partial assistance from staff (staff do half of the work) for toileting and transfers, and required substantial assistance for bathing (staff do more than half of the work). Resident B was transferred to the hospital on 6/25/24 and 12/8/24. The clinical record lacked documentation of a bed hold provided for the transfer to the hospital on 6/25/24. The clinical record lacked documentation of a bed hold provided for the transfer to the hospital on 12/8/24.	F 0625	**How corrective action will be taken for those affected by the alleged deficient practice:** Residents have been interviewed with no negative outcomes noted. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** How the facility identified other residents: All residents who have been transferred or discharged have the potential to be affected by the same alleged deficient practice. Social Service Director and Director of Nursing, Nursing Staff were in-serviced on requirements of notifying the resident and the resident's representative of the transfer or discharge and the reason for the move in writing, ensure clinical documentation including Bed Hold Policy is sent with the resident upon transfer/discharge. **The measures the facility will take or systems the facility will alter to ensure that the**	05/06/2025

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	During an interview on 4/9/25 at 12:49 P.M. the Director of Nursing (DON) indicated there was no documentation of records sent with the resident during transfers on 6/25/24 or 12/8/24. 2. On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, epileptic seizures, wedge compression fracture of unspecified lumbar vertebra, repeated falls, unsteadiness on feet, and weakness. Resident D was discharged to the hospital on 4/4/25 and was anticipated to return. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/18/25, indicated Resident D had severe cognitive impairment, required substantial to maximal assistance of staff (staff does more than half of the effort) for toileting, bathing, and transferring, and had 2 or more falls without injury since the prior assessment on 1/6/25. A nursing progress note, dated 4/4/25 at 3:10 P.M., indicated a new order was received to send the resident to the hospital for treatment and evaluation. A nursing progress note, dated 4/4/25 at 3:41 P.M., indicated ambulance staff picked up the resident from the facility and transported him to the hospital for the possibility of "trauma from a fall". On 4/9/25 at 12:14 P.M., the Director of Nursing (DON) indicated she was unable to find the bedhold document for Resident D's transfer to acute care on 4/4/25. On 4/9/25 at 12:14 P.M., the DON provided a current undated Discharge/Transfer or Resident policy that indicated "Complete Transfer Form		**problem will be corrected and will not occur:** Measures put into place/system changes: Social Service Director and Director of Nursing, Nursing Staff were in-serviced on requirements of notifying the resident and the resident's representative of the transfer or discharge and the reason for the move in writing, ensure clinical documentation including Bed Hold Policy is sent with the resident upon transfer/discharge. **Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** How the corrective action will be monitored: DON/Designee will perform 5 random Medical Record reviews a week to ensure the resident and resident representative have been provided written notice of transfer & bed hold policy. **The results of these interviews will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	accurately and completely including vital signs ... Assure required "notices"...are sent with the resident". 3.1-12(a)(25) 3.1-12(a)(26)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) Assessment was completed accurately for 1 of 1 residents reviewed for weight loss. (Resident S) Finding includes: On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, diabetes mellitus, and dysphagia. The most current Annual Minimum Data Set (MDS) Assessment, dated 2/5/25, indicated Resident S had severe cognitive impairment, required setup assistance from staff for eating, weighed 179 pounds (lbs), and had no weight loss. The most current Quarterly MDS Assessment, dated 2/20/25, indicated Resident S had severe cognitive impairment, required setup assistance from staff for eating, weighed 132 lbs, and had no weight loss. A review of the weights and vitals tab indicated Resident S was weighed on the following days: - 1/3/25 - 179.3 lbs standing - 2/18/25 - 131.7 lbs wheelchair (a 26.55% weight loss)	F 0641	**How corrective action will be taken for those affected by the alleged deficient practice:** Resident S's MDs has been modified **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by the same alleged deficient practice. The MDS/CP Coordinator has been educated on accurately completing the MDS assessment **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:** The MDS/CP Coordinator has been educated on accurately completing the MDS assessment. **Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** ADM/Designee will perform 5 MDS reviews a week for 4 weeks, then 3 times a week for 8 weeks.to	05/06/2025

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	On 4/8/25 at 2:51 P.M., CNA 18 weighed Resident S. The resident weighed 162.8 lbs including the wheelchair weight. The wheelchair's weight was 39.5 lbs. CNA 18 confirmed Resident S currently weighed 123.3 lbs (a 6.38% weight loss since 2/18/25 and a 31.23% weight loss since 1/3/25). On 4/9/25 at 9:19 A.M., the MDS Coordinator indicated that the resident had a weight loss and it should have been coded as such on the Quarterly MDS Assessment. On 4/9/25 at 12:50 P.M., the Director of Nursing (DON) indicated the facility followed the Resident Assessment Instrument (RAI) Manual as a policy for MDS coding. 3.1-31(d)		ensure MDS accuracy **The results of these interviews will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons Based on record review and interview, the facility failed to ensure Qualified Medication Aides (QMA) practiced within the QMA scope of practice for 2 of 5 residents reviewed for unnecessary medications. (Resident U and Resident P) Findings include: 1. On 4/7/25 at 12:29 P.M., Resident U's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 diabetes mellitus. The most recent Admission Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident U was moderately cognitively intact.	F 0659	**How corrective action will be taken for those affected by the alleged deficient practice:** Resident U has been assessed with no negative outcome. Resident P has been assessed with no negative outcome. QMA's have been educated on the QMA Scope of Practice. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by the same alleged deficient practice. QMA's have been educated on the	05/06/2025

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	Physician orders included, but were not limited to: Hydrocodone-acetaminophen (pain medication) oral tablet 7.5-325 mg (milligrams) give one tablet by mouth every four hours as needed for pain for 30 days; Start date 3/18/25. The following days indicate a QMA administered Hydrocodone-acetaminophen 7.5-325 mg tablet without prior authorization from a nurse: - 3/24/25 7:02 P.M. - 3/28/25 9:37 A.M. - 3/29/25 3:41 P.M. 2. On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy, diabetes mellitus, and pain. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/24/25, indicated Resident P was cognitively intact and received insulin and an opioid during the 7-day look back period. Current physician orders included, but were not limited to: - Admelog SoloStar (a fast-acting insulin) 100 units per milliliter (ml) solution - Inject as per sliding scale: 0 - 140 = 0; 141 - 180 = 2; 181 - 240 = 4; 241 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401 - 450 = 12 re-check in one hour, subcutaneously before meals and at bedtime related to diabetes mellitus, dated 1/1/25 - Hydrocodone-acetaminophen (an opioid pain medication) tablet 5-325 milligrams (mg) - Give one		QMA Scope of Practice **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:** QMA's have been educated on the QMA Scope of Practice. **Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** DON/Designee will perform 5 Medical Records reviews a week for 4 weeks, then 3 times a week for 8 weeks.to ensure QMA's follow the Scope of Practice **The results of these interviews will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	tablet by mouth every four hours as needed (PRN) for moderate pain, dated 12/31/24. - Hydrocodone-acetaminophen tablet 5-325 mg - Give two tablets by mouth every four hours PRN for severe pain, dated 12/31/24 - Excedrin (a pain medication) Migraine Oral Tablet 250-250-65 mg (Aspirin-Acetaminophen-Caffeine) - Give one tablet by mouth every 24 hours PRN for migraine, dated 3/19/24 Tylenol (a pain medication) Extra Strength Tablet 500 mg - Give two tablets by mouth every eight hours PRN for pain, dated 8/28/23 The Medication Administration Record (MAR) for March and April 2025 was reviewed. Qualified Medication Aide (QMA) 5 administered Admelog insulin on the following days: - 3/28/25 7:00 A.M. dose - 4/2/25 8:00 P.M. dose - 4/3/25 8:00 P.M. dose QMA 5 administered a PRN dose of hydrocodone-acetaminophen without prior authorization from a nurse on 4/3/25 5:12 P.M. QMA 5 administered a PRN dose of Tylenol without prior authorization from a nurse on 3/28/25 at 12:04 P.M. QMA 3 administered a PRN dose of hydrocodone-acetaminophen without prior authorization from a nurse on the following days: - 3/2/25 at 9:47 A.M. - 3/11/25 at 9:29 A.M. - 3/18/25 at 6:56 A.M.			

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	- 3/20/25 at 7:03 A.M. - 3/27/25 at 8:27 A.M. - 3/31/25 at 6:39 A.M. QMA 15 administered a PRN dose of hydrocodone-acetaminophen without prior authorization from a nurse on the following days: - 3/4/25 at 2:58 P.M. - 3/19/25 at 8:18 P.M. - 3/20/25 at 7:21 P.M. - 3/21/25 at 7:19 P.M. - 3/24/25 at 8:27 P.M. - 4/4/25 at 7:26 P.M. QMA 15 administered a PRN dose of Excedrin without prior authorization from a nurse on the following days: - 3/6/25 at 8:04 P.M. - 3/13/25 at 4:00 P.M. On 4/8/25 at 9:22 A.M., the Director of Nursing (DON) indicated that the corporate policy of the facility did not allow QMAs to administer insulin even if they were insulin certified. On 4/9/25 at 9:00 A.M., the QMA Scope of Practice was reviewed. It indicated "Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D)			

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	Ensure that the resident ' s record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty". On 4/9/25 at 12:14 P.M., the DON provided a current QMA job description, dated 3/23/17, that indicated "Essential Duties and Responsibilities: ...Administers and documents medications given by following specifically written physician orders including oral, topical, and suppository medications, as well as eye and ear drops ... Maintains compliance to all personnel policies, established community policies and procedures, and Federal and State regulations and standards...". 3.1-35(g)(2)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to ensure residents dependent on staff for ADLs (activities of daily living) were showered and hair was shampooed for 9 of 10 residents reviewed for ADL care. (Resident P, Resident S, Resident G, Resident D, Resident B, Resident N, Resident F, Resident L, and Resident U) Findings include: 1. During an interview on 4/4/25 at 9:03 A.M., Resident P indicated that she only got a shower once a week most weeks. She preferred a shower because staff didn't wash her hair when they gave her a bed bath. She indicated that she was told they were short staffed and sometimes didn't have time to get her up for a shower. She indicated that	F 0677	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident P has received a shower Resident S has received a shower Resident G has received a shower Resident D has received a shower Resident B has received a shower Resident N has received a shower Resident F has received a shower Resident U has received a shower. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to	05/06/2025

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	there was no one in the facility to cut her hair and that her family tried to fill that role. At that time, Resident P's hair was observed to be oily. On 4/7/25 at 12:35 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy, diabetes mellitus, and major depressive disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/25/25, indicated Resident P was cognitively intact and was dependent on staff (staff does all of the effort) for bathing and toileting. The most current care plan conference was completed on 10/31/24. Care plans were reviewed and updated at that time. A current preferences care plan, initiated 2/12/21, indicated Resident P preferred showers twice weekly in the morning. A Point of Care (a charting system for CNAs) Tasks Response Form for showers indicated Resident P preferred showers on Tuesday and Friday day shift. Showers for the past 30 days were reviewed. Showers were not received on the following dates: 3/11/25 3/21/25 2. On 4/3/25 at 11:32 A.M., Resident S was observed sleeping in her wheelchair in the hallway. Her hair was observed to be disheveled and unbrushed. She was noted to smell like urine. On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, repeated falls, and		be affected by this alleged deficient practice. Nursing Staff have been re-educated on the Facility's Bathing Shower and Tub Bath. A new Shower Process has been implemented. Nursing Staff has been educated on the New Shower Process. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing Staff have been re-educated on the Facility's Bathing Shower and Tub Bath. A new Shower Process has been implemented. Nursing Staff has been educated on the New Shower Process. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Interdisciplinary Team will complete 5 resident interviews a week for 12 weeks to ensure showers are being provided. Identified concerns will be addressed timely and discussed in scheduled morning meetings. The results of these audits will be reviewed in Quality Assurance	

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	155820	A. BUILDING 00 B. WING	04/09/2025

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	major depressive disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/20/25, indicated that Resident S had severe cognitive impairment and required substantial to maximal assistance from staff (staff does more than half of the effort) for bathing and toileting. The most current care plan conference was completed on 11/14/24. Care plans were reviewed and updated at that time. A current preferences care plan, initiated 6/16/21, indicated Resident S preferred showers twice a week. An ADL care plan, initiated 5/29/24, indicated the resident needed substantial to maximal assistance with showers, and if the resident resisted care, to return five to ten minutes later and try again. A self care deficit care plan, initiated 6/16/21, indicated to staff to perform hair care daily and upon rising from nap. A Point of Care Tasks Response Form for showers indicated Resident P preferred showers on Tuesday and Friday evenings. Showers for the past 30 days were reviewed. Showers were not received on the following dates: 3/11/25 3/14/25 3/18/25 3/21/25 received a bed bath without shampoo 3/25/25 3/28/25 3. During an interview on 4/3/25 at 11:44 A.M., Resident G indicated she was the last person to		Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	get up in the morning and she didn't want to be the last person to get up. She indicated that she only got bed baths and they never washed her hair during the bed bath. She indicated that she had just gotten a bed bath and her hair was not washed. At that time, Resident G's hair was observed to be in a braid, dry, and disheveled. On 4/7/25 at 11:16 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, cerebral infarction, and depression. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 3/17/25, indicated that Resident G had mild cognitive impairment and was dependent on staff (staff does all of the effort) for bathing and toileting. The most current care plan conference was completed on 2/27/25. Care plans were reviewed and updated at that time. A current preferences care plan, initiated 2/23/24, indicated Resident G preferred showers twice a week in the morning. A Point of Care Tasks Response Form for showers indicated Resident P preferred showers on Tuesday and Thursday day shift. Showers for the past 30 days were reviewed. Showers were not received on the following dates: 3/11/25 3/13/25 3/18/25 received a bed bath without shampoo 3/20/25 received a bed bath without shampoo 3/25/25 3/27/25 4. During an interview on 4/3/25 at 2:29 P.M.,			

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	Resident D's family member indicated that since there was no one in the facility to cut the residents hair, he cut Resident D's hair. A few weeks ago, Resident D had sustained a fall that required staples to his head. Five days after the resident received the staples, the family member visited Resident D and attempted to cut his hair. He indicated that there was still blood behind his ears like he hadn't been showered well since the incident. On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, wedge compression fracture of unspecified lumbar vertebra and unsteadiness on feet. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/18/25, indicated Resident D had severe cognitive impairment, required substantial to maximal assistance of staff (staff does more than half of the effort) for bathing and toileting, and had two or more falls without injury since the prior assessment. The most current care plan conference was completed on 11/7/24. Care plans were reviewed and updated at that time. A current preferences care plan, initiated 2/14/24, indicated Resident D preferred showers twice a week. An ADL care plan, initiated 1/27/25, indicated the resident needed substantial to maximal assistance with showers, and if the resident resisted care, to return five to ten minutes later and try again. A Point of Care Tasks Response Form for showers indicated Resident P preferred showers			

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	on Monday and Thursday day shift. Showers for the past 30 days were reviewed. Showers were not received on the following dates: 3/10/25 received a bed bath without shampoo 3/13/25 3/20/25 received a bed bath with shampoo 3/24/25 3/27/25 received a bed bath with shampoo 3/31/25 On 4/8/25 at 10:14 A.M., CNA 23 indicated that there was never enough staff to get everything done. 5. On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, hypertensive encephalopathy. The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact, required partial assistance from staff (staff do half of the work) for toileting and transfers, and required substantial assistance for bathing (staff do more than half of the work). Resident B's Activities of Daily Living (ADL) tasks indicated bathing was preferred on Tuesdays and Fridays. During the last 30 days, Resident B did not receive showers during the following dates: 3/11/25 3/21/25 3/25/25 6. On 4/4/25 at 12:48 P.M., Resident N's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus with diabetic polyneuropathy.			

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	The most recent Quarterly MDS assessment, dated 3/20/25, indicated Resident N was cognitively intact, required substantial assistance from staff (staff do more than half of the work) for bathing and transfers, was at risk for pressure ulcers, and had no pressure ulcers. Resident N's Activities of Daily Living (ADL) tasks indicated bathing was received on Monday and Thursday. During the last 30 days, Resident N did not receive showers during the following dates: 3/17/25 3/24/25 3/27/25 3/31/25 4/3/25 7. On 4/7/25 at 11:57 A.M., Resident F's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension. The most recent Quarterly MDS assessment, dated 2/17/25, indicated Resident F was cognitively intact, required partial assistance (staff do half of the work) for showers and substantial assistance for transfers to the shower. Resident F's Activities of Daily Living (ADL) tasks indicated bathing was preferred on Monday and Thursday. During the last 30 days, Resident F did not receive showers during the following dates: 3/13/25 3/17/25 3/24/25 3/27/25 4/7/25			

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8. During an observation on 4/4/25 at 8:59 A.M., Resident L's hair appeared unkempt and her fingernails were long and yellow tinged. Resident L indicated she had not had her hair washed since admission.

On 4/7/25 at 8:55 A.M., Resident L's clinical record was reviewed. Resident L was admitted on 3/19/25. Diagnosis included, but was not limited to, malignant neoplasm.

The most recent Admission Minimum Data Set (MDS) assessment, dated 3/25/25, indicated Resident L was cognitively intact and required partial assistance (staff do half of the work) for toileting and bathing.

Resident L's Activities of Daily Living (ADL) tasks indicated Resident L had zero days documented for shampoo during bathing since admission.

9. On 4/7/25 at 12:29 P.M., Resident U's clinical record was reviewed. Resident U was admitted on 3/18/25. Diagnosis included, but was not limited to, type 2 diabetes mellitus.

The most recent Admission Minimum Data Set (MDS) assessment, dated 3/24/25, indicated Resident U was moderately cognitively intact, required substantial assistance for bathing (staff do more than half of the work), was dependent on staff for toileting (staff do all of the work), and required partial assistance for transfers (staff do at least half of the work).

Resident U's Activities of Daily Living (ADL) tasks indicated bathing was received on Monday and Thursday.

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	During the last 30 days, Resident U did not receive showers during the following dates: 3/24/25 3/27/25 3/31/25 4/3/25 During an interview on 4/9/25 at 10:14 A.M., the Director of Nursing (DON) indicated the interdisciplinary team was aware ADL's such as showers not being given were an ongoing concern and indicated there was not a specific person in charge of making sure showers were given, and that ADL's not being performed was an ongoing issue during the last year. On 4/9/25 at 12:14 P.M., the DON provided a policy titled Bathing Shower and Tub Bath, revised 1/18, that indicated "A shower, tub bath or bed/sponge bath will be offered according to resident's preferences two times per week or according to the resident's preferred frequency and as needed or requested." This citation relates to Complaint IN00456840 and Complaint IN00449780. 3.1-38(a)(3)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on interview, record review, and observation, the facility failed to identify the potential for the development of pressure ulcers, perform routine skin checks, and follow the plan of care to promote wound healing for 2 of 2 residents reviewed for facility acquired heel	F 0686	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice.** Resident N has had a skin	05/06/2025

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	wounds. (Resident F, Resident F) Findings include: 1. During an interview on 4/4/25 at 2:29 P.M., Resident N was observed to have a wound vac (a medical device that uses negative pressure to promote wound healing) on his right heel. Resident N indicated it started out as a blister and developed larger requiring surgical debridement and a skin graft. Resident N indicated the wound resulted in him staying in the facility longer than anticipated. On 4/4/25 at 12:48 P.M., Resident N's clinical record was reviewed. Resident N was admitted on 11/29/24 for therapy following a recent fracture surgery. Diagnosis included, but was not limited to, diabetes mellitus with diabetic polyneuropathy. An Admission Minimum Data Set (MDS) assessment, dated 12/29/24, indicated Resident N was cognitively intact, required partial assistance (staff do at least half of the work) to roll left to right, required substantial assistance (staff do more than half of the work) for bathing, transfers, putting on and taking off footwear, and performing personal hygiene, and was at risk for pressure ulcers but had no pressure ulcers. The clinical record lacked a comprehensive care plan related to Resident N's risk for pressure ulcer development. The clinical record lacked weekly skin observations from 11/29/24 to 1/8/25. A weekly skin observation, dated 1/8/25 at 2:49 P.M., indicated Resident N had a skin concern of		assessment completed Resident N's Care Plan has been updated to include an at risk for pressure ulcer development Resident F's treatment has been administered Resident F's Care Plan has been updated to include an at risk for pressure ulcer development **How the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents with pressure ulcer or potential for pressure ulcers have the potential to be affected by the alleged deficient practice. Nursing staff have been educated on the Facility's pressure ulcer prevention policy, the Facility's Pressure ulcer policy including completing weekly skin assessments. A complete Skin Assessment has been completed on residents, with Physician notification completed on any new skin impairment identified, any new orders followed, a new the Plan of Care reviewed and updated accordingly. MDS/CP Coordinator has been educated on implementation of "At Risk "Care Plans" as appropriate.	

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	the pressure injury to the right heel and "skin concerns observed are not new." A skin wound report, dated 1/8/25, indicated Resident N had developed a new in-house acquired pressure injury to the right heel. Measurements of the wound were: length 6 cm (centimeters), width 8 cm, and depth 0.2 cm, and staging was left blank. A medication order was started on 1/9/25 for ascorbic acid 500 mg (milligrams) tablet give one tablet by mouth one time a day for wound healing, and was discontinued on 1/23/25. A treatment order was started on 1/9/25 that indicated to cleanse area with wound cleanser and pat dry, skin prep peri-wound area and allow to completely dry, cover wound bed with honey alginate (a type of wound dressing that combines the properties of honey and calcium alginate, works by absorbing wound fluid, forming a gel that helps maintain a moist environment conducive to healing and potentially supporting the removal of necrotic tissue), cover with ABD (abdominal) pad and wrap with Kerlix (gauze wrap) every day shift for pressure injury to right heel, and was discontinued on 1/23/25. A wound evaluation, dated 1/13/25, indicated Resident N's right heel wound was an unstageable deep tissue pressure injury. The evaluation indicated to float the residents heels. A nursing progress note on 1/18/25 at 9:09 P.M., indicated Resident N was sent to the hospital for coffee ground emesis. 2. During an interview on 4/7/25 at 10:59 A.M., Resident F indicated that he was admitted for		**Measures the facility will take to ensure that the problem will be corrected and will not recur:** Nursing staff have been educated on the Facility's pressure ulcer prevention policy, the Facility's Pressure ulcer policy including completing weekly skin assessments. A complete Skin Assessment has been completed on residents, with Physician notification completed on any new skin impairment identified, any new orders followed, a new the Plan of Care reviewed and updated accordingly. MDS/CP Coordinator has been educated on implementation of "At Risk "Care Plans" as appropriate. **Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** DON/Designee will perform Medical Record Reviews 5 times a week for 4 weeks, then 3 times a week for 8 weeks to ensure weekly skin assessments are completed. DON/Designee will perform	

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	therapy from a wreck but stayed at the facility due to the wound on his foot, and he believed was not healed yet due to the dressing not being changed. On 4/7/25 at 11:57 A.M., Resident F's clinical record was reviewed. Resident F was admitted on 11/18/24. Diagnosis included, but was not limited to, hypertension. An Admission MDS assessment, dated 11/26/24, indicated Resident F was cognitively intact, was dependent (staff do all of the work) for putting on and taking off footwear, required substantial assistance from staff (staff do more than half of the work) for bathing and transfers, required partial assistance (staff do at least half of the work) to roll left to right, was at risk for pressure ulcers, and had no unhealed pressure ulcers. A skin wound report, dated 12/18/24, indicated Resident F had developed a new in-house acquired pressure injury to the left heel. Measurements of the wound were: length 2.5 cm (centimeters), width 7 cm, and was a deep tissue injury. A care plan was created on 12/19/24 and indicated I have a pressure injury to my left heel related to immobility. The care plan lacked at risk for developing skin breakdown monitoring prior to pressure ulcer development. A treatment order was started on 1/3/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, apply skin prep peri-wound area and allow to completely dry, apply honey impregnated calcium alginate to wound bed and cover with ABD (abdominal) pad		Medical Record Reviews 5 times a week for 4 weeks, then 3 times a week for 8 weeks to ensure Plan of Care is updated accordingly. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x3months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	and wrap with Kerlix (gauze wrap) every day shift for pressure injury to left heel, and was discontinued on 1/13/25. The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused: 1/4/25 1/13/25 A physician progress note, dated 1/3/25, indicated Resident F had been working with therapy and was using the parallel bar, but now had a heel ulcer and unable to walk as much. A treatment order was started on 1/21/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, apply skin prep peri-wound area and allow to completely dry, apply honey alginate to wound bed, cover with ABD pad, wrap with Kerlix and secure with medical tape, every day shift for pressure injury to left heel, and was discontinued on 1/28/25. The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused: 1/23/25 1/25/25 A treatment order was started on 1/29/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry. Apply skin prep peri-wound area and allow to completely dry. Paint area with betadine and allow to dry, cover with ABD pad, wrap with Kerlix and secure with medical tape every day shift for pressure injury to left heel, and was discontinued on 2/24/25.			

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	The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused: 2/7/25 2/8/25 2/14/25 2/21/25 The most recent Quarterly MDS assessment, dated 2/17/25, indicated Resident F was cognitively intact, required partial assistance (staff do half of the work) for showers and putting on and taking off foot wear, and substantial assistance for transfers to the shower, was at risk for pressure ulcers, and had an unstageable pressure ulcer. A treatment order was started on 2/25/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, apply skin prep peri-wound area and allow to completely dry, cut to fit honey alginate and place in wound bed, cover with ABD pad, wrap with Kerlix and secure with medical tape, and was discontinued on 3/17/25. The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused: 3/4/25 3/9/25 A medication order was started on 3/12/25 that indicated cephalexin (antibiotic) capsule 500 MG (milligrams) give one capsule by mouth three times a day for (foot wound) infection for 10 days, and was discontinued on 3/22/25.			

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A treatment order was started on 3/18/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, apply skin prep peri-wound area and allow to completely dry, apply layer of Manuka Honey to wound bed, place calcium alginate over wound bed, cover with Hydra Lock dressing, cover with ABD pad, wrap with Kerlix and secure with medical tape, every day shift for pressure injury to left heel, and was discontinued on 3/31/25.

The following dates in the electronic treatment administration record (TAR) indicated Resident F's wound treatment was not changed and was not refused:
3/21/25

A treatment order was started on 3/31/25 that indicated enhanced barrier precautions: staff to wear gown and gloves during all high contact resident care activities every shift for surgical site to right heel.

The most recent wound measurements, dated 3/31/25, indicated Resident F's left heel wound measured 2 cm length, 2 cm width, and 0.3 cm depth.

A treatment order was started on 4/1/25 that indicated cleanse area (left heel) with wound cleanser, gently pat dry, skin prep peri-wound and allow to completely dry, cover wound bed with HydraLock (an absorbent dressing) dressing, cover with ABD (abdominal) pad, wrap with Kerlix (gauze bandage), and secure with medical tape every day shift for pressure injury to left heel.

The following dates in the electronic treatment administration record (TAR) indicated Resident

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	155820	A. BUILDING 00 B. WING	04/09/2025

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	F's wound treatment was not changed or refused: 4/1/25 4/8/25 During an interview on 4/8/25 at 1:23 P.M. the Director of Nursing (DON) indicated staff should be following physician's orders as written. During an observation on 4/9/25 at 11:40 A.M., Resident F was observed with a dressing, dated 4/7, around his left foot. On 4/9/25 at 12:14 P.M., the DON provided a policy titled Pressure Ulcer Prevention, revised 1/15/18, indicated "The purpose: to prevent pressure sores/ pressure injury. Maintain clean/dry skin.. inspect the skin several times daily. Use positioning devices to reduce pressure.. (provide) supplements as ordered". This citation relates to complaint IN00456840. 3.1-40(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to follow fall protocol, revise care plans, and follow interventions to reduce the risk of falls for 2 of 2 residents reviewed for falls. (Resident D and Resident S) Findings include: 1. During a confidential interview during the survey, it was indicated that Resident D had fallen a lot while attempting to self toilet because when he pushed his call light no one came to help him to the bathroom.	F 0689	**How corrective action will be taken for those affected by the alleged deficient practice:** Resident D's Fall interventions have been implemented Resident D's Plan of Care has been reviewed and updated accordingly Resident S's Fall interventions have been implemented. Resident S's Plan of Care	05/06/2025

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	On 4/4/25 at 1:26 P.M., Resident D was observed sitting by himself in his wheelchair in his room eating. The call light was wrapped around the bed rail and was not clipped to or within reach of the resident. There was not a dycem in his wheelchair. The resident was wearing socks without nonskid bottoms. Non skid strips were not observed anywhere in the resident's room. On 4/7/25 at 2:40 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, epileptic seizures, wedge compression fracture of unspecified lumbar vertebra, repeated falls, unsteadiness on feet, and weakness. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/18/25, indicated Resident D had severe cognitive impairment, required substantial to maximal assistance of staff (staff does more than half of the effort) for toileting, bathing, and transferring, and had 2 or more falls without injury since the prior assessment on 1/6/25. The last care plan conference was completed on 11/7/24. Care plans were reviewed and updated at that time. A current high fall risk care plan, initiated 2/17/24, included the following interventions: Anticipate and meet residents needs, dated 2/17/24 Be sure residents call light is within reach and encourage resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, 2/17/24 Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in wheel		has been reviewed and updated accordingly. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by the same deficient practice. Nursing staff have been educated on the Facility's Fall Protocol, including following interventions. MDS/CP Coordinator has been educated on Revision of the Care Plans with Fall interventions **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:** Nursing staff have been educated on the Facility's Fall Protocol, including following interventions. MDS/CP Coordinator has been educated on Revision of the Care Plans with Fall interventions. **Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** DON/Designee will perform 5 observations a week for 4 weeks then 3 times a week for 8 weeks of Fall interventions to ensure implementation. DON/Designee will perform 4 Medical Record reviews a week for 4 weeks, then 3 times a week for 8 weeks to ensure Fall	

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	chair, dated 2/17/24 Follow facility fall protocol if fall occurs, dated 2/17/24 Notify family and physician of all falls, dated 2/17/24 Physical Therapy (PT) and Occupational Therapy (OT) evaluations and treatments as ordered and as needed (PRN), dated 2/17/24 The resident needs activities that minimize the potential for falls while providing diversion and distraction, dated 2/17/24 Resident placed on night shift get up list as he is an early riser, dated 3/5/24 Call light clip placed on call light and staff educated to clip call light to resident clothes or chair so resident can easily find call light, dated 3/24/24 Ensure resident is toileted prior to resident going to bed, dated 4/21/24 Anti-rollbacks to wheelchair, dated 6/8/24 Anti-tippers to wheelchair, dated 6/11/24 "Call, Don't Fall" signs in room and in bathroom as reminder for him to call before he attempts to get up unassisted, dated 6/19/24 Dycem to wheelchair, dated 6/23/24 Fall mat to be placed at bedside when he is in bed, dated 6/25/24 Reach out to Medical Doctor (MD) for a sleep aide, dated 6/29/24 Offer sleep aide, dated 6/29/24 Staff to offer resident assistance to recliner to rest after lunch, dated 7/5/24 Therapy to adjust anti-rollbacks on resident's wheelchair, dated 7/15/24 Resident is not to be left in his room in his wheelchair unattended, dated 8/6/24 Re-educate nursing staff that resident is not to be left alone in room alone in wheelchair, dated 9/9/24 Ensure resident is toileted before and after each meal, dated 11/13/24		interventions are updated on the Care Plan. **The results of these interviews will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	Reinforce to nursing staff that resident is not to be left alone in room while in wheelchair, dated 11/27/24 Keep personal belongings within reach of resident, dated 1/6/25 Staff to encourage resident to sleep in his bed at night instead of recliner, dated 1/23/25 "Call, Don't Fall" sign placed in public restroom next to pantry on first floor, dated 2/3/25 Bolster mattress placed on bed to prevent resident from rolling out of bed while sleeping, dated 3/10/25 The clinical record indicated Resident D fell 23 times in the past year. Fall 1 On 5/22/24 at 5:30 P.M., Resident D had an unwitnessed fall while attempting to self transfer between the wheelchair and bed. He was found sitting on the floor in his room in front of his wheelchair and bed. The clinical record lacked an Interdisciplinary Team (IDT) note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 5/22/24, indicated Resident D was at high risk for falls. Fall 2 On 5/23/24 at 2:17 P.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA heard a noise coming from the resident's room and went to check on the resident. The resident was sitting in his wheelchair in the bathroom next to the toilet. The resident indicated that he fell down and put himself back into his wheelchair. The nurse assessed the resident. The physician and responsible party were not notified about that fall.			

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	The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment was not completed. Fall 3 On 6/8/24 at 8:25 A.M., Resident D had an unwitnessed fall while attempting to close the door in his room. The IDT reviewed that fall on 6/11/24. "Anti-rollbacks to wheelchair" was added to the care plan. A fall risk assessment, dated 6/8/24, indicated Resident D was at high risk for falls. Fall 4 On 6/11/24 at 8:09 P.M., Resident D had an unwitnessed fall while attempting to self toilet. He was found lying on his bathroom floor in front of his wheelchair. The IDT reviewed that fall on 6/11/24. "Anti-tippers to wheelchair" was added to the care plan. A fall risk assessment was not completed. Fall 5 On 6/12/24 at 1:42 A.M., Resident D had an unwitnessed fall while attempting to self toilet. He was found sitting on the bathroom floor. The physician and responsible party were not notified about that fall. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment was not completed. Fall 6 On 6/19/24 at 10:35 A.M., Resident D had an			

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	unwitnessed fall while attempting to self toilet. A CNA responded to a call light in the resident's room and found the resident lying on the floor on his right side with his feet towards the door of the bathroom. The resident complained of bilateral hip pain. The physician was notified, and an order was received for an x-ray of the hip and pelvis. The results of that x-ray were negative. The IDT reviewed that fall on 6/21/24. "Call, Don't Fall signs in room and in bathroom as reminder for him to call before he attempts to get up unassisted" was added to the care plan. A fall risk assessment, dated 6/19/24, indicated Resident D was at high risk for falls. Fall 7 On 6/23/24 at 8:35 A.M., Resident D had an unwitnessed fall while in his room. The resident was found on his knees on the floor in front of his bed. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 6/23/24, indicated Resident D was at high risk for falls. Fall 8 On 6/23/24 at 12:25 P.M., Resident D had an unwitnessed fall while in his room. A visitor alerted the nurse that the resident was lying on the floor in his room. The resident was noted to have a two inch by one inch bruised area on the top right side of his head. The physician was notified, and an order was received to send the resident to the hospital for evaluation. The resident returned to the facility from the hospital at 7:05 P.M. A computed tomography (CT) scan (a medical imaging technique used to obtain detailed internal images of the body)			

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	indicated there were no new injuries related to recent falls; however, the resident's chronic back fracture had gotten worse. The clinical record lacked an IDT note about that fall. "Dycem to wheelchair" was added to the care plan on 6/23/24. A fall risk assessment, dated 6/23/24, indicated Resident D was at high risk for falls. Fall 9 On 6/25/24 at 10:16 A.M., Resident D had an unwitnessed fall in his room. The resident was found lying on the floor between his bed and wheelchair. The IDT reviewed that fall on 6/26/24. "Fall mat to be placed at bedside when he is in bed" was added to the care plan. A fall risk assessment, dated 6/25/24, indicated Resident D was at high risk for falls. Fall 10 On 6/29/24 at 10:34 P.M., Resident D had an unwitnessed fall while in his room. The resident was found on the floor next to his bed. He complained of right knee pain. The physician was notified, and an order was received to send the resident to the hospital for evaluation. The resident returned to the facility from the hospital on 6/30/24 at 5:15 A.M. with a new order for bacitracin ointment to the abrasion on his right knee twice a day for seven days. No other injuries were noted. The IDT reviewed that fall on 7/1/24. "Reach out to Medical Doctor (MD) for a sleep aide" and "Offer sleep aide" were added to the care plan. A new order to give melatonin (a supplement to help with insomnia) 5 milligrams (mg) by mouth every 24 hours as needed for trouble sleeping was received on 7/3/24.			

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	A fall risk assessment was not completed. Fall 11 On 7/4/24 at 3:30 P.M., Resident D had an unwitnessed fall while attempting to put himself to bed. The resident was found on the floor in front of his bed. The clinical record lacked an IDT note about that fall. "Staff to offer resident assistance to recliner to rest after lunch" was added to the care plan. A fall risk assessment, dated 7/4/24, indicated Resident D was at high risk for falls. Fall 12 On 7/15/24 at 2:30 P.M., Resident D had a witnessed fall while trying to get up using the rail in the hallway. The wheelchair moved and the resident fell and hit the back of his head. The clinical record lacked an IDT note about that fall. "Therapy to adjust anti-rollbacks on resident's wheelchair" was added to the care plan on 7/15/24. A fall risk assessment, dated 7/15/24, indicated Resident D was at high risk for falls. Fall 13 On 8/6/24 at 11:17 A.M., Resident D had an unwitnessed fall while attempting to pick something up off the floor. The resident was found lying on the floor in the doorway of his room. The IDT reviewed that fall on 8/7/24. "Resident is not to be left in his room in his wheelchair unattended" was added to the care plan. A fall risk assessment, dated 8/6/24, indicated Resident D was at high risk for falls. Fall 14			

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	On 8/14/24 at 2:00 A.M., Resident D had an unwitnessed fall in his room. He was found lying on his fall mat. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 8/14/24, indicated Resident D was at high risk for falls. Fall 15 On 8/19/24 at 2:09 P.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA responded to the resident's call light and found him sitting against the wall next to the toilet. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 8/21/24, indicated Resident D was at high risk for falls. Fall 16 On 11/13/24 at 11:15 A.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA responded to an emergency call light in the hallway bathroom and found the resident lying on his back on the floor next to the toilet with his wheelchair by his side. The resident was noted to have a bruise on the left side of his forehead. The IDT reviewed that fall on 11/25/24. "Ensure resident is toileted before and after each meal" was added to the care plan. A fall risk assessment, dated 11/24/25, indicated Resident D was at high risk for falls. Fall 17 On 11/27/24 at 3:12 P.M., Resident D had an unwitnessed fall while attempting to self toilet.			

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	The resident was found sitting on the floor between the toilet and the sink. The IDT reviewed that fall on 12/3/24. "Reinforce to nursing staff that resident is not to be left alone in room while in wheelchair" was added to the care plan. A fall risk assessment, dated 11/27/24, indicated Resident D was at high risk for falls. Fall 18 On 12/27/24 at 4:30 P.M., Resident D had an unwitnessed fall while attempting to throw an item away. The resident was found sitting upright on the floor next to his recliner. The IDT reviewed that fall on 12/31/24. The new intervention determined at that meeting was to add non skid strips in front of the resident's recliner. The care plan was not updated with a new intervention. A fall risk assessment, dated 12/27/24, indicated Resident D was at high risk for falls. Fall 19 On 1/6/25 at 7:00 A.M., Resident D had an unwitnessed fall while attempting to walk to get a tissue box that was in the corner of his room. The resident was found lying on the floor on his back next to his wheelchair. The resident complained of pain to his right abdomen. The physician was notified. On 1/7/25 at 3:09 P.M., an order was received for an x-ray of the thoracic spine right side rib due to pain after the fall. The x-ray was completed on 1/8/25. Results were negative and there were no new orders. The IDT reviewed that fall on 1/9/25. "Keep personal belongings within reach of resident" was added to the care plan. A fall risk assessment, dated 1/9/25, indicated			

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	Resident D was at high risk for falls. Fall 20 On 1/23/25 at 4:14 A.M., Resident D had an unwitnessed fall while attempting to self transfer from his recliner to his wheelchair. The resident was found lying on his back on the floor in front of his recliner. The IDT reviewed that fall on 1/23/25. "Staff to encourage resident to sleep in his bed at night instead of recliner" was added to the care plan. A fall risk assessment, dated 1/23/25, indicated Resident D was at high risk for falls. Fall 21 On 2/3/25 at 6:00 P.M., Resident D had an unwitnessed fall while attempting to self toilet. A CNA responded to a call light in the hallway bathroom. The resident was found lying on the ground next to the toilet. The IDT reviewed that fall on 2/5/25. "Call, Don't Fall sign placed in public restroom next to pantry on first floor" was added to the care plan. A fall risk assessment, dated 2/3/25, indicated Resident D was at high risk for falls. Fall 22 On 3/10/25 at 5:15 A.M., Resident D had an unwitnessed fall in his room. The resident was found on the floor between his bed and the bathroom floor. The resident was noted to have bleeding from a laceration on the back of his head and there was a large amount of blood on the floor. The physician was notified, and an order was received to send the resident to the hospital for treatment and evaluation. The resident returned back to the facility from the hospital on 3/10/25 at 10:06 A.M. with eight stapes to the back of his head on the left side. The IDT reviewed that fall on 3/11/25. "Bolster			

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	mattress placed on bed to prevent resident from rolling out of bed while sleeping" was added to the care plan. A fall risk assessment, dated 3/10/25, indicated Resident D was at high risk for falls. Fall 23 A 72-hour charting note, dated 4/3/25 at 6:53 P.M., indicated Resident D was assessed for a fall. The note did not indicate when, where, or how the fall took place. The clinical record lacked documentation regarding the fall that took place on 4/3/25. The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment was not completed. A nursing progress note, dated 4/4/25 at 9:17 A.M., indicated that the resident was not acting like himself. He was unable to stand up and complained of pain to his left hip, left arm, left shoulder, and left flank. The physician was notified. A nursing progress note, dated 4/4/25 at 10:47 A.M., indicated that the physician was in the facility and assessed the resident. Orders for bloodwork and an x-ray of the left shoulder and left hip were received. A nursing progress note, dated 4/4/25 at 2:13 P.M., indicated the resident was hallucinating. A nursing progress note, dated 4/4/25 at 3:10 P.M., indicated a new order was received to send			

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	the resident to the hospital for treatment and evaluation. A nursing progress note, dated 4/4/25 at 3:41 P.M., indicated ambulance staff picked up the resident from the facility and transported him to the hospital for the possibility of "trauma from a fall". Hospital admission paperwork, dated 4/4/25, indicated the CT scan was negative for acute injury or fracture, urinalysis was negative for UTI, and blood workup was unremarkable. The resident was admitted to the hospital for evaluation of acute encephalopathy. A hospital neurology note, dated 4/7/25, indicated that the resident was on anticonvulsant medication for seizures prior to his hospitalization and because there were no other remarkable findings, a new anticonvulsant medication would be trialed to attempt to address the mental and ADL decline. 2. On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, muscle weakness, and repeated falls. The most recent Annual Minimum Data Set (MDS) Assessment, dated 2/5/25, indicated Resident S had severe cognitive impairment, required partial to moderate assistance of staff (staff does less than half of the effort) for transferring, required substantial to maximal assistance of staff (staff does more than half of the effort) for toileting and bathing, and had two or more falls since the prior assessment. The last care plan conference was completed on			

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	11/14/24. Care plans were reviewed and updated. A current increased risk for falls care plan, initiated 6/16/21, included the following interventions: Anticipate and meet residents needs, dated 6/16/21 Be sure residents call light is visible and within reach. The resident needs prompt response to all requests for assistance, dated 6/16/21 Follow facility fall protocol if fall occurs, dated 6/16/21 Notify family and physician of all falls, dated 6/16/21 Nursing to check on resident every hour throughout the night, dated 11/22/21 Place "Call, Don't Fall" sign within view of resident's recliner, dated 3/4/22 Place a "call for assistance with showers" sign in bathroom, dated 3/15/22 Resident is always cleaning and tidying up her room. "Call, don't fall" sign replaced and resident encouraged to leave it up as a reminder, dated 3/16/22 Move resident to room closer to nurses station for closer observation, dated 4/6/22 Staff to offer toileting/shower/hygiene needs an hour prior to dinner, dated 4/10/22 Physical Therapy (PT) and Occupational Therapy (OT) to assess seating positioning in recliner; replace recliner, dated 4/15/22 Place STOP sign in shower entry, dated 4/24/22 Offer/assist with toileting prior to lunch, dated 4/24/22 Offer/encourage and assist resident with toileting needs prior to breakfast, dated 5/30/22 Use a wheelchair to get resident monthly weights, dated 6/2/22 OT to screen for transfers/positioning, dated 8/26/22			

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	Remove recliner from resident room and replace it with a stationary chair, dated 8/26/22 Re-educate nursing staff to assist resident with toileting needs prior to lunch, dated 9/29/22 If resident is ambulating outside of her room, ensure resident is wearing appropriate footwears. She prefers to be barefoot however, assist her with footwear prior to leaving her room, dated 12/4/22 Staff to assist resident with toileting prior to her bedtime, dated 3/15/23 Re-educate nursing staff to encourage and assist resident to put on proper footwears and keep it on at all times, dated 3/30/23 Therapy to assess walker for safety, dated 4/14/23 Staff to ensure walker is within reach at all times, dated 6/12/23 Ensure slippers are within reach at all times, dated 6/20/23 Staff to check in with resident approximately 30 minutes prior to dinner to see if she needs anything before her tray arrives, dated 9/15/23 Urinalysis for recent falls and increased confusion, dated 10/14/23 Ensure staff bathes resident in shower room for safety of resident and staff in case of an episode where staff has more room to ensure resident's safety, dated 3/2/24 Staff to offer resident assistance with toileting when picking up room tray at lunch, dated 3/4/24 Resident referred to therapy for screen due to lower extremity weakness, dated 3/20/24 Kitchen chair removed from resident room, 3/26/24 Toilet rise to be placed on toilet, dated 4/29/24 Psych med review per (name of mental health provider) Nurse Practitioner (NP), dated 6/28/24 Bolsters placed on bed, dated 7/3/24 Staff to encourage/assist resident with laying in bed with feet elevated rather than sit on the side leaning over the bed, dated 7/14/24			

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	Staff to offer opportunities for 1:1 activities throughout the day, dated 7/22/24 Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/IDT as to causes, dated 8/12/24 Remove non-skid strips from floor as these appear to be more of a hazard to her as she is always leaned over picking at them and pulling them up, putting her at an increased risk for falls, dated 8/28/24 Re-educate nursing staff on offering assistance to resident with toileting and her safety checks, dated 8/29/24 Therapy to screen/evaluate resident for safe self transfers, dated 11/27/24 Therapy to trial assistive device to help assist with proper functioning, dated 12/4/24 Environmental room check for furniture placement to better suit resident's needs, dated 12/4/24 Therapy to fit for appropriate wheelchair, dated 1/13/25 Ankle Brachial Index (ABI) (a test that measures blood pressure in your arms and ankles to check for peripheral artery disease) ordered to assess current status of vascular insufficiency to confirm or rule out any worsening disease processes that may possibly be causing increase in pain to BLE, dated 1/14/25 Maintenance to assess status of TV and address issues if found, dated 1/21/25 Notify MDS for Med Review for sleep aid, dated 1/23/25 Staff to frequently ensure resident is wearing appropriate footwear, dated 1/25/25 Bolster mattress to be placed on bed, dated 3/3/25 The clinical record indicated Resident S fell 34 times in the past year.			

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	Fall 1 On 4/29/24 at 9:05 A.M., Resident S had an unwitnessed fall while attempting to self toilet. The resident was found on the floor between the toilet and the sink with her walker in front of her. The Interdisciplinary Team (IDT) reviewed that fall on 4/30/24. "Toilet rise to be placed on toilet" was added to the care plan. A fall risk assessment, dated 4/29/24, indicated Resident S was at high risk for falls. Fall 2 A 72-hour charting note, dated 6/3/24 at 9:56 A.M., indicated Resident S was assessed for a fall. The note did not indicate when, where, or how the fall took place. The clinical record lacked documentation regarding the fall that took place on 6/3/24. The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment was not completed. Fall 3 On 6/6/24 at 8:45 A.M., Resident S had a witnessed fall while attempting to pick something up off the bed. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 6/6/24, indicated Resident S was at high risk for falls. Fall 4 On 6/8/24 at 1:45 P.M., Resident S had an			

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	unwitnessed fall while attempting to self toilet. The resident was found on the floor. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 6/8/24, indicated Resident S was at high risk for falls. Fall 5 On 6/11/24 at 11:30 A.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on the bedroom floor next to her bed with her walker next to her. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 6/11/24, indicated Resident S was at high risk for falls. Fall 6 On 6/28/24 at 4:30 P.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found on the floor near the foot of the bed. The clinical record lacked an IDT note about that fall. "Psych med review per [name of mental health provider] NP" was added to the care plan on 6/28/24. A fall risk assessment, dated 6/28/24, indicated Resident S was at high risk for falls. Fall 7 On 7/2/24 at 9:35 A.M., Resident S had an unwitnessed fall while attempting to peel up the non skid strips from the floor. The resident was found sitting on the floor by her bed. The clinical record lacked an IDT note about that			

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	fall. "Non-skid strips replaced at bedside" was added to the care plan on 7/2/24. A fall risk assessment, dated 7/2/24, indicated Resident S was at high risk for falls. Fall 8 On 7/3/24 at 2:00 A.M., Resident S had an unwitnessed fall. The resident slid out of bed and was found sitting on the floor by her bed. The IDT reviewed that fall on 7/3/24. "Bolsters placed on bed" was added to the care plan. A fall risk assessment was not completed. A mental health provider note, dated 7/9/24, indicated mental health medications were reviewed and no medication changes were made. Fall 9 On 7/14/24 at 7:15 P.M., Resident S had a witnessed fall while attempting to sit up straight. She slid out of bed. The clinical record lacked an IDT note about that fall. "Staff to encourage/assist resident with laying in bed with feet elevated rather than sit on the side leaning over the bed" was added to the care plan on 7/14/24. A fall risk assessment was not completed. Fall 10 On 7/18/24 at 1:51 P.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on the floor at the entrance to her bathroom. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment was not completed.			

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	Fall 11 On 7/22/24 at 2:25 P.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on the floor in her room. The clinical record lacked documentation to indicate the physician was notified of that fall. The clinical record lacked an IDT note about that fall. "Staff to offer opportunities for 1:1 activities throughout the day" was added to the care plan on 7/22/24. A fall risk assessment, dated 7/22/24, indicated Resident S was at high risk for falls. Fall 12 On 7/23/24 at 8:15 A.M., Resident S had an unwitnessed fall while attempting to self toilet. She was found sitting on her bedroom floor with her walker in front of her. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 7/23/24, indicated Resident S was at high risk for falls. Fall 13 On 8/4/24 at 6:20 P.M., Resident S had an unwitnessed fall while in her room. The resident was found sitting on the floor in the doorway to her room. The IDT reviewed that fall on 9/11/24. The care plan was not updated with a new intervention. A fall risk assessment, dated 8/4/24, indicated Resident S was at high risk for falls. Fall 14 On 8/5/24 at 11:20 A.M., Resident S had an			

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	unwitnessed fall while attempting to self toilet. The resident was found sitting on the floor in the doorway to her room. The IDT reviewed that fall on 9/11/24. "Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/IDT as to causes" was added to the care plan on 8/12/24. The clinical record lacked documentation to indicate a review was completed, possible root causes for the resident's falls were determined, and education about those causes were provided. A fall risk assessment, dated 8/5/24, indicated Resident S was at high risk for falls. Fall 15 On 8/28/24 at 12:30 P.M., Resident S had an unwitnessed fall while attempting to self toilet. A CNA responded to the resident's call light and found her sitting on the floor with her walker next to her. The clinical record lacked an IDT note about that fall. "Remove non-skid strips from floor as these appear to be more of a hazard to her as she is always leaned over picking at them and pulling them up, putting her at an increased risk for falls" was added to the care plan on 8/28/24. A fall risk assessment, dated 8/28/24, indicated Resident S was at high risk for falls. Fall 16 On 8/29/24 at 1:20 P.M., Resident S had an unwitnessed fall while attempting to self toilet. The resident was found sitting in the bathroom with her wheelchair close to her. She had a skin tear on her right forearm. The IDT reviewed that fall on 9/11/24. "Re-educate nursing staff on offering assistance to resident with toileting and her safety checks"			

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	was added to the care plan. A fall risk assessment, dated 8/29/24, indicated Resident S was at high risk for falls. Fall 17 On 10/13/24 at 11:30 P.M., Resident S had an unwitnessed fall while in the dayroom. She was found lying on the floor in front of her wheelchair. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment was not completed. Fall 18 On 10/18/24 at 12:10 A.M., Resident S had an unwitnessed fall while walking with her walker. The resident was found sitting on the floor at the entrance to her room. The walker was broken on one side. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 10/18/24, indicated Resident S was at high risk for falls. Fall 19 On 10/27/24 at 2:15 A.M., Resident S had an unwitnessed fall while in her room. The resident was found sitting on the floor in her room in front of her wheelchair. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment, dated 10/27/24, indicated Resident S was at high risk for falls. Fall 20			

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	On 11/27/24 at 6:00 P.M., Resident S had a witnessed fall while attempting to self toilet. The IDT reviewed that fall on 12/3/24. "Therapy to screen/evaluate resident for safe self transfers" was added to the care plan. A fall risk assessment, dated 11/27/24, indicated Resident S was at high risk for falls. An Occupational Therapy evaluation and plan of treatment, dated 12/3/24, indicated Resident S was certified to receive therapy two to three times a week from 12/3/24 until 1/1/25. Fall 21 On 12/4/24 at 8:45 A.M., Resident S had an unwitnessed fall while getting up from her chair. She was found sitting on her bedroom floor next to her chair. The IDT reviewed that fall on 1/8/25. "Therapy to trial assistive device to help assist with proper functioning" and "Environmental room check for furniture placement to better suit resident's needs" were added to the care plan. A fall risk assessment was not completed. Fall 22 On 12/8/24 at 1:17 A.M., Resident S had an unwitnessed fall in her room. The resident was found on the floor adjacent to her bed. The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall. The clinical record lacked an IDT note about that fall. The care plan was not updated with a new intervention. A fall risk assessment was not completed. Fall 23 On 12/8/24 at 7:00 A.M., Resident S had an			

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	unwitnessed fall while walking with her walker. She was found on her back on the floor in her room. The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall.The clinical record lacked an IDT note about that fall.The care plan was not updated with a new intervention.A fall risk assessment was not completed.Fall 24On 12/10/24 at 9:45 A.M., Resident S had an unwitnessed fall while attempting to self toilet. The resident was found sitting on her bathroom floor next to the toilet.The IDT reviewed that fall on 1/8/25. The new intervention determined at that meeting was to increase the frequency of monitoring when the resident has had a change in condition.The care plan was not updated with a new intervention.A fall risk assessment was not completed.Fall 25On 12/13/24 at 10:49 P.M., Resident S had a witnessed fall. Staff witnessed the resident sliding out of her wheelchair onto the floor.The clinical record lacked an IDT note about that fall.The care plan was not updated with a new intervention.A fall risk assessment was not completed.Fall 26An alert note, dated 12/30/24 at 11:01 P.M., indicated Resident S had no pain or discomfort noted from her recent fall.A 72-hour charting note, dated 12/31/24 at 10:52 A.M., indicated Resident S was			

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	assessed for a fall. The note did not indicate when, where, or how the fall took place.The clinical record lacked documentation regarding the fall that took place on 12/30/24.The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall.The clinical record lacked an IDT note about that fall.The care plan was not updated with a new intervention.A fall risk assessment was not completed.Fall 27On 1/7/25 at 9:00 A.M., Resident S had an unwitnessed fall while attempting to self toilet. The resident was found sitting on the floor in the hallway next to a chair that was placed in the hallway next to her bedroom.The IDT reviewed that fall on 1/13/25. "Therapy to fit for appropriate w/c [wheelchair]" was added to the care plan.A fall risk assessment, dated 1/13/25, indicated that Resident S was at high risk for falls.Fall 28An alert note, dated 1/14/25 at 10:15 P.M., indicated Resident S had no pain or discomfort noted from her recent fall.An IDT Fall Note, dated 1/28/25 at 12:57 P.M., indicated that the committee met to review the fall from 1/14/25. The resident's bathroom emergency light sounded and the resident was found on the floor of the bathroom. "Therapy to fit for appropriate wheelchair" was added to the care plan on 1/13/25."Ankle Brachial Index			

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	(ABI) (a test that measures blood pressure in your arms and ankles to check for peripheral artery disease) ordered to assess current status of vascular insufficiency to confirm or rule out any worsening disease processes that may possibly be causing increase in pain to bilateral lower extremities (BLE)" was added to the care plan on 1/14/25.A fall risk assessment, dated 1/17/25, indicated that Resident S was at high risk for falls.Fall 29On 1/19/25 at 3:01 A.M., Resident S had an unwitnessed fall while in her room. The resident was found sitting on the floor in front of her stationary chair.The clinical record lacked an IDT note about that fall.The care plan was not updated with a new intervention.A fall risk assessment was not completed.Fall 30On 1/19/24 at 9:30 A.M., Resident S had an unwitnessed fall in her room. She was found by a lab technician sitting on the ground with her walker next to her.The clinical record lacked documentation to indicate the physician and responsible party were notified of that fall.The clinical record lacked an IDT note about that fall.The care plan was not updated with a new intervention.A fall risk assessment was not completed.Fall 31On 1/21/25 at 10:24 A.M., Resident S had an unwitnessed fall while attempting to fix her TV. A CNA responded to a call light in the resident's room and found the resident			

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	155820	A. BUILDING 00 B. WING	04/09/2025

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	lying on the bedroom floor in front of her TV. The resident reported hitting her head and was noted to have a hematoma on the right side of her head.The IDT reviewed that fall on 1/22/25. "Maintenance to assess status of TV and address issues if found" was added to the care plan.A fall risk assessment was not completed.Fall 32On 1/23/25 at 12:54 A.M., Resident S had an unwitnessed fall while in her room. The resident was found sitting on the floor in the doorway in front of her wheelchair.The IDT reviewed that fall on 1/24/25. "Notify MDS for Med Review for sleep aid" was added to the care plan.A fall risk assessment, dated 1/23/25, indicated that Resident S was at high risk for falls.Fall 33On 1/25/25 at 12:20 P.M., Resident S had an unwitnessed fall while in her room. A CNA responded to a call light in the resident's room and found the resident sitting on the floor next to her wheelchair. The resident was noted to have a hematoma to the left side of her forehead.The IDT reviewed that fall on 1/28/25. "Staff to frequently ensure resident is wearing appropriate footwear" was added to the care plan.A fall risk assessment was not completed.A mental health provider note, dated 1/28/25, indicated Resident S reported no sleep disturbance. A medication to assist with sleep was not ordered at that time.ABI test results, dated 1/28/25, were			

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	negative. Fall 34On 3/3/25 at 12:12 A.M., Resident S had an unwitnessed fall while in bed. The resident indicated she slid out of bed. She was found sitting on the floor beside the left side of her bed.The IDT reviewed that fall on 3/3/25. "Bolster mattress to be placed on bed" was added to the care plan.A fall risk assessment, dated 3/3/25, indicated that Resident S was at high risk for falls.On 4/4/25 at 1:18 P.M., Resident S was observed sitting in her wheelchair in her room eating lunch. The resident was wearing socks without nonskid bottoms. A kitchen chair was observed in the room. The call light was wrapped around the kitchen chair and was not within reach of the resident. There was not a bolster mattress on the bed. There were no bolsters in the room. There was not a "Call, Don't Fall" sign in the resident's room. There was not a "Call for assistance with showers" sign in the bathroom. There was not a STOP sign in the shower entry. There was not a toilet riser on the toilet.In an interview on 4/8/25 at 1:40 P.M., the Director of Nursing (DON) indicated that after a resident fell, the physician and responsible party were notified. The IDT met the next business day to review the fall and determine a new and appropriate intervention. The intervention was put into the care plan immediately. There should be a new intervention with			

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	every fall. If the intervention was a lab or other form of assessment, the results would be reviewed and followed up on appropriately and timely, and another intervention would be determined if necessary.On 4/9/25 at 12:14 P.M., the DON provided a current Fall Prevention Program policy, revised 11/21/17, that indicated "The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision ... The Fall Prevention Program includes the following components: ... notification of physician, family/legal representative...documentation requirements...Care plan incorporates: Identification of all risk/issues, addresses each fall, interventions are changed with each fall, as appropriate, and preventative measures ... Safety interventions will be implemented for each resident identified at risk ... All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained ... Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions ... Fall/safety interventions may include but are not limited			

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	to:...The nurse call device will be placed within the resident's reach at all times ... Call lights are answered promptly ... Foot wear will be monitored to ensure the resident has proper fitting shoes and/or footwear is non-skid...".On 4/9/25 at 12:14 P.M., the DON provided a current undated Documentation Procedures and Guidelines policy that indicated "Each health care professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable ... Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner ... Late entries must be dated on the date it is written, and will include the date and time that the original entry should have been made".This citation related to Complaints IN00449780 and IN00450874.3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, interview, and record review, the facility failed to provide nutritional care and services including failure to identify significant weight loss, failure to notify the physician of significant weight loss, and failure to be reviewed by the Registered Dietician for 1 of 1 residents reviewed for weight loss (Resident S). Finding includes:	F 0692	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice.** Resident S's weight has been reviewed by the Registered Dietician. Resident S's weight loss has been	05/06/2025

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	On 4/4/25 at 12:40 P.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, diabetes mellitus, and dysphagia. The most current Annual Minimum Data Set (MDS) Assessment, dated 2/5/25, indicated Resident S had severe cognitive impairment, required setup assistance from staff for eating, weighed 179 pounds (lbs), and had no weight loss. The most current Quarterly MDS Assessment, dated 2/20/25, indicated Resident S had severe cognitive impairment, required setup assistance from staff for eating, weighed 132 lbs, and had no weight loss. The most recent care plan conference was completed on 11/14/24. The care plan was reviewed and updated. A current nutritional status care plan, revised on 10/26/22, indicated Resident S was at risk for altered nutritional status. Current physician orders included, but were not limited to: mirtazapine (Remeron) oral tablet 15 milligrams (mg) - Give one tablet by mouth at bedtime related to major depressive disorder, dated 1/30/2025 Namenda tablet 5 mg - Give one tablet by mouth one time a day related to dementia, dated 1/30/25 A review of the weights and vitals tab indicated Resident S was weighed on the following days: 4/5/24 - 192.2 lbs standing 5/8/24 - 186.6 lbs standing 6/7/24 - 183.4 lbs standing		communicated to the Physician. **How the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the alleged deficient practice. A New Weight Process has been implemented. The Dietary Manager has been educated on the new Weight Process including notification to the RD with documentation. The DON has been educated on the New Weight Process including notification to the Physician with documentation. M**easures the facility will take to ensure that the problem will be corrected and will not recur:** A New Weight Process has been implemented. The Dietary Manager has been educated on the new Weight Process including notification to the RD with documentation. The DON has been educated on the New Weight Process including notification to the Physician with	

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	7/10/24 - 182.1 lbs standing 8/9/24 - 183.6 lbs standing 9/9/24 - 181.2 lbs standing 10/10/24 - 178.8 lbs wheelchair 12/16/24 - 179.0 lbs wheelchair 1/3/25 - 179.3 lbs standing 2/18/25 - 131.7 lbs wheelchair (a 26.55% weight loss) A nursing progress note, dated 1/29/25 at 3:20 P.M., indicated the mental health Nurse Practitioner (NP) reviewed the resident's mental health medications on 1/28/25. Namzaric (a medication used to slow the progression of dementia with a side effect of anorexia) was discontinued due to not eating and weight loss. Remeron (an antidepressant medication with side effects of increased appetite and weight gain) was decreased from 45 mg at bedtime to 15 mg at bedtime. Namenda (a medication used to slow the progression of dementia without the anorexia side effect) 5 mg daily was ordered. A psychiatry encounter progress note, dated 2/24/25 at 11:00 P.M., included a weight loss warning and indicated the patient was tolerating the previous medication changes. No medication changes were made at that visit. A psychiatry encounter progress note, dated 3/11/25 at 12:00 A.M., indicated that the resident had a significant weight loss and to have staff re-weigh the resident. A psychiatry encounter progress note, dated 3/25/25 at 12:00 A.M., indicated that the resident had a significant weight loss and to have staff re-weigh the resident. It indicated the mental health provider was waiting for the March weight.		documentation. **Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** DON/Designee will perform 5 Medical Record Reviews a week to ensure any weight loss has been identified, RD notified, and Physician notified. The results of the above audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	The clinical record lacked documentation to indicate the resident was re-weighed after the 2/18/25 weight was taken. The clinical record lacked documentation to indicate the resident was referred to the dietitian for weight loss. The clinical record lacked a nutritional assessment of the resident by the dietitian. The clinical record lacked notification to the physician about the resident's significant weight loss. The clinical record lacked documentation to indicate the resident was reviewed by the Interdisciplinary Team (IDT) for weight loss. On 4/4/25 at 1:56 P.M., Resident S was observed sitting in her wheelchair in the hallway. The strap of her shirt was hanging over her shoulder. At that time, the resident indicated that she had lost a lot of weight, and her clothes did not fit anymore. She was not sure why she had lost weight. On 4/8/25 at 2:51 P.M., CNA 18 weighed Resident S. The resident weighed 162.8 lbs including the wheelchair weight. The wheelchair's weight was 39.5 lbs. CNA 18 confirmed Resident S currently weighed 123.3 lbs (a 6.38% weight loss since 2/18/25 and a 31.23% weight loss since 1/3/25). On 4/8/25 at 3:43 P.M., the Director of Nursing (DON) indicated that the Registered Dietitian (RD) ran monthly reports to know which residents to follow for weight loss. The facility's Nurse Practitioner (NP) also reviewed charts monthly for weight loss. At that time, the DON indicated she was unable to find any notes from the RD or NP			

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	regarding Resident S's weight loss. The only notes she could find related to Resident S's weight loss were from the mental health NP. On 4/9/25 at 9:19 A.M., the MDS Coordinator indicated that the resident had a weight loss and it should have been coded as such on the Quarterly MDS Assessment, but the weight loss did not trigger and the dietitian did not reach out to her. On 4/9/25 at 12:14 P.M., the DON provided a current Regional Dietitian Consultant job description, dated 7/3/17, that indicated "Essential Duties and Responsibilities: ... Assesses the nutritional status of customers inclusive of...weight maintenance ... Ensures appropriate documentation of nutritional assessment and recommended intervention in the customer chart and/or care plan; reviews the documentation of others regarding nutritional concerns and responds appropriately". On 4/9/25 at 12:14 P.M., the DON provided a current Weights policy, revised 10/17/19, that indicated "Each resident shall be weighed on admission and at least monthly thereafter, or in accordance with Physician orders or plan of care ... Re-weight should be obtained if there is a difference of 5 lbs or greater (loss or gain) since previous recorded weight ... Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physician, Dietician and/or Dietary Manager as appropriate". This citation relates to Complaint IN00449780. 3.1-46(a)(1)			

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F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record review, the facility failed to ensure physician orders were followed and a resident's nutritional feedings were administered for 1 of 1 residents reviewed for tube feedings. A resident's enteral nutrition refusals were not documented, and feeding equipment was not changed daily. (Resident G) Finding includes: On 4/3/25 at 11:44 A.M., Resident G was observed sitting in her wheelchair in her room. Jevity (tube feeding) formula, dated 4/2/25, was observed in the room but was not hooked up to the resident. A syringe was observed hanging in a bag and was dated 4/1/25. On 4/4/25 at 1:24 P.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. A syringe was observed hanging in a bag and was dated 4/1/24. On 4/7/25 at 11:37 A.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. The feeding tube was wrapped around the pole and there was no cap on the end of the tubing. On 4/8/25 at 10:57 A.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time. On 4/8/25 at 2:43 P.M., the enteral nutrition was observed turned off in Resident G's room. Resident G was not in her room at that time.	F 0693	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice.** Resident G is receiving her Enteral Feeding as Physician order unless refused Resident G's refusals are being documented. Resident G;s Enteral Feeding equipment is being changed. **How the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents with Enteral Feeding have the potential to be affected by the alleged deficient practice. Licensed Nursing Staff have been educated on following Physician orders. QMA's have been educated on following Physician orders. Licensed Nursing Staff have been educated on documentation of resident refusal of Enteral Feeding. QMA's have been educated on	05/06/2025

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	On 4/7/25 at 11:16 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, dysphagia, and dementia. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 3/17/25, indicated Resident G had mild cognitive impairment, was dependent on staff (staff does all of the effort) for transfers, and the resident received 51% or more of her nutrition through a feeding tube. The most recent care conference was completed on 2/27/25. The care plans were reviewed and updated. A current tube feeding care plan, initiated 3/17/25, included an intervention to monitor caloric intake. Current physician orders included, but were not limited to: Nothing By Mouth (NPO) diet - may have four ounces (oz) cups of ice chips at bedside and per her request for dysphagia following cerebral infarction, dated 3/14/25 Continuous Enteral Feeding: Formula: Jevity 1.5 at 60 milliliters (ml) per hour for 22 hours per day (1320 ml total), off for 2 hours per day Activities of Daily Living (ADLs); Flush with 250 ml of water every six hours. Monitor every shift, dated 3/25/25. Change Syringe every 24 hours and as needed, dated 3/14/25 The Medication Administration Record (MAR) for the continuous enteral feeding for March and		documentation of resident refusal of Enteral Feeding. **Measures the facility will take to ensure that the problem will be corrected and will not recur:** Licensed Nursing Staff have been educated on following Physician orders. QMA's have been educated on following Physician orders. Licensed Nursing Staff have been educated on documentation of resident refusal of Enteral Feeding. QMA's have been educated on documentation of resident refusal of Enteral Feeding. **Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** DON/Designee will perform 5 Medical Record Reviews a week for 4 weeks, then 3 times a week for 8 weeks to ensure Physician Orders related to Enteral Feeding is being followed. DON/Designee will perform 5 Medical Record Reviews a week for 4 weeks, then 3 times a week for 8 weeks to ensure	

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	April was reviewed. The record included, but was not limited to: 3/14/25 - 180 (evening); 360 (night) - 540 (total) 3/15/25 - 50 (day); 50 (evening); 400 (night) - 500 (total) 3/16/25 - 50 (day); 50 (evening); 400 (night) - 500 (total) 3/17/25 - not documented (day); 360 (evening); 480 (night) - 840 (total) 3/18/25 - "order" (day); 420 (evening); 390 (night) - unable to be calculated 3/19/25 - 370 (day); 50 (evening); 295 (night) - 715 (total) 3/20/25 - 477 (day); 60 (evening); 400 (night) - 937 (total) 3/21/25 - 600 (day); 60 (evening); 390 (night) - 1050 (total) 3/22/25 - 365 (day); 1320 (evening); 400 (night) - 2085 (total) 3/23/25 - 420 (day); 1320 (evening); 46 (night) - 1786 (total) 3/24/25 - 350 (day); 420 (evening); 395 (night) - 1165 (total) 3/25/25 - 330 (day); 360 (evening); 460 (night) - 1150 (total) 3/26/25 - NA (day); 1320 (evening); 480 (night) - 1800 (total) 3/27/25 - 350 (day); resident refused (evening); 400 (night) - 750 (total) 3/28/25 - 360 (day); 360 (evening); 480 (night) - 1200 (total) 3/29/25 - 500 (day); 360 (evening); NA (night) - 860 (total) 3/30/25 - 440 (day); 360 (evening); 480 (night) - 1280 (total) 3/31/25 - 360 (day); "y" (evening); 480 (night) - total unable to be calculated 4/1/25 - 360 (day); 1122 (evening); NA (night) - 1482 (total) 4/2/25 - "60/hr" (day); 1.5 (evening); NA (night) -		documentation of Enteral Feeding is completed as needed. The results of the above audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	total unable to be calculated 4/3/25 - 60 (day); 480 (evening); 460 (night) - 1000 (total) 4/4/25 - 360 (day); 60 (evening); NA (night) - 420 (total) 4/5/25 - 360 (day); 360 (evening); 460 (night) - 1180 (total) 4/6/25 - 240 (day); 480 (evening); 460 (night) - 1180 (total) The clinical record lacked notification to the physician when the resident received more or less than the ordered 1320 ml of formula in a 24 hour period. The clinical record lacked documentation that the enteral nutrition was turned off or that the resident refused nutrition on 4/3/25, 4/4/25, 4/7/25, and 4/8/15 outside of the two hours ordered by the physician. On 4/8/25 at 1:45 P.M., the Director of Nursing (DON) indicated that Resident G sometimes refused her enteral nutrition. She indicated that all refusals should be documented and that the physician would be notified if there was an extended refusal. On 4/8/25 at 3:43 P.M., the DON provided all documented refusals of enteral nutrition. She indicated she could only find two documented refusals and subsequent notifications to the physician dated 3/14/25 at 5:29 P.M. and 4/6/25 at 3:11 P.M. On 4/9/25 at 12:14 P.M., the DON provided a current Enteral Nutrition (EN) - Tube Feeding policy, dated 2020, that indicated "Nursing staff will follow the community enteral nutrition policies and guidelines ... Close monitoring of tube feeding			

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	155820	A. BUILDING 00 B. WING	04/09/2025

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	tolerance, intake and output records, nursing notations on physical assessment for characteristics such as skin turgor, available labs, etc. are essential to ensure adequate fluids are being provided". On 4/9/25 at 12:14 P.M., the DON provided a current Physician-Family Notification- Change in Condition policy, revised 11/13/18, that indicated "The facility will inform...consult with the resident's physician...when there is: ... a need to alter treatment...". On 4/9/25 at 12:14 P.M., the DON provided a current undated Documentation Procedures and Guidelines policy that indicated "Each health care professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable ... Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner". On 4/9/25 at 1:30 P.M., the Regional Nurse indicated it was the facility's policy to follow the physician orders. 3.1-44(a)(2)			
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on record review and interview, the facility failed to ensure residents were free from significant medication errors for 1 of 2 residents reviewed for hospitalization. A resident did not receive blood pressure medications and was admitted to the hospital two times for	F 0760	***How corrective action will be taken for those affected by the alleged deficient practice:*** Resident B is receiving hypertensive medications as ordered. ***How will the facility identify***	05/06/2025

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	hypertensive emergencies. (Resident B) Finding includes: On 4/7/25 at 9:24 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, hypertensive encephalopathy. The most recent Annual Minimum Data Set assessment, dated 1/3/25, indicated Resident B was moderately cognitively intact. Care plans included, but were not limited to: Resident had a diagnosis of hypertension: Administer medications as ordered; Assess for side effects and effectiveness; Notify physician of noted signs/symptoms for further evaluation, initiated 2/17/24. Physician orders included, but were not limited to: Carvedilol (a medication used to treat high blood pressure) oral tablet 12.5 mg (milligrams) give one tablet by mouth two times a day for hypertension; Start date 2/9/24 Isosorbide Mononitrate (a medication used to treat high blood pressure) ER (extended release) oral tablet 60 mg give one tablet by mouth two times a day for paroxysmal atrial fibrillation; Start date 2/9/24 Lisinopril (a medication used to treat high blood pressure) oral tablet 10 mg give one tablet by mouth two times a day for hypertension; Start date 2/9/24 Clonidine (a medication used to treat high blood pressure) HCl Oral Tablet 0.1 mg give one tablet		***other residents having the potential to be affected by the same deficient practice?*** All residents that have Hypertensive medications ordered have the potential to be affected by alleged deficient practice. education provided to licensed nurses on ensuring medications are administered as prescribed. ***The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:*** education provided to licensed nurses on ensuring medications are administered as prescribed. ***Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:*** DON/Designee will complete 5 observations of Medication Administration a week for 4 weeks, then 3 times a week for 8 weeks to ensure hypertensive medications are being administered as ordered. DON/Designee will complete 5 Medical Record reviews a week, then 3 times a week for to ensure hypertensive medication are administered. The results of the above	

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	by mouth three times a day for hypertension, hold if systolic blood pressure is less than 160; Start date 3/26/24 Discontinued 7/3/24 The electronic medication administration record (MAR) indicated Resident B did not receive his blood pressure medications (Carvedilol 12.5 mg, Isosorbide Mononitrate ER 60 mg, or Lisinopril 10 mg) at 8:00 A.M. on 6/25/24. in accordance with the physician orders. A nursing progress note, dated 6/25/24 at 2:06 P.M., indicated Resident B was heard yelling from his bedroom, the CNA went to check on him, and found him kneeling with his elbows on the floor in front of the toilet, and his rollator was next to him. The resident was barefoot, this nurse and two CNAs assisted him to lie down in a comfortable position. This nurse then assessed the resident for injury and none was observed at this time. This nurse and two CNAs then tried to assist the resident off the floor but the resident started complaining of back and neck pain, the nurse then decided not to move the resident and notified triage (a physician communication line). Triage gave an order to send the resident to the emergency room, ambulance was called and came to assist the resident off the floor and transported him to the hospital. The blood pressure was 155/84. A hospital admission history, dated 6/25/24 at 10:10 A.M., indicated Resident B's blood pressure was 240/103 on admission and resident had a "hypertensive emergency with encephalopathy-likely due to not receiving proper medication regimen in nursing home." On 10/1/24 a new physician's order for hydralazine (a medication used to treat high blood pressure)		audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	HCl oral tablet 25 mg give 1 tablet by mouth every eight hours as needed was initiated. The electronic medication administration record (MAR) indicated Resident B did not receive his previous doses of blood pressure medications (Carvedilol 12.5 mg, Isosorbide Mononitrate ER 60 mg, Lisinopril 10 mg) on 12/7/24 at 8:00 P.M., and did not have a blood pressure recorded or blood pressure medications (Hydralazine 50 mg) given on 12/7/24 at 4:00 P.M. A nurses note, on 12/8/24 at 4:04 A.M., indicated Resident B was having chest pain and was given nitroglycerin (medication used to treat chest pain). A nurses note, on 12/8/24 at 6:00 A.M., indicated Resident B had been transported to the hospital. A hospital history and physician note, dated 12/8/24 at 11:30 A.M., indicated Resident B's blood pressure was 224/174 and he was having a hypertensive emergency. During an interview on 4/8/25 at 1:23 P.M., the Director of Nursing (DON) indicated each resident had different blood pressure parameters to notify the physician about, nursing staff should use their nursing judgement if a blood pressure falls outside of normal parameters, and that the charting system flags systolic blood pressure above 139 as elevated. On 4/9/25 at 12:14 P.M., a policy relating to blood pressure parameters and following physician orders was requested and not provided. During an interview on 4/9/25 at 1:20 P.M., the regional nurse indicate the policy of the facility was for staff to follow physician orders.			

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	3.1-48(c)(2)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, record review, and interview, the facility failed to ensure food that was served at palatable temperature for 1 of 1 trays tested for food temperature. Findings include: On 4/7/35 at 12:50 P.M., a hall tray was obtained on the 200 Unit. The following temperatures were observed: Carrots-115 degrees F During an interview on 4/7/25 at 12:45, the Dietary Manager indicated that the holding temperatures on the steam table should be 145 degrees F or higher. On 4/9/25 at 12:14 P.M., The Director of Nursing (DON) provided a current, non-dated policy "Monitoring Food Temperatures for Meal Service." The policy indicated "... food temperatures will be monitored to prevent foodborne illness and ensure foods are served at palatable temperatures...serving/holding temperatures require 140 minimum when checked prior to meal service...meals that are served on room trays ...prefer hot foods to be at 120 degrees F or greater for the palatability for the resident..." This citation relates to Complaint IN00449780. 3.1-21(a)(2)	F 0804	Food Temps are now within Range **How the facility will identify other residents having the potential to be affected by the same deficient practice:** ·All residents have the potential to be affected by the same alleged deficient practice ·. Dietary Staff educated on the Facility's Food Temperature Policy to ensure ongoing compliance **Measures the facility will take to ensure that the problem will be corrected and will not recur:** ·Dietary Staff educated on the Facility's Food Temperature Policy. **Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** Dietary manager/designee will perform checks of food temperatures 5 times a week for 12 weeks to ensure food is being served at appropriate temperatures.	05/06/2025

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			The results of the above audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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 was stored in sanitary manner for 1 of 2 kitchen observations. Food containers were not labeled in the reach in refrigerator and dry storage. Findings include: On 4/3/25 at 10:35 A.M., the following was observed in the dry storage area: - One bag of Zita noodles with no open date - One bag of marshmallows with no open date On 4/3/25 at 10:57 A.M., the following was observed in the reach in refrigerator: - One container of orange juice without preparation date or use by date - One container of apple juice without a preparation date or use by date - One green container with orange colored fluid without a label, preparation date, or use by date - One pink container with brown colored fluid without a label, preparation date, or use by date - One clear container with purple colored fluid without a label, preparation date, or use by date - Two green colored containers with fluid, without	F 0812	**1 Immediate actions taken for those residents identified:** The bag of Zita noodles were discarded The bag of Marshmallows were discarded The container of Orange Juice was discarded The container of Apple Juice was ddiscarded The Green container orange colored fluid was discared The pink container the brown colored fluid was discarded The clear container purple colored fluid was discarded Two additional green colored containers fluid was discarded The yellow container fluid was discarded 2 All residents have potential to be affected by alleged deficient practice. All Dietary Staff have been	05/06/2025

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	a label, preparation date, or use by date - One yellow container with fluid, without a label, preparation date, or use by date During an interview on 4/8/25 at 9:31 A.M., the Dietary Manager indicated containers should be labeled and have a preparation and use by date. On 4/9/25 at 12:14 P.M., the Director of Nursing provided a current, non-dated policy " Food Storage (Dry, Refrigerated, and Frozen." The policy indicated "...the general storage guidelines including all food items will be labeled. The label must include the name of the food and the date it should be...consumed by..." 3.1-21(i)(2) 3.1-21(i)(3)		educated on Proper Food Storage, and the Facility's Labeling and Dating Foods Policy. **3) Measures put into place/ System changes:** All Dietary Staff have been educated on Proper Food Storage, and the Facility's Labeling and Dating Foods Policy. **4) How the corrective actions will be monitored:** ADM/Designee will complete random 5 observations a week for 12 weeks to ensure proper food handling and storage. **The results of these interviews will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control practices were implemented for 2 of 3	F 0880	**1) Immediate actions taken for those residents identified:**	05/06/2025

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	residents observed for care. Gloves were not changed and hand hygiene was not performed. (CNA 23, RN 28, RN 7) Findings include: 1. On 4/8/25 at 10:42 A.M., incontinence care was observed for Resident 22. CNA 23 sanitized with hand sanitizer and donned gloves while RN 28 only donned gloves. CNA 23 gathered supplies with the gloves on, turned the resident to the right side, and removed the resident's sweatpants and soiled brief. CNA 23 provided incontinence care using three wash cloths and turned the resident to the left side, then RN 28 completed the incontinence care with two more washcloths. RN 28 removed the soiled gloves and washed hands with soap and water. CNA 23 utilized the same gloves to place barrier cream on Resident 22. CNA 23 wiped the gloved hands with the barrier clean inside the clean incontinence brief and then put the clean incontinence brief on Resident 22. 2. During an observation of wound care on 4/9/25 at 11:40 A.M., RN 7 gathered supplied and entered Resident F's room. RN 7 applied hand sanitizer, put a gown and gloves on, and cut Resident F's dressing off. The dressing was dated 4/7. RN 7 cleansed the wound with wound cleanser on gauze, applied skin prep, HydraLock SA (absorbent dressing), and wrapped the left foot in Kerlex (gauze wrap). RN 7 taped the Kerlex in place and dated the dressing 4/9, removed her gown and gloves, put a new pair of gloves on, and put a heel boot on Resident F's left foot. RN 7 gathered the trash, gloves, and exited Resident F's room. RN 7 did not perform hand hygiene during or after performing wound care. During an interview on 4/9/25 at 9:37 A.M., the Infection Preventionist Nurse indicated that		Resident 22 is receiving incontinence care per policy. Resident 22 has been assessed with no negative outcome noted. Resident F is receiving Wound Care per policy. Resident F has been assessed with no negative outcome noted. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. Nursing staff have been reeducated on the Facilitys' Infection Control & Prevention Policy including sanitizing of hands, changing of gloves, incontinence care and wound care. **3) Measures put into place/ System changes:** Nursing staff have been reeducated on the Facilitys' Infection Control & Prevention Policy including sanitizing of hands, changing of gloves, incontinence care and wound care **4) How the corrective actions will be monitored:**	

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	gloves should be changed and hand hygiene should be performed when visibly soiled and in between going from dirty to clean tasks. On 4/9/25 at 12:14 P.M., the Director of Nursing (DON) provided a current, revised 1/31/18 "Glove Use- Nursing" The policy indicated "... non-sterile gloves shall be worn for procedures involving contact with mucus membranes and for resident care...requiring direct contact with body fluids...examples may include... incontinence care...handling of linens, clothing, or other materials soiled with body fluids or blood... Gloves used for contact shall be removed and discarded with each person. fluid item or surface... Hand hygiene will be performed after removing gloves..." 3.1-18(b)(1)		DON/Designee will complete 5 observations of peri care a week for 4 weeks then 5 observations of peri care 3 times a week for 8 weeks to ensure appropriate hand hygiene and glove changing. DON/Designee will complete 5 observations of dressing changes a week for 4 weeks then 5 observations of dressing changes 3 times a week for 8 weeks to ensure appropriate hand hygiene and glove changing. . **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role Based on interview and record review, the facility failed to ensure designation of a certified Infection Preventionist (IP). The IP did not currently dedicate at least part time hours to the role of IP for 1 of 1 staff members reviewed for IP. Finding includes: On 4/9/25 at 9:30 A.M., the DON's employee file	F 0882	**1) Immediate actions taken for those residents identified:** The Facility has Designated Infection Control Preventionist in place for all residents. **2) How the facility identified other residents:**	05/06/2025

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	was reviewed. The employee file lacked a signed job description for the Infection Preventionist role. On 4/9/25 at 9:37 A.M., the DON indicated she was currently responsible for the infection prevention and control program in the facility. She indicated she also worked full time in the facility as the DON. On 4/9/25 at 12:14 P.M., the DON provided a current Infection Preventionist job description, dated 4/14/22, that indicated "Reports to: Director of Nursing and/or Administrator ... The role of the Infection Preventionist is to oversee the infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases". On 4/9/25 at 12:14 P.M., the DON provided a current Director of Nursing job description, dated 5/2/17, that indicated "The primary purpose of the Director of Nursing position is to plan, organize, develop and direct the overall operation of our Nursing Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility".		All residents have the potential to be affected by the alleged deficient practice. An IP Nurse has been hired **3) Measures put into place/ System changes:** An IP Nurse has been hired **4) How the corrective actions will be monitored:** The ADM/Designee will review/discuss weekly times twelve weeks the current status of the Infection Control Processes. The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing in-service education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:	F 9999	**1) Immediate actions taken for those residents identified:** No Resident has been affected by the alleged deficient practice.	05/06/2025

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	(1) Residents' rights. (4) Safety and accident prevention This state rule was not met as evidenced by: Based on interview and record review, the facility failed to maintain personnel records 7 of 10 staff members reviewed. (LPN 20, Receptionist, CNA 19, Minimum Data Set (MDS) Coordinator, CNA 21, RN 4, RN 7) Findings include: On 4/9/25 at 9:30 A.M., employee files were reviewed. The employee files for LPN 20, Receptionist, CNA 19, MDS Coordinator, CNA 21, RN 4, and RN 7 lacked documentation of completed in-services related to residents' rights and abuse after the employee's start date. During an interview on 4/9/25 at 12:30 P.M., the Human Resource Director indicated staff needed one hour of resident rights training. 3.1-14 PERSONNEL (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by:		**2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. Staff have completed the required Training. **3) Measures put into place/ System changes:** Staff have completed the required Training. **4) How the corrective actions will be monitored:** **Administrator will complete 5 employee file reviews a week for 12 weeks to ensure ongoing compliance.** **Identified concerns will be addressed timely and discussed in scheduled morning meetings.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING 00 B. WING	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

(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
	Based on interview and record review, the facility failed to ensure dementia training was completed for 5 of 10 staff members reviewed. (CNA 19, MDS Coordinator, CNA 21, RN 4, RN 7) Findings include: On 4/9/25 at 9:30 A.M., employee files were reviewed. The employee files for CNA 19, MDS Coordinator, CNA 21, RN 4, and RN 7 lacked documentation of a completed in-service related to dementia training. - CNA 19 lacked 3 hours of dementia training. - MDS Coordinator lacked 3 hours of dementia training. - CNA 21 lacked 6 hours of dementia training. - RN 4 lacked 6 hours of dementia training. - RN 7 lacked 6 hours of dementia training. During an interview on 4/9/25 at 12:30 P.M., the Human Resource Director indicated she was not aware of how many dementia in services hours were required annually, but six hours were required for new hires. During an interview on 4/9/25 at 2:00 P.M., the Administrator indicated the facility had no policy that indicated the amount of inservices hours were needed for dementia training.		**patterns and make recommendations to revise the plan of correction as indicated.**	