STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
UNIVERSITY PARK REHABILITATION AND HEALTHCARE	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(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 IN00456775. Complaint IN00456775 - Deficiencies related to the allegations are cited at F727, F809, and F921. Survey dates: April 7, 8, 9, 10, and 11, 2025 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 7 Medicaid: 58 Other: 2 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 16, 2025	F 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, interview and record review the facility failed to ensure accurate weights were obtained for 2 of 16 residents reviewed (Resident 48 and Resident 5).	F 0692	It is the Policy of this facility to obtain accurate weights 1) Immediate actions taken for those residents identified: Resident #48 and Resident #5 had	05/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brent Swan	Executive Director	05/01/2025

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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	Findings include: 1. Resident 48's record was reviewed on 4/7/25 at 1:21 PM. Diagnoses included adult failure to thrive, major depressive disorder, recurrent, and type 2 diabetes without complications. A review of Resident 48's current quarterly Minimum Data Set (MDS) dated 3/26/25 indicated their Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact, etc.). The MDS indicated Resident 48 had a significant weight loss. A review of Resident 48's current care plan titled ...altered nutritional status ... indicated the resident had a problem of being severely underweight with a goal date of 5/20/25. Interventions included obtaining weights as indicated and reporting significant changes to the dietician, physician and family. A review of current physician orders did not contain orders specific to obtaining weight. A review of a document titled Weight and Vitals Summary indicated Resident 48's weights were recorded as follows: On 7/18/24 at 2:24 PM, 140.2 lbs. On 7/19/24 at 5:54 PM, 139 lbs. On 8/2/24 2:28 PM, 144 lbs. On 9/16/24 at 11:28 PM, 132 lbs. On 10/10/24 at 11:06 PM, 141 lbs. On 11/12/24 at 8:32 AM, 120.4 lbs. On 12/5/24 at 2:19 PM, 101.5 lbs. On 12/10/24 at 2:05 PM, 98.4 lbs. On 12/18/24 at 12:20 PM, 101 lbs. On 12/23/24, at 2:41 PM, 101 lbs. On 12/24/24, at 3:15 PM, 99 lbs. On 12/27/24, at 2:31 PM, 99.3 lbs.		their most current weights obtained and are accurate. 2) How the facility identified other residents: Residents who reside in the facility have the potential to be affected by this finding. 3) Measures put into place/ System changes: All weights will be reviewed by DON/Designee to be sure that the most recent weight obtained and documented is accurate. The DON/Designee will Inservice the nursing staff on obtaining an accurate weight by 5-11-25. The DON/Designee will monitor weights as being timely and accurate. The DON/Designee will monitor weights weekly for accuracy and timeliness as part of the morning Clinical meetings. This will be an ongoing part of the meeting agenda. Weights will also be reviewed at the weekly SNAR meetings going forward. 4) How the corrective actions will be monitored: The DON or Designee will complete an audit weekly to validate accuracy of weights. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends	

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	On 1/6/25 at 9:42 AM, 98.5 lbs. On 1/13/25 at 12:07 PM, 100.4 lbs. On 1/13/25 at 12:31 PM, 100.4 lbs. On 2/5/25 at 4:44 PM, 109 lbs. On 2/5/25 at 6:38 PM, 109 lbs. On 3/5/25 at 4:11 PM, 112 lbs. On 4/10/25 at 11:02 AM, 117.8 lbs. No additional weights were available for review. A review of progress notes, dated 11/12/24 at 9:59 AM, indicated the Dietician recommended a reweight due to a 21 lb. weight loss in 30 days. A progress note, dated 11/27/24 at 12:21 PM, indicated the Dietician had requested a reweight and a re-weight had not been obtained. The note indicated the Dietician recommended weekly weights. A progress note, dated 12/27/24 at 2:34 PM, indicated the Clinical Support Nurse had reviewed hospital notes prior to admission, recording Resident 48's weight at 116 lbs. prior to admission to the facility and weights obtained around the time of admission were 135-140 lbs. Daily weights were ordered, and staff should have been using the same scale and the wheelchair weight should have been subtracted if used. Progress notes reviewed, dated between 10/1/24 and 4/10/25, did not include any record of weight refusals. In an interview, on 4/11/25 at 2:30 PM, the Administrator indicated staff had not been weighing residents as they should. During an interview, on 4/10/25 at 11:10 AM, the Director of Nursing (DON) indicated she noticed		or patterns and make recommendations to revise the plan of correction as indicated	

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	weight inconsistencies around October 2024. She indicated weight variances might have been due to not using the same scale or not subtracting off a wheelchair weight. She indicated daily unit huddles included discussion of using the same device and accurately recording weight device in the medical record. She indicated this topic was also covered during a November 2025 in-service. She indicated she and the dietician reviewed weights monthly and would request reweights if a weight was significantly different than the prior month. She indicated she had not identified any inconsistent weights since December. She indicated any weight refusals would be documented in the progress notes.2. Resident 5's record was reviewed on 4/10/25 at 2:00 PM. Diagnoses included hypertension, heart failure, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and chronic kidney disease stage 3. A review of Resident 5's current quarterly Minimum Data Set (MDS) dated 2/13/25 indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact, etc.). The MDS indicated Resident 5 had a significant weight gain. A review of a document titled Weight and Vitals Summary indicated Resident 5's weights were recorded as follows: On 11/8/24 at 5:30 PM, 184.0 lbs. On 11/15/24 at 5:53 PM, 184.0 lbs. On 11/30/24 at 12:49 PM, 211.5 lbs. On 12/6/24 at 4:56 PM, 211.0 lbs. On 1/3/25 at 4:50 PM, 198.5 lbs. On 2/5/25 at 4:44 PM, 198.5 lbs. On 3/5/25 at 4:11 PM, 197.0 lbs. On 4/10/25 at 8:12 AM, 168.5 lbs. On 4/10/25 at 2:55 PM, 187.0 lbs.			

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	During an interview, on 04/10/25 at 3:03 PM, CNA 4 indicated, when a weight was 5 lbs. or more different than the previous weight, they would let the nurse know. A current procedure undated, received from the DON at 4/11/25 at 1:45 PM, indicated staff should zero the scale, record weight immediately, and report unusual readings to the nurse. The procedure indicated "accuracy is necessary." A current policy, dated 8/1/23, provided by the Administrator, on 4/10/25 at 11:37 AM, indicated nursing staff should measure weights on admission and at least monthly unless otherwise ordered by the physician. The policy indicated the dietician should follow the individual weight trends over time and the team should evaluate negative trends to determine whether the criteria were met for significant weight changes. The policy indicated the threshold for significant, unplanned weight loss should be based on the following criteria: Greater than 5% in 1 month Greater than 7.5% in 3 months Greater than 10% in 6 months. 3.1-46			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on observation, interview and record review, the facility failed to ensure a registered nurse was on duty for 8 consecutive hours every day. 65 residents resided at the facility. Findings include:	F 0727	It is the policy of the facility to ensure that a registered nurse is on duty 8 consecutive hours every day. 1) Immediate actions taken for those residents identified: No residents were adversely affected	05/11/2025

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	On 4/11/25 at 10:14 AM, a review of the as worked nursing schedule, dated 4/3/25 through 4/10/25, indicated the following: On 4/4/25, Registered Nurse (RN) 4 clocked in at 8:44 AM and clocked out at 2:10 PM. On 4/5/25, RN 4 clocked in at 9:49 AM and clocked out at 2:05 PM. On 4/7/25, RN 4 clocked in at 11:20 AM and clocked out at 2:41 PM. In an interview, on 4/11/25 at 10:51, the Director of Nursing (DON) indicated RN 4 was the only RN scheduled on 4/4/25 and 4/7/25. The DON indicated they had split the shift with RN 4 on 4/5/25. The DON indicated the Assistant Director of Nursing (ADON) covered the rest of the required 8 hours on 4/4/25 and 4/7/25. The DON indicated the time clock entries were accurate for RN 4. In an interview, on 4/11/15 at 11:00 AM, the ADON indicated they had been in the facility on 4/4/25 and 4/7/25. There were no time clock entries or other documentation to indicate the DON or ADON, in conjunction with RN 4, had filled the consecutive 8 hour RN requirement available for review by the time of exit. This citation is related to Complaint IN00456775. 3.1-17(b)(3)		by the alleged deficient practice. The facility will ensure that an RN works 8 consecutive hours every day per regulation. 2) How the facility identified other residents: All residents are at risk to be affected by the deficient practice. 3) Measures put into place/ System changes: Staffing will be reviewed daily by the Administrator/Director of Nursing to determine appropriate staffing /RN coverage 8 hours daily /7 days a week. The Executive Director and Director of Nursing were educated on the requirements of F727. 4) How the corrective actions will be monitored: Daily review of staffing patterns to ensure RN coverage for 8 consecutive hours for 7 days each week. The results of these audits will be reviewed in Quality Assurance Meeting monthly for a minimum of 6 months until 100% compliance is achieved for 90days. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0740 SS=D	483.40 Behavioral Health Services			

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Bldg. 00	Based on observation, interview and record review, the facility failed to ensure behavioral interventions were resident specific for 1 of 2 residents reviewed (Resident 37). Findings include: On 4/8/25 at 9:22 AM, Resident 37 was observed sitting in the activity room. Resident 37 was yelling loudly to be assisted to the restroom. An unknown male resident indicated Resident 37 "yells all day." Resident 37's record was reviewed on 4/10/25 at 10:28 AM. Diagnoses included congestive heart failure, emphysema, cognitive communication deficit and tobacco use. Resident 37's Admission Minimum Data Set, (MDS) dated 2/13/25, indicated the resident's Brief Interview for Mental Status (BIMS) score was 8 (moderate cognitive impairment). A physician order, dated 2/13/25, indicated Resident 37 could be treated by counseling services. A physician order, dated 2/14/25, indicated Resident 37 could receive mental health services as needed. A Baseline Care Plan, dated 2/17/25, indicated Resident 37 had a history of substance abuse. The Baseline Care Plan indicated Resident 37 had a BIMS score of 13. A progress note, dated 3/18/25 at 11:58 AM, indicated Resident 37 was tearful and missed her	F 0740	It is the policy of this facility to ensure behavioral interventions are resident specific. 1) Immediate actions taken for those residents identified: Resident # 37 plan care reviewed, and updates made as necessary to ensure behavioral interventions are resident specific. 2) How the facility identified other residents: All residents who have behaviors have the potential to be affected by the deficient practice. 3) Measures put into place/ System changes: It is the policy of the facility to ensure behavioral interventions are resident specific. All behavioral plan of cares will be reviewed and updated as needed to include resident specific interventions by 5-11-25. Education will be provided to IDT Team on the behavioral health policy on or before 5-11-25. This will include monitoring behaviors and updating the care plan. The IDT will review all behaviors during the clinical meeting to ensure resident specific interventions are in place on the care plan for all residents exhibiting behaviors. 4) How the corrective actions will be monitored:	05/11/2025

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	family. A physician order, dated 3/25/25, indicated Resident 37 was to be administered methadone 10 milligrams once daily for pain and for substance abuse. A progress note, dated 3/27/25 at 8:54 AM, indicated Resident 37 refused to participate in a doctor's appointment. The resident refused to be examined and refused to answer questions. A progress note, dated 3/27/25 at 3:27 PM, indicated Resident 37 had refused to allow their eye drops to be administered. A progress note, dated 3/27/25 at 3:28 PM, indicated Resident 37 had refused to take their supplement. A progress note, dated 3/27/25 at 10:06 PM, indicated Resident 37 had refused to allow their eye drops to be administered. A progress note, dated 4/1/25 at 2:44 PM, indicated Resident 37 had been repeatedly yelling for help. Resident 37 began yelling for help again immediately after their needs were met. Resident 37 had been repeatedly asking to go smoke. A progress note, dated 4/2/25 at 7:50 PM, indicated Resident 37 had refused to allow their eye drops to be administered. A progress note, dated 4/3/25 at 2:49 PM, indicated Resident 37 had been continuously yelling out. Redirection was not effective. A progress note, dated 4/3/25 at 9:16 PM, indicated Resident 37 had refused to allow their		The Social Service Director or Designee will complete an audit weekly for 4 weeks, then twice monthly for 2 months, then monthly for 3 months to ensure specific behavior interventions are in place for residents with behaviors. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	

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	eye drops to be administered. A progress note, dated 4/3/25 at 2:49 PM, indicated Resident 37 had been continuously yelling out. Redirection was not effective. A progress note, dated 4/5/25 at 11:52 AM, indicated Resident 37 had been continuously yelling out. Redirection was not effective. A progress note, dated 4/5/25 at 12:57 PM, indicated Resident 37 had been continuously yelling out. Redirection was not effective. A progress note, dated 4/6/25 at 3:49 PM, indicated Resident 37 had been continuously yelling out. Redirection was not effective. A progress note, dated 4/7/25 at 3:37 PM, indicated Resident 37 had refused to take all their medications. A progress note, dated 4/8/25 at 8:33 AM, indicated Resident 37 had refused their supplement. A progress note, dated 4/8/25 at 9:48 AM, indicated Resident 37 had been continuously yelling out. Resident 37 repeatedly asked to smoke. Resident 37 continued to yell after numerous needs had been met. The Psychiatric Nurse Practitioner had been notified of the resident's increased yelling. A progress note, dated 4/9/25 at 3:15 PM, indicated Resident 37 had been continuously yelling out. The resident continued to yell after their needs were met. Redirection was not effective.			

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	A progress note, dated 4/9/25 at 9:01 PM, indicated Resident 37 had refused to take all their medications. Resident 37's Care Plan, dated 2/17/25, indicated the resident was at risk for impaired psychosocial well-being. The resident had a history of substance abuse. Interventions for mood and behavior included encourage socializing, non-judgmental support, discussing possible conflict solutions, and psychiatric services as needed. Resident 37's Care Plan did not include resident specific behaviors such as refusal of medications, refusal of care, being tearful or frequent yelling. The Care Plan did not include resident specific stressors. In an interview, on 4/10/25 at 2:10 PM, Resident 37 reported displeasure due to the smoke break being 10 minutes late. Resident 37 abruptly ended the interview and started yelling for help. In an interview, on 4/11/25 at 2:13 PM, the Social Service Director (SSD) indicated they had not been made aware of Resident 37's behaviors of yelling, refusal of meds or refusal to be evaluated by a doctor. The SSD indicated they learned of behaviors on report sheets and behavior logs. The SSD indicated new behaviors are reviewed at Interdisciplinary (IDT) meetings. The SSD indicated regular IDT meetings had not been completed this week due to the annual state survey. The SSD indicated Resident 37 had signed on for substance abuse counseling but had refused to attend the sessions.			

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	In an interview on 4/11/25 at 2:40 PM, the Administrator indicated Resident 37's behavior of yelling was new. The Administrator indicated the resident had signed the substance abuse contract. The Administrator indicated the resident had not participated in the substance abuse program due to refusal. A current facility policy, dated 12/26/24, provided by the SSD on 4/11/25 at 2:20 PM indicated documentation of behaviors should be precise. The policy indicated documentation should include specific behaviors and possible triggers. The policy indicated identified behaviors should be included in the resident's plan of care. 3.1-37 3.1-43			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review the facility failed to ensure medications are stored and labeled properly in 2 of 4 storage areas. Findings include: During a continuous observation, on 4/9/25 at 1:57 PM - 2:10 PM, the following was observed: In the 200 hall medication room, 6 of 7 boxes of Pulmicort were found to be expired on 12/2024. In an interview, on 4/9/25 at 1:59 PM, Licensed Practice Nurse (LPN) 10 indicated third shift was supposed check for outdates and the expired medication removed from the current storage area.	F 0761	It is the policy of the facility to ensure medications are stored and labeled properly in appropriate storage areas. 1) Immediate actions taken for those residents identified: Expired Pulmicort was removed and destroyed per facility policy. Vials of insulin were that had been opened and not dated were removed, destroyed, and replaced with new vial. All vials will be dated upon opening. Bottle of liquid Konvomep was removed, destroyed, and replaced per policy. All biologicals requiring refrigeration will be stored	05/11/2025

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	In the 200 hall medication cart, 2 open vials of insulin did not have an opened date. The insulin was delivered by the pharmacy on 1-2-25. A bottle of liquid Konvomep was expired on 4/4/25. The bottle was labeled to refrigerate, but was not refrigerated. In an interview, on 4/9/25 at 2:05 PM, LPN 10 indicated insulin should be labeled, and the expired medication should be removed from the cart. In an interview, on 04/11/25 at 01:57 PM, the Director of Nursing indicated medications should be labeled when opened. A current policy, dated 1/27/25, provided by Administration on 4/11/25 at 3:10 PM, indicated medications requiring refrigeration should not be stored in the medication cart. Temperatures for refrigerated medications will be kept at 36-46 degrees Fahrenheit. Disposal of outdated medications should be timely and removed immediately from stock. 3.1-25 (1)		accordingly. 2) How the facility identified other residents: All residents are at risk to be affected by the deficient practice. 3) Measures put into place/ System changes: All storage areas for medications and biologicals were audited by the nurse managers on 4/28/25. All QMA's and licensed nursing will be retrained on the proper storage and labeling of biologicals and medications on or before 5/11/25. All vials and bottles of medications will have the date recorded on the bottle on the date the medication is opened. All medications and biologicals that require refrigeration will be stored in medication refrigerator. Expired/outdated medications shall not be administered and will be promptly disposed/destroyed per facility policy. 4) How the corrective actions will be monitored: The nurse managers will be responsible to complete the Medication/Med room Audit tool twice weekly for the next 8 weeks, then weekly x 8 weeks and then monthly thereafter to monitor ongoing compliance. Any issues will be corrected upon discovery and documented on QAPI log. The results of these audits will be	

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	155567	A. BUILDING 00 B. WING	04/11/2025

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			reviewed in Quality Assurance Meeting monthly for a minimum of 6 months and until 100% compliance is achieved for 90days. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results Based on interview and record review the facility failed to ensure notification of significant abnormal results for 1 of 2 reviewed. (Resident 12) Findings include: A review of Resident 12's record on 04/10/25 at 2:53 PM, indicated diagnoses of diabetes type 2, obesity, depression, and hypertension. During a record review, on 4/10/2024 at 2:53 PM, a blood glucose, dated 4/4/25 at 7:31 PM, measured 527 mg/dL. The progress notes did not indicate a physician was notified of a glucose measurement of > 500 mg/dL. During a record review, on 4/10/2024 at 2:53 PM, a blood glucose, dated 4/10/2025 12:01 AM, measured 560 mg/dL. The progress notes did not indicate a physician was notified of >500 blood glucose. In an interview, on 04/10/25 at 3:01 PM, LPN 11 indicated notifying a physician when a glucose measurement was over 500mg/dL was the facility policy.	F 0773	1) Immediate actions taken for those residents identified: Resident #12 had their most current blood glucose results reported to the provider for review. 2) How the facility identified other residents: All Residents who reside in the facility have the potential to be affected by this finding. 3) Measures put into place/ System changes: All blood glucose results will be reviewed by the DON/Designee to ensure that any blood glucose results outside of clinical reference ranges will be reported to the provider. The DON/Designee will in-service the nursing staff on promptly notifying the provider of blood glucose results that fall outside of clinical reference ranges in accordance with facility policies and procedures on or before	05/11/2025

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	A current policy, dated 9/11/2023, provided by the Director of Nursing, on 4/9/25 at 1:32 PM, indicated the physician should be notified for a glucose > 500 mg/dL. 3.1-49 (2)		5-11-25. The DON/Designee will monitor blood glucose results outside of the clinical reference range being timely reported to the provider. The DON/Designee will monitor these as part of the morning clinical meetings. This will be an ongoing part of the meeting agenda. 4) How the corrective actions will be monitored: The DON/Designee will complete an audit 3 times per week for 4 weeks, then 2 times per week for 8 weeks, then weekly for 3 months to validate blood glucose results outside of the clinical reference range being timely reported to the provider. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0809 SS=D Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime Based on observation, interview and record review the facility failed to ensure snacks were available at night for 3 of 24 residents reviewed (Resident B, Resident C and Resident D)	F 0809	It is the policy of the facility to ensure that mealtimes have been adjusted to have no more than 14 hours in between dinner and breakfast mealtime unless a substantial bedtime snack is	05/11/2025

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	Findings include: During an observation, on 4/8/25 at 10:18 AM, the west hall refrigerator contained a few packages of snacks with names of residents written on the packages. No general snacks available to all residents on the unit were observed. No dry storage of snacks was observed on the unit. In an interview, on 4/18/25 at 10:19 AM, Registered Nurse (RN) 7 indicated general snacks for all residents were not stored on the unit. She indicated snacks were delivered by the kitchen staff and given to residents when the snacks were received. During an interview, on 4/9/25 at 1:55 PM, Resident B indicated snacks were usually gone in the evening and there was nothing available during the night when a person was hungry. They indicated when snacks were available, they were not always diabetic friendly or easy for people without teeth to consume. During an interview, on 4/9/25 at 1:56 PM, Resident C indicated snacks were delivered to the unit most evenings, but the same people would take them all off the tray and back to their rooms so no one else would be able to receive any. They indicated when residents were not waiting at the desk as the snacks were delivered, they wouldn't get any. During an interview, on 4/9/25 at 1:57 PM, Resident D indicated no food was available during the nighttime hours when a person needed it. During an interview on, 4/9/25 at 3:30 PM, Certified Nurse Aide (CNA) 5 indicated snacks were brought down to the unit by dietary staff		provided 1) Immediate actions taken for those residents identified: Residents A, B, and C were offered snacks at HS as preferred. 2) How the facility identified other residents: Residents who reside in the facility have the potential to be affected by this finding, however no one was identified. 3) Measures put into place/ System changes: Mealtimes have been adjusted to have no more than 14 hours in between dinner and breakfast mealtime unless a substantial bedtime snack is provided. The dietary staff will be educated on or before 5-11-25 on mealtimes and requirement of no more than 14 hours in between meal times. 4) How the corrective actions will be monitored: Random audits will be conducted 3 times weekly for four weeks, then weekly for four months of various meals to ensure there is no more than 14 hours between dinner and breakfast mealtimes. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved	

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	and offered to each resident. When some snacks were left over, they were kept on the unit. The sncaks were left at the desk until they run out. She indicated there was nothing staff could do when they ran out of snacks. During an interview, on 4/9/25 at 3:32 PM, CNA 4 indicated there were not always snacks available when residents call for snacks in the night. She indicated she had gone into the kitchen to retrieve food once, although she was not allowed to be in there. During an interview, on 4/9/25 at 3:33 PM, Qualified Medicine Aide 6 indicated dietary staff were supposed to bring snacks to the unit each day, but they did not always bring them. He indicated nursing staff signs for snacks when they are delivered to the unit and then they offer them to the residents. He indicated any leftover snacks were kept at the nurses station for residents to eat during the night but they normally run out. When residents requested snacks and they were not available, he indicated he would buy residents food with his own money, so they had something to eat. He indicated staff could not access the kitchen. A current undated policy titled Mealtimes and Frequency, provided by the Administrator on 4/10/25 at 11:37 AM, indicated the facility should provide at least 3 meals daily at regular times in accordance with resident's needs, preferences and requests. The policy indicated all residents should be offered a snack at bedtime. This citation is related to Complaint IN00456775. 3.1-21(i)(e)		x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	

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F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review the facility failed to ensure open items in the kitchen and unit refrigerators were labeled, dated, discarded when appropriate, and hair was covered for all employees present in the kitchen. 65 of 65 residents residing in the facility were served food prepared in the kitchen. Findings include: During an observation, on 4/7/25 at 9:16 AM, a container of a brown lumpy substance covered with clear plastic wrap and a plastic bag of parsley with its original seal opened, twist ied shut were observed on a shelf in the walk-in cooler. Neither item was labeled or dated. A container of strawberries soaking in red liquid on a shelf in the cooler was dated 3/28. A bag of corn observed in the walk-in freezer was tied closed and did not have an open date. A large, uncovered cart holding trays with food items was observed adjacent to the tray line where two dietary staff members were assembling and serving food items to residents. A tray containing bowls of uncovered lettuce salads and a tray of cups of fruit cocktail was observed on the cart. In an interview, on 4/7/25 at 9:18 AM, the Dietary Manager (DM) indicated the container with the lumpy brown substance was left over bananas foster from a previous day. He indicated leftovers should be labeled and dated. He indicated all bags of fresh produce should be labeled and dated when opened. He indicated the bowls of salad and fruit cocktail were left over from the evening meal and should not have been stored on	F 0812	1) Immediate actions taken for those residents identified: No residents were identified in the deficiency. 2) How the facility identified other residents: All residents at facility could be affected by this deficient practice. 3) Measures put into place/ System changes: Upon discovery, the Food Service Director audited and labeled all food items in the kitchen. The Environmental Services Directed emptied both unit refrigerators. All staff will be in-serviced on or before 5-11-25 on the proper labeling, dating, and discarding of food when appropriate in all resident used refrigerators. All staff were also in-serviced on appropriate hair coverings when present in the kitchen. The EVS Director or their Designee will monitor unit refrigerators 3 times per week to ensure compliance. The Food Service Director will monitor, and audit labeling of all food items located within the kitchen 3 times per week. 4) How the corrective actions will be monitored: The Dietary Manager or designee will complete an audit ensuring	05/11/2025

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	the tray line with the drinks and food items set up for the current breakfast service. He indicated the items were not covered or dated and should have been discarded. During an observation, on 4/7/25 at 9:28 AM, Certified Nurse Aide (CNA 3) walked into the dish room entrance to the kitchen, walked throughout the food prep and service area stopping at the tray line to obtain food items. CNA 3's waist length hair was not restrained or contained in a hairnet. In an interview, on 4/7/25 at 9:29 AM, the DM indicated no employees should be in the kitchen without a hairnet. During an observation, on 4/8/25 at 10:18 AM, a container of grapes with no label or date was observed in the west hall nurses station refrigerator. A snack package containing cheese and crackers had a piece of tape partially closing the container with the cellophane cover turned up, allowing air to the product. The package had a resident's name, but no open date. Three separate containers were labeled with resident names but did not have dates. The containers appeared to contain leftover food items. A Styrofoam cup of ice and a container half full of ice cream were observed in the freezer with no label or date. In an interview, on 4/8/25 at 10:36 AM, Registered Nurse 7 indicated all items in the refrigerator should be labeled with a resident's name and date. During an observation, on 4/8/25 at 10:34 AM, a large bowl of grapes, cut up melon and a cup of foamy, coffee colored liquid was observed in the unit refrigerator with no label or date. Four insulated, zippered bags were observed in the		food is labeled, dated, and discarded when appropriate, and hair coverings are utilized by all employees present in the kitchen 3 times weekly for four weeks, then weekly for four months. EVS Director will monitor labeling of items in the Unit Refrigerators 3 times weekly for four weeks, then weekly for four months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	

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	refrigerator. The freezer contained an open ice cream container with no date and a candy bar with no label or date. In an interview, on 4/8/25 at 10:35 AM, Qualified Medicine Aide 8 indicated there were not many resident items in the refrigerator. Most of the items in the refrigerator belonged to staff. In an interview, on 4/8/25 at 10:42 AM, the Administrator indicated he had asked an employee to check the unit refrigerators, and was displeased that it had not been done. He indicated items should be labeled, dated and staff should not be storing their lunches in resident designated refrigerators. A current policy titled General Food Preparation and Handling, undated, provided by the Administrator on 4/8/25 at 10:45 AM indicated leftover food must be dated, labeled, covered, cooled and stored. Leftovers should be used within 7 days and then discarded. A current policy titled Employee Hygiene for Food Safety, dated 2022, provided by the Administrator on 4/8/25 at 10:45 AM indicated Hair restraints should be worn to prevent hair from contact with exposed food. A current policy titled Food Safety for Your Loved One, dated 2022, provided by the Administrator on 4/8/25 at 10:45 AM indicated foods in unmarked, unlabeled containers should be marked with the current date the food item was stored and the resident's name. A current policy titled Food Brought in from Outside Sources and Personal Food Storage, undated, provided by the Administrator on 4/8/25			

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	at 10:45 AM indicated food and beverages brought in from outside sources that require refrigeration or freezing should be labeled with the resident's name and date, and stored in the refrigerator or freezer apart from facility food. Unlabeled or undated foods dated outside facility policy should be disposed of by staff. 3.1-21(i)(3)			
F 0814 SS=D Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly Based on observation, record review and interview, the facility failed to ensure garbage and refuse were contained inside the dumpster for 2 of 3 observations. Findings include: During an observation, on 4/7/25 at 9:05 AM, a dumpster lid was observed flipped up leaving the dumpster wide open and fully accessible. A large plastic bag was observed partially hanging out of the dumpster door. Multiple tears were observed in the trash bag with a fast-food cup, lid and straw partially hanging out of the bag. Cups, straws, snack and candy packages, gloves, and plastic bags were observed strewn throughout the lawn near the dumpster. Additional cups, candy and snack wrappers, cigarette packs and straw papers were observed in the parking lot, sidewalks, and grassy enclosures in the parking lot area. During an interview, on 4/7/25 at 9:32 AM, the Dietary Manager (DM) indicated all dumpster doors should be closed to prevent rodent access. The DM indicated trash should not be present in the lawn area.	F 0814	It is the Policy of this facility to ensure garbage and refuse are contained inside the dumpster. 1) Immediate actions taken for those residents identified: No residents were identified in the deficiency. 2) How the facility identified other residents: All residents at facility could be affected by this deficient practice. 3) Measures put into place/ System changes: Upon discovery, the litter around the dumpsters was removed and the dumpster lids were closed. Signage was placed on dumpsters reminding staff to keep doors/lids closed. Staff will be in-serviced on or before 5-11-25 on the proper disposal of garbage and refuse. The Maintenance Supervisor/Designee will monitor the dumpster 5 times per week	05/11/2025

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	During an observation, on 4/7/25 at 1:22 PM, the side door of the dumpster was observed to be partially open with a trash bag partially hanging out of the door. Trash remained (cups, candy and snack wrappers, cigarette packs and straw papers) in the parking lot, sidewalks, and grassy enclosures in the parking lot area were observed. In an interview, on 4/7/25 at 1:35 PM, the Administrator indicated he had closed the dumpster at the beginning of his shift at 7:45 AM and did not know why it had been left open. He indicated the dumpster should have had all lids and doors closed to prevent access to rodents He indicated trash items should never be found in the lawn, sidewalks and parking lots. A current policy titled Waste Storage, dated 5/2012, indicated the Maintenance supervisor or designee should verify the lids were closed three times daily after each meal service. The policy indicated waste should be stored in such a way to protect it from animals. 3.1-21(i)(5)		after meals to ensure compliance. 4) How the corrective actions will be monitored: Maintenance Supervisor or designee will complete an audit ensuring garbage and refuse is properly disposed of 3 times weekly for four weeks, then weekly for four months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities Based on interview and record review the facility failed to ensure a process was in place to correct deficiencies and keep them from re-occurring. 65 residents resided in the building. Findings include: An annual survey completed on 6/7/2024 identified non-compliance of labeling and dating	F 0867	It is the Policy of this facility to ensure a process is in place to correct deficiencies and keep them from reoccurring. 1) Immediate actions taken for those residents identified: No residents were identified in the deficiency.	05/11/2025

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	food items in the kitchen. The facility indicated the deficient practice would be corrected by 7/5/24. An annual survey completed on 6/7/2024 identified non-compliance of maintaining facility waste in the dumpster. The facility indicated the deficient practice would be corrected by 7/5/24. See F812 for additional information about current kitchen findings. See F814 for additional information about current maintenance of facility waste findings. A review of the current Quality Assurance and Improvement Program (QAPI) did not include performance improvement plans pertaining to labeling and dating items in the kitchen or maintenance of the facility dumpster. During an interview, on 4/11/25 at 2:30 PM, the Administrator indicated he had reviewed the kitchen and waste container concerns cited last annual survey for six months as committed to in the plan of correction. He indicated at the end of six months the concerns were closed and the Quality Assurance team moved on to different areas of concern, including the physical environment, infection control, weights and falls. A current policy titled Quality Assurance and Improvement Program Policy, dated 10/1/23 provided by the Administrator on 4/11/24 at 2:51 PM, indicated the facility's QAPI plan should develop corrective actions to ensure the monitoring of effectiveness of performance improvement activities. The policy indicated the program should ensure the improvements are sustained.		2) How the facility identified other residents: All residents in the facility have the potential to be affected. 3) Measures put into place/ System changes: The facility Administrator or designee will ensure QAPI meetings and necessary audits related to this citation are reviewed in QAPI/QAA monthly. All food related items were appropriately dated and labeled as necessary on 5-9-25. Staff will be re-educated on labeling and dating food items in the kitchen on or before 5-11-25. All waste was noted to be appropriately contained in the dumpsters on 5-8-25. Staff will be in-serviced on or before 5-11-25 on the proper disposal of garbage and refuse. The Maintenance Supervisor/Designee will monitor the dumpster 5 times per week after meals to ensure compliance. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0880 SS=D Bldg. 00	3.1-52 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to maintain procedures to help prevent the development and transmission of communicable diseases and infections during 3 of 3 observations. Findings include: 1. During an observation on 04/09/25 at 09:53 AM, Licensed practical nurse (LPN) 2 placed her laptop on the mattress of Resident 23. The resident's covered foot contacted the laptop during a blood glucose measurement. LPN 2 placed the laptop and the glucometer on top of the medication cart without disinfecting the devices. LPN 2 placed the glucometer into the drawer of the medication cart. In an interview, on 04/09/25 at 10:05 AM, LPN 2 indicated Resident 23 was the only resident that used the glucometer. 2. During an observation, on 04/09/25 at 10:42 AM, LPN 2 had gloves on, gave an intramuscular injection, removed the gloves, but did not perform hand hygiene before touching the medication cart. In an interview, on 04/09/25 at 10:59 AM, the Assistant Director of Nursing (ADON), indicated staff should perform hand hygiene before and after giving medications to each resident. 3. During an observation on 04/09/25 at 11:02 AM LPN 2 returned from the medication room and	F 0880	It is the policy of this facility to maintain procedures to help prevent the development and transmission of communicable diseases and infections. 1) Immediate actions taken for those residents identified: The glucometer for Resident 23 was removed from the cart and immediately sanitized. The laptop, med cart, and ice scoop were sanitized at the time of identification. 2) How the facility identified other residents: All residents have the potential to be affected by the deficient practice. 3) Measures put into place/ System changes: All nurses were immediately educated on when to complete hand hygiene and the cleaning of the glucometer. All nursing staff will be re-educated on when to complete hand hygiene on or before 5-11-25. New laptop mounts were ordered for the Medication Carts to ensure that laptops are not taken into resident rooms. The ADON/Designee will	05/11/2025

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	155567	A. BUILDING 00 B. WING	04/11/2025

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	placed medication on the cart. LPN 2 took the pitcher of water from the cart to the ice chest and scooped new ice into the pitcher without performing hand hygiene before touching the ice scoop. In an interview, on 04/09/25 at 11:15 AM, the Director of Nursing (DON) indicated staff should wipe down the glucometer with Super Sani-Cloth Wipes before putting the meter into a drawer. She also indicated the laptop should not have been on the bed with a resident. A current policy, dated 6/11/24, titled Capillary Blood Sampling Devices, provided by the DON on 4/9/25 at 1:32 PM, indicated blood glucose meters are cleaned and disinfected between resident use. Use an approved disinfectant, wipe the meter clean and allow the meter to stay wet during the duration of the manufacturer's contact time. Remove gloves and wash hands. A current policy, dated 9/11/23, titled Handwashing/ Hand Hygiene/ Gloving, provided by the DON on 4/9/25 at 1:32 PM, indicated staff should use an alcohol-based hand rub before and after direct contact with residents, before preparing or handling medications, after contact with resident's intact skin, after contact with blood and body fluid, after removing gloves, and before handling food. A current policy, undated, titled Intramuscular Injections, provided by the DON on 4/9/25 at 1:32 PM, indicated staff should perform hand hygiene before putting on gloves. After removing gloves, staff should wash and dry hands. 3.1-18(a)(l)		randomly audit all nursing staff for routine hand hygiene and adherence to standard precautions during resident interactions on a weekly basis. 4) How the corrective actions will be monitored: The DON or Designee will complete an audit weekly to observe at least three observation of hand hygiene and cleaning of the glucometer to verify proper procedures. Results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview and record review, the facility failed to ensure a clean and sanitary environment was maintained on 3 of 3 units observed. 65 residents resided in the facility. Findings include: During a facility tour, on 4/11/25 from 9:50 AM until 10:07 AM, an air vent above the 200 hall nurses' station was observed to be covered with grey clumps too numerous to count. Near the 300-hall entrance, an air vent was observed to be covered with grey clumps. An air vent near room 110, was observed to have grey clumps around the edges. During an observation, on 4/11/25 at 11:14 AM, pencil eraser sized grey clumps too many to count were observed on the vented cover of the return air duct above the hallway near the east nurses' station. The Maintenance Director opened the cover causing clumps to fall to the counter of the nurses' station and nearby floor. The Maintenance Director pulled out the filter covering the circle shaped return air duct and revealed a covering of dust on the outside of the filter (part of the filter facing the cover). The filter was dated 3/26/25. During an interview, on 4/11/25 at 11:17 AM, the Maintenance Director indicated the filters were changed monthly. The Maintenance Director indicated the vent covers were cleaned monthly. The Administrator indicated due to the filter's proximity to the residents' smoking area door and high traffic of the unit, the filter typically accumulated a lot of dust and debris.	F 0921	It is the policy of this facility to ensure a clean and sanitary environment is maintained. 1) Immediate actions taken for those residents identified: No residents were identified. 2) How the facility identified other residents: All residents have the potential to be affected by the deficient practice. 3) Measures put into place/ System changes: Facility Administrator and Maintenance Director inspected all HVAC exchange vents for any dust and debris throughout the entire facility immediately upon finding. On 4-11-25 the preventative maintenance schedule for HVAC vent cleaning was increased from one time monthly to every two weeks and as needed. Maintenance Director or designee will physically inspect and clean vent covers at least every two weeks. High traffic areas have been identified to ensure accumulation of debris does not occur. 4) How the corrective actions will be monitored:	05/11/2025

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	A current facility policy, dated 9/11/23, indicated the facility would maintain the cleanliness of exhaust fans monthly. The policy indicated all the dust from the vents would be removed with a vacuum and an air compressor when needed. This citation is related to Complaint IN00456775. 3.1-19(e)		The Maintenance Director or designee will complete a weekly inspection to ensure vents remain free of all dirt and debris. The facility's preventative maintenance schedule has been updated to include physical cleaning on a two-week interval. The results of the physical inspections and maintenance logs will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated	