STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 2, 3, 4, 5, and 6, 2025 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 7 Medicaid: 50 Other: 18 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/10/25.	F 0000	**F 0000** **By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective March 3rd for the survey ending march 6th, 2025** **Chesterton Manor respectfully request a desk review/paper compliance of this plan of correction.**	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on observation, record review and interview, the facility failed to protect a resident's right to be free from misappropriation of property related to bank fraud by Agency CNA 1, for 1 of 1 resident reviewed for misappropriation of property. (Resident 25) The deficient practice was corrected by 1/27/25, prior to the start of the survey, and was therefore past noncompliance. The facility thoroughly	F 0602	F 602 WAS CORRECTED BY 1/27/25 No plan of correction needed.	03/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherrie Lamore	Administrator	03/21/2025

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	investigated the incident related to the bank fraud once being notified by the police. A report was initiated by the police department and a detective was assigned to the case. The Staffing Agency was notified as soon as the Administrator was made aware and the Agency CNA had not worked at the facility since 11/7/24. Finding includes: On 3/2/25 at 2:30 p.m., Resident 25 was observed in her room. She indicated it was not a good time to talk due to her floor being wet and she was busy. On 3/4/25 at 2:00 p.m., the resident indicated it was not a good time to talk. The record for Resident 25 was reviewed on 3/3/25 at 3:32 p.m. Diagnoses included, but were not limited to, rheumatoid arthritis, scoliosis, spinal stenosis, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 2/17/25, indicated the resident was cognitively intact. A Social Service Note, dated 1/27/25 at 3:00 p.m., indicated the Social Service Director met with the resident to inquire about personal items. The resident indicated something was missing, however, "they already know." The resident was offered a lock box to secure her valuables but she declined. The resident was observed with a keychain around her wrist with keys. She indicated she was able to keep personal items in her dresser that locked with a key. She presented at her baseline without signs or symptoms of emotional distress.			

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	A facility reportable to the State Agency was dated 1/27/25 and indicated the following: The facility was notified by (name of town) detective of fraudulent funds from the resident's checking account. The police were notified by the resident's daughter of the fraudulent activity occurring since November. The detective notified the facility of the alleged involvement by an agency employee. The staffing agency was notified and the suspected staff member was removed from the schedule. The facility was working with the family and detective. The physician was notified and the resident was offered to keep her possessions in the safe in the business office. A statement completed by the Administrator indicated, on 1/27/25, a detective arrived at the facility and met with the Administrator. The detective informed the writer (Administrator) there were fraudulent charges on Resident 25's checking account going back to November 2024. The detective informed the Administrator of the Agency CNA's name. The CNA's file was pulled and the last time she had worked was 11/7/24, her certificate expired 11/10/25, and she had not worked in the facility since 11/7/24. The Administrator called the staffing agency and alerted them of the investigation and indicated there might be two more aides involved but the detective had no evidence yet. The Administrator spoke with the resident to ask if she had anything of value in her room and if she would like to have it locked up. The bank had refunded the lost funds to the resident. Resident interviews were completed related to misappropriation of property on 1/28/25 and 1/29/25 and no concerns were voiced.			

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	On 1/30/25, the Administrator went in with the Human Resource (HR) Director and met with the resident, and asked her again if she had anything she would like put in the safe. The resident indicated she had $150 in her night stand and the Administrator encouraged her to please put the money in the safe. The resident handed over an envelope that had $120 in it. The resident's daughter was called and informed of amount of money her mother had as well as another envelope with $30 that she wanted to keep. A follow up investigation on 2/3/25, indicated the detective alerted the facility of an agency aide in possible connection with fraudulent activity in the resident's checking account. The aide last worked in the facility on 11/7/24 and has since been put on the "do not return" list. The resident agreed to have the facility place any cash or checks in the facility safe. The facility was cooperating with the police department and the resident's bank had replaced the cash back into the resident's account. On 2/3/25, the Administrator called the detective for an update, who indicated he was pressing charges against the aide and had just started an investigation on the other two agency aides and would keep the facility updated. During an interview on 3/6/25 at 8:51 a.m., the Administrator indicated she had no previous knowledge of the incident prior to the detective coming to the facility on 1/27/25. The resident's daughter had not brought the issue to her attention or any other staff member. As soon as the Administrator was aware of the alleged incident, she called the staffing agency to make them aware. The staffing agency indicated the CNA no longer worked there. The Nurse Consultant was also notified due to the facility			

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	having a "sister" facility in the same city where the staffing agency was located. The Administrator indicated staff and residents who worked and resided on the 100 Unit were interviewed with no concerns voiced. 3.1-28(a)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to falls, fractures, and hospice services for 2 of 21 MDS assessments reviewed. (Residents 69 and 17) Findings include: 1. The record for Resident 69 was reviewed on 3/4/25 at 9:52 a.m. Diagnoses included, but were not limited to, fracture of the right femur and orthopedic aftercare. The resident was admitted to the facility on 1/14/25. The Admission Minimum Data Set (MDS) assessment, dated 1/20/25, indicated the resident was cognitively impaired for daily decision making. Section J1700 indicated the resident had a fall in the last month prior to admission/entry or reentry. The resident was not identified as having any fractures related to a fall in the six months prior to admission/entry or reentry. Section J1800 indicated the resident had a fall since admission/entry or reentry or the prior assessment.	F 0641	No plan of correction needed.	04/11/2025

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	Section J1900 indicated the resident had one fall that resulted in a major injury since admission or the prior assessment. During an interview on 3/6/25 at 1:15 p.m., the Unit Manager indicated the MDS was coded incorrectly. She indicated the resident's fracture occurred prior to being admitted to the facility. The resident had no falls with a major injury since being admitted. 2. During an interview on 3/2/25 at 2:15 p.m., Resident 17 indicated she had been under hospice care for about one year. The record for Resident 17 was reviewed on 3/3/25 at 1:47 p.m. Diagnoses included, but were not limited to, Parkinson's Disease, lupus, and depression. The 12/11/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was not receiving hospice care. A Physician's Order, dated 2/8/24, indicated the resident was being admitted to hospice care. A Care Plan, revised 2/8/24, indicated the resident had a terminal condition and was receiving hospice services. During an interview on 3/05/25 at 3:21 p.m., the MDS Coordinator indicated the resident was on hospice at the time of the assessment and she would modify it. 3.1-31(i)			
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

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Bldg. 00	Based on record review and interview, the facility failed to ensure a care plan meeting was conducted at least quarterly for 1 of 5 residents reviewed for care planning. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 3/4/25 at 9:05 a.m. Diagnoses included, but were not limited to, pneumonia and hypertensive heart disease. The 12/27/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A review of the care plan notes indicated the last care plan meeting conducted was on 3/14/24. The resident declined a care plan meeting on 9/18/24. There was no documentation of subsequent care plan meetings conducted or refused. During an interview on 3/5/25 at 4:05 p.m. the Social Service Director indicated care plan meetings normally would take place at least quarterly, with each MDS assessment. A policy titled, "Care Plans, Comprehensive Person - Centered", received as current from the Director of Nursing on 3/6/25 at 9:00 a.m. indicated, " ... The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident ... The Interdisciplinary Team must review and update the care plan: ... At least quarterly, in conjunction with the required quarterly MDS assessment..."	F 0657	F 657- Care plan timing and revision: It is the practice of this facility to ensure care plan meetings are conducted at least quarterly. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: A care plan meeting was held for resident 4 on 3/19/25 How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: · All residents have the potential of being affected by the deficient practice. · Quality assurance tool developed that audit quarterly care plans for all residents What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: The policy "Care Plans, Comprehensive Person-Centered" was reviewed by the IDT. An in-service was held with the Social Service Director on the policy concerning quarterly care plan meetings. A performance improvement tool was developed to audit that quarterly care plan meeting are being held. A review of the care plan schedule will be	04/11/2025

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	3.1-35(d)(2)(B)		conducted during morning clinical meetings. How the corrective actions will be monitored to ensure the deficient practices will not occur. TA A quality Assurance tool has been developed and implemented that audits quarterly care plans for all residents. This tool will be completed by Social Services/designee weekly times three, then monthly times three, and then quarterly times three. In the event any further concerns are identified the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance program at least quarterly. By what date the systematic changes for the deficiency will be completed. 4/11/25	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure medications were held per blood sugar parameters for 1 of 1 resident reviewed for insulin. The facility also failed to ensure areas of discoloration and dry flaky skin were assessed and monitored for 4 of 4 residents reviewed for skin conditions non-pressure related and signs and symptoms of constipation were monitored and treated for 2 of 2 residents reviewed for constipation. (Residents 53, 3, 69, 58, 176, 13, and 226)	F 0684	F 684 QUALITY OF CARE It is the practice of this facility to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan and resident choice. What corrective actions will be accomplished for those residents found to have been affected by the	04/11/2025

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	Findings include: 1. The record for Resident 53 was reviewed on 3/3/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes and chronic kidney disease stage 3. The Quarterly Minimum Data Set (MDS) assessment, dated 1/27/25, indicated the resident was cognitively intact and he had received insulin injections within the past seven days. A Care Plan, dated 10/29/24 and reviewed on 1/8/25, indicated the resident had a diagnosis of diabetes mellitus which placed him at a risk for medical complications. Interventions included, but were not limited to, administer medications as ordered by the physician. A Physician's Order, dated 1/23/25, indicated the resident was to receive 6 units of Lispro insulin subcutaneously (a method of administering medication by injecting it into the fatty layer of tissue just beneath the skin) three times a day. The insulin was to be held if the resident's blood sugar was 150 or less. The January 2025 Medication Administration Record (MAR) indicated the resident's insulin was administered when his blood sugar was 150 or less for the following dates and times: - 7:00 a.m.: 1/24/25 and 1/27/25 - 5:00 p.m.: 1/24/25 and 1/25/25 The February 2025 MAR indicated the resident's insulin was administered when his blood sugar was 150 or less for the following dates and times: - 7:00 a.m.: 2/6/25, 2/13/25, 2/14/25, 2/18/25, 2/19/25, 2/21/25, 2/22/25, 2/23/25, 2/24/25, and		deficient practice: · The physician was notified of insulin parameter orders not being followed for resident 53, noted skin discolorations for residents 3, 69, and resident 13 after area assessed, treatment and monitoring of constipation not completed for resident 58 and 176, and lack of treatment for lower leg skin issues for resident 226. Orders were received to treat/monitor skin conditions if indicated for resident 3, 69, 13 and 226. Care plan was updated to include the skin issue of resident 226 leg(s). How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents who have orders for insulin parameters, risk factors for constipation and skin impairments have the potential be be affected by the deficient practice. An audit of all resident charts was completed to review insulin parameters and bowel movement pattern with no further concerns identified. A skin sweep was performed on all residents and the physician was notfied of any identified areas of concern, orders received if indicated and care plans updated.	

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	2/27/25 - 12:00 p.m.: 2/9/25 - 5:00 p.m.: 2/17/25 and 2/28/25 The March 2025 MAR, indicated the resident's insulin was administered when his blood sugar was 150 or less for the following date and time: - 7:00 a.m.: 3/3/25 During an interview on 3/6/25 at 1:15 p.m., the Unit Manager indicated the insulin should have been held as ordered. 2. On 3/2/25 at 2:41 p.m., a fading reddish/purple bruise was observed on the top of Resident 3's right hand. The record for Resident 3 was reviewed on 3/5/25 at 11:21 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, atrial fibrillation (an irregular heart rhythm), and anemia. The 12/2/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and required substantial to maximum assistance with rolling left and right and with chair to bed transfers. A Care Plan, dated 7/27/23 and reviewed on 12/2/24, indicated the resident was at risk for bleeding due to Aspirin therapy. Interventions included, but were not limited to, observe for increased bruising on skin assessments and with care. A Physician's Order, dated 4/23/24 and listed as current on the March 2025 Physician's Order Summary (POS), indicated the resident received		What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: The policy "Skin and Wound Management System", "Charting and Documentation" and the bowel protocol were reviewed by the IDT. Nursing staff were in-serviced on the policies and protocols. A performance improvement tool has been developed to monitor that skin conditions have been identified and physician has been notified for treatment and monitoring is in place, insulin has been administered per parameters and constipation has been monitored and treated as indicated. Bowel records, following insulin parameters and skin condition monitoring and documentation will be reviewed in morning clinical meetings. How the corrected actions will be monitored to ensure the deficient practice does not recur: · A performance improvement tool has been initiated that audits insulin parameters, skin condition documentation and monitoring and bowel pattern monitoring and treatment. The performance improvement audit tool will be	

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	Aspirin Enteric Coated 81 milligrams (mg) daily related to atrial fibrillation. There was no order to assess and monitor the discoloration on the right hand. The last Weekly Non-Pressure Bruise Evaluation was dated 1/21/25, which indicated bruising to the left and right forearms was resolved. During an interview on 3/5/25 at 2:25 p.m., the Unit Manager was informed of the discoloration to the resident's right hand. A Nurse's Note, dated 3/6/25 at 7:14 a.m., indicated the resident was observed with a bruise to the right posterior hand, which was pink in color. The area measured 0.5 centimeters (cm) in length and 0.5 cm in width. The area was to be monitored until the bruise was healed. 3. On 3/3/25 at 8:50 a.m., Resident 69 was observed with two small areas of reddish/purple discoloration to the top of her left hand. The record for Resident 69 was reviewed on 3/4/25 at 9:52 a.m. Diagnoses included, but were not limited to, hypertension and fracture of the right femur. The 1/20/25 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making and she required substantial to maximum assistance with rolling left and right and with chair to bed transfers. A Care Plan, dated 1/17/25, indicated the resident was at increased risk for bleeding related to		completed by the Director of Nursing/ designee weekly for 3 weeks then monthly for three months, then quarterly x's three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.	

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	anticoagulant (blood thinner) use of Aspirin. Interventions included, but were not limited to, observe skin with care and report abnormalities to the nurse. There was no order to assess and monitor the discoloration to the left hand. A Weekly Skin Assessment, dated 2/25/25, indicated the resident's skin was intact and a bruise to the right side of her face near her brow was lightening. There was no documentation related to the resident's left hand. During an interview on 3/5/25 at 2:25 p.m., the Unit Manager was informed of the discoloration to the resident's left hand. 4. During an interview on 3/3/25 at 9:34 a.m., Resident 58 indicated she was very constipated and sometimes did not have a bowel movement within 3 days. The record for Resident 58 was reviewed on 3/4/25 at 9:30 a.m. Diagnoses included, but were not limited to, chronic kidney disease, chronic migraines, atrial fibrillation, high blood pressure, major depressive disorder, anxiety, joint disorder, and obsessive compulsive disorder. The 1/29/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, was always incontinent of bowel, and was not on a bowel toileting program. The resident needed substantial to maximum assistance with toileting. The Care Plan, dated 12/2/24, indicated the resident was constipated related to decreased			

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mobility. The nursing approaches were to follow the facility's bowel protocol for bowel management.

The bowel movement documentation, in the CNA task section, indicated the resident had no bowel movement on 11/1/24, 11/3/24, 11/4/24, 11/5/24, 11/6/24, 11/8/24, 11/9/24, 11/19/24-11/22/24, and 11/27/24-11/30/24. There was no documentation and was blank on 11/2/24, 11/7/24 and 11/24/24.

The resident had no bowel movements on 12/1/24, 12/3/24, 12/4/24, 12/6-12/10, 12/15/24, 12/18/24, 12/22/24, 12/24/24, 12/26/24, 12/27/24, 12/28/24, 12/29/24, and 12/31/24. There was no documentation and was blank on 12/2/24, 12/16/24, 12/19/24-12/21/24, 12/23/24, 12/25/24, and 12/30/24.

The resident had no bowel movement on 1/4/25, 1/6/25, 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/17/25, 1/18/25, 1/19/25, and 1/20/25. There was no documentation and was blank on 1/3/25 and 1/5/25.

The resident had no bowel movement on 2/12/25, 2/14/25, 2/15/25, 2/16/25, 2/28/25, 3/2/25, 3/3/25, and 3/4/25. There was no documentation and was blank on 2/13/25, 3/1/25, and 3/5/25.

A Physician's Order, dated 11/21/24, indicated Milk of Magnesia oral, give 30 milliliters (ml) by mouth every 24 hours PRN (as needed) for constipation.

A Physician's Order, dated 12/1/24, indicated Milk of Magnesia oral, give 30 milliliters (ml) by mouth at bedtime for constipation.

The Medication Administration Record (MAR) for

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	the months of 11/2024, 12/2024, 1/2025, and 2/2025 indicated the PRN Milk of Magnesia was only administered two times in four months on 11/29/24 and 2/5/25. During an interview on 3/5/25 at 2:00 p.m., the Unit Manager indicated if a resident had no bowel movement after three days then nursing staff should be administering the PRN medications. 5. During an interview on 3/2/25 at 9:35 a.m., Resident 176 indicated she had constipation and it might be longer than 3 days before she had a bowel movement. The record for Resident 176 was reviewed on 3/3/25 at 2:40 p.m. The resident was admitted to the facility on 2/9/25. Diagnoses included, but were not limited to, wedge compression fracture of T11 and T12 vertebra, anxiety disorder, chronic pain, adult failure to thrive, severe protein calorie malnutrition, and atrial fibrillation. The 2/14/25 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed minimal assistance with toileting. The resident was always continent of bowel and constipation was not present. A Care Plan, dated 2/11/25, indicated the resident had constipation related to decreased mobility. The approaches were to follow the facility protocol for bowel management and record bowel movements each day. The bowel movement documentation, in the CNA task section, indicated the resident had no bowel movement on 2/14/25-2/16/25 and there was no			

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	documentation and it was blank on 2/17/25. A Physician's Order, dated 2/10/25, indicated Glycolax Powder, give 17 gram by mouth one time a day for constipation. The 2/2025 and 3/2025 Medication Administration Record (MAR) indicated the Glycolax powder was refused by the resident on 2/22/25, 2/27/25 and 3/4/25. During an interview on 3/5/25 at 2:00 p.m., the Unit Manager indicated if a resident had no bowel movement after three days, then nursing staff should have followed the bowel protocol if the resident had no "as needed" medications for constipation. The current and revised 9/8/2014 "Bowel Protocol" policy, provided by the Unit Manager on 3/6/25 at 10:30 a.m., indicated if a resident had no bowel movement after two days, then give prune juice or bran. If no bowel movement after three days, then administer Milk of Magnesia 30 ml and if no results with 24 hours, administer a Dulcolax suppository. If no results after the suppository within 12 hours, administer a Fleets enema. 6. During an observation of wound care on 3/4/25 at 10:27 a.m., a tennis ball-sized purple bruise was observed below Resident 13's right buttock. The record for Resident 13 was reviewed on 3/3/25 at 1:57 p.m. Diagnoses included, but were not limited to, disruption of surgical wound, dementia, and rheumatoid arthritis. The 2/9/25 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and required			

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moderate assistance with ADLs (activities of daily living) and transfers.

A Care Plan, revised on 2/4/25, indicated the resident was taking a blood thinner. Interventions included watching for bruising and reporting abnormalities.

The record lacked an assessment of the bruise below the resident's right buttock.

During an interview on 3/5/25 at 11:31 a.m., the Unit Manager indicated the bruise was probably from one of the resident's falls, there was no assessment of that bruise documented, and staff would have to do a new skin assessment.

A policy titled, "Incidents - Bruising", received as current from the Unit Manager on 3/6/25 at 10:30 a.m. indicated, " ... The nurse will complete an incident report when a bruise is identified ... An identified bruise will be measured. This measurement will be noted on the incident report and in the clinical record..."

7. On 3/3/25 at 9:05 a.m., Resident 226's left lower leg was observed to have reddened, scaly, flaking skin below an area with a traumatic wound. The resident indicated her skin had "been that way" due to cellulitis.

On 3/3/25 at 1:12 p.m., the resident was observed seated in her wheelchair with her left leg elevated on the footrest. The skin to her lower leg remained dry and scaly. At that time, the resident indicated there was no treatment being provided for that area.

During an observation of wound care on 3/4/25 at

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	10:48 a.m., the skin to the right lower leg remained unchanged. At that time, LPN 3 indicated she thought there was a treatment for the scaly skin that was flaking off of the resident's leg, but she was not sure what it was. The record for Resident 226 was reviewed on 3/4/25 at 11:31 a.m. Diagnoses included, but were not limited to, cerebral infarction and hypertension. The 2/19/25 Nursing Admission Evaluation assessment indicated the resident was cognitively intact for daily decision making and required limited assistance from staff with ADLs and transfers. There were no orders or care plans for treatment of the resident's dry, scaly skin. During an interview on 3/5/25 at 2:27 p.m., the Unit Manager was informed of the findings and offered no further information. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on record review and interview, the facility failed to ensure pressure ulcer treatments were completed as ordered by the physician for 1 of 4 residents reviewed for pressure ulcers. (Resident 10) Finding includes: During an interview on 3/2/25 at 11:55 a.m., Resident 10 indicated his pressure ulcer treatment was completed one time a week and was just	F 0686	F 686 Treatments/SVCS to prevent/ heal pressure ulcer. It is the practice of this facility to ensure residents with pressure ulcer treatments are completed as ordered by the physician. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.	04/11/2025

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	changed on the midnight shift and that has never happened. On 3/4/25 at 2:00 p.m., the resident refused to have the surveyor observe the pressure ulcer and the treatment. The record for Resident 10 was reviewed on 3/4/25 at 11:40 a.m., Diagnoses included, but were not limited to, stroke, left hemiplegia, abnormal posture, heart failure, heart disease, pain in the left wrist anxiety and major depressive disorder. The 2/25/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had one Stage 3 (full-thickness tissue loss where subcutaneous fat was visible within the wound, but bone, tendon, or muscle were not exposed) unhealed pressure ulcer. The Care Plan, revised on 2/6/25, indicated the resident had an impairment to his skin integrity. The approaches were for nursing to provide the treatment as ordered by the physician. The Care Plan, dated 9/17/24, indicated the resident had an actual Stage 3 pressure ulcer. The approaches were to apply the treatment as ordered. A Physician's Order, dated 10/16/24, indicated to clean the coccyx wound with normal saline, pat dry, apply moistened collagen powder and cover with a bordered gauze daily. The 11/2024 Treatment Administration Record (TAR) indicated the treatment was not signed out as being completed on 11/7/24, 11/8/24, 11/9/24, 11/10/24, 11/21/24, and 11/29/24.		· **Resident # 10 treatments have been documented as completed or as refused since survey end date.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: · All residents with orders for treatments to pressure injuries have the potential of being affected by the deficient practice. Treatment documentation was reviewed for all residents having pressure injuries with no further negative findings. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: · The facility policy for pressure ulcer treatments was reviewed by the IDT. An in-service was conducted with all facility licensed nursing staff on the policy. Performance improvement tool has been developed to audit all pressure ulcer treatments. Documentation of completion of pressure injuries will be reviewed in morning clinical meetings.	

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	A Physician's Order, dated 12/9/24, indicated to clean the coccyx wound with normal saline, pat dry, apply moistened collagen matrix sheet and cover with a bordered gauze every night shift. The 12/2024 TAR indicated the treatment was not signed out as being completed on 12/11/24, 12/19/24, 12/23/24, and 12/29/24. The 1/2025 and 2/2025 TARs indicated the treatment was not signed out as being completed on 1/2/25, 1/9/25, and 2/3/25. A Physician's Order, dated 2/17/25, indicated to clean the coccyx wound with normal saline, pat dry, apply collagen to the wound bed and skin prep to the periwound and cover with a bordered gauze every night shift. The 2/2025 and 3/2025 TAR indicated the treatment was not signed out as being completed on 2/20/25, 2/27/25, and 3/2/25. The last documented Wound Nurse Practitioner (NP) note, dated 2/28/25, indicated the wound was improving and smaller in size. The pressure ulcer measured 1.2 centimeters (cm) in length, 0.4 cm in width, and 0.3 cm in depth and had 90% granulation tissue with 10% slough (dead tissue). There was documentation in nursing notes for the month of 1/2025 and 2/2025 the resident had refused to lay down during the day as he wished to stay up and smoke. During a phone interview on 3/4/25 at 2:00 p.m., the Wound NP indicated the resident refused debridement all the time, and was noncompliant with lying down daily as he indicated he wanted		How the corrected actions will be monitored to ensure the deficient practice does not recur: · A performance improvement tool has been initiated that audits the treatments on residents with pressure injuries. The quality assurance audit tool will be completed by the Director of Nursing/ designee weekly for 3 weeks then monthly for three months, then quarterly x's three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systematic changes for the deficiency will be completed. 4/11/2025	

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	to smoke and was not going to bed during the day. During an interview on 3/5/25 at 2:00 p.m., the Unit Manager indicated treatments were to be completed as ordered by the physician. 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, record review, and interview, the facility failed to ensure an orthotic device was in place for a resident with a limited range of motion to the hand for 1 of 2 residents reviewed for range of motion. (Resident 10) Finding includes: During an interview on 3/2/25 at 11:54 a.m., Resident 10 indicated he used to wear a splint on his left hand, but now he did not. The resident's left hand was observed to be flaccid (soft and limp characterized by a decrease in or absence of muscle tone) and he was not able to open the left hand on his own, he used his right hand to open the hand. During random observations on 3/3/25 at 1:04 p.m., and on 3/4/25 at 9:35 a.m. and 12:00 p.m., the resident was observed seated in his wheelchair. At those times, his left hand was flaccid and there was no orthotic device observed in that hand. During an interview on 3/4/25 at 2:05 p.m., the resident indicated he had not seen his hand splint in a long time. The record for Resident 10 was reviewed on 3/4/25	F 0688	F688 Increase/prevent decrease in ROM/mobility It is the practice of this facility to ensure orthotic devices are by physicians orders. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: · Resident # 10 was screened by therapy for orthotic device. A passive range of motion program has been initiated to treat the limited range of motion in the resident left hand. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:	04/11/2025

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	at 11:40 a.m. Diagnoses included, but were not limited to, stroke, left hemiplegia, abnormal posture, heart failure, heart disease, pain in the left wrist anxiety and major depressive disorder. The 2/25/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a range of motion impairment to one side for his upper extremity. A Care Plan, revised on 1/16/24, indicated the resident had an ADL (activities of daily living) self care performance deficit related to hemiplegia affecting his left side. A Care Plan, revised on 1/16/24, indicated the resident was at risk for falls related to left-sided paralysis. The approaches were to wear the left wrist orthotic device as ordered. A Physician's Order, dated 12/20/22, indicated left wrist/hand orthotic device to be donned and doffed as the resident tolerated or requested every day and night shift. The Treatment Administration Record (TAR) for 11/2024 indicated the orthotic device lacked documentation of it being signed out on the night shift on 11/7/24, 11/8/24 and 11/29/24 and on the day shift on 11/10/24. The TAR for the month of 12/2024 indicated there were no documented refusals of the resident not wearing the orthotic device. The device lacked documentation of it being signed out on the night shift on 12/11/24, 12/23/24 and 12/31/24. The 1/2025, 2/2025 and 3/2025 TAR indicated the orthotic device was signed out as being donned		· All residents who have physicians' orders for splint/orthotic devices have the potential to be affected by the deficient practice. A facility audit was completed on residents with orders for splints/orthotic devices with all devices being available and in place What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: The facility policy for ROM mobility was reviewed by IDT. An in-service with all licensed nursing staff on the policy. A performance improvement tool has been developed to audit residents with orders for splint/orthotic devices. Documentation of the application of orthotic devices will be reviewed in morning clinical meeting. How the corrective actions will be monitored to ensure the deficient practice does not recur. A quality assurance tool has been developed and implemented that audits all residents requiring splint/orthotic devices. The tool will be completed by the Director of Nursing/ Designee weekly three times, then monthly three times and then quarterly three times. In the event any further concerns are	

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	for day and night shift with no documentation of refusals. During an interview on 3/4/25 at 3:20 p.m., the Unit Manager indicated the orthotic device was attached to his motorized wheelchair and he no longer used that wheelchair. The order for the device should have been discontinued a long time ago. 3.1-42(a)(2)		identified the issue will be immediately corrected, and additional training will be initiated, The outcomes will be reviewed through the quality assurance program at least quarterly. By what date will the systematic changes for the deficiency be corrected. 4/11/2025	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for residents with a history of falls related to floor mats, bed position, and call lights in reach for 2 of 2 residents reviewed for falls. (Residents 46 and 13) The facility also failed to ensure hot water temperatures were below 120 degrees Fahrenheit on 3 of 4 halls throughout the facility. (100, 300 and 400 halls) This had the potential to affect 53 of the 75 residents who resided in the facility. Findings include: 1. During random observations on 3/2/25 at 9:17 a.m., 9:44 a.m. and 3:05 p.m., Resident 46 was observed in bed. At those times, a green wedge cushion was on the floor and a floor mat for between the beds was folded up against the wall. The floor mat closest to the room door was under the bed.	F 0689	F689 Free of Accident Hazards/Supervision/Devices It is the practice of this facility that the resident environment remains as free of accident hazards as possible. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·Interventions per the care plan were put in place for residents 46 (floor mats on both sides of the bed) and 13 (call light in reach and bed at a low position). ·Resident 13 call light had clip placed on it and attached to blanket was put in place immediately and physician made aware ·Room 104, 107, 301, 306, 401, 408, 409, and 410 water	04/11/2025

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	On 3/3/25 at 9:03 a.m., the resident was observed in bed. The green wedge cushion was on the floor and floor mat between the beds was folded up against the wall. The floor mat closest to the room door was half under the bed. On 3/3/25 at 1:07 p.m. and 2:38 p.m., the resident was observed in bed and the floor mat closest to the door was folded up and against the wall. During random observations on 3/4/25 at 9:40 a.m. and 11:00 a.m., the resident was observed in bed. At those times, the floor mat closest to the room door was folded up against the wall. On 3/5/25 at 1:54 p.m., the resident was observed in bed. At that time, the floor mat between the beds was folded up against the wall. LPN 1 was in the room and indicated the resident was to have both floor mats on the floor beside her bed. The record for Resident 46 was reviewed on 3/3/25 at 1:30 p.m. Diagnoses included, but were not limited to, stroke, left side hemiplegia, high blood pressure, anxiety disorder, and major depressive disorder. The 1/9/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had no falls since the last assessment. The Care Plan, revised on 8/4/24, indicated the resident was at risk for falls and preferred to stay in bed. The approaches were to provide a thicker mat on the floor, exit side of bed. A Nurse's Note, dated 11/9/24 at 3:30 p.m., indicated the resident was observed on the floor mat beside the bed.		temperatures were adjusted to proper temperatures *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* *All residents have the potential of being affected by the deficient practice. Audits were conducted on all residents at risk for falls to ensure care plan interventions where in place and water temperatures checked in all rooms. Any deficiencies were immediately corrected.* *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·IDT reviewed policy and procedure for fall interventions ·Nursing inserviced on call lights properly in place ·Maintenance Department inserviced on weekly audits on temperature checks ·A performance improvement tool has been developed to monitor that fall interventions are in place and water temperatures are below 120 degrees. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly	

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	A Nurse's Note, dated 11/25/24 at 12:33 p.m., indicated the resident was found on the floor next to the wheelchair. A Nurse's Note, dated 11/29/24 at 10:17 a.m., indicated the resident was observed on the floor in the lounge. A Nurse's Note, dated 1/28/25 at 8:15 p.m., indicated the resident was observed on the floor at 5:30 p.m., in the dining room. A Nurse's Note, dated 2/5/25 at 5:47 a.m., indicated the resident was observed on the floor next to her roommate's bed. An Interdisciplinary Note, dated 2/7/25 at 9:22 a.m., indicated the resident was in bed and decided she wanted to get up and fell. The intervention was to ask hospice to bring in a thicker floor mat for that side of the bed. A Nurse's Note, dated 2/17/25 at 1:06 p.m., indicated the resident fell out of the broda chair. During an interview on 3/5/25 at 2:00 p.m., the Unit Manager indicated the floor mats were to be on both sides of the bed when the resident was in the bed. 2. During random observations on 3/2/25 at 9:05 a.m. and 11:08 a.m., 3/3/25 at 8:50 a.m. and 1:15 p.m., and 3/4/25 at 10:20 a.m. and 2:28 p.m., Resident 13 was observed resting in bed. She had a WanderGuard band (a safety alarm device for residents who may wander) on her right ankle. The bed was in a high position. During random observations on 3/2/25 at 9:05 a.m., 3/4/25 at 2:28 p.m. and 3:18 p.m., and 3/5/25 at 10:07 a.m., Resident 13 was observed resting in		check (5) patients to assure all fall interventions are in place and that water temperatures are below 120 degrees. This Quality Assurance Audit Tool will be completed by the Administrator/designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 4/11/2025 /div	

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	155246	A. BUILDING 00 B. WING	03/06/2025

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	bed. At those times, her call light was out of reach on the floor. The record was reviewed for Resident 13 on 3/3/25 at 1:57 p.m. Diagnoses included, but were not limited to, disruption of surgical wound, dementia, and rheumatoid arthritis. The 2/9/25 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and required moderate assistance with ADLs (activities of daily living) and transfers. A Care Plan, revised on 2/11/25, indicated the resident was at risk for falls. Interventions included ensuring the resident's call light was within reach. A Nurse's Note, dated 2/7/25, indicated the CNA found the resident on the floor in her room. A Nurse's Note, dated 2/11/25, indicated the resident fell while at a doctor's appointment with family. A Nurse's Note, dated 2/24/25, indicated the nurse found the resident lying on the floor in her room. On 3/4/25 at 10:27 a.m., when asked about fall prevention and the high position of the bed, LPN 3 indicated the bed could be positioned lower, but she did not think the resident ever fell in the facility. During an interview on 3/5/25 at 10:07 a.m., the resident indicated she would like to have the call light clipped to her blanket. During an interview on 3/5/25 11:31 a.m., the Unit			

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	Manager was informed of the findings and offered nothing further. A policy titled, "Falls Management System", received as current from the Unit Manager on 3/6/25 at 10:30 a.m. indicated, " ... It is the policy of this center to provide each resident with appropriate evaluation and interventions to prevent falls and to minimize complications if a fall occurs... ". 3. During environmental observations on 3/2/25 and 3/3/25, with the Maintenance Director, the hot water temperatures were found to be higher than 120 degrees in multiple rooms throughout the facility. 100 Hallway a. In Room 104, the hot water in the bathroom was very hot to touch. Two residents shared this bathroom. b. In Room 107, the hot water in the bathroom was very hot to touch and one's hand could not be held in the stream of hot water flowing from the faucet. One resident resided in this room. 300 Hallway a. In Room 301, the hot water temperature was checked in the bathroom. The Maintenance Director placed the thermometer under the running water in the bathroom and the temperature gauge displayed 142 degrees. Two residents resided in this room. b. In Room 306, the hot water in the bathroom was very hot to touch. Two residents resided in this room.			

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	400 Hallway a. In Room 401, the hot water in the bathroom was very hot to touch. There were two residents who used this bathroom. b. In Room 408, the hot water in the bathroom was very hot to touch. One resident resided in this room. c. In Room 409, the hot water in the bathroom was very hot to touch. One resident used the bathroom. d. In Room 410, the hot water in the bathroom was very hot to touch. One resident resided in this room. During an interview on 3/3/25 at 9:05 a.m., the Maintenance Director indicated the water heater was set at 120 degrees, and that the water heater "might have increased on him again." The mixing valve was set at 130 and he would set the hot water tank to 118 degrees. 3.1-19(r)(1) 3.1-19(r)(2) 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review, and interview, the facility failed to ensure food consumption logs were completed for residents with a history of weight loss for 2 of 2 residents reviewed for nutrition. (Residents 6 and 176) Findings include:	F 0692	F-692-Nutrition/Hydration Status Maintenance. It is the practice of this facility to establish and maintain meal consumption logs for residents with a history of weight loss · Resident # 176 and resident	04/11/2025

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	1. The record for Resident 6 was reviewed on 3/4/25 at 12:22 p.m. Diagnoses included, but were not limited to, protein calorie malnutrition, feeding difficulties, dysphagia (difficulty swallowing), and Alzheimer's disease. The 12/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making. He required partial to moderate assistance with eating and received a mechanically altered diet. A Care Plan, dated 7/15/24 and reviewed on 12/4/24, indicated the resident was at nutritional risk associated with dysphagia diet due to dysphagia and Parkinson's disease causing impaired dexterity and movement, history of significant weight changes (7/12/24) and the diagnosis of protein calorie malnutrition. Interventions included, but were not limited to, diet as ordered by the physician and monitor diet acceptance and intake. A Dietary Note, dated 1/27/25, indicated the resident had a significant weight loss of 6.3% within the last 30 days. The Food Consumption Logs for the months of February and March 2025, located in the Task section of the electronic medical record, indicated the following: - There was no documentation of breakfast intake on 2/8/25 - There was no documentation of dinner intake on 2/21/25 and 2/27/25 - There was no documentation of food intake for all three meals on 2/10/25, 2/11/25, 2/19/25, 2/22/25, and 3/3/25 During an interview on 3/5/25 at 2:25 p.m., the Unit		#6 were audited for omission in the meal consumption logs since the alleged deficient practice with no findings. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: · All residents who consume meals at the facility have the potential to be affected by the alleged deficient practice. · The meal consumption logs were audited for omissions on all residents eating at the facility since the alleged deficient practice with no negative findings. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not occur: · IDT reviewed policy on food consumption documentation. · Nursing staff were in-serviced on completing documentation of food consumption. · A performance improvement tool has been developed to monitor complete documentation of food consumption.	

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	Manager indicated the resident's food intake should have been documented. 2. The record for Resident 176 was reviewed on 3/3/25 at 2:40 p.m. The resident was admitted to the facility on 2/9/25. Diagnoses included, but were not limited to, wedge compression fracture of T11 and T12 vertebra, anxiety disorder, chronic pain, adult failure to thrive, severe protein calorie malnutrition, and atrial fibrillation. The 2/14/25 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and required set up assistance with eating. The resident had no oral problems and weighed 73 pounds with no weight loss. A Care Plan, dated 2/11/25, indicated the resident was at risk for nutritional deficits related to underweight status. The approaches were to monitor by mouth intakes. A Care Plan, dated 2/11/25, indicated the resident had a nutritional problem or a potential nutritional problem related to serve protein calorie malnutrition. The approaches were to monitor weight and food intake. A Registered Dietitian (RD) Progress Note, dated 2/17/25, indicated the resident was at an underweight status with a body mass index of 14.7. The resident's admission weight was 73 pounds and her weight was 72 pounds on 2/24/25. The Food Consumption Log, in the CNA Task Section, indicated breakfast was not documented on 2/10/25, 2/11/25, 2/22/25, 2/26/25, and 2/27/25. Lunch was not documented on 2/10/25, 2/11/25,		Meal consumptions with be reviewed on the clinical dashboard in PCC during morning clinical meeting to ensure documentation is present for food consumption on all residents. How the corrective actions will be monitored to ensure the deficient practice does not recur.: A Quality Assurance tool has been developed and implemented that audits all food documentation to ensure all meals are documented. The tool will be completed by the Director of nursing/designee weekly times three, monthly times three, then quarterly times three. In the event any concerns are identified, the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility quality Assurance Program at least quarterly. By what date the systematic changes for the deficiency will be completed. 4/11/25	

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	2/22/25, 2/26/25, and 2/27/25, and dinner was not documented on 2/10/25, 2/11/25, 2/17/25, and 2/18/25. During an interview on 3/5/25 at 2:00 p.m., the Unit Manager indicated meal consumptions should be completed before the end of each CNA's shift. The current and undated "Food Acceptance Methods of Measurement" policy, provided by the Administrator on 3/6/25 at 9:00 a.m., indicated determining food intake by facility staff and family was an important part of monitoring the food consumed by residents. Comparing food intake over time was a way to evaluate trends in a resident's nutritional status such as low intake and possibility of changes in the weight. 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 2 of 3 residents reviewed for oxygen. (Residents 7 and 58) Findings include: 1. During a random observation on 3/2/25 at 9:09 a.m., Resident 7 was observed seated in her wheelchair. At that time, she was wearing oxygen per a portable tank via nasal cannula at 2.5 liters per minute. On 3/2/25 at 12:12 p.m. and 3:04 p.m., the resident was observed seated in her wheelchair. At those times she was wearing oxygen per a portable tank via nasal cannula at 2 liters per minute.	F 0695	**F695** It is the practice of this facility to assure that residents receive oxygen in accordance with the physician orders. *The corrective action taken for those residents found to be affected by the deficient practice include:* Residents #7 and #58 oxygen flow rate was adjusted in accordance with the physician's orders. *Other residents that have the potential to be affected have been identified by:* All residents that require oxygen have the potential to be affected. An audit was completed on all residents	04/11/2025

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	During random observations on 3/3/25 8:55 a.m., 1:00 p.m., and 3:00 p.m., the resident was observed seated in her wheelchair. At those times she was wearing oxygen per a portable tank via nasal cannula at 2 liters per minute. During random observations on 3/4/25 at 9:40 a.m., 11:00 a.m., 11:49 a.m., and 1:59 p.m., the resident was observed seated in her wheelchair. At those times she was wearing oxygen per the portable tank via nasal cannula at 2.5 liters per minute. On 3/4/25 at 3:00 p.m., the Unit Manager was in the main dining room where the resident was seated. The Unit Manager was asked to look at the oxygen setting and verified it was set to 2.5 liters per minute. The record for Resident 7 was reviewed on 3/3/25 at 1:15 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), asthma, bronchitis, dementia, heart failure, heart disease, and high blood pressure. The 1/27/25 Annual Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for decision making and used oxygen while a resident. The revised 3/17/23 Care Plan, indicated the resident has asthma, COPD and has shortness of breath while lying flat and was at risk for complications. The approaches were to provide oxygen per the doctor's orders. A Physician's Order, dated 4/13/23, indicated oxygen at 3 liters per minute continuously.		receiving oxygen to ensure the flow rate was set per physicians orders and rate adjusted as indicated. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:* The policy "Oxygen Administration" was reviewed by the IDT. The nurses have been in-serviced related to ensuring that the oxygen flow rate is set is in accordance with the physician's orders. Via routine nurse rounds, the nurses will be responsible for assuring that the flow rate is correct. A label has been placed on all resident's concentrators and portable tanks with the liter flow the rate is to be set at. *The corrective action taken to monitor performance to assure compliance through quality assurance is:* A Performance Improvement Tool has been initiated that randomly reviews 5 residents that utilize oxygen to assure that the oxygen flow is in accordance with the physician's order. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools. *The date*	

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	During an interview on 3/4/25 at 3:00 p.m., the Unit Manager indicated the oxygen rate should have been set to 3 liters per minute. 2. During random observations on 3/2/25 at 11:49 a.m. and 3:12 p.m., Resident 58 was observed in bed. At those times, she was wearing oxygen on the room concentrator via nasal cannula at 1.5 liters per minute. During random observations on 3/3/25 at 9:32 a.m., and 1:03 p.m., on and 3/4/25 at 9:44 a.m., the resident was observed in bed. At those times she was wearing oxygen on the room concentrator via nasal cannula at 1.5 liters per minute On 3/4/25 at 2:00 p.m., LPN 2 was observed in the room and was asked to look at the oxygen level. At that time, she verified the oxygen was not at 2 liters, as the middle of the ball was below the 2 on the concentrator. The record for Resident 58 was reviewed on 3/4/25 at 9:30 a.m. Diagnoses included, but were not limited to, chronic kidney disease, chronic migraines, atrial fibrillation, high blood pressure, major depressive disorder, anxiety, joint disorder, and obsessive compulsive disorder. The 1/29/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was not receiving oxygen. A Care Plan, dated 2/7/25, indicated the resident was at risk for alterations in oxygen levels due to diagnosis of pneumonia. The approaches were to set the oxygen at 2 liters per minute.		*the systemic changes will be completed:4/11/25*	

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	A Physician's Order, dated 2/6/25, indicated oxygen at 2 liters per minute. During an interview on 3/4/25 at 3:20 p.m., the Unit Manager indicated the oxygen was to be at 2 liters per minute. 3.1-47(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on record review and interview, the facility failed to ensure a resident was free from pain related to pain medications and transportation to the pain clinic not being available for 1 of 1 resident reviewed for pain. (Resident 36) Finding includes: During an interview on 3/2/25 at 11:44 a.m., Resident 36 indicated she did not get her medications on time or at all, as they were always running out of them. The record for Resident 36 was reviewed on 3/5/25 at 9:10 a.m. Diagnoses included, but were not limited to, rheumatoid arthritis, anemia, anxiety disorder, end stage renal disease, and osteoarthritis of the hip. The Quarterly Minimum Data Set (MDS) assessment, dated 2/7/25, indicated the resident was cognitively intact for daily decision making and received an opioid medication. The resident indicated she had frequent pain that interfered with her sleep and activities of daily living. Her pain was a five out of 10 on the pain scale. A Care Plan, revised on 1/27/25, indicated the	F 0697	F 697 PAIN MANAGEMENT It is the practice of this facility to ensure residents are free from pain. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: · Resident # 36 was transported on 3/7/25 to the pain clinic by facility bus and will attend appointments to the pain clinic monthly to recieve script for pain medication. · An audit has been completed ,resident has not missed any pain medication since the deficient practice. How other residents have the potential to be affected by the same deficient practice: · All residents receiving pain medication have the potential to	04/11/2025

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	resident had behaviors of making false accusations related to stating she does not receive her medications. A Care Plan, revised on 2/25/25, indicated the resident had arthritis, a fractured right foot and chose to go to another pain clinic. The approaches were to anticipate the need for pain relief and respond immediately and encourage the resident to call for assistance when in pain. A Physician's Order, dated 12/30/24, indicated Methocarbamol (a type of muscle relaxant that works by calming overactive nerves in your body and treats muscle pain and stiffness) tablet 500 milligrams (mg), give one tablet by mouth two times a day. A Nurse's Note, dated 12/31/24 at 9:56 a.m., indicated the Methocarbamol had not arrived to the facility. The 1/2025 Medication Administration Record (MAR) indicated the Methocarbamol tablet 500 mg was coded with a "16", meaning "see nurse's notes", at 8:00 a.m. on 1/1/25, 1/2/25, 1/3/25, 1/4/25, 1/5/25, and 1/6/25 and at 8:00 p.m. on 1/1/25, 1/2/25, 1/4/25, and 1/5/25. Nurse's Notes, dated 1/1/25, 1/2/25, 1/3/25, 1/4/25, 1/5/25 and 1/6/25, indicated the Methocarbamol had not arrived to the facility. A Nurse's Note, dated 1/13/25 at 2:49 p.m., indicated a message was left for the pain clinic to reschedule the resident's appointment due to the transportation company canceled the pick up. A Nurse' Note, dated 1/13/25 at 4:03 p.m., indicated the pain clinic called back with a new		be affected by the deficient practice. An audit was completed on all residents who receive pain medication with no omissions found in the administration of pain medication. All residents who attend pain management appointments have been transported to their appointments. What measures will be put in place and what systematic changes will be made to ensure the deficient practice will not recur. The facility policies for pain management and transportation was reviewed by the IDT . Nursing staff and transportation driver have been in-serviced on the policies. A performance improvement tool has been developed to audit residents pain medication administration and transportation to appointments. Pain medication administration and appointment transportation will be reviewed in morning clinical meetings. How the corrective actions will be monitored to ensure the deficient practice does not recur: · A performance improvement tool has been	

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	appointment on 1/28/25 at 11:30 a.m. A Physician's Order, dated 1/1/25, indicated Oxycodone 10 mg, give one tablet four times a day for pain. The 2/2025 MAR indicated the Oxycodone was coded with a "16" on 2/15/25 at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. and on 2/16/25 at 12:00 p.m. and 6:00 p.m. Nurse's Notes for the above dates indicated the medication was not available and they were awaiting it from pharmacy. Nurse's Notes, dated 2/26/25 at 7:33 p.m., indicated the resident missed the pain clinic appointment due to transportation. A phone call was placed to the clinic to reschedule. The 3/2025 MAR indicated the Oxycodone was coded with a "16" on 3/4/25 at 12:00 p.m. and 6:00 p.m. and on 3/5/25 at 12:00 a.m. Nursing Notes for the above dates indicated the medication was not available and they were awaiting it from pharmacy. During an interview on 3/5/25 at 2:00 p.m., the Unit Manager indicated the resident had missed two pain clinic appointments due to no transportation because they canceled. She was aware the resident had missed doses of pain medication, however, the pharmacy only supplied a limited amount of medication in the EDK (emergency drug kit) box, therefore sometimes nursing staff could not give her the medication due to not having enough in the EDK box. 3.1-37(a)		initiated that audits pain medication administration and transportation. The performance improvement audit tool will be completed by the Director of Nursing/ designee weekly for 3 weeks then monthly for three months, then quarterly x's three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systematic changes for the deficiency will be completed: 4/11/2025	

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	155246	A. BUILDING 00 B. WING	03/06/2025

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, record review and interview, the facility failed to ensure proper medication storage related to medicated creams not stored securely for 2 of 2 residents randomly observed. (Residents 58 and 13) Findings include: 1. During random observations on 3/2/25 at 11:49 a.m. and 3:12 p.m., Resident 58 was observed in bed. At those times there was a tube of Bacitracin medicated cream on the dresser. During random observations on 3/3/25 at 9:32 a.m. and 1:03 p.m. and on 3/4/25 at 9:44 a.m., the Bacitracin medicated cream remained on top of the dresser in the resident's room. On 3/4/25 at 2:00 p.m., LPN 2 was observed in the room. At that time, the LPN was shown the medicated cream on top of the dresser. During an interview at that time, LPN 2 indicated the Bacitracin was to be locked in the treatment cart and not left in the resident's room. The record for Resident 58 was reviewed on 3/4/25 at 9:30 a.m. Diagnoses included, but were not limited to, chronic kidney disease, chronic migraines, atrial fibrillation, high blood pressure, major depressive disorder, anxiety, joint disorder, and obsessive compulsive disorder. The 1/29/25 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making.	F 0761	It is the practice of the facility to ensure medicated creams are properly stored in the medication carts. **What corrective actions will be accomplished for those residents who are found to have been affected by the deficient practice:** **All nurses were in-serviced on not leaving medicated creams at bedside and to be secured in the medication cart.** **Residents #58 and #13 were audited for creams left at bedside with negative findings.** **How other residents having the potential to be affected by the deficient practice will be identified and what corrective actions will be taken.** **All residents who have orders for medicated creams have the potential of being affected by the deficient practice.** **An audit of residents with orders of medicated creams was completed with no negative findings.** **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not occur.** **The facility policy "Storage of medications and**	04/11/2025

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	A Physician's Order, dated 2/27/25, indicated Bacitracin Ointment 500 units, apply to right shin and right lower leg open blisters one time a day. There was no order to keep the medicated cream at the bedside in the resident's room. During an interview on 3/4/25 at 3:20 p.m., the Unit Manager indicated the Bacitracin cream should not have been left in the resident's room on the dresser. 2. During random observations on 3/02/25 at 9:05 a.m. and 11:08 a.m., a tube of Medihoney (a topical wound medication) was observed on Resident 13's dresser. During an interview on 3/5/25 at 11:31 a.m., the Unit Manager was informed of the findings and offered no further information. A policy titled, "Storage of Medications and Biologicals", received as current on 3/6/25 at 10:30 a.m. from the Unit Manager, indicated, " ... The facility is required to secure all medications in a locked storage area and to limit access to only authorized or licensed personnel consistent with state or federal requirements and professional standards of practice ..." 3.1-25(j) 3.1-25(m) 3.1-25(n)		**biologicals" was reviewed by the IDT. An in-service was conducted with all facility licensed nursing staff on the policy. A performance improvement plan has been developed to audit all medicated creams weekly to ensure none left at bedside.** **How the corrective actions will be monitored to ensure the deficient practices will not occur.** **A quality assurance tool has been developed and implemented that audits residents with orders for medicated creams are not left in room. This tool will be completed by the Director of nursing/designee weekly x's three , then monthly x's three, and then quarterly. In the event any further concerns are identified , the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance program.** **By what date the systematic changes for the deficiency will be completed** **4/11/25**	
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place and implemented related to not donning personal protective equipment (PPE) for residents in enhanced barrier precautions (EBP) for 3 of 3 wound care treatments observed. (Residents 3, 6, and 226) Findings include: 1. On 3/5/25 at 11:30 a.m., the Assistant Director of Nursing (ADON) was observed performing the treatment to Resident 3's sacral pressure area. The ADON entered the resident's room and proceeded to wash her hands with soap and water. She donned a pair of gloves, repositioned the resident in bed, and removed the dressing to the resident's sacrum. She was not wearing a gown when she repositioned the resident and removed the dressing. The ADON proceeded to remove her gloves, used hand sanitizer, donned new gloves and a gown and completed the resident's treatment to her sacrum. The record for Resident 3 was reviewed on 3/5/25 at 11:21 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, chronic kidney disease stage 4, and hypertensive heart disease. The Quarterly Minimum Data Set (MDS) assessment, dated 12/2/24, indicated the resident was moderately impaired for daily decision making and she had one Stage 4 pressure area (the wound extends through all layers of the skin, reaching the underlying muscle, tendon, or bone). A Care Plan, reviewed on 12/2/24, indicated the resident was in enhanced barrier precautions	F 0880	F880-Infection Prevention and Control: **It is the practice of the facility to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by ensuring infection control guidelines are in place and implemented.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** ***ADON was in-serviced on donning and doffing of gown during wound care.*** *How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:* ***All residents who are cared for with isolations have the potential to be affected by the alleged deficient practice.*** ***Facility audit was conducted on all residents in EBP. Precautions were followed with no negative outcomes.*** *What measures will be put into place and what systematic changes will be made to ensure*	04/11/2025

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	(EBP) due to a wound to the coccyx area. The March 2025 Physician's Order Summary (POS) indicated EBP (a set of infection control measures that used gowns and gloves to reduce the spread of multidrug-resistant organisms) was to be maintained due to the resident's sacral wound. During an interview on 3/5/25 at 3:00 p.m., the ADON indicated she should have worn a gown when removing the resident's dressing to the sacrum. 2. On 3/5/25 at 2:34 p.m., the Assistant Director of Nursing (ADON) was observed performing wound care for Resident 6. The ADON entered the resident's room, she washed her hands with soap and water and donned a gown and gloves. She removed the dressing to the resident's left heel. The dressing to the resident's sacrum was already removed due to receiving incontinence care. After changing gloves, sanitizing her hands, and donning new gloves, the ADON completed the treatment to the resident's sacrum. The ADON removed her gown and gloves and left the resident's room to retrieve more supplies from the treatment cart. Upon entering the room, the ADON washed her hands, donned a pair of gloves, and proceeded to complete the treatment to the resident's left heel. She was not wearing a gown at that time. During an interview on 3/5/25 at 3:00 p.m., the ADON indicated she should have worn a gown while completing the treatment to the resident's left heel. The record for Resident 6 was reviewed on 3/4/25 at 12:22 p.m. Diagnoses included, but were not		*that the deficient practice does not recur.* ***IDT reviewed policy on EBP.*** ***Nursing staff including ADON were in-serviced on EBP donning and doffing.*** ***A performance improvement tool has been developed to monitor proper EBP procedure is being followed, and proper donning of gown is being performed.*** ***How the corrective actions will be monitored to ensure the deficient practice does not recur*** A performance tool has been initiated that randomly audits five days a week on both shifts to monitor EBP procedure is being followed and proper donning of gown is being performed. The quality assurance audit tool will be completed by the Director of nursing/ designee weekly for 3 weeks then monthly for three months, then quarterly x's three. In the event any further concerns are identified the issue will be	

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	limited to, Alzheimer's disease and Stage 4 pressure ulcer to the left buttock. The 12/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making. He was identified as having one Stage 3 (full thickness tissue loss) pressure ulcer, one Stage 4 (the wound extends through all layers of the skin, reaching the underlying muscle, tendon, or bone) pressure ulcer, and four Deep Tissue Injuries (a type of pressure ulcer that occurs when prolonged pressure or shear forces damage to the underlying soft tissues, such as muscles and bones). A Physician's Order, dated 3/2/25, indicated to maintain EBP (a set of infection control measures that used gowns and gloves to reduce the spread of multidrug-resistant organisms) related to wounds. 3. During an observation on 3/3/25 at 9:05 a.m., Resident 226 was observed resting in bed. She had a dressing on her left lower leg. An EBP (enhanced barrier precautions) sign was on her door. At that time, the resident indicated the Assistant Director of Nursing (ADON) only wore gloves, not a gown, when performing the daily dressing change on her leg. During an observation of wound care on 3/5/25 at 2:03 p.m., the ADON removed the resident's dressing to her leg, and reached over her uncovered wound to get her tablet. She then put on a gown, cleansed the wound, and applied the dressing. The record for Resident 226 was reviewed on 3/4/25 at 11:31 a.m. Diagnoses included, but were not limited to, cerebral infarction and hypertension.			

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	The 2/19/25 Nursing Admission Evaluation Assessment indicated the resident was cognitively intact for daily decision making and required limited assistance from staff with ADLs and transfers. A Care Plan, revised on 3/2/25, indicated the resident required EBP due to her wound. A Physician's Order, dated 3/2/25, indicated the EBP were to be in place because the resident had a wound. During an interview on 3/5/25 at 2:20 p.m., the ADON indicated she forgot to put a gown on before beginning wound care. A policy titled, "Enhanced Barrier Precautions", received as current from the Unit Manager on 3/6/25 at 10:30 a.m. indicated, " ... Gloves and gown are applied prior to performing the high contact resident care activity ... Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: ... wound care ...". 3.1-18(b)			
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System Based on observation and interview, the facility failed to ensure the call light system in a resident's room and the call light system at the nurses' station was properly functioning during random call light observations. (Residents 38 & 18) Findings include:	F 0919	F919-RESIDENT CALL SYSTEM **It is the practice of the facility to establish and maintain a working call light system. What corrective actions will be accomplished for those residents found to have been affected by the deficient**	04/11/2025

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	1. During an observation on 3/2/25 at 12:00 p.m., Resident 38's call light button was pushed. The light inside the room on the wall was observed to be functioning. At 12:27, there was no staff response to the resident's light. The call light in the hallway outside the resident's room was observed and was not activated. At 12:29 p.m., the nurse indicated that the call light was not working, and she would notify the Maintenance Director. 2. On 3/3/25 at 9:24 a.m., Resident 18 indicated her call light lit up outside of her room, but did not work at the nurse's station. She said the staff would only know if her light was going off if they looked down the hall for it. During the environmental tour with the Maintenance Director and the Administrator on 3/6/25 at 2:49 p.m., the Maintenance Director tested the call light in Resident 18's room then observed the call light system at the nurses' station and found the call light system was not functioning properly. During an interview on 3/6/25 at 3:10 p.m., the Maintenance Director indicated he knew the call light at the nurses' station was not operating properly. He contacted the repair technician on 3/6/25 to come and repair the system. 3.1-19(u)(1)		**practice:** Bell to alert staff was given to resident to use while waiting for technician.· **The call light for resident 38 was repaired by the technician on 3/7/24to enable to light to activate at the resident room and nurses station. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** · **All residents have the potential to be affected by the alleged deficient practice. An audit of all call lights was completed with no further issues identified.** · **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur:** · The maintenance Director and staff were in-serviced on ensuring call lights are functioning properly. ***A performance improvement tool has been developed to monitor the functioning of the call light system.*** **How the corrective actions will be monitored to ensure the deficient practice does not recur.:**A performance tool has been initiated that randomly audits five rooms a week on both shifts to monitor proper functioning of the call system. The quality assurance audit tool will be completed by the Maintenance	

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			Director/ designee weekly for 3 weeks then monthly for three months, then quarterly x's three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure employees received the required annual dementia training for 5 of 10 employee records reviewed. (QMA 1, Housekeeper 1, Activities Assistant 1, Dietary Cook 1, and CNA 1) Finding includes: The employee files were reviewed on 3/5/25 at 9:50	F 9999	F 9999- It is the practice of this facility to ensure staff is trained annually 3 hours of dementia care training. What corrective actions will be accomplished for those residents and staff to be affected by the deficient practice: **Required Dementia training was added, one hour and five minutes** **QMA 1 , HOUSKEEPER 1, Activities assistant, Dietary Cook, and CNA 1 have been assigned one hour and five minutes.** How other staff having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All staff and residents have the potential of being affected by the deficient practice. The added hour and five minutes have been assigned to all staff	04/11/2025

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	a.m. The following employees lacked documentation of three hours of annual dementia training for 2024. 1. QMA 1, hired on 10/8/01, had two hours of annual dementia training. 2. Housekeeper 1, hired on 2/18/02, had two hours of annual dementia training. 3. Activities Assistant 1, hired on 10/20/16, had two hours of annual dementia training. 4. Dietary Cook, hired on 12/27/2017, had two hours of annual dementia training. 5. CNA 1, hired on 8/23/22, had two hours of annual dementia training. During an interview on 3/5/25 at 10:05 a.m., the Human Resource Director indicated she was unaware that the dementia training they provided did not meet the requirement of three hours annually. No further in person in-services were conducted.		What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not occur: An in-service was conducted with all facility staff, a performance improvement tool has been developed to audit staff complete three hours annually of dementia training. How the corrective action will be monitored to ensure the deficient practice will not recur: A quality Assurance tool has been developed and implemented. This tool will be completed by Human resources/designee weekly times three, then monthly times three, and then quarterly times three. In the event any further concerns are identified the issue will be immediately corrected, and additional training will be initiated. The outcomes will be reviewed through the facility Quality Assurance **By what date the systematic changes for the deficiency will be completed** **4/11/25**	