STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 00 B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLOVERLEAF OF KNIGHTSVILLE	9325 N CRAWFORD ST KNIGHTSVILLE, IN 47857

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00446893 and IN00449471. Complaint IN00446893 - No deficiencies related to the allegations are cited. Complaint IN00449471 - No deficiencies related to the allegations are cited. Survey dates: December 12, 13, 16, 17, and 18, 2024 Facility number: 000296 Provider number: 155542 AIM number: 100467820 Census Bed Type: SNF/NF: 65 Total: 65 Census Payor Type: Medicare: 10 Medicaid: 46 Other: 9 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 30, 2024.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Cloverleaf Healthcare of Knightsville with the allegations and citations listed. Cloverleaf Healthcare of Knightsville maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alexa	Abbott	01/13/2025

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 observations, interviews, and record reviews, the facility failed to ensure residents were addressed in a dignified manner and the facility failed to ensure a resident was assisted during meal service in a dignified manner for 2 of 3 dining observations. (Residents 56 and 31). Findings include: 1. During the lunch meal observation in the activity dining room, on 12/12/24 at 12:41 p.m., Resident 56 was sitting at a table eating her lunch when CNA 5 addressed the resident as "Honey." CNA 5 stated from the opposite table, "Honey use your silverware" to Resident 56. Resident 56's record was reviewed, on 12/16/24 at 1:48 p.m. The profile indicated the resident's diagnosis included, but were not limited to, unspecified dementia, severe, with anxiety (a person who is experiencing a significant level of cognitive decline where the exact type of dementia is not known, and alongside this cognitive impairment, they are also exhibiting symptoms of anxiety) and cerebral infarction affecting right dominant side (a stroke (cerebral infarction) has occurred in the right hemisphere of the brain, which is considered the dominant side for most people causing symptoms like weakness or paralysis on the left side of the body. A quarterly Minimum Data Set (MDS) assessment, dated 11/26/24, indicated the resident had severe cognitive impairment and was independent with eating. A care plan, dated 5/15/24, indicated the resident had personal preferences in regards to her care based on her personal preferences assessment. Interventions included, but were not limited to,	F 0550	*F 550* Resident Rights/Exercise of Rights **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #31 and #56 was not negatively outcome from being called honey, and sweet girl by CNA #5 Resident #31 was not negatively affected by CNA #5 standing next to her while being assisted with her meal. CNA #5 was provided with 1:1 individual education by the DON/designee on resident rights, refraining from referring to residents anything than their names unless otherwise care planned as preference. Education was also provided on sitting down next to resident while assisting with meals. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who are referred to other than by their legal first or last name have the potential to be affected. DON/designee will preview resident preferences and will update the plan of care as indicated for specific preferences. Other residents who require assistance with meals have the	01/17/2025

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	call me by my first name. The record lacked a care plan indicating resident preferred to be called, "Honey." 2. During the lunch meal observation on the rehab unit, on 12/16/24 at 1:17 p.m., CNA 5 was standing up next to Resident 31 assisting her with lunch meal. CNA 5 continued to assist with feeding the resident while standing next her. CNA 5 addressed Resident 31 as "Honey." She asked Resident 31, "How are you doing Honey?" She proceeded to feed the resident and asked, "Sweet girl, are you hungry?" Resident 31's record was reviewed, on 12/16/24 at 2:01 p.m. The profile indicated the resident's diagnosis included, but were not limited to, unspecified dementia (a person who is experiencing a significant level of cognitive decline where the exact type of dementia is not known) and syndromes with complex partial seizures (most common type of seizures in adults, they can last between 30 seconds and 2 minutes). The record lacked a care plan indicating resident preferred to be called, "Honey or Sweet girl." An annual Minimum Data Set (MDS) assessment, dated 10/1/24, indicated the resident had severe cognitive impairment and was a maximum assist with eating. During an interview, on 12/16/24 at 1:27 p.m., the Director of Nursing (DON) indicated staff should not stand up next to a resident to assist with feeding. The staff should sit next to the resident while assisting with a meal. She further indicated staff should address residents by their preferred name. She would do some training with staff on making sure to address residents by their preferred name and in a dignified manner.		potential to be affected. DON/designee will provide education to associates in all departments on Resident Rights to include calling residents by their preferred name and sitting next to residents while assisting with meals. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee will provide education to associates in all departments on Resident Rights to include calling residents by their preferred name and sitting next to residents while assisting with meals. DON/designee will complete routine auditing to ensure residents are being called by their preferred name, and that staff are seated when assisting residents with meals. Residents who prefer to be called something other than their name will be reflected in their care plan. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will complete routine auditing to ensure residents are being called by their preferred name, and that staff are seated when assisting residents	

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	On 12/16/24 at 1:53 p.m., the Administrator provided a document with a revised date of July 2017, titled, "Assistance with Meals," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Residents shall receive assistance with meals in a manner that meets the individual needs of each resident ...3. Residents who cannot feel themselves will be fed with attention to safety, comfort, dignity, for example: a. Not standing over residents' while assisting them with meals ...." On 12/16/24 at 1:53 p.m., the Administrator provided a document with a revised date of January 2019, titled, "Resident Rights," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights included resident's right to: a. a dignified existence b. be treated with respect, kindness, and dignity ...." 3.1-3(a)		with meals. Residents who prefer to be called something other than their name will be reflected in their care plan. Observations to occur: During mealtimes 3 x's wkly x's 30 days, then wkly x's 30 days, then monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if findings of noncompliance are identified through the auditing process. Compliance Date: 1/17/2025	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to monitor a resident's weight as ordered for 1 of 4 reviewed for nutrition (Resident 59). Finding includes: During an interview, on 12/12/24 at 11:14 a.m., Resident 59 indicated he had some weight loss when he first came to the facility, but he thought his weight had stabilized now. Resident 59's record was reviewed on 12/17/24 at	F 0684	*F 684 Quality of Care* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #59 did not experience a negative outcome from lack of admission weights and has not experienced a significant weight loss while residing in facility.	01/17/2025

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	10:18 a.m. The profile indicated the resident's diagnosis included, but were not limited to, chronic kidney disease, stage 3 (a person has moderate damage to their kidneys where they are not filtering waste effectively, resulting in mild to moderate loss of kidney function), prediabetes (you have a higher-than-normal blood sugar), and repeated falls. An admission Minimum Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively intact and had an admission weight of 210 pounds. A care plan, dated 11/20/24, indicated the resident was at risk for nutritional deficits related to chronic kidney disease stage 3 and prediabetes. Interventions included, but were not limited to, weights as directed and observe and report to MD (medical doctor) for signs and symptoms of malnutrition. A physician order, dated 11/20/24, to obtain a weight daily for 3 days then weekly times 4 weeks. Review of Resident 59's weights in the electronic health record indicated the following: a. dated 11/20/24 at 2:44 p.m. - 208.5 pounds and documentation was struck out in error on 11/25/24 by nurse. b. dated 11/20/24 at 2:51 p.m. - 210 pounds and documentation was struck out in error on 11/25/25 by nurse. c. dated 11/25/24 at 11:55 a.m. - 197 pounds d. dated 12/4/24 at 12:36 p.m. - 201.6 pounds		Resident #59 has a current weight documented with no significant weight loss. Resident #59's C/P has been updated to reflect current nutritional status and needs. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents with new admission orders have the potential to be affected. DON/designee will audit the medical record of new admissions x's 30 days. Residents identified as having missed or untimely admission weights documented, will be weighed, and will notify the physician and RP of the late/untimely weight monitoring and of the residents' current weight. C/P's will be updated, if indicated to reflect current nutritional status/needs. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The facility has implemented a new weight monitoring protocol that has been approved by the Medical Director. The DON/designee will provide education to licensed and certified nursing staff on the new admission weight protocol, and on the requirement to obtain weights	

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	e. dated 12/11/24 at 4:28 p.m. - 196 pounds f. dated 12/16/24 at 1:50 p.m. - 199 pounds The record lacked documentation of a weight being obtained until 11/25/24. Review of an admission evaluation, dated 11/19/24 at 5:37 p.m., the record lacked documentation of a weight for Resident 59 was recorded. Review of Treatment Administration Record (TAR) for November 2024 lacked documentation of a daily weight being completed on 11/21/24 and 11/22/24. The record lacked documentation of a resident's refusal to obtain his weight. Review of a care plan note, dated 11/25/24 at 12:23 p.m., indicated Resident's current weight was 210 pounds and on a regular diet. During an interview, on 12/17/24 at 11:54 a.m., the Director of Nursing (DON) indicated she could not find where Resident 59 had daily weights completed per the physician order in his electronic health record. Daily weights for 3 days and the weekly for 4 weeks was a standard order that would be placed in the electronic health record for new admissions. Review of a paper report sheet, dated 11/19/24, was provided by the DON and indicated it had a weight of 198.7 pounds for Resident 59. The DON indicated the weight was not placed in the electronic health record at the time of admission by the nurse and the DON placed it in the record on 12/17/24. On 12/17/24 at 12:57 p.m., the Administrator provided a document with a revised date of March		per admission weight orders. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will provide education to licensed and certified nursing staff on the new admission weight protocol, and on the requirement to obtain weights per admission weight orders. The DON/designee will complete routine auditing to ensure that admission weight orders are being followed per orders. Auditing to occur: all newly admitted residents wkly x's 30 days then 4 newly admitted residents monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process. Compliance Date: 1/17/2025	

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	2019, titled, "Weight Assessment and Intervention," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. The nursing staff will measure weight on admission ...2. Weights will be recorded in each individual's medical record ...3. If a resident declines to participate in a weight loss goal or weights being obtained, the resident's wishes will be documented, and those wishes will be respected ...." 3.1-37			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure a resident's indwelling urinary catheter (a thin, flexible tube that is inserted into the bladder through the urethra to drain urine), drainage bag and tubing were maintained in a manner to prevent contact with the floor for 1 of 2 residents reviewed for urinary catheters (Resident 1). Findings include: During the initial pool observation, on 12/13/24 at 8:50 a.m., Resident 1 was observed in her bed and the bed was in the low position. Her indwelling urinary catheter drainage bag (catheter bag) was observed in contact with the floor. At the same time, the catheter's tubing was observed sitting on the electrical cord for the resident's oxygen concentrator (a medical device that supplies oxygen-enriched air by removing nitrogen from the air around the patient). The electrical cord was observed in contact with the floor.	F 0690	*F 690 Bowel/Bladder Incontinence, Catheter, UTI* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** On 12/18254, Licensed nurse/designee positioned Resident #1's catheter tubing off of the electrical. Due to Resident #q being a high fall risk, a low bed was implemented as a safety measure to reduce risk of injuries r/t falls and cannot safely be dc'd, therefore, licensed nursing staff placed a bath basin under the catheter bag to prevent it from touching the floor. Licensed and certified nursing staff have been provided with education by the DON/designee on ensuring Resident #1's catheter tubing and bag does not	01/17/2025

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	During a random observation, on 12/13/24 at 3:10 p.m., the resident was observed in her bed. The bed was observed in the low position. The resident's catheter bag was observed to be in contact with the floor. During a random observation, on 12/16/24 at 1:10 p.m., the resident was observed in her bed in the hallway outside of her room due to a temporary power outage. Her bed was in the low position. The resident's catheter bag was observed to be in contact with the floor. During a random observation, on 12/16/24 at 1:53 p.m., the resident was observed in her bed which had been moved back into her room. Her bed was in the low position. The resident's catheter bag was observed to be in contact with the floor. Resident 1's record was reviewed on 12/16/24 at 2:10 p.m. The profile indicated the resident's diagnoses included, but were not limited to, stage 3 chronic kidney disease (mild to moderate damage to the kidneys where they are less able to filter waste and fluid out of the blood), stage 4 pressure ulcer to sacral region (a very severe wound on the skin over the tailbone area where the damage extends through all layers of skin, potentially exposing muscle, bone, and tendons), and muscle wasting an atrophy (the loss of muscle tissue and strength). A significant change Minimum Data Set (MDS) assessment, dated 10/18/24, indicated the resident had severe cognitive deficit, had an indwelling urinary catheter, and received hospice services. A care plan, dated 10/17/24, indicated the resident had a Foley (brand name) catheter related to wounds. The interventions lacked documentation		touch the floor. Resident #1's C/P has been updated to reflect proper positioning of the catheter tubing and drainage bag to prevent contact with the floor. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who have urinary catheters have the potential to be affected The DON/designee completed observations on other residents who have catheters on 12/18/24 to ensure the tubing and drainage bag was not touching the floor. No findings observed. Licensed and certified nursing staff will be provided with education by the DON/designee on ensuring Resident #1's catheter tubing and bag does not touch the floor. Current residents plan of care who require catheters will be updated to reflect proper positioning of the catheter tubing and drainage bag to prevent contact with the floor **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed and certified nursing associates on the	

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	of monitoring the catheter bag or tubing from coming in contact with the floor. A physician's order, dated 10/17/24, indicated that the resident have a 16 French (Fr) (size of a catheter described in French units) catheter. A physician's order, dated 10/17/24, indicated for staff to perform catheter care (a set of practices that help prevent infection and maintain the health of a catheter and the surrounding area) every shift two times a day. During an interview, on 12/16/24 at 2:41 p.m., the Director of Nursing (DON) indicated the resident's catheter bag was likely in contact with the floor due to her bed being in the low position. Catheter bags and tubing should never come in contact with the floor. On 12/16/24 at 3:01 p.m., the Administrator (ADM) provided a document, with a revised date of September 2014, titled, "Catheter Care, Urinary," and indicated it was the policy currently being used by the facility. The policy indicated, "...Infection Control...2.b. Be sure catheter tubing and drainage bag are kept off the floor...." 3.1-41(a)(2)		requirement that catheter tubing and catheter bags are positioned off of the floor. A bath basin will be placed under the catheter bag to be used as a barrier when a resident requires a low bed for safety to prevent it coming into contact with the floor. The DON/designee will complete routine auditing of residents who require catheters to ensure that current and newly admitted residents who require a catheter is properly positioned to prevent the tubing and draining bag coming into contact with the floor. A bath basin may be used as a barrier for residents who require a low bed for safety to prevent the drainage bag from coming into contact with the floor. The DON/designee will complete routine auditing to ensure that newly admitted residents who require a catheter have care plans that reflect proper positioning of the cath tubing and drainage bag to prevent contact with the floor. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine auditing to ensure that current and newly admitted residents who require a	

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			catheter is properly positioned to prevent the tubing and draining bag from touching the floor. A bath basin may be used as a barrier for residents who require a low bed for safety to prevent drainage bag from coming into contact with the floor. Auditing to occur: Residents who require a catheter 3 x's wkly x's 30 days, residents who require a catheter wkly x's 30 days, then residents who require a catheter monthly x's 4 months for a total of 6 months of monitoring. The DON/designee will complete routine auditing to ensure that residents who require a catheter have care plans that reflect proper positioning of the cath tubing and drainage bag to prevent contact with the floor. Auditing to occur: Residents who require a catheter 3 x's wkly x's 30 days, residents who require a catheter wkly x's 30 days, then residents who require a catheter monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be	

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			increased as needed, if areas of noncompliance are identified through the auditing process. Compliance Date: 1/17/2025	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on observation, record review and interview the facility failed to assess a resident's condition for complications before and after hemodialysis treatments (a procedure that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly) which were received at a certified dialysis facility for 1 of 2 residents reviewed for dialysis (Resident 49). Findings include: On 12/12/24 at 11:34 a.m., during observation and interview, Resident 49 indicated when she received hemodialysis on Monday, Wednesday, and Friday. The staff did not check the access site (also known as vascular access, a surgically created opening in the body that allows a patient to receive hemodialysis) in her left arm after returning from dialysis treatment. She indicated when she returned yesterday 12/11/24, the access site bled and soaked through the bandage on her arm. She indicated she changed the bandage using the supplies she had in her room. On 12/13/24 at 3:30 p.m., during observation after the resident returned from dialysis. A dressing was covering the left forearm dialysis access site. The resident indicated the nurse had not checked the dressing for bleeding since returning earlier.	F 0698	***F 698 Dialysis*** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #49 was assessed by licensed nurse to include her vascular access site. The physician was notified of not having current appropriate dialysis assessments. Orders received for pre and post dialysis assessments on dialysis days, as well as daily assessments of the vascular access site. Responsible party was notified by licensed nursing staff The DON/designee will ensure that Resident #49's pre/post dialysis assessments and vital sign monitoring on dialysis days and daily assessment of the vascular access site are added to the electronic EMAR for Resident #49. Resident #49's C/P has been updated to reflect assessment needs r/t dialysis **How other residents have the potential to be affected by the**	01/17/2025

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	On 12/16/24 at 9:23 a.m., reviewed the medical record of Resident 49. The resident was admitted to the facility on 4/24/24. Diagnosis included but were not limited to end stage renal disease (a permanent condition that occurs when the kidneys are no longer able to function and require dialysis or a kidney transplant to sustain life), dependence on renal dialysis, type 2 diabetes mellitus with diabetic chronic kidney disease (a disease that occurs when your blood glucose, also called blood sugar, is too high). A Physician order, dated 4/13/24, indicated the resident was to have dialysis - FYI (for your information) - Dialysis Treatments 3 X (times) week at 10 a.m. A care plan, dated 4/14/24, indicated Resident 49 had a diagnosis of end stage renal disease and was at risk for complications with dialysis treatment. Interventions included but were not limited to, go to dialysis 3 days a week, to administer medications as ordered, to observe for pain at site, and to notify physician if pain is present. The record lacked a care plan for access site observation for bleeding, swelling or abnormalities. A Physician order, dated 4/15/24, indicated staff were to check access site for bruit (a whooshing or swooshing sound that can be heard near the access site with a stethoscope) and thrill (a vibration or buzzing sensation that can be felt by placing your fingers just above the incision line) daily on return shift. Staff were to document Y (yes) if monitored and N (no) if thrill or bruit were absent. Staff were to select chart code "Other/See Nurses Notes" and record findings if N (no) was selected and document abnormalities.		**same deficient practice will be identified and what corrective actions will be taken?** Residents who require hemodialysis have the potential to be affected. The DON/designee will review the medical record to ensure that residents who receive hemodialysis all will ensure they have orders for pre/post dialysis assessment and vital sign monitoring orders on dialysis days, and daily assessments of the vascular access site. These assessments will be added to the electronic eMAR. Residents C/P's who require hemodialysis will be updated by the DON/designee to reflect assessment needs r/t dialysis **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed nursing staff on the requirement to complete and to document pre/post dialysis assessments including vital signs on dialysis days, and daily vascular access assessments. Education also provided that these assessments will be added to the electronic EMAR and that C/P's are to reflect dialysis assessment needs.	

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	A Physician order, dated 4/15/24, indicated staff were to assess vitals (blood pressure, pulse, respiration, temperature) on return from dialysis every Monday, Wednesday, and Friday. Task was scheduled to be completed on return from dialysis-on-dialysis days. A quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was cognitively intact. On 12/13/24 at 3:20 p.m., during interview with Licensed Practical Nurse (LPN) 8, she indicated the nurse checked the access site each shift after administration of dialysis. On 12/13/24 at 3:40 p.m., during an interview, the Director of Nursing indicated the nurse should assess the resident after the dialysis resident returned from dialysis to ensure the site was not bleeding. The DON acknowledged an order to check for bleeding at the access site had not been obtained from the physician prior to interview. A Physician order, dated 12/13/24, indicated twice a day staff were to check dialysis access site for bleeding every shift, and notify MD (medical doctor) if symptoms. On 12/16/2024 at 10:40 a.m., the Director of Nursing provided a document, titled, "Dialysis" dated 11/28/2016, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...Based on comprehensive assessment of a patient, the facility must ensure that patient(s) who require dialysis receive such services, consistent with professional standards of proactive ...Post Dialysis ...5. Monitor shunt site on a routine basis. Notify physician if any unusual problems are noted with shunt site		**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The DON/designee will complete routine auditing to ensure residents require hemodialysis have pre/post dialysis assessments including vital signs on dialysis days, and daily assessments of the vascular access site. Auditing to occur: All residents receiving hemodialysis wkly x's 30 days, then 3 residents receiving hemodialysis monthly x's 5 months for a total of 6 months of monitoring. ·The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Any findings of non-compliance identified through the auditing process will be addressed re-education, increase of frequency and/or duration of auditing until full compliance achieved. Compliance Date: 1/17/2025	

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	(tenderness, bleeding) ...General guidelines ...4. Monitor for any complaints or observations at vascular access site ...." 3.1-37(a)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services Based on record review and interview, the facility failed to ensure behavior monitoring was completed for 1 of 5 residents reviewed for unnecessary medications (Resident 30). Findings include: Resident 30's record was reviewed on 12/16/24 at 9:36 a.m. The profile indicated the resident's diagnoses included, but were not limited to, alcoholic cirrhosis of the liver with ascities (a condition where the liver is damaged by chronic alcohol consumption and has a buildup of fluid in the abdomen), visual hallucinations (seeing things that are not there), other chorea (a movement disorder that causes involuntary, rapid, and irregular muscle contractions that affect the face, arms, legs, and trunk), anxiety disorder (a mental health condition that causes excessive and persistent feelings of fear, dread, and uneasiness that interfere with daily life), major depressive disorder (a mental health condition that can cause a persistent feeling of sadness, hopelessness, and a lack of interest in activities), and irregular muscle contractions that affect the face, arms, legs, and trunk. A quarterly Minimum Data Set (MDS) assessment, dated 9/9/24, indicated the resident had no cognitive deficit and no documented	F 0740	*F 740 Behavioral Health Services* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #30 did not experience a negative outcome r/t lack of behavior documentation. The physician and RP have been updated on residents' current behavioral status. The DON/designee will provide licensed and certified nursing associate on the requirement to document Resident #30's behaviors. **How other residents have the potential to be affected by the same deficient practice will be** Other residents that require psychotropic medications have the potential to be affected SS/designee will complete an audit of the electronic medical record to identify current residents receiving psychotropic medications and will ensure behavior monitoring orders are in place.	01/17/2025

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	behaviors. A care plan, with a revision date of 3/20/24, indicated the resident was at risk for ineffective coping related to a significant traumatic event. The resident was counseling a patient who committed murder. Interventions included, but were not limited to, administer medications as ordered and collaborate care with medical and psychiatric service providers as needed. A care plan, dated 2/4/20, indicated the resident was at risk for emotional and physical distress related to a history of physical, emotional, and mental abuse. The resident reported her former spouse threatened her with a gun. Interventions included, but were not limited to, administer medications as ordered and collaborate care with medical and psychiatric service providers as needed. A physician's order, dated 1/18/21, indicated to monitor behaviors of depression and tearfulness and document the number of episodes, interventions, and outcomes, every shift and as needed. A physician's order, dated 1/18/21, indicated to monitor behaviors of insomnia and document the number of episodes, interventions, and outcomes, every shift and as needed. A physician's order, dated 1/18/21, indicated to monitor behaviors of visual hallucinations and document the number of episodes, interventions, and outcomes, every shift and as needed. A Pharmacy recommendation, dated 2/28/24, indicated to evaluate the resident's medications of Cymbalta (antidepressant medication) 90		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** SS/designee will provide education to licensed and certified nursing associates on the requirement to document behaviors on residents receiving psychotropic medications. SS/designee will routinely review behavior documentation on residents who require psychotropic medications to ensure documentation is in place for resident experiencing behaviors. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will review the medical record of newly admitted residents to ensure behavior monitoring orders are in place for residents who require psychotropic medication use. Auditing to occur: within 24 hours of all new admissions x's 30 days, new admissions wkly x's 30 days, then new admissions monthly x's 4 months for a total of 6 months of monitoring. SS/designee will routinely review behavior documentation on residents who require psychotropic medications to	

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	milligrams (mg) daily and Risperdal (antipsychotic medication) 0.5 mg at bedtime, for symptoms the depression, pain, and hallucinations, and consider dose reductions. The facility's behavior committee reported the resident was still symptomatic and recommended a dose reduction of the medications be contraindicated. The physician agreed with the behavior committee's recommendation and documented that no dose reduction should be completed. Review of the resident's February 2024 Treatment Administration Record (TAR) and progress notes lacked documentation that the resident had exhibited any behavioral symptoms during the month. A Pharmacy recommendation, dated 5/29/24, indicated to evaluate the resident's medication of Ativan (antianxiety medication) 0.5 mg two times daily for anxiety. The physician indicated to continue the therapy as ordered and documented that the resident continued to be symptomatic. Review of the resident's May 2024 TAR, and progress notes lacked documentation that the resident had exhibited any behavioral symptoms during the month. A Pharmacy recommendation, dated 8/26/24, indicated to evaluate the resident's medication of Cymbalta 90 mg daily for depression and pain. The facility's behavior committee reported the resident was still symptomatic and recommended a dose reduction not be completed at that time. The physician agreed with the behavior committee's recommendation and drew an arrow which pointed to the statement of the behavior committee's recommendation and documented the continued same-symptomatic.		ensure documentation is in place for resident experiencing behaviors. Auditing to occur: 4 random residents who require psychotropic medications to ensure exhibited behaviors have been documented wkly x's 30 days, then 4 random residents who require psychotropic medications to ensure exhibited behaviors have been documented The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if findings of noncompliance are identified through the auditing process. Compliance Date: 1/17/2025	

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	Review of the resident's August 2024 TAR lacked documentation that the resident had exhibited any behavioral symptoms during the month. The progress notes for August 2024, indicated the resident was stable and lacked documentation of any behaviors during the month. During an interview, on 12/16/24 at 2:07 p.m., the Director of Nursing (DON) indicated the physician made his decision regarding dose reductions based upon the recommendation from the behavior committee. The behavior committee received their information about the resident's behaviors by talking with the nurses. The nurses did need more education on completing the TAR resident's exhibit behaviors. During an interview, on 12/17/24 at 9:20 a.m., the Social Services Director (SSD) indicated she felt the reason that the behaviors were not being documented in the TAR was related to how the new system allowed for documentation by the Certified Nursing Assistants (CNAs). Under the old company's system, the CNAs should directly document behaviors into their Point of Care (POC) system, and it went to the TAR. The new system no longer allowed for that to happen. The nurses were the only ones who were able to document on the TARs. The nurses were laxed in documentation of behaviors. On 12/17/24 at 2:43 p.m., the DON provided a document, with a revision date of September 2022, titled, "Behavioral Assessment, Intervention, and Monitoring," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation...Assessment...3. The nursing staff will identify, document, and inform...about			

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	specific details regarding changes in an individual's...behavior...4. New onset or changes in behavior will be documented...Monitoring: 1...the IDT (interdisciplinary team) will...document...improvements or worsening in the individual's behavior...." 3.1-43(a)(1)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation and record review, the facility failed to ensure a medication error rate of less than 5 percent with an error rate of 21.43 percent for 3 of 4 residents reviewed for medication administration (Residents 169, 14 and 26). Findings include: 1. On 12/17/24 at 7:45 a.m., observed Registered Nurse (RN) 15, prepare and administer medications to Resident (169). Ferrous Sulfate 1 tablet and Klor-Con 1 tablet were removed from medication card and crushed. Medications were then administered to the resident in applesauce. On 12/17/24 at 9:30 a.m., the medical records of Resident 169 were reviewed. The resident was admitted with diagnosis including but not limited to anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells) and hypokalemia (a condition where the level of potassium in your blood is lower than normal). Physician orders included but not limited to administer 1 tablet ferrous sulfate EC (enteric	F 0759	*F 759 Free of Medication Error Rts 5 Prcnt or More* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** DON/designee notified the physician and the responsible parties for Resident #169 and resident #14 r/t medications not being crushed. Don/designee also notified pharmacy for Resident #169 and 14 and requested that their med orders listed on the do not crush list be sent in suspension form. DON/designee provided 1:1 education with RN 15 on the requirement to not crush medications on the do not crush list. DON/designee notified the physician and responsible party of Resident # 26 r/t insulin pen not being primed potentially resulting in decreased dose. DON/designee will provide 1:1	01/17/2025

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	coated) (tablets or capsules with a coating that prevents the medication from dissolving in the stomach and instead allows it to pass into the small intestine, where it can be absorbed) 325 mg (milligrams) administer by mouth once daily for anemia, and administer 1 tablet Klor-Con 20 meq (milliequivalent) administer by mouth once daily for hypokalemia. On 12/17/24, the Director of Nursing (DON) provided a document titled, "oral dosage forms that should not be crushed". The list included medications that were enteric coated (EC) and Klor-Con a slow-release medication (medications that release a consistent amount of the drug over a longer period of time). 2. On 12/17/24 at 8:05 a.m., observed Registered Nurse (RN) 15 prepare and administer medications to Resident (14). Ferrous sulfate 1 tablet and Myrbetriq ER 1 tablet were removed from medication card and crushed. Medications were then administered to the resident in applesauce. On 12/17/24 at 10:00 a.m., the medical record of Resident 14 was reviewed. The resident was admitted with diagnosis including but not limited to, anemia, benign prostatic hyperplasia (a condition in which the prostate gland is larger than normal). Physician orders included but were not limited to an order, dated 2/2/24, for 1 tablet ferrous sulfate EC (enteric coated) 325 mg to be administered by mouth once a day for anemia. A physician order, dated 2/2/24, for 1 tablet Myrbetriq ER (extended release) to be administered by mouth once a day for overactive bladder.		education to RN# 17 on the requirement to prime insulin pen with 2 units prior to administration with **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who require crushed medications have the potential to be affected. DON/designee has provided a “do not crush list” to be kept on or near the medication carts and at the nurse’s stations. DON/designee will identify residents who require crushed medications to ensure medications that cannot be crushed are dispensed in the appropriate form. Any findings will be addressed by discussing alternative options with the physician. Other residents who require insulin administration with an insulin pen have the potential to be affected. DON/designee will provide education to licensed nursing staff on insulin pen administration to including priming the pen. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee will provide education to associated who	

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	On 12/17/24, the Director of Nursing (DON) provided a document titled, "oral dosage forms that should not be crushed". The list included medications that were enteric coated (EC) and Klor-Con a slow-release medication (medications that release a consistent amount of the drug over a longer period of time). The medications Myrbetriq (mirabegron) and Ferrous sulfate were listed as slow-release medication on the do not crush document. 3. On 12/17/24 at 9:00 a.m., observed Registered Nurse (RN) 17 prepare and administer Basaglar insulin and Admelog SoloStar insulin to Resident (26). RN 7 adjusted the insulin pens to the prescribed dose to be administered to the resident. The RN did not prime the insulin administration pen according to manufacture guidelines. Priming the pen ensures all of the prescribed insulin was administered to the resident by removing the air space within the needle. The RN went into the resident's room, left the door open and did not pull the curtain to provide privacy to the resident. The RN advised the resident that she was going to administer the insulin in his abdomen. The RN administered the insulin and counted to ten during administration of insulin, and immediately removed the insulin needle. On 12/17/24 at 10:30 a.m., the medical record of Resident 26 was reviewed. The resident was admitted with diagnosis including but not limited to Type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high).		administer medications to including not crushing medications on the “do not crush list” and priming insulin pens prior to administering ordered dose. DON/designee will complete medication observations to ensure medications are being appropriately administered; including not crushing meds on the do not crush list and priming of the insulin pen. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will complete medication observations to ensure medications are being appropriately administered; including not crushing meds on the do not crush list and priming of the insulin pen. Observations to occur: med pass observations on 5 residents wkly x’s 30 days, then 5 med pass observations monthly x’s 5 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or	

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	A Physician orders included but were not limited to. An order, dated 7/7/24, for Basaglar insulin 100 unit/ml (milliliter) 40 units subcutaneously (under the skin) two times a day for type 2 diabetes. A Physician order, dated 11/19/24, Admelog SoloStar insulin 100 unit/ml. Administer as per sliding scale (a type of insulin prescription that adjusts the amount of insulin a person takes based on their blood sugar level) before meals. On 12/17/24 at 9:05 a.m., during interview, RN 17 indicated she did not know if the insulin pen should be primed before administration, and indicated she counted to ten while administering the insulin. She acknowledged she should have closed the door when she administered insulin to the resident. On 12/17/2024 at 1:57 p.m., the Director of Nursing (DON) provided a document, titled, "SOP-Insulin Preparation and Administration," dated 5/20/20, and indicated it was the policy currently being used by the facility. The policy indicated, "...2. Procedure ...h. Procedure for insulin pen ...v. Attach need to the pen ...vii. Remove air from insulin pen ...1. Turn the dial to 2 units ...3. Gently tap pen to remove air bubbles ...viii ...Press the inject button ...Select the correct dose of insulin on the pen by turning the dial to the number of units you need to inject ...3. Insulin Administration Procedure ...b. provide privacy ...i. Close doors, curtains and or room curtains as needed ...j. insert needle ...k. push plunger with thumb at a moderate steady pace until insulin is completely administered, approximately 5-10 seconds ...." 3.1-48(c)(1)		duration of reviews will be increased as needed, if findings of noncompliance are identified through the auditing process. Compliance Date: 1/17/2025	

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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
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observations, interviews, and record reviews, the facility failed to ensure medication were labeled properly for 3 of 4 medication carts reviewed for medication storage (Residents 58, 26, and 2). Findings include: On 12/17/25 at 8:00 a.m., medication storage cart A was observed. Tresiba Insulin pen prescribed for Resident 2. Pharmacy dispensed date was 11/14/24. Date opened was not indicated on the insulin pen. On 12/17/24 at 8:20 a.m., medication storage cart 1 was observed. Lantus Insulin pen prescribed for Resident 58. Pharmacy dispensed date was 11/19/24. Date opened was not indicated on the insulin pen. On 12/17/24 at 9:00 a.m., medication storage cart B was observed. Basaglar Insulin pen prescribed for Resident 26. Pharmacy dispensed date was 11/28/24. Date opened was not indicated on the insulin pen. On 12/17/24 at 8:05 a.m., during interview Registered Nurse (RN) 15 indicated insulin pens should be dated when opened and an expiration date added to label. On 12/17/24 at 9:05 a.m., during interview Qualified Medication Aide (QMA) 18 indicated insulin pens should be dated when opened and an expiration date added.	F 0761	***F 761 Label/Store Drugs and Biologicals*** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The insulin pens for Residents #58, #26, and #2 were appropriately disposed of, and the insulin pens were replaced, and dated/labeled. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who require insulin have the potential to be affected. The DON/designee will review the medical record to identify residents who receive insulin and will do a med storage audit to ensure that insulins are appropriately labeled/dated. Pens will be replaced with new insulin pens if any findings observed of expired or pens not dated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide education to licensed	01/17/2025

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	155542	A. BUILDING 00 B. WING	12/18/2024

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	On 12/17/24 at 9:08 a.m., during interview RN 17 indicated insulin pens must be dated when opened, if no date was on the pen or if in doubt the pen was thrown out. On 12/17/24 at 9:30 a.m., the medical record of Resident 58 was reviewed. The resident was admitted to the facility with diagnosis including but not limited to, Type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and acute kidney failure (a condition where the kidneys suddenly stop working properly). A Physician Order, dated 12/12/24, for Lantus SoloStar insulin 100 units/ml (milliliter), iInject 10 units subcutaneous (under the skin) daily for diabetes. On 12/17/24 at 9:40 a.m., the medical record of Resident 26 was reviewed. The resident was admitted with diagnosis including but not limited to, Type 2 diabetes, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems). A Physician order, dated 7/7/24, for Basaglar insulin 100 units/ml inject 40 units subcutaneous (under the skin) daily for diabetes. On 12/17/24 at 10:00 a.m., the medical record of Resident 2 was reviewed. The resident was admitted with diagnosis including but not limited to, type 2 diabetes, and chronic kidney disease (the kidneys are damaged and can't filter blood the way they should). A Physician order, dated 10/15/24, for Tresiba flex touch insulin solution 100units/ml, inject 15 units		nurses on the requirement to appropriately date/label insulins when opened. Routine auditing of medication storage areas will be completed by the DON/designee to ensure that insulins are appropriately labeled/dated upon opening and that insulins are not expired. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee to complete routine auditing of medication carts to ensure that insulins are being labeled/dated upon opening and that no expired insulins remain on carts. Auditing to occur: all med carts wkly x's 4 wks, then monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Any findings of non-compliance identified through the auditing process will be addressed re-education, increase of frequency and/or duration of auditing until full compliance achieved. Compliance Date: 1/17/2025	

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	subcutaneous daily for type 2 diabetes. On 12/17/2024 at 1:57 p.m., the Director of Nursing (DON) provided a document, titled, "Specific Procedures for all Medications," dated 5/20/20, and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure ...5. Check expiration date on package/container. When opening a multidose container, place the date on the container, place the date on the container ...." 3.1-25(j) 3.1-25(m) 3.1-25(n)			
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed Based on interview, observation and record review, the facility failed to honor food preferences of 1 of 1 resident reviewed for dietary preferences (Resident 49) Findings include: On 12/12/24 at 11:25 a.m., during observation and interview, Resident 49 indicated she had asked several times not to be served vegetables and the facility continued to put them on her plate. On 12/12/24 at 12:27 p.m., observation of the dietary tray slip of Resident 49 indicated the dietary slip food dislikes did not indicate the resident did not want vegetables. On 12/16/24 at 9:00 a.m., the medical record of Resident 49 was reviewed. The resident was admitted to the facility on 4/24/24. Diagnosis	F 0803	*F 803 Menus Meet Resident Nds/Prep in Adv/Followed* **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Dietary Manager/designee interviewed Resident #49 and obtained food preferences including likes and dislikes. Resident #49 plan of care and meal ticket has been updated by the Dietary Manager to reflect those preferences **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents who are served	01/17/2025

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	included but were not limited to end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life, dependence on renal dialysis (a treatment that filters waste and excess fluid from your blood when your kidneys can no longer perform this function), and type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high) with diabetic chronic kidney disease (the kidneys are damaged and can't filter blood the way they should). A Physician order, dated 4/15/24, ordered a CCHO (controlled carbohydrate) diet, regular texture, thin (liquids) consistency. Only one serving of dairy daily, no oatmeal or sausage no more OJ (orange juice) no more juices until CA (calcium) levels lower, no pudding, cottage cheese, no milk products, limit amount of breads, pizza, cereal, crackers. A quarterly Minimum Data Set (MDS) assessment, dated 10/14/24, indicated the resident was cognitively intact. A care plan, dated 4/14/24, indicated the resident was at nutritional risk. Interventions included but were not limited to RD (Registered Dietitian) to evaluate and make diet change recommendations as needed, and to provide Diet: CCHO regular texture, thin consistency, 1800 ml (milliliters) fluid restriction. Review of activity preference form, dated 4/16/24, which was completed on admission the record did not indicate any dietary preferences.		food from the kitchen have the potential to be affected The Dietary Manager/designee will complete food preference interviews and will update the plan of care and meal tickets on current residents to reflect those preferences **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The facility has implemented a personal preference interview form that will be utilized to obtain food preferences on admission and then annually. The Administrator/designee will provide education to the Dietary Manager on the requirement to ensure food preferences have been obtained, listed in the plan of care and on the meal ticket, as well as ensuring alternative food choices are offered for food dislikes that are on the menu. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Administrator/designee will audit preference forms including on newly admitted residents to ensure food likes/dislikes are reflected in the plan of care and on the meal	

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	On 12/12/24 at 12:25 p.m., during an interview, Employee 7 indicated the residents choose from a menu each day and decide what they want to eat. If they do not want what was served they could get the substitute. She indicated the activities department staff asked the residents their preferences and recorded it on the diet menu selection forms. On 12/16/24 at 11:01 a.m., during an interview, Employee 6 indicated she asked the residents daily if they wanted what was on the menu. She recorded choices and turned it into dietary department. She indicated the preferences were then recorded on the diet slip and indicated Resident 49 had told her previously she did not like vegetables. On 12/16/24 at 11:08 a.m., during an interview the Administrator indicated she updated the dietary tray slip all the time. She provided a copy of the current dietary tray slip for Resident 49 and indicated the resident did not like cooked vegetables and it was on the updated dietary slip. On 12/16/2024 at 2:45 p.m., the Administrator provided a document, titled, "Resident Food Preferences ," dated 7/2023, and indicated it was the policy currently being used by the facility. The policy indicated, "...Individual food preferences will be assessed upon admission and updated as needed. Reaseonable efforts will be made to accommodate resident choices and preferences ...2. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes ...." 3.1-20(c)(7)		ticket. Auditing to occur: 4 residents wkly x's 30 days, then 4 residents monthly x's 5 months for a total of 6 months of monitoring. The Administrator/designee will complete routine meal services observations to ensure food served to residents do not conflict with meal tickets and that alternative options have been offered for food dislikes that are on the menu. Auditing to occur: 4 meals wkly x's 30 days, then 4 meals monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process. Compliance Date: 1/17/2025	

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F 0812 SS=D 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 undated and expired foods were disposed of for 1 of 2 kitchen observations. Findings include: During a food storage observation with Cook 3 on 12/12/24 at 9:50 a.m., the walk in refrigerator contained a clear plastic container with a lid that had corn, the corn was dated 12/5/24. There was a clear plastic bag of lettuce with a delivery dated 10/31/24, the lettuce was brown and wilted inside the bag. Three cucumbers were found on a shelf in an open and undated plastic bag. During an interview, on 12/12/24 at 9:52 a.m., Cook 3 indicated food was good for 3 days once it was opened and placed in a new container. She indicated the corn should have been disposed of by now and the lettuce was no longer good because it was delivered in October and was brown and wilted. She was unsure why they hadn't been disposed of them by now because she was not the person responsible for that. Cook 3 indicated food should be labeled once it was delivered to the facility and she had no idea when the cucumbers were delivered and how long they were in the walk-in refrigerator. The cucumbers would have to be disposed of since they were not labeled properly. On 12/12/24 at 10:30 a.m., the Administrator provided an undated document, titled, "Keeping Food Safe for the Residents in Cloverleaf Facility," and indicated it was the policy currently being used by the facility. The policy indicated, "	F 0812	F812 Food Procurement , Store/ Prepare/Serve-Sanitary **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** No resident was identified in this statement of deficiencies **How other residents have potential to be affected by the same deficient practice will be identified and what corrective action will be taken** Residents who are served food from the kitchen will have the potential to be affected The Dietary Manager/designee will complete an audit of the kitchen stock and make sure all items are dated **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?** The Administrator/designee will provide education to the Dietary Manager and kitchen staff to ensure all items are dated and discarded after the appropriate date. **How the corrective actions will be monitored to ensure the deficient practice will not**	01/17/2025

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	...8. When to Discard Food ...c. Food is over 72 hours old. d. If there is no identification or date on the item ...." On 12/12/24 at 12:57 p.m., the Administrator provided a document with a revised date of July 2014, titled, "Food Receiving and Storage," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Foods shall be received and stored in a manner that complies with safe food handling practices ...7. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date) ...." 3.1-21(i)(3)		**reoccur, i.e, what quality assurance program will be put into place?** The Dietary Manager/designee will complete routine auditing of the kitchen stock to ensure food is appropriately dated and is not expired. Auditing to occur: 3 x's wkly x's 30 days, then wkly x's 30 days, then monthly x's 4 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if findings of noncompliance are identified through the auditing process. Compliance Date: 1/17/2025	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program Based on record review and interview, the facility failed to follow the antibiotic stewardship protocol program for 1 of 5 residents reviewed for antibiotics (Resident 46).	F 0881	*F 881Antibiotic Stewardship Program* **What corrective actions will be accomplished for those residents found to have been affected by the deficient**	01/17/2025

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	Findings include: On 12/17/24 11:14 a.m., the medical record of Resident 46 was reviewed. The resident was admitted to the facility with diagnosis of, but not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), urinary retention (a medical condition that occurs when a person is unable to empty their bladder or has difficulty starting or maintaining a steady urine flow), and history of recurrent urinary tract infections (bacteria in the urine, resulting in an infection). A Physician order, dated 8/31/24, indicated to administer one capsule of Ampicillin 500 mg (milligram) via (by way of) G-tube (a tube that is surgically inserted through the abdomen and into the stomach to provide nutrition, fluids, and medicine) daily for prophylactic (something that prevents or protects). A quarterly Minimum Data Set (MDS) assessment, dated 11/11/24, indicated the resident had a cognition deficit, required max assistance of two persons, received nutrition and medications through gastric tube and was currently on an antibiotic. A care plan, dated 11/11/24, indicated the resident was on antibiotic therapy related to recurrent urinary tract infections. Interventions included but not limited to, collect labs as ordered and report results to physician, administer medications as ordered, and notify physician of any change or worsening of condition.		**practice?** Resident #46's prophylactic ATB order has been dc'd and the plan of care has been updated to reflect this. DON/designee provided education to the resident's daughter who had requested the prophylactic ATB on the risks vs benefits as well as potential negative outcomes of long term ATB use. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Other residents who have a prophylactic ATB order has the potential to be affected DON/designee completed an audit of the electronic medical record and verified that there are no other current residents with prophylactic ATB orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON/designee will provide education the Infection Preventionist and licensed nursing staff on the requirement to utilize the McGreers criteria for residents on an ATB. When an ATB is indicated per the McGreers criteria, orders for ATB will be written for a specific time and will have appropriate dx.	

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	The medical record indicated the resident had been on an antibiotic since previous admission. Documentation lacked evidence of physician assessment to determine the need for prophylactic long-term use of an antibiotic. Documentation lacked evidence of physician education or education being provided to the responsible party regarding long term use of antibiotics. On 12/17/24 at 2:00 p.m., during an interview, the Director of Nurses (DON) indicated the resident was on antibiotic therapy for history of chronic urinary tract infections. She indicated the resident was admitted with the antibiotic and diagnosis of VRE (Vancomycin-Resistant Enterococci, is a type of bacteria that has become resistant to many antibiotics, including vancomycin) and indicated the antibiotic had been administered for some time at the previous facility the resident resided in. She indicated the resident had multiple urinalysis (analysis of urine by microscopical means to test for the presence of disease) and culture (a lab test that checks for bacteria or other microorganisms in urine to help diagnose a urinary tract infection (UTI) of the urine) while at the other facility. A urinalysis and culture were completed at the facility upon admission and no additional testing had been repeated. On 12/18/24 at 1:00 p.m., during review of the antibiotic stewardship program with the DON and Infection Prevention Nurse, both indicated the facility utilized the McGeer's criteria surveillance tools for infections in the long-term care facility. On 12/18/24 at 2:30 p.m., during interview with the Medical Director and the DON. The Medical Director indicated the resident was on long term antibiotics because the family wanted her to be on		**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** IP/designee will complete routine auditing of ATB orders to ensure that the McGreers criteria has been met for residents on an ATB. When an ATB is indicated per the McGreers criteria, ATB orders will be written for a specific time period and will have appropriate dx. Auditing to occur: 4 residents with an ATB order wkly, if they exist, x's 30 days, then 4 residents with ATB orders, if they exist, monthly x's 5 months for a total of 6 months of monitoring. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process. Compliance Date: 1/17/2025	

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	an antibiotic due to previous history of urinary tract infections. The Medical Director acknowledged the resident was probably resistant to penicillin, (resistance occurs when bacteria develop the ability to withstand the effects of antibiotics), since she had VRE when she was admitted. He indicated at the time of admission the bacteria causing the infection was sensitive to the antibiotic. (Sensitivity occurs when a bacterial pathogen is inhibited or not inhibited by exposure to certain antibiotics). The Medical Director indicated he would be discontinuing the medication and trying alternate non-antibiotic measures to prevent re-occurrence of infection. On 12/11/2024 at 11:00 a.m., the Administrator provided a document titled, "Antibiotic Stewardship," dated July 20, 2018, and indicated it was the policy currently being used by the facility. The policy indicated, "...1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents ...4. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements ...d. Duration of treatment; 1. Start and Stop Date, or 2. Number of days of therapy ...." The Centers for Disease Control and Prevention (CDC) webpage, "The Core Elements of Antibiotic Stewardship", accessed online at: https://www.cdc.gov/antibiotic-use/hcp/core-elements, indicated, "... Improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance ...."			
F 0912 SS=A Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident			

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	Based on record review, observation, and interview, the facility failed to provide at least 80 square feet per resident in multiple occupancy resident rooms. This was observed in 2 of 50 resident rooms in the facility (Rooms 14 and 15). Findings include: On 12/18/24 at 9:52 a.m., the Maintenance Director provided a copy of a letter, dated 12/4/23. The letter indicated a waiver had been granted for room 14 and room 15. At the same time, he indicated this was the only letter that the Administrator had related to the waiver requests for the rooms. During an observation of Room 14, on 12/18/24 at 10:06 a.m., two beds were observed in the room. No residents were residing in the room at the time of the observation. Measurements obtained by the Maintenance Director indicated Room 14 measured 225 total square feet. Square footage would equal 75 square feet per resident, for three beds. During an observation of Room 15, on 12/18/24 at 10:12 a.m., two beds were observed in the room. Both beds were occupied by residents. Measurements obtained by the Maintenance Director indicated room 15 measured 225.63 total square feet. Square footage would equal 75.21 square feet per resident for three beds. During an interview, on 12/18/23 at 11:11 a.m., the Maintenance Director indicated each of the rooms were licensed for three beds. Currently, both rooms had three beds each in them. The facility was requesting a waiver for both of the rooms.	F 0912	***F 912 Bedrooms Measure at Least 80 Sq Ft/Resident*** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident rooms 14 and 15 were identified. The facility has submitted a waiver request related to the square footage requirements. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No Other residents or resident's rooms are affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The square footage requirements in no way affect the care that is provided to the residents in rooms 14 and 15. These residents receive the highest quality of services. A waiver has been submitted related to the square footage requirements which have been granted annually. Facility will ensure residents in room 14 and 15s needs are being met. **How the corrective actions will be monitored to ensure the**	01/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155542	A. BUILDING 00 B. WING	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-19(l)(2)		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** The square footage requirements in no way affect the care that is provided to the residents in rooms 14 and 15. These residents receive the highest quality of services. A waiver has been submitted related to the square footage requirements which have been granted annually. Facility will ensure all needs of residents are being met in room 14 and 15. **Compliance Date: 1/17/2025**	