STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

(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 Complaint IN00452428 and IN00455837. Complaint IN00452428 - Federal/State deficiencies related to the allegations are cited at F623, F625 and F755. Complaint IN00455837 - Federal/State deficiencies related to the allegations are cited at F694, F755 and F842. Survey dates: March 23, 24, 25, 26, 27 and 28, 2025 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 2 Medicaid: 61 Other: 18 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 4/3/2025	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of non-compliance cited during the survey process. Please accept this plan of correction as the provider's credible allegation of compliance. The facility is respectfully requesting a desk review	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Olivia Shirley	Executive Director	04/17/2025

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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	Based on interviews and record review, the facility failed to ensure a resident's choice of code status was documented consistently in the medical record for 1 of 3 residents reviewed for code status (Resident 70). Finding includes: During an interview, on 3/26/2025 at 2:02 P.M., LPN 7 indicated Resident 70 was a full code. During an interview, on 3/27/2025 at 10:00 A.M., the Social Service Designee (SSD) indicated Resident 70 was his own representative, had not been deemed incompetent and was capable of making his own legal decisions. The SSD indicated Resident 70 had reported to her he wanted to be a full code. The clinical record of Resident 70 was reviewed on 3/26/2025 at 9:27 A.M. The resident's diagnoses included but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting the dominant right side, chronic obstructive pulmonary disease, cerebrovascular disease, hypertension, other reflux and obstructive uropathy, dysarthria, and dysphagia. A Quarterly Minimum Data Set assessment, dated 1/3/2025, indicated Resident 70 was cognitively intact. A Physician Order, dated 9/30/2024, indicated Resident 70 had a CPR status (a life-saving emergency procedure used when someone's breathing or heartbeat has stopped, combining chest compressions and rescue breaths to restore blood circulation and oxygenation).	F 0578	**The facility respectfully requests a desk review.** **Alleged deficiency:** Failed to ensure a resident's choice of code status was documented consistently in the medical record. **Corrective Action for resident(s) found to have deficient:** POST form corrected to reflect advance directive with no negative outcome, prior to survey exit. **Identify other residents having same potential deficient:** Residents that have had a admission/readmission to the facility have the potential to be affected by the alleged deficient practice. All current residents have been audited by the Social Service Director/designee, ensuring all orders, careplans, and post forms represent the preferred advanced directive. No other residents were identified as affected. This was audited by nursing during the survey and no other issues identified. **Measures put into place or systemic changes:** The Director of Nursing or designee will provide education to the licensed nurses on the policy/procedures for obtaining and recording advanced directives on admission and readmission, by the day of compliance.	04/28/2025

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	A current Care Plan, dated 9/30/2024, indicated Resident 70 had a full code status. A POST (Physician Orders for Scope of Treatment) form (a medical order form that documents a patient's treatment preference as medical orders that can be easily understood and enacted by health care providers), dated 9/27/2024, indicated Resident 70 had a status of Do Not Attempt Resuscitation (no life-sustaining measures if a person's heart or breathing stops). Resident 70's code status was unclear in the medical record. \ On 3/28/2025 at 1:00 P.M., the Administrator provided a policy titled,"Cardiopulmonary Resuscitation (CPR)," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...facility staff should verify the presence...the resident's wishes with regard to CPR, upon admission...if the resident's wishes are different than the admission orders...facility staff should document the resident's wishes in the medical record..." 3.1-4(l)(5)		**Plan to monitor performance to maintain compliance:** Social Service Director or designee will audit advanced directives on all admissions and readmissions on the next business day for a minimum of 6 months until 100% of compliance is maintained. Audit will ensure orders, care plan, and post forms match and represent the residents choice. If any compliance trends are identified, they will be reviewed in QAPI meetings	
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to provide written notification of a transfer/discharge to the resident or resident's representative for 3 of 3 residents reviewed for hospitalization. (Residents H, L and M) Findings include: 1. A record review was completed on 3/24/2025 at	F 0623	**The facility respectfully requests a desk review.** **Alleged Deficient Practice:** The facility failed to provide the facility's Bed Hold Policy to the resident or resident representative for 3 of 3 residents reviewed for hospitalization. **Corrective Action for resident(s)**	04/28/2025

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	10:14 A.M. for Resident H. Diagnoses included, but were not limited to, schizophrenia. A Quarterly Minimum Data Set (MDS) assessment, dated 1/29/2025, indicated Resident H's cognition was intact. A discharge order, dated 1/7/2025, indicated transfer resident to the hospital for "severe symptoms that cannot be controlled otherwise." During an interview on 3/24/2025 at 1:18 P.M., Resident H indicated he was admitted to a psychiatric hospital on 1/7/2025 and did not receive written notification of the transfer/discharge. A Nurses Progress Note, dated 1/7/2025, indicated Resident H had alerted staff he was in danger of harming himself or others, had not slept in days and was talking to himself. He also made threatening gestures toward staff. A physician's order was received to send the resident to (name of local hospital) for an evaluation. During an interview on 3/25/2025 at 9:25 A.M., LPN 7 indicated the transfer/discharge documentation was to be documented in the "document section" of the clinical record and the Medical Records staff scanned the documentation into the record.. Documents for Resident H's transfer to the hospital, on 1/7/2025, could not be located in his clinical record. During an interview on 3/25/2025 at 9:25 A.M., the Divisional Director of Risk Management indicated there was no signed transfer/discharge notice in the clinical record for the 1/7/2025 hospitalization		**found to have deficient:** Resident H, M and L have returned to the facility with no adverse effects **Identify other residents having same potential deficient:** All residents that discharge from the facility have the ability to be affected by the alleged deficient practice. Facility currently has no residents in the hospital that require transfer/discharge notice or bedhold **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Licensed Nurses have been re-educated on facility Policy & Procedure by the DON/Designee related to transfer/discharge and Bedhold. **Plan to monitor performance to maintain compliance:** DON/designee will audit all discharges on the next business day to ensure the bed hold policy is completed. This audit will be ongoing. A summary of the audits will be presented to the Quality Assurance committee monthly by DON/designee for 6 months.	

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	and the facility should have provided the transfer/discharge notice to the resident. 2. During an interview on 3/23/2025 at 2:08 P.M., Resident M indicated he was hospitalized for urinary retention on 2/21/2025. A record review was completed on 03/25/2025 9:30 A.M. for Resident M. Diagnoses included, but were not limited to, inflammatory polyneuropathy and urinary retention. A Medicare 5 Day Minimum Data Set (MDS) assessment, dated 3/3/2025, indicated Resident M's cognition was moderately impaired. A Nurses Progress note indicated Resident M had been transferred to the hospital on 2/21/2025. The Notice of Transfer/Discharge documentation/form could not be located in the clinical record. During an interview on 3/25/2025 at 9:25 A.M., LPN 7 indicated the transfer/discharge documentation was supposed to be located in the document section of the clinical record and the Medical Records staff scanned them in the record. During an interview on 3/25/2025 at 9:25 A.M., the Divisional Director of Risk Management indicated there was no signed transfer/discharge notice in the clinical record for the 2/21/2025 hospitalization and the facility should have provided the transfer/discharge notice to the resident.3. The clinical record for Resident L was reviewed on 3/25/2025 at 10:15 A.M. The resident's diagnoses included, but were no limited to: multiple sclerosis, adult failure to thrive, chronic pain syndrome, hypertension, repeated			

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	falls, bipolar disorder, anxiety, cannabis use and borderline personality disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated the resident was cognitively intact. A Nursing Note, dated 11/10/2024, indicated Resident L was transferred to (name of local hospital). The note also indicated Resident L was her own representative. A Nursing Admission Evaluation, dated 11/23/2024, indicated Resident L had been re-admitted back to the facility on 11/23/2024 at 2:30 P.M. During an interview, on 3/25/2025 at 1:51 P.M., the Social Service Designee (SSD) indicated she was unable to find a signed bed hold notice or a signed transfer/discharge notice in Resident L's electronic chart. During an interview, on 3/25/2025 at 2:09 P.M., the Divisional Director of Risk Management indicated there was no signed bed hold and no signed transfer notice in Resident L's chart for the 11/9/2024 through 11/23/2024 hospitalization. She indicated the facility had not provided the resident with a written transfer policy or a bed hold policy prior to or immediately after the resident's transfer from the facility. During an interview, on 3/25/2025 at 3:02 P.M., Resident L indicated the staff had not provided any paperwork for her to sign prior to her hospitalization in November 2024. On 3/25/2025 at 2:35 P.M., the Divisional Director of Risk Management provided a policy titled,			

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	"Transfer and Discharge Policy", undated and indicated the policy was the one currently used by the facility. The policy indicated "...present the Acute Transfer Letter to the resident prior to the transfer unless the resident is incapable of understanding due to cognitive impairment or unless the transfer is an emergency..." This citation relates to complaint IN00452428. 3.1-12(a)(6)(i)			
F 0625 SS=E 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 provide the facility's Bed Hold Policy to the resident or resident representative for 3 of 3 residents reviewed for hospitalization. (Residents H, L and M) Findings include: 1. A record review was completed on 3/24/2025 at 10:14 A.M. for Resident H. Diagnoses included, but were not limited to, schizophrenia. A Quarterly Minimum Data Set (MDS) assessment, dated 1/29/2025, indicated Resident H's cognition was intact. A discharge order, dated 1/7/2025, indicated transfer resident to the hospital for "severe symptoms that cannot be controlled otherwise." During an interview on 3/24/2025 at 1:18 P.M., Resident H indicated he was admitted to a psychiatric hospital on 1/7/2025 and had not received a copy of the facility's Bed Hold Policy.	F 0625	**The facility respectfully requests a desk review.** **Alleged Deficient Practice:** The facility failed to provide the facility's Bed Hold Policy to the resident or resident representative for 3 of 3 residents reviewed for hospitalization. **Corrective Action for resident(s) found to have deficient:** Resident H, M and L have returned to the facility with no adverse effects **Identify other residents having same potential deficient:** All residents that discharge from the facility have the ability to be affected by the alleged deficient practice. Facility currently has no residents in the hospital that require transfer/discharge notice or bedhold **What measures will be put into place or what systemic changes will be made to**	04/28/2025

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	A Nurses Progress Noted, dated 1/7/2025, indicated Resident H had alerted staff he was in danger of harming himself or others, had not slept in days and was talking to himself. He also made threatening gestures toward staff. A physician order was received to send the resident to (name of local hospital) for an evaluation. During an interview on 3/25/2025 at 9:25 A.M., LPN 7 indicated a copy of the Bed Hold Policy issue to Resident H would be located in the "document section" of the clinical record. The copy of the Bed Hold Policy would have been scanned into the electronic record by the Medical Records staff. Documents pertaining to Resident H's transfer to the hospital could not be located in the clinical record. During an interview on 3/25/2025 at 9:25 A.M., the Divisional Director of Risk Management indicated there was no copy of the facility's Bed Hold Policy in the clinical record for the 1/7/2025 hospitalization and the facility should have provided a copy of the facility's Bed Hold Policy to the resident. 2. During an interview on 3/23/2025 at 2:08 P.M., Resident M indicated he was hospitalized for urinary retention on 2/21/2025. A record review was completed on 03/25/2025 9:30 A.M. for Resident M. Diagnoses included, but were not limited to, inflammatory polyneuropathy and urinary retention. A Medicare 5 Day Minimum Data Set (MDS) assessment, dated 3/3/2025, indicated Resident M's cognition was moderately impaired.		**ensure that the deficient practice does not recur:** Licensed Nurses have been re-educated on facility Policy & Procedure by the DON/Designee related to transfer/discharge and Bedhold. **Plan to monitor performance to maintain compliance:** DON/designee will audit all discharges on the next business day to ensure the bed hold policy is completed. This audit will be ongoing. A summary of the audits will be presented to the Quality Assurance committee monthly by DON/designee for 6 months.	

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	A Nurses Progress Noted indicated Resident M was transferred to the hospital on 2/21/2025. A copy of the facility's Bed Hold Policy could not be found in the clinical record. During an interview on 3/25/2025 at 9:25 A.M., LPN 7 indicated copy of the facility's Bed Hold Policy would have been scanned into the electronic clinical reord by the Medical Records staff. During an interview on 3/25/2025 at 9:25 A.M., the Divisional Director of Risk Management indicated there was no copy of the facility's Bed Hold Policy in the clinical record for Resident M's 2/21/2025 hospitalization and the facility should have provided a copy of the facility's Bed Hold Policy to the resident.3. The clinical record of Resident L was reviewed on 3/25/2025 at 10:15 A.M. The resident's diagnoses included, but were no limited to: multiple sclerosis, adult failure to thrive, chronic pain syndrome, hypertension, repeated falls, bipolar disorder, anxiety, cannabis use and borderline personality disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated the resident was cognitively intact. A Nursing Note, dated 11/10/2024, indicated Resident L was transferred to (name of local hospital) and indicated Resident L was her own representative. A Nursing Admission Evaluation, dated 11/23/2024, indicated Resident L had been re-admitted back to the facility on 11/23/2024 at 2:30 P.M.			

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	During an interview, on 3/25/2025 at 1:51 P.M., the Social Service Designee (SSD) indicated she was unable to locate a signed bed hold notice or a signed transfer notice in Resident L's electronic record. During an interview, on 3/25/2025 at 2:09 P.M., the Divisional Director of Risk Management indicated there was no signed bed hold and no signed transfer notice in Resident L's chart for the 11/9/2024 through 11/23/2024 hospitalization. She indicated the facility had not provided the resident with a written transfer policy or a bed hold policy prior to or immediately after the resident's transfer from the facility. During an interview, on 3/25/2025 at 3:02 P.M., Resident L indicated the staff had not provided any paperwork for her to sign prior to her hospitalization in November of 2024. On 3/25/2025 at 2:35 P.M., the Director of Nursing (DON) provided a policy titled, "Bed Hold Policy," undated and indicated the policy was the one currently used by the facility. The policy indicated "...the bed hold authorization form may be signed prior to the patient leaving the building, or within 24 hours...in the event a resident returns to the hospital...the nurse or designee will present the Acute Transfer Letter at time of transfer with a copy going with the resident..." This citation relates to complaint IN00452428. 3.1-12(a)(26)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents			

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	Based on observation, interview and record review, the facility failed to ensure showers, hair care and/or nail care were provided for 2 of 6 residents. (Resident L- showers and hair care, Resident K- nail care) Findings include: 1. During an observation and interview, on 3/23/2025 at 1:51 P.M., Resident L indicated she could not recall the last shower she had been offered and had had bed baths only. She indicated the last bed bath she had received was given about a week ago. Resident L had a mass of hair that was matted. The matted hair was the size of a softball and was located at her back of her head. Resident L indicated she had only been offered disposable shower caps in regards to shampooing and does not remember the last time her hair was washed in a shower or was brushed. During an observation and interview, on 3/25/2025 at 9:14 A.M., Resident L indicated she still had not had a shower. The back of Resident L's hair still had a softball-sized hair matt present. During an interview, on 3/25/2025 at 11:10 A.M., CNA 9 indicated she had frequently offered her residents daily bed baths due to the bed bound status of many of the facility's residents. CNA 9 indicated she provided a disposable hair shampoo bonnet,as well as hair care, after a resident's bed bath. CNA 9 indicated she had attempted to brush out Resident L's hair matts 2 days ago but the resident's hair had become tangled again within a few days. During an observation and interview, on 3/26/2025 at 9:58 A.M., Resident L was observed with uncombed hair with a visible, large softball-sized tangled hair matt in the posterior of her head. The	F 0677	**The facility respectfully requests a desk review.** **Alleged Deficient Practice:** Residents could not be identified due to complaint survey. Residents were not harmed by the alleged deficient practice. Failed to provide hair care and toe nail trimming **Correcti ve Action for resident(s) found to have deficient:** Resident immediately given shower and hair combed through prior to survey exit. Identified residents Resident L had a shower during the survey and hair was braided. Resident #22 has seen podiatrist and had toenails trimmed. **Identify other residents having same potential deficient:** All residents who require assistance with ADLs have the potential to be affected by same alleged deficient practice. All residents who require assistance with ADLs have been reviewed to ensure showers and/or nail care has been provided. **Measures put into place or systemic changes:** DON/Designee has educated nursing staff on the routine resident care policy with a focus on showering and nail care. **Plan to monitor performance to maintain compliance:**	04/28/2025

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	resident indicated she could not remember the last time had staff assisted her with brushing her hair. During an interview, on 3/26/2025 at 10:10 A.M., CNA 10 indicated she had showered residents twice a week unless the resident's care plan dictated the resident was to be cleaned more frequently. During an interview, on 3/26/2025 at 11:22 A.M., the Divisional Director of Risk Management indicated Resident L was showered and had her hair brushed and braided. During an interview, on 3/26/2025 at 3:33 P.M., CNA 11 indicated she bathed her residents twice a week and it included a disposable shampoo cap and nail care if the resident was not diabetic. The clinical record of Resident L was reviewed on 3/25/2025 at 10:15 A.M. The resident's diagnoses included, but were no limited to: multiple sclerosis, adult failure to thrive, chronic pain syndrome, hypertension, repeated falls, bipolar disorder, anxiety, cannabis use and borderline personality disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated the resident was cognitively intact, was dependent for showering and/or bathing and required substantial assistance for personal hygiene. A current Care Plan, revised 3/17/2025, indicated Resident L had an Activity of Daily Living (ADL) Self-Care Performance deficit. Interventions included, but were not limited to: shower/bathe- Resident L was dependent with two or more helpers to do all the effort of the task and personal hygiene- Resident L required substantial		DON/Designee will audit 5 residents requiring assistance with shaving/ showering and nail care. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. The results of these audits/observations will be reported, reviewed and trended for compliance and further follow up through the facility QAPI Committee. Ongoing, the angel round manager assigned to residents will ask the resident about facility compliance. The DON/designee will also monitor regarding their preferences as well as monitoring the shower sheets for trends of refusals and compliance.	

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	155496	A. BUILDING 00 B. WING	03/28/2025

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	assistance for more than half the effort of the task. The shower documentation, dated 2/13/2025 thru 3/27/2025, indicated Resident L was only documented as having received showers on the following dates: -2/13/2025, 2/21/2025, 3/4/2025, 3/7/2025, 3/10/2025, 3/14/2025, 3/21/2025 and 3/25/2025. Resident L had not received 5 of the scheduled 13 showers during the time frame. It was unclear why Resident L had not received hair care to prevent her hair from becoming matted. 2. A record review was completed on 3/27/2025 at 10:22 A.M. for Resident 22. Diagnoses included, but were not limited to dementia. An Annual Minimum Data Set (MDS) assessment, dated 1/20/2025, indicated Resident 22's cognition was severely impaired and was dependent for shower/bathing needs. A current Care Plan, revised on 1/22/2025, indicated Resident 22 was dependent for shower/bathing and staff performed all care tasks. Observations on 3/23/2025 at 12:11 P.M., 3/25/2025 at 9:16 A.M., and 3/27/2025 at 1:45 P.M., indicated Resident 22's toenails were very long and had grown past the end of her toes. During an interview on 3/27/2025 at 1:48 P.M. CNA 14 indicated a shower included washing a resident's hair with shampoo, washing their body, drying their body, applying lotion, got dressing the reisdent. She indicated nail care was included in the showering process. CNA 14 indicated Resident 22 had received a shower twice a week and if she refused, they re-approached the resident and reported the refusal to the nurse.			

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	During an interview on 3/27/2025 at 1:52 P.M., LPN 8 indicated the nurse was responsible for trimming toenails and if a podiatrist was needed, they let the Social Worker know to add the resident to the list for the podiatry visit. During an interview on 3/27/2025 at 2:11 P.M., the Social Worker Designee indicated the nursing staff let her know who needed to see the podiatrist. She indicated the nusing staff had not reported that Resident 22 needed to be seen by the podiatrist. On 3/28/2025 at 1:10 P.M., the Director of Nursing (DON) provided an undated policy title, "Foot Care" and indicated it was the policy currently used by the facility. The policy indicated, "... Foot care is often performed in conjunction with shower/bathing... In some residents, foot care including trimming of nails should only be performed by a professional...." 3.1-38(a)(3)(A) 3.1-38(a)(3)(B)			
F 0694 SS=E Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, interview and record review, the facility failed to change the dressings of residents who had a peripherally inserted central catheter (PICC) line for 3 of 3 residents whose PICC lines were reviewed. (Residents B, D and C) Findings include: 1. During an observation on 3/24/2025 at 3:02 P.M., Resident B's PICC line dressing was dated, 3/14/2025 and was rolled up with the insertion site	F 0694	**The facility respectfully requests a desk review.** **Alleged Deficiency:** The facility failed to ensure accurate documentation of PICC dressing changes for 3 of 3 residents reviewed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/28/2025

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	exposed. Resident B indicated the dressing had not been changed in over a week. During an interview on 3/24/2025 at 3:05 P.M., LPN 6 indicated the PICC line dressing should not be rolled up and the dressing should have been changed after seven days. Resident B's record review was completed on, 3/25/2025 at 8:30 A.M. Diagnoses included, but were not limited to: subacute osteomyelitis of the left ankle and foot, Type 1 diabetes mellitus, methicillin-resistant staphylococcus aureus, below-knee amputation of right leg. An Admission Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated Resident B had intact cognition. A current Physician's order, dated 3/14/2025, indicated Resident B's PICC line dressing was to be changed every Friday on day shift (6:00 A.M. -2:00 P.M.). A current Care Plan, initiated on 3/5/2025, indicated Resident B was on intravenous (IV) antibiotics for treatment of osteomyelitis. The goal for the Care Plan was to be free of infection at insertion site. Interventions included, but were not limited to: visually inspect IV site each shift. Resident B's record lacked the documentation he had refused any dressing changes. 2. A record review was completed on 3/25/2025 at 2:45 P.M. for Resident D. Diagnoses included, but were not limited to, pneumonia. An Admission Minimum Data Set (MDS) assessment, dated 3/8/2025, indicated Resident D's cognition was intact.		**practice**: Dressings changed prior to survey exit. **Identify other residents having same potential deficient:** All residents with PICC lines have the potential to be affected by the same deficient practice. No residents harmed by the alleged deficiency. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur** All nursing staff were in serviced on PICC line dressing change policy as well as documentation. **Plan to monitor performance to maintain compliance** DON/designee will audit all new admissions and re admissions with PICC lines daily to ensure appropriate medical record documentation is completed. Current residents will be audited weekly while they have their PICC line to ensure dressing changes are done appropriately. A summary of the audits will be presented to the Quality Assurance committee monthly by DON/designee for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	

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	A Physician Order, dated 3/14/2025, indicated the PICC line dressing was to be changed once weekly, on Fridays. During an observation on 3/24/2025 at 11:07 A.M., the dressing for a peripherally inserted central catheter (PICC), a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart, in Resident 76's left upper arm, was peeled up along all edges of the transparent dressing and was dated 3/3/2025. During an interview on 3/24/2025 at 11:07 A.M., the Unit Manager indicated the dressing should have been changed every week. 3. During an observation, on 3/24/2025 at 10:08 A.M., Resident C had a PICC (peripherally-inserted central catheter) (a long, thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart and used for long-term intravenous access for medications, fluids, or blood draws, and can stay in place for weeks or months) visible to his right upper arm with a dressing dated 3/14 which was peeling up slightly at the very base of the dressing. During an interview, on 3/24/2025 at 11:06 A.M., LPN 6 indicated Resident C's PICC dressing should have been changed weekly. During an observation and interview, on 3/25/2025 on 11:34 A.M., observed Resident C's right upper arm without the presence of a PICC or a dressing, the inside of Resident C's right upper arm had a quarter-sized purple/green bruise without a hematoma or drainage. Resident C indicated his PICC was removed yesterday.			

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	The clinical record of Resident C was reviewed on 3/26/2025 at 1:25 P.M. The resident's diagnoses included, but were no limited to: cerebral ischemia, cerebral amyloid angiopathy, morbid obesity, chronic kidney disease, systolic and diastolic congestive heart failure, venous insuffiency, chronic venous hypertension, obstructive sleep apnea, ischemic cardiomyopathy, paroxysmal atrial fibrillation, occlusion and stenosis of bilateral carotid arteries, ventral hernia, spinal stenosis and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/2025, indicated Resident C was cognitively intact. The MDS assessment indicated the resident had been receiving IV medications. A Physician Order, dated 1/29/2025, indicated the PICC line site dressing was to be changed weekly on Fridays. A current Care Plan, revised on 2/10/2025, indicated Resident C had received intravenous antibiotics due to osteomyelitis (bone infection). Interventions included but were not limited to: change the dressing weekly for the PICC line. During an interview, on 3/28/2025 at 9:00 A.M., LPN 7 indicated in the chart that everything in the electronic medical record would turn green when all tasks and medications were completed. LPN indicated there was a QMA (qualified medication aide) on the hall on 3/21/2025 and the QMA had clicked on the PICC dressing change without having done the PICC dressing change yet. LPN 7 had then charted the PICC dressing change task in error due to "being in a different mindset" with the QMA on the hall.			

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	On 3/28/2025 at 1:00 P.M., the Administrator provided a policy, "Pharmscript Infusion Intravenous Access Line Maintenance Protocol," dated 2/7/2020 and indicated the policy was the one currently used by the facility. The policy indicated "...PICC dressing changes on admission or 24 hours post-insertion, then weekly and as needed..." This citation relates to complaint IN00455837. 3.1-47(a)(2)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to provide medications to residents as ordered by the Physician for 4 of 6 residents whose medications were reviewed. In addition, the facility failed to appropriately store medications in 1 of 3 Medication Carts reviewed. (Residents F, N, O, C & 100 Hall Medication Cart) Findings include: 1. Resident F's record review was complete on 3/27/2025 at 10:10 A.M. Diagnoses included, but were not limited to: Parkinson's disease, anxiety disorder, insomnia, history of myocardial infarction and major depressive disorder. A current Physician's order, dated 4/6/2024, indicated Resident F was to receive the following mediations: - 0.4 milligram (mg)/hour transdermal nitroglycerin patch (treats chest pain) every morning. -20 mg of omeprazole (treats heartburn) every morning.	F 0755	**The facility respectfully requests a desk review.** **Alleged deficiency:** Failed to provide medications to residents as ordered by the physician for residents F, N, O, C. In addition, the facility failed to appropriately store medications in 1 of 3 medication carts reviewed. **Corrective Action for resident(s) found to have deficient**: Physician and responsible party notified of medications/treatments not signed out for Residents F,N,O and C. Expired insulin was removed and replaced from medication cart #1. Eye drops that did not have a date unopened were removed and replaced. Medication Cart #1 had medications rearranged to ensure medications in the correct storage area in medication cart.	04/28/2025

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	A current Physician's order, dated 10/5/2025, indicated Resident F was to receive 50 mg of trazodone (sleep aid) at bedtime. A March 2025 Medication Administration Record (MAR) indicated Resident F had not received the 0.4 mg nitroglycerin patch or the 50 mg of omeprazole on 3/8/2025 and he had not received his trazodone on 3/14/2025. Resident F's record lacked the documentation he had refused his medications or a Physician had been notified that he had missed doses of his medications. 2. Resident N's record review was completed on 3/27/2025 at 11:30 A.M. Diagnoses included, but were not limited to: dementia with psychotic disturbance, major depressive disorder, generalized anxiety disorder and anorexia. Current Physician's orders for Resident N included orders for the following medications: - 7.5 mg milligrams (mg) of mirtazapine (appetite stimulant) at bedtime. - 10 mg of melatonin (sleep aid) at bedtime. A March 2025 Medication Administration Record (MAR) indicated Resident N had not received 7.5 mg of mirtazapine or 10 mg of melatonin on 3/2, 3/7 or 3/9/2025. Resident N's record lacked the documentation she had refused her medications or a Physician had been notified that she had missed doses of her medications. 3. Resident O's record review was complete on 3/27/2025 at 1:30 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 with		**Identify other residents having same potential deficient:** An audit has been completed for all residents, Physician and responsible parties notified of any medications/ treatments not signed out. An audit has been completed on all medication carts to ensure medication storage is correct, and any medications that have expired or did not contain a date opened have been removed. **Measures put into place or systemic changes:** Licensed Nurses and QMA's have been educated on facility Policy & Procedure related to Medication Pass to include signing out all medications administered and Medication Storage. **Plan to monitor performance to maintain compliance:** The Director of Nursing or designee will audit to identify medications not given and that medications are properly stored in the carts. Audit will be performed on all medication carts within a 1-week period x 1, then two medication carts per week x 1 month, then one medication cart weekly x 1 month, then two carts per month x 3 months until 100% compliance. MAR and TAR's will be reviewed to ensure compliance If any compliance trends are identified, they will be reviewed in QAPI meeting.	

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	diabetic neuropathy, cerebral palsy, hypertension, and dementia. Current Physician's orders for Resident O included orders for the following medications: - 5 units of insulin glargine at bedtime. - 5 milligrams (mg) of terazosin (controls high blood pressure) at bedtime. - 2 to 10 units of Novolog (insulin) daily at 4:00 P.M., depending on her blood sugar test results. A March 2025 Medication Administration Record (MAR) indicated Resident O had not received 5 units of insulin glargine or 5 mg of terazosin on 3/7 or 3/9/2025, and she had not received her 4:00 P.M. dose of novolog on 3/17/2025. Resident O's record lacked the documentation she had refused her medications or a Physician had been notified that she had missed doses of her medications. During an interview on 3/28/2025 at 1:13 P.M., the Director of Nursing (DON) indicated she believed all the medications had been given but the staff had forgotten to sign off on the administration. She indicated staff should sign off on the medication after it was given. 3. The clinical record of Resident C was reviewed on 3/26/2025 at 1:25 P.M. The resident's diagnoses included, but were no limited to: cerebral ischemia, cerebral amyloid angiopathy, morbid obesity, chronic kidney disease, systolic and diastolic congestive heart failure, venous insuffiency, chronic venous hypertension, obstructive sleep apnea, ischemic cardiomyopathy, paroxysmal atrial fibrillation, occlusion and stenosis of bilateral carotid arteries, ventral hernia, spinal stenosis and diabetes mellitus.			

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	A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/2025, indicated Resident C was cognitively intact. The MDS assessment indicated the resident had received insulin, anticoagulants, diuretic and an anticonvulsant. Physician Orders for Resident C, included but were not limited to: -Atorvastatin Calcium Oral Tablet 80 MG (milligram) (Atorvastatin Calcium) -Give 1 tablet by mouth at bedtime, -Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/mL (milliliter) (Insulin Glargine) - Inject 10 units subcutaneously at bedtime, - Insulin Lispro Injection Solution 100 unit/mL (Insulin Lispro) - Inject subcutaneously before meals with sliding scale, - Santyl External Ointment 250 unit/Gm(gram) (Collagenase) - Apply to rIght lower extremity topically every evening shift for wound care. Cleanse wound to right lateral inferior lower leg with normal saline, pat dry, spread a santyl nickel thick on adaptic and place on wound, cover with ABD pads and wrap with Kerlix, secure with tape and apply TubiGrip G daily until healed, - Ertapenem Sodium Injection Solution reconstituted 1 gram IV (intravenously) in the morning, and - Vancomycin Hydrochloride Intravenous Solution 1000 mg/ 250 mL 1 gram every day. The March 2025 Medication Administration Record for Resident C indicated the following missed medications and treatments: -Atorvastatin Calcium Oral Tablet 80 mg on 3/8 - Ertapenem Sodium 1 gram on 3/5 and 3/6 - Lantus SoloStar Subcutaneous Solution Pen-injector 10 units at bedtime on 3/8, 3/10 and 3/19			

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	- Santyl External Ointment 250 unit/G on 3/2, 3/5, 3/8, 3/10, 3/14, 3/15, 3/16, 3/19 and 3/22 - Vancomycin Hydrochloride Intravenous Solution 1000 mg/ 250 mL 1 gram: on 3/13. During an interview, on 3/28/2025 at 1:14 P.M., the Director of Nursing (DON) indicated she believed the missing and undocumented medications and treatments on the Medication Administration Records had been given. The DON indicated the medications and treatments should have been signed off only after it had been given or completed. 4. On 3/28/2025 at 10:37 A.M., a medication storage observation was completed with QMA 12 on the 100 Hall cart, cart one and the following was observed: -Two opened bottles of eye drops not in a pharmacy labeled container sitting on top of a packages of nicotine patches and in with a box of antibiotic oral medication. On 3/28/2025 at 10:45 A.M., a medication storage observation was completed with QMA 12 on the 100 Hall cart, cart two and the following was observed: -An open bottle of eye drops undated and not in a pharmacy labeled container. -An open Humalog pen with an open date of 2/27/2025. During an interview on 3/28/2025 at 10:55 A.M., QMA 12 indicated eye drops should not have been mixed with other types of medication and it should have been in a pharmacy labeled container. She indicated that the insulin pen was used to administer insulin that morning and should not have been used since it was expired. On 3/28/2025 at 1:10 P.M., the DON provided a			

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	policy titled, "Storage of Medication," 8/2024, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The provider pharmacy dispenses medication in container that meet regulatory requirements, including standards set forth by the United States Pharmacopoeia (USP) Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medication to the original container. 4. Orally administered medication are stored separately from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye mediations are stored separately per facility policy. 6. The nurse will check the expiration date of each medication before administering it. 7. No expired medication will be administered to a resident....." On 3/28/2025 at 3:12 P.M., the ED provided a policy titled, "Medication Administration," undated, and indicated the policy was the one currently used by the facility. The policy indicated "... I. Procedure: dd. Medications will be charted when given. IV. Documentation a. Documentation of medication will be current for medication administration. b. Documentation will follow accepted standards of nursing practice....." This citation relates to complaints IN00452428 and IN00455837. 3.1-25(g)(1)(o) 3.1-25(b)(3)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record	F 0812	**The facility respectfully**	04/28/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

(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
	review, the facility failed to store and serve food in a sanitary manner in the pantries, dining rooms, and kitchen. This had the potential to affect 81 of 81 residents who consumed food from the kitchen, pantries and dining room. Findings include: 1. During the initial kitchen tour with dietary aide 2 on 3/23/2025 at from 10:00 A.M. - 10:30 A.M., the following was observed: -the reach-in freezer had an unsealed and undated bag of pollack fish and potato patties, unsealed boxes of chicken patties, biscuits, cinnamon rolls, frozen cookie dough, pretzels, 2 boxes of dinner rolls, and an employee's bottle of water. - the refrigerator had opened unsealed bags of mozzarella cheese and parmesan cheese, an undated package of hot dogs, celery and an undated pan of broccoli/cauliflower mix. -the dry goods room had an undated package of elbow noodles, an open package of hamburger buns and an open container of powdered milk. During an interview at 10:10 A.M. the dietary aide indicated all food should be dated and properly sealed and no employee beverages should be stored in the freezer. 2. During a return trip to the kitchen on 3/23/2025 at 11:05 A.M., the following was observed: -A soup bowl was noted lying on top of the brown sugar and powdered sugar in the bins. -Seven spice lids were open on a shelf and a bottle of Dawn dishwashing soap was stored next to the spices. During an interview on 3/23/2025 at 11:10 A.M.,		**requests a desk review.** **Alleged deficiency:** The facility failed to store and serve food in a sanitary manner in the pantries, dining rooms, and kitchen. **Corrective Action for resident(s) found to have deficient:** Items not dated were dated and/or disposed of prior to the exit survey. Bowl was removed from the sugar bins and spice lids were closed and dish liquid stored appropriately. Staff educated on the need for lids on pitchers as well as proper serving of food. **Identify other residents having same potential deficient:** No residents harmed by the alleged deficiency. All other residents have the potential to be affected by the deficient practice. **Measures put in place or systemic changes:** Staff reeducated on dating, storing, and serving food in a sanitary manner. **Plan to monitor performance to maintain compliance:** ED or Designee will audit all open containers to ensure date open labels are present and other food items to ensure they are stored appropriately daily for two weeks, twice weekly for one month, one time weekly for one month, and one time monthly x 3 months until 100% compliance is acheived . Meals will be audited daily by the appropriate meal manager to ensure pitchers have lids and plates are served appropriately.	

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	the Dietary Manager indicated there should not have been any bowls in the bins, the lids to the spices should have been closed and the dish soap should not have been on that shelf with the spices. 3. During an observation of meal service in the Main Dining Room on 3/23/2025 at 12:15 P.M., the following was observed: -Punch and lemonade pitchers were on a cart with the lids off. -CNAs served the beverages from the pitchers without the lids. -CNA served meal plates with their thumb on the eating surface of the dinner plates. During an interview on 3/23/2025 at 12:41 P.M., CNA 13 indicated he should have served the meal plate with his thumb/hand underneath the plates and the beverage pitchers should have had lids on them. 4. During an observation of the Memory Care's Pantry refrigerator on 3/24/2025 at 9:27 A.M., the following was observed: -Four containers of fruit/cottage cheese, an opened container of sour cream and bag of shredded cheese were unlabeled. During an interview on 3/24/2025 at 9:27 A.M., the Mobile Dietary Manager indicated the items should have been labeled with a name and date. On 3/24/2025 at 9:07 A.M., the ED provided a policy titled, "Safe Handling for Foods from Visitors," revised on 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated "...4. Label foods with the		Audits will be reviewed monthly at QAPI, and will adjust as needed.	

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	resident name and the current date....." And a policy titled, "Food Storage: Cold Foods,"revised 2/2023. The policy indicated "...5. All foods will be stored and wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination....." And a policy titled, "Food Storage: Dry Goods," revised 2/2023. The policy indicated "...5. All packaged and canned food items will be kept clean, dry, and properly sealed. 6. Storage area will be neat, arranged for easy identification, and date marked as appropriate....." 3.1-21(3)			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observation, record review and interview, the facility failed to ensure accurate documentation of PICC (peripherally-inserted central catheter) dressing changes for 3 of 3 residents reviewed. (Residents C, D and B) Findings include: 1. During an observation, on 3/24/2025 at 10:08 A.M., Resident C had a PICC line to his right upper arm with a dressing, dated 3/14/25, peeling up slightly at the very base. The clinical record of Resident C was reviewed on 3/26/2025 at 1:25 P.M. The resident's diagnoses included, but were not limited to: cerebral ischemia, cerebral amyloid angiopathy, morbid obesity, chronic kidney disease, systolic and diastolic congestive heart failure, venous insuffiency, chronic venous hypertension, obstructive sleep apnea, ischemic cardiomyopathy, paroxysmal atrial fibrillation,	F 0842	**The facility respectfully requests a desk review.** **Alleged Deficiency:** The facility failed to ensure accurate documentation of PICC dressing changes for 3 of 3 residents reviewed. Resident B &D have been discharged. Pic Line dressings changed on March 24th. Resident C no longer has a PIC line. Dressing was changed on March 24th. **Identify other residents having same potential deficient:** An audit has been completed to ensure any resident with a PIC line has had dressing changes completed per order **What measures will be put into place or what systemic changes will be made to**	04/28/2025

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	occlusion and stenosis of bilateral carotid arteries, ventral hernia, spinal stenosis and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/2025, indicated Resident C was cognitively intact. The MDS assessment indicated the resident had been receiving insulin, anticoagulants, diuretic, an anticonvulsant and IV(intravenous) medications. A Physician Order, dated 1/29/2025, indicated the PICC line site dressing change was to be done weekly on Fridays. The March Treatment Administration Record 2025 indicated the PICC line dressing change was completed on 3/21/2025 but Resident C's PICC line dressing was dated 3/14. During an interview, on 3/24/2025 at 11:06 A.M., LPN 6 indicated Resident C's PICC line dressing should have been changed weekly. During an interview, on 3/28/2025 at 9:00 A.M., LPN 7 indicated in the chart that everything in the electronic medical record would have turned green when all tasks and medications were completed. LPN 7 indicated there was a QMA (qualified medication aide) on the hall on 3/21/2025 and LPN 7 indicated she may have clicked on the PICC dressing change without having done the PICC dressing change yet. LPN 7 had charted the PICC dressing change in error due to being in a "different mindset" with the QMA on the hall. During an interview, on 3/28/2025 at 1:14 P.M., the Director of Nursing (DON) indicated the medications or treatments should have been signed off only after they had been given or		**ensure that the deficient practice does not recur** DON/Designee has re-educated licensed nurses on signing out and following MD orders related to PIC line dressings **Plan to monitor performance to maintain compliance** DON/designee will audit all new admissions and re admissions with PICC lines daily to ensure appropriate medical record documentation is completed. Current residents will be audited weekly while they have their PICC line to ensure dressing changes are done appropriately. A summary of the audits will be presented to the Quality Assurance committee monthly by DON/designee for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	

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	completed. 2. During an observation of Resident D's peripherally inserted central catheter (PICC), a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart, on 3/24/2025 at 11:07 A.M., the date on the dressing over the insertion site was 3/3/2025. During an interview on 3/24/2025 at 11:07 A.M., the Unit Manager indicated the PICC line dressing should have been changed weekly. Documentation on the Treatment Administration Record (TAR) indicated the dressing was changed on 3/14/2025 and 3/21/2025. During an interview on 3/27/2025 at 9:59 A.M., LPN 8 indicated the dressing should have been changed on 3/14/2025 and she was not sure how her initials had been documented on the TAR as having chnaged the dressing. LPN 8 indicated she must have documented it accidentally. During an interview on /28/2025 at 11:23 A.M., LPN 4 indicated PICC line dressings should be changed weekly. His initials on the TAR on 3/21/2025 was more than likely because he had passed it off to the next shift but he should not have signed off that he had xompleted the dressing change. 3. During an observation on 3/24/2025 at 3:02 P.M., Resident B's PICC dressing was dated, 3/14/2025 and was rolled up with the insertion site exposed. Resident B indicated the dressing had not been changed in over a week. During an interview on 3/24/2025 at 3:05 P.M., LPN 6 indicated the PICC dressing should not be rolled up and the dressing should have been changed after seven days.			

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	Resident B's record review was completed on, 3/25/2025 at 8:30 A.M. Diagnoses included, but were not limited to: subacute osteomyelitis of the left ankle and foot, Type 1 diabetes mellitus, methicillin-resistant staphylococcus aureus, below-knee amputation of right leg. A current Physician's order, dated 3/14/2025, indicated Resident B's PICC dressing was to be changed every Friday on day shift (6:00 A.M.-2:00 P.M.). A current Care Plan, dated 3/5/2025, indicated Resident B was on intravenous (IV) antibiotics for the treatment of osteomyelitis. The goal was to be free of infection at the insertion site. Interventions included, but were not limited to: visually inspect IV site each shift. Resident B's March 2025 Medication Administration Record (MAR), indicated LPN 7 had changed the PICC dressing on 3/21/2025. Resident B's record lacked the documentation he had refused any dressing changes. During an interview on 3/28/2025 at 8:58 A.M., LPN 7 indicated it was her initials on Resident B's PICC dressing change for 3/21/2025 on March 2025's MAR. She indicated the process for signing off on a task was to mark the task complete in the Electronic Medical Record after the task was completed and she had made a mistake by signing off on the PICC dressing change when the task had not been completed. On 3/28/2025 at 2:30 P.M., the Director of Nursing (DON) provided an undated policy, titled, "Clinical Documentation Standards" and			

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	identified it as the policy currently used by the facility. The policy indicated, "... Nurses will follow the basic standard of practice for documentation including, but not limited to providing a timely and accurate account of resident information in the medical record... b. The nurse is expected to: i. Document accurately and truthfully to the best of his/her knowledge...." This citation relates to complaint IN00455837. 3.1-50 (a)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review the facility failed to follow the standards of practice for infection control for 1 of 1 resident reviewed for tracheostomy care (Resident 3), for 2 of 3 residents reviewed for PICC line care (Residents B and 76) and 2 residents observed for mediction administration. (Resident K and 13) Findings include: 1. During an observation on 3/24/2025 at 9:27 A.M. Resident 3's tracheostomy stoma dressing was dirty with yellowish/brown stains and was not dated. A record review was completed on 3/25/2025 09:53 A.M. for Resident 3. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and tracheostomy. A Quarterly Minimum Data Set MDS) assessment, dated 1/10/2025, indicated Resident 3's cognition was intact and received tracheostomy care.	F 0880	**The facility respectfully requests a desk review.** **Alleged Deficiency:** The facility failed to ensure standards of practice for infection control. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Trash was removed from room for Resident 3. Resident 76 no longer resides at the facility. Resident B no longer resides at the facility. Resident K had no negative outcome related to lack of barrier on over bed table for eye drops. Resident 13 had no negative outcome related to the disinfecting of glucometer. **Identify other residents having same potential deficient:** All	04/28/2025

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	Physician Orders included, but were not limited to, an order on 3/13/2025 to cleanse the tracheostomy site with normal saline, pat dry, apply gauze and secure with tape until healed. A current Care Plan revised on 8/8/2024, indicated the tracheostomy was discontinued and care to the stoma was to be done per physician orders. During an observation of tracheostomy stoma care and dressing change on 3/25/2025 at 1:38 P.M., LPN 8 used proper infection control measures to cleanse and dress the site but put the old dressing in the the Resident 3's trash. She did not take the trash out of the room and dispose of it properly. During an interview on 3/25/2025 at 1:45 P.M., LPN 8 indicated she should have removed the trash and put it in the soiled utility room's Biohazard box. 2. During an observation on 3/24/2025 at 11:07 A.M., the dressing for a peripherally inserted central catheter (PICC), a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart, in Resident 76's left upper arm, was peeled up along all edges of the transparent dressing and was dated 3/3/2025. A record review was completed on 3/25/2025 at 2:45 P.M. for Resident 76. Diagnoses included, but were not limited to, pneumonia. An Admission Minimum Data Set (MDS) assessment, dated 3/8/2025, indicated Resident 76's cognition was intact. A Physician Order, dated 3/14/2025, indicated the PICC line dressing should be changed once		residents in the facility have to potential to be affected. Infection Control rounds have been completed. Any identified issues were corrected immediately. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Nurses and QMAs have been re-educated on proper medication administration related to infection control, and following provider orders regarding PICC line dressing changes. **Plan to monitor performance to maintain compliance** DON/designee will audit 3 med passes each week for 4 weeks, and then 1 med pass a week for 3 months, and 1 med pass monthly for 3 months. A summary of the audits will be presented to the Quality Assurance committee monthly by DON/designee for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	

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	weekly on Friday. During an interview on 3/24/2025 at 11:07 A.M., the Unit Manager indicated the dressing should have been changed every week.3. During an observation on 3/24/2025 at 3:02 P.M., Resident B's PICC dressing was dated, 3/14/2025, and was rolled up with the insertion site exposed. Resident B indicated the dressing had not been changed in over a week. During an interview on 3/24/2025 at 3:05 P.M., LPN 6 indicated the PICC dressing should not be rolled up and the dressing should have been changed after seven days. Resident B's record review was completed on, 3/25/2025 at 8:30 A.M. Diagnoses included, but were not limited to: subacute osteomyelitis of the left ankle and foot, Type 1 diabetes mellitus, methicillin-resistant staphylococcus aureus, below-knee amputation of right leg. An Admission Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated Resident B had intact cognition. A current Physician's order, dated 3/14/2025, indicated Resident B's PICC dressing was to be changed every day shift (6:00 A.M.-2:00 P.M.) on Fridays. A current Care Plan, dated 3/5/2025, indicated Resident B was on intravenous (IV) antibiotics for treatment of osteomyelitis. The goal for the Care Plan was to be free of infection at insertion site. Interventions included, but were not limited to: visually inspect IV site each shift. Resident B's record lacked the documentation he			

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	had refused any dressing changes.4. During an observation of medication administration of eye drops on 3/24/2025 at 9:58 A.M., for Resident K, LPN 4 donned gloves and entered the room with oral medication and eye drops. The eye drops were placed on the bedside table without a barrier. LPN 4, with gloved hands, handed Resident K nine oral medications one at a time. LPN 4, with same gloved hands, then wiped crust away from both of Resident K ' s eyes and then applied the eye drops without washing her hands or changing her gloves. During an interview on 3/24/2025 at 10:08 A.M., LPN 4 indicated he should have sanitized his hands before donning the gloves and should not have used the same gloves after administering oral medication and wiping of the eyes to administer eye drops. LPN 4 indicated he should have brought the eye drops into the room in the pharmacy provided bag. 5. During an observation on 3/24/2025 at 10:16 A.M., LPN 4 took a glucometer that was just used by Resident 13 with ungloved hands, cleaned it with a Sani-wipe and did not wash his hands afterwards. During an interview on 3/24/2025 at 10:17 A.M., LPN 4 indicated he should have washed his hands prior to disinfecting glucometer, put on gloves and then performed hand hygiene after glove removal. 6. During an observation on 3/24/2025 at 11:20 A.M., LPN 6 placed a glucometer on the bedside table without a barrier and did not perform hand hygiene after removing her gloves after administering insulin.			

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	During an interview on 3/24/2025 at 11:23 A.M., LPN 6 indicated she should have placed a barrier under the glucometer and performed hand hygiene after glove removal. On 3/24/2025 at 12:38 P.M., the ED provided a policy titled, "Eye Drop Administration," dated 9/2018, and indicated the policy was the one currently used by the facility. The policy indicated "... 4. Remove the cap, taking care to avoid touching the dropper tip. Place the cap on the barrier or a clean, dry surface. 13. Remove and dispose of gloves. Discard any barrier used for carrying or storing the medication and supplies. Wash hands thoroughly with antimicrobial soap and water or facility-approved hand sanitizer....." And a policy titled, "Blood Sugar Monitoring, "dated 2018. The policy indicated "...d. Turn on machine and place on a hard surface, with a clean barrier under device. f. (v)Remove gloves and perform hand hygiene....." And a policy titled, "Standard Precautions."3/2016. The policy indicated "...II, When to perform hand hygiene B. Before and after direct contact with a resident's skin. C. After contact with blood, body fluids or excretions, mucous membranes, non-intact skin or wound dressings. G. After glove removal....." And policy titled, " Blood Glucose Point of Care Testing, "dated 2018. The policy indicated,"...Clean and Store Equipment a. Place a clean barrier under glucometer until disinfected. c. Perform hand hygiene prior to disinfecting. d. Don gloves. e. Perform cleaning and disinfection procedure. f. Remove gloves and perform hand hygiene....." On 3/28/2025 at 1:00 P.M., the Administrator provided a policy, "Pharmscript Infusion Intravenous Access Line Maintenance Protocol," dated 2/7/2020 and indicated the policy was the			

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	one currently used by the facility. The policy indicated "...PICC dressing changes on admission or 24 hours post-insertion, then weekly and as needed..." 3.1-18(l)			