STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING 00 B. WING	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN CROSSING AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254

(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 IN00452836. Complaint IN00452836 - No deficiencies related to the allegations are cited. Survey dates: February 24, 25, 26, 27, and 28, 2025 Facility number: 013280 Provider number: 155826 AIM number: 201270670 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 2 Medicaid: 69 Other: 22 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 11, 2025.	F 0000	b>	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to ensure a comprehensive and individualized care plan was developed for a resident with behaviors related to wandering, adjustment to new living conditions	F 0656	**Corrective action for residents found to be affected by deficient practice:** No residents were found to have adverse outcomes as a result of	03/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Lea Spall	HFA	04/02/2025

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	and personal hobbies for 1 of 1 residents reviewed for elopement, (Resident 88) and failed to implement a comprehensive care plan for a resident who admitted to the facility with a trans metatarsal amputation (TMA) (a surgical procedure that involves the removal of the distal portion of the metatarsal bones in the foot) for 1 of 5 residents reviewed (Resident 196). Findings include: 1. On 2/24/25 at 11:36 a.m., Resident 88 was observed through his open door. He refused to allow entrance and instead of answering questions, he became agitated and demanded that he get his bicycle back. He adamantly declared he was a cyclist, his bicycle had been confiscated from him, that he was being kept against his will, and institutionalized. Resident 88 was observed to wear slick-styled nylon sports pants and wore cleats. A wanderguard bracelet was observed around his left ankle. During an interview on 2/24/25 at 11:40 a.m., Licensed Practical Nurse (LPN) 13 indicated sometimes Resident 88 got upset and demanded to get his bike. It was best to just let him blow off steam because he was very hard to redirect, and the staff were not sure what other approaches to take with him since they could not offer him his bike. On 2/26/25 at 10:18 a.m., Resident 88 was observed as he held his arms out wide and jogged up and down the hallway making swishing sounds as if he was an airplane. During an interview on 2/26/25 at 11:09 a.m., the Social Service Director (SSD) indicated when Resident 88 first got to the facility he had a hard		alleged Care Plan deficiency. Resident 88 and Resident 196 Care Plans were updated and there were no adverse outcomes noted. **Identification of residents having the potential to be affected by the same alleged deficient practice and corrective action taken:** All residents whom have behaviors related to wandering, adjustment to new living conditions or a trans metatarsal amputation have the potential to be affected by the alleged deficient practice. The facility completed an audit of care plans for residents who have behaviors related to wandering, adjustment to new living conditions or a trans metatarsal amputation. No residents were found to be affected by the alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:="" b="">="" b="">="" span="">="" b="" education="" was="" provided="" to="" licensed="" nurses="" using="" the="" rai="" manual="" with="" emphasis="" on="" implementing="" care="" plans="" for <="">Education was provided to licensed nurses using RAI manual with**	

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	time adjusting to the new environment and would become very upset that he was not allowed to ride his bicycle. He made statements about wanting to leave to go get the bike, so the decision was made to place a wandergard on him. After a couple weeks, he seemed to adjust and she did not consider him at risk for elopement any longer. She did not know if he still had a wanderguard in place, and had not heard form nursing staff if he continued to have any behaviors. On 2/26/25 at 1:04 p.m., Resident 88 was observed as he continued to jog and weave up and down the halls with his arms out and made airplane sounds. During an interview on 2/27/25 at 9:08 a.m., the Vice President of Risk, provided an elopement assessment, dated 1/29/25, which indicated Resident 88 was at risk for elopement. He was assessed after his first several days when he began to make statements about getting out to catch the bus and go to his apartment to get his bike. He was adamant about being a cyclist and wanting to ride, and talked constantly about how much he rode his bike. Resident 88 was very fit, and liked to stay moving. On 2/25/25 at 1:46 p.m., Resident 88's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, cerebral amyloid angiopathy (CAA, a condition in which proteins called amyloid build up on the walls of the arteries in the brain causing bleeding into the brain), alcohol abuse, and unspecified dementia. His admission Minimum Data Set (MDS) assessment, dated 1/31/25, did not indicate any wandering behaviors noted in the 7-day look back		**emphasis on implementing care plans for behaviors related to wandering, adjustment to new living conditions or a trans metatarsal amputations. =”” b=”” education=”” was=”” provided=”” to=”” licensed=”” nurses=”” using=”” the=”” rai=”” manual=”” with=”” emphasis=”” on=”” implementing=”” care=”” plans=”” for <=””> How the corrective measures will be monitored to ensure there is no reoccurrence: DON/MDS/designee will conduct audits of resident Care Plans who require a Care Plan for trans metatarsal amputation, wandering and new living conditions to ensure they are completed and updated as needed 3 residents a week x4 weeks, 1 resident a week x 8 weeks and 1 resident a month x 3 months. Any discrepancies will be immediately corrected.** =”” span=””> =”” span=””> The results of the audit observations will be reported, reviewed and trended for compliance through the facility QA committee for 6 months and sporadically as needed thereafter	

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	window. His behavior monitoring was reviewed from the time of his admission through 2/25/25 and lacked documentation of behaviors of wandering. A care plan, dated 1/30/25, indicated he wandered aimlessly from place to place and interventions included but were not limited to,offering structured activities, but lacked revision to include person-centered preferences for his hobbies. Overall, his comprehensive care plan and lacked implementation of an individualized, person-centered plan of care to address his hobby of being a cyclist, fitness enthusiasm, and/or interventions to help address his irritation about not being able to ride his bike. 2. On 2/26/25 at 11:27 a.m., a record review was completed for Resident 196. He had the following diagnoses which included but were not limited to end stage renal disease, trans metatarsal amputation (TMA), hypertension, left above the knee amputation, and major depressive disorder. Resident 196's care plan lacked a care plan problem of TMA. During an interview with the Vice President of Risk Management, she indicated she could not find a care plan for TMA for Resident 196. On 2/27/25 at 10:35 a.m., a policy titled, "Plan of Care overview " was provided by the Vice President of Risk Management on 2/27/25 at 10:35 a.m. It indicated, " ...The facility will provide an Registered Nurse (RN) assessment of the resident as an on-going, periodic review that provide the foundation for the resident focused care and the			

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	care planning process. 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, interview, and record review, the facility failed to reassess the effectiveness of interventions and review and revise a resident's care plan (Resident 28 and Resident 241) for 2 of 23 residents reviewed for care plan revision. Findings include: 1. Resident 28's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, hemiplegia (paralysis of one side of the body), and dysphagia (difficulty swallowing.). A social service note that was a summary of a care plan meeting, dated 8/2/24, indicated they reviewed dietary concerns and Resident 28 indicated she cannot chew the food. Resident 28 had a care plan with a revision date of 9/16/24 that indicated the Resident was at nutritional risk due to poorly fitting dentures and a mechanically altered diet. The care plan lacked documentation of interventions related to the resident's complaints of chewing or swallowing noted. Resident 28 had an order, dated 9/18/24, that indicated she was on a regular texture diet. Resident 28 had a care plan with a revision date of 9/28/23 that indicated the resident had poor fitting	F 0657	**Corrective action for residents found to be affected by deficient practice:** No residents were found to have adverse outcomes as a result of alleged Care Plan deficiency. Care Plans for Resident 28 and Resident 241 were updated. No adverse outcomes were noted. **Identification of residents having the potential to be affected by the same alleged deficient practice and corrective action taken:** All residents whom have off loading boots or dentures have the potential to be affected by the alleged deficient practice No other residents were found to be affected by the alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:** Education provided for licensed nurses using the RAI manual with emphasis on ensuring care planned interventions are effective and changing the interventions when appropriate.	03/24/2025

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	dentures. The care plan lacked documentation of interventions related to the resident's complaints of chewing or swallowing noted. On 2/26/25 at 1:01 p.m., Resident 28 indicated it took her so long to chew up bacon and other tough meats. She indicated she cannot eat a lot of the food they brought because it is too hard and hurt her gums when she chewed. 2. Resident 241's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to, sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection, leading to widespread inflammation and organ damage) and open wounds. A skin and wound note, dated 11/12/24, indicated it was recommended Resident 241 wear pressure relieving boots while in bed. A skin and wound note, dated 12/17/24, indicated Resident 241 refused to wear his heel boot. A skin and wound note, dated 1/17/25, indicated Resident 241 would not allow the Nurse Practitioner (NP) to put heel boots on him. A nursing note from 2/20/25 indicated Resident 241 refused to wear his pressure-relieving boots for both heels. Resident 241 had a care plan with a revision date of 2/19/25 that indicated he has episodes of refusing medications, refusing care, wound care and interventions. All interventions related to this care plan were dated 2/7/24. Upon review it was found that there was no care		=”” a=””> =”” a=””> =”” span=””> **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** **DON/MDS/Designee will conduct audits of care plans and interventions for residents who require dentures and off-loading boots to ensure they are completed and updated as needed for 3 residents per week x 4 weeks and then one resident per week for 4 weeks and then 1 resident per week for 8 weeks, then one resident per month for 3 months.** =”” span=””>The results of the audit observations will be reported, reviewed and trended for compliance through the facility QA committee for 6 months and /as needed thereafter.	

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	plan interventions related to the resident's regular refusal of pressure relieving boots and no interventions outlining what staff should do when the resident refuses to wear pressure relieving boots. On 2/28/25 at 11:57 a.m., a policy related to care plan revision was requested. Registered Nurse (RN) 11 indicated they could not find a policy specifically related to care plan revision at this time. 3.1-35(c)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when call lights were observed out of reach, neurological checks were not completed, for 3 of 3 residents reviewed for accidents (Residents 10, 142, and 15), and failed to ensure medications were not left at bedside for 1 of 3 residents reviewed for accidents (Resident 10). Findings include: 1. On 2/25/25 at 9:23 a.m., Resident 10 was observed. She was reclined in her bed with the head of the bed (HOB) slightly elevated. She held a piece of toast, but her eyes were closed, and she appeared to be asleep. A half-eaten plate of breakfast was observed on her overbed table. Her call light was observed on the floor to the left side of her bed, out of her line of sight, and out of reach. On 2/25/25 at 9:50 a.m., Resident 10's breakfast tray had been removed, but her call light remained	F 0689	**Corrective action for residents found to be affected by deficient practice:** No residents were found to have adverse outcomes as a result of alleged deficiency. Medications found at bedside were immediately destroyed. Residents 10, 142 and 15 were noted to have no adverse outcomes. Residents noted to not have their call lights were given their call lights. **Identification of residents having the potential to be affected by the same alleged deficient practice and corrective action taken:** All residents have the potential to be affected by the alleged deficient practice. Full house audit completed on call lights by Maintenance 3/15/25 to ensure they were in reach. The facility	03/24/2025

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	on the floor. On 2/26/25 at 9:58 a.m., Resident 10 was observed. She sat on the right edge of her low air loss mattress, her bare feet on the floor. She leaned back and rested an elbow near the edge of the bed and indicated, "I'm slipping." Her call light was observed on the floor on the left side of the bed. The call light was pushed and within a few minutes, nursing staff answered the light and helped reposition Resident 10 into the middle of her bed, with the HOB elevated to a sitting position and rolled the over-bed table so that she could eat sitting up in bed. During an interview on 2/26/25 at 10:05 a.m., the Minimum Data Set Coordinator (MDSC) indicated Resident 10 had left-sided paralysis/weakness after a stroke, and should not have been positioned on the side of the bed since she has a hard time sitting with correct posture and her call light should be within reach of her right had so that she could access and use it at any time. On 2/26/25 at 10:10 a.m., Resident 10 was being assisted to reposition in bed. Two pills were observed on top of the drawers beside her bed. During an interview on 2/26/25 at 10:15 a.m., the MDSC indicated the pills should not have been left on her dresser. She did not know if they were left, or if the Resident put them there. During an interview on 2/26/25 at 10:36 a.m., the MDSC indicated she checked with the nurse, and they were not able to identify the pills which were found at Resident 10's bedside. On 2/26/25 at 11:39 a.m., Resident 10's medical record was reviewed. She was a long-term care		completed observations on 2/26/25 of all resident room to ensure no other medications were at bedside. No others were found. The facility completed an audit of all falls within the last 30 days to ensure neuro checks were completed per policy and fall interventions were implemented. Any discrepancies were reported to the provider. No residents were found to be affected by the alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:** Call light education provided to all team members utilizing the Resident Rights Policy on ensuring resident call light is within reach and answered in a timely manner on 3/24/25. Nurse education provided on 3/20/25 utilizing the Medication Administration Policy with emphasis on not leaving medications at resident bedside. Education was provided to all direct care staff utilizing the Fall Management Policy with emphasis on ensuring interventions and neuro checks are implemented appropriately. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** ="" span="">="" span="">a="" name="_Hlk193452502">**DON/De**	

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	resident with diagnoses which included, but were not limited to, hemiplegia/hemiparesis (weakness/paralysis) after cerebral infarction (stroke), muscle weakness, and lack of coordination. A care plan, revised 3/13/24, indicated she was at risk for falls related to weakness, incontinence and psychotropic drug use. Interventions included, but were not limited to, place call bell within reach and ensure resident wore non-skid foot ware. A nursing progress note, dated 10/8/24 at 9:23 a.m., indicated Resident 10 had an unwitnessed fall in her room after she attempted to go to the bathroom without assistance. She complained of pain in her left arm and an x-ray was ordered. A nursing progress note, dated 10/11/24 at 2:58 p.m., indicated, Resident 10 had been seen by an orthopedic doctor and diagnosed with a horizontal fracture of the humeral metaphysis. A Stop & Watch follow up visit, dated 10/14/24, indicated Resident 10 had a fall last week and sustained a horizontal fracture through the proximal humeral metaphysis. She was seen and treated at a local orthopedic urgent care center and received orders for an immobilizer sling and ice to the area 2 to 3 times daily for 3 to 5 days. A care plan, revised 11/19/24, indicated she had an activities of daily living (ADL) self-care performance deficit related to hemiplegia, and that she "prefers to lean and slouch in wheelchair related to stroke." Interventions included, but were not limited to, her need for substantial to maximum assistance to go from lying in bed to sitting on the edge of the bed but did not detail or		**signee will conduct audits of medications at bedside x 1weekly x 4 weeks and every-other-week x 8weeks, then 1 x monthly x 3months. Any discrepancies will be immediately corrected and education will be provided as needed. IDT will participate in Call Light Audits x5 weekly x 4 weeks, 1 x weekly x 3 months and monthly x 6months on variant shifts and on the weekends beginning 3/24/25. Maintenance Supervisor or Designee will audit call lights for appropriate cord length and overall function 1x weekly x 1month, every-other-week x 3 months and monthly x 6months as part of the Preventative Maintenance Program. DON/Designee will complete a full house audit of fall and fall interventions ensuring all have neuro checks as appropriate 1x weekly x 1 month, every-other-week x 3 months and monthly x 6 months.** ="" p="">
="" span="">Results of the audits observations will be reported, reviewed and trended for compliance through the facility QA committee for 6 months and sporadically as needed thereafter.	

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	include set up details related to her positioning/slouching/posture. A nursing progress note, dated 12/5/24 at 1:54 p.m., indicated Resident 10 had an unwitnessed fall in her bathroom as she attempted to transfer herself from the toilet to her wheelchair. A nursing progress note, dated 2/14/25 at 12:50 p.m., indicated Resident 10 had an unwitnessed fall and indicated she tried to get out of bed to go smoke. She did not wait for the staff to come to her room once her call light was pressed. A neurological assessment tool was opened on 2/14/25 but the assessment was incomplete at the time of review. Resident 10 did not have an assessment/evaluation, care plan or physician's order to have/keep medications at bedside. 2. On 2/25/25 at 9:23 a.m., Resident 142 was observed. She was covered up in bed, faced away from the door, and the lights were off. She rested on her left side. Her call light was observed to be on the floor on the right side of her bed, out of sight and out of reach. On 2/26/25 at 10:54 a.m., Resident 142 was observed. She was seated in her wheelchair at the foot of her bed, and the wheelchair breaks were engaged. An over-bed table was placed in front of her. Her call light was on the floor behind her, at the head of her bed. During an interview on 2/26/25 at 10:55 a.m., Resident 142 indicated she had just returned from dialysis, and was waiting for staff to bring her re-warmed breakfast tray for her. Resident 10			

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	indicated she had a fall at home and sustained a back fracture which brought her to the facility for rehab. She indicated she had fallen since being admitted to the facility. She indicated she used the call light, but it was taking too long and she couldn't wait any longer before she thought she would have an incontinent accident. She attempted to get to the bathroom herself but fell in front of the bathroom door. On 2/26/25 at 10:59 a.m., the MDSC brough a breakfast tray for Resident 10. She helped set up her plate and asked if Resident 10 needed anything before she left. The MDSC did not look for or place the call light within reach. On 2/25/25 at 12:54 p.m., Resident 142's medical record was reviewed. She was a long-term care resident with a diagnosis which included, but was not limited to, a wedge compression fracture of the second lumbar vertebra. A nursing progress note dated 2/4/25 at 10:02 a.m., indicated Resident 142 was on the bathroom floor. She was found lying on her left side and verbalized she fell while she attempted to transfer to the toilet. An IDT progress note, dated 2/5/25 at 10:01 a.m., indicated a new intervention was put in place to remind the resident to ask for help to transfer. A nursing progress note, dated 2/23/25 at 1:30 p.m. indicated Resident 142 was found lying on the floor. She indicated she attempted to stand and transfer herself to her recliner but fell. An IDT progress note dated 2/24/25 at 6:45 p.m., indicated a new intervention was put in place to place her call light within reach.			

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	Neurological assessment tools were opened for her 2/4/25 and 2/23/25 falls but were incomplete at the time of the review. Resident 142 had a comprehensive care plan revised 2/1/25 which indicated she had an ADL self care performance deficit and required substantial to maximum assistance with toilet transfers. 3. On 2/24/25 at 10:47 a.m., Resident 15 was observed. She sat up in bed with the HOB elevated and her over-bed table in front of her. Her call light was observed clipped to right corner of the mattress sheet which was out of the resident's line of sight. Resident 15 indicated she could not reach the light because she could not move/extend/reach her arms in that direction. On 2/26/25 at 10:16 a.m., Resident 15 was observed. She was reclined in bed and indicated she had her call light "hidden" under her blanket, so it would not get misplaced. On 2/26/25 at 12:57 p.m., Resident 15 was observed. She was reclined in her bed, with the HOB elevated at approximately a 45-degree angle. She was positioned high up on the mattress and held the mobility rail tightly. Resident 15 indicated she felt she was in an awkward position after some of the nurse aides had cleaned her up and changed her brief. Resident 15 indicated they forgot to put her call light back within her reach. The call light was observed wrapped around the bottom rail of the mobility bar on the left side of her bed and hung to the floor. Resident 15 indicated she was afraid to fall, and that was why she held onto the mobility bar.			

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	155826	A. BUILDING 00 B. WING	02/28/2025

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	On 2/27/25 at 9:08 a.m., the Vice President of Risk provided a copy of current, but undated, facility policy titled, "Fall Prevention and Management." The policy indicated, " ...it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Fall prevention and management is the process of identifying risk factors that can minimize the potential for falls and also a process to manage a resident's care if a fall occurs ... attempt to put an intervention in place that could prevent further falls ... If the resident hit their head or the fall was unwitnessed, complete Neuro Checks per policy ...." On 2/27/25 at 9:08 a.m., the Vice President of Risk provided a copy of current, but undated, facility policy titled, "Resident Rights." The policy indicated, " ...Resident will be treated with dignity and respect including but not limited to ... to have a method to communicate needs to staff, call light or bell access will be within reach of the resident as one method to communicate needs to staff ...." 3.1-45(a)			
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 a resident without teeth or dentures was provided interventions to ensure the resident was able to eat and did not have significant weight loss of 11 percent over 6 months for 1 of 5 residents reviewed for nutrition (Resident 28). Findings include:	F 0692	**Corrective action for residents found to be affected by deficient practice:** No residents were found to have adverse outcomes as a result of alleged deficiency. Dental referral made for resident, resident will be followed in our Nutrition At Risk meeting and RD consulted for further interventions.	03/24/2025

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	On 2/24/25 at 10:52 a.m., Resident 28 was observed as she sat up in her bed, she appeared thin and petite in stature. Licensed Practical Nurse (LPN) 12 was in the room checking to see if she had eaten her lunch. LPN 12 indicated Resident 28's family had brought her lunch before she left the resident's room. Resident 28 had her over the bed table in front of her with a Styrofoam tray with several pieces of fried catfish, fried whole chicken wings, and other assorted fried sides on it. Resident 28 indicated she could not eat the food in front of her because it was too hard for her to chew. Resident 28 opened her mouth to show that she had no natural teeth and did not have dentures in place. The resident indicated she had dentures, but she had not had them for a while. She indicated she liked the Glucerna (a nutrition supplement) shakes, but she did not always get them. Resident 28 indicated she was concerned because she had started to notice that she had lost weight. During an interview on 2/25/25 at 12:59 p.m. CNA 10 indicated Resident 28 did not have any teeth on top or bottom and did not have top or bottom dentures. On 2/25/25 at 1:08 p.m., Resident 28's lunch tray was delivered. She was served a cheeseburger whole, fried tater tots, coleslaw, and mixed fruit. Resident 28 was picking at the food, she indicated the hamburger meat was alright, but she could not eat the tater tots, coleslaw, or fruit because they were too hard for her to chew without her teeth. She indicated she wanted new dentures, but she could not afford them. During an interview on 2/26/25 at 1:12 p.m. LPN 12 indicated she normally would wait to see how much the residents would eat and then she would		**Identification of residents having the potential to be affected by the same alleged deficient practice and corrective action taken:** All residents have the potential to be affected by the alleged deficient practice. No residents were found to be affected by the alleged deficient practice. The facility reviewed all residents weights for last 30 days to ensure anyone with significant weight loss has interventions in place. No residents were found to be affected by the alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:** **Education** was provided to direct care givers utilizing the Weight management Policy with emphasis on implementing interventions to prevent weight loss timely. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** ="" p="">
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Unit Manager/Designee will conduct audits of meal-set up, weights for accuracy and residents with dentures and their use 1 x weekly x 4 weeks, every-other-week x 8 weeks	

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	offer them the shake. LPN 12 indicated the Glucerna shakes do not come on the residents' tray, the nurses gave them. On 2/26/25 at 1:21 p.m., Resident 28's lunch tray was delivered. She was served a piece of ham whole, mashed potatoes, mixed vegetables, a roll, and a dessert. The resident indicated she could not chew the ham or the vegetables because they were too hard to chew, and they choked her up. The Administrator had brought her a peanut butter and jelly sandwich whole as a substitute. Resident 28 indicated she believed if she had her dentures, she would be able to eat more because she would be able to chew up the food better. On 2/25/25 at 12:26 p.m., Resident 28's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, hemiplegia (paralysis of one side of the body) and dysphagia (difficulty swallowing.). Dental documents, dated 5/30/24, indicated Resident 28 had full upper dentures that were rubbing on the left side of her gums present, but no lower dentures were present. Resident 28 had an order, dated 6/28/24, to be evaluated and treated by speech therapy. A speech therapy note, dated 6/28/24, indicated Resident 28 expressed a desire to upgrade her diet to a regular diet so she could get bacon for breakfast. Resident 28 had an order, dated 7/4/24, that indicated speech therapy had upgraded the resident's diet from advanced dysphagia (a modified diet designed for individuals with moderate to severe difficulty swallowing,		**and 1x per month for 6 months. Any discrepancies will be immediately corrected and education will be provided** ="" p="">
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="" a="">Results of audit observations will be reported, reviewed and trended for compliance through the facility QA committee for 6 months and /as needed thereafter.
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	residents who are on this diet receive ground meats and moist foods) to a regular texture diet. Resident 28 had an order, dated 7/5/23, for monthly weights. A speech therapy note, dated 7/9/24, indicated Resident 28 complained of mouth soreness to the facilities Nurse Practitioner (NP). A Speech therapy note, dated 7/15/24, indicated Resident 28 continued to complain of difficulty chewing and swallowing certain foods. A speech therapy note, dated 7/16/24, indicated the speech therapist cut Resident 28's sandwich into quarters for safe oral intake. A speech therapy note, dated 7/17/24, indicated Resident 28 was assisted in setting up her tray prior to her meal, which included cutting of solid foods to ensure safe oral intake. A speech therapy discharge note, dated 7/17/24, indicated Resident 28 should be a set up assist with meals. On 8/3/24 Resident 28 weighed 118.6 pounds. A social services note that was a summary of a care plan meeting, dated 8/2/24, indicated they had reviewed dietary, and the resident indicated she could not chew the food. A weight change note dated 9/11/24 indicated the resident weighed 111 pounds, which was a loss of 6.4% in the past thirty days. It was recommended that the Resident be weighed weekly. Resident 28's medical record showed she was			

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	weighed on 9/18/24, 10/10/24, 11/6/24, 11/12/24, 12/5/24, 12/17/24, 12/24/24, 12/31/24, 1/7/25, 1/14/25 and 2/3/25, which indicated the resident was not weighed weekly consistently. Resident 28 had an order, dated 9/18/24, that indicated she was on a regular texture diet. A weight change note dated 12/17/24 indicated the Residents' weight triggered for significant weight loss of 5% in the last thirty days. It was recommended that the Resident be seen during Nutritionally at Risk (NAR) rounds for weekly weight and intake review. On 1/7/25 Resident 28 weighed 106.8 pounds. A weight change note, dated 1/17/25, indicated the Residents' weight triggered for significant weight loss of 10% since 8/3/24. The note indicated no new recommendations were warranted. On 1/14/25 Resident 28 weighed 109.6 pounds. On 2/3/25 Resident 28 weighed 104.8 pounds, which is a 11.64 % loss in six months. This fluctuation indicated the Residents weight had not been stable for 30 days. An annual Health Risk Assessment (HRA) note, dated 2/11/25, indicated Resident 28 had been upgraded to a regular texture diet, her appetite was poor, and she disliked the food. Her weight was 104.8 pounds and her BMI was 19. Notable 10% weight loss over 180 days and no current interventions were noted. A weight change note, dated 2/24/25, indicated Resident 28's weight from 2/3/24 triggered for			

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	significant weight loss of 10% in the past 180 days. The note indicated the Residents' meal intake was variable and the resident's weight had been stable for the last 30 days, but it had been trending down. During an interview on 2/28/25 at 11:48 a.m. Qualified Medication Aide (QMA) 15 indicated when a resident was a set up assist with meals the staff member who served the tray to that resident was expected to open any drinks, take off any plastic coverings, salt and pepper the food upon request, and cut up solid foods into bite size pieces to ensure safe oral intake. On 2/28/25 at 11:57 a.m., a policy for nutrition management, weight loss management and set up assist with meals were requested. RN 11 indicated they were unable to find policies that related to the care areas that were requested. 3.1-46			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to hold medications when a resident's vital signs were outside of the ordered parameters for 3 of 5 residents reviewed for unnecessary medications (Resident 196, 59, and 195). Findings include: 1. On 2/26/25 at 11:27 a.m., a record review was completed for Resident 196. He had the following diagnoses which included, but were not limited to, end stage renal disease, trans metatarsal amputation (TMA), hypertension, left above the knee amputation, and major depressive disorder.	F 0757	**Corrective action for residents found to be affected by deficient practice:** No residents were found to have adverse outcomes as a result of alleged deficiency. MD notified that resident was given medication outside of perimeters no new orders received. No adverse outcome noted. **Identification of residents having the potential to be affected by the same alleged**	03/24/2025

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	He had an order, dated 1/29/25, for metoprolol succinate (a blood pressure medication) extended release oral tablet 24 hour, 25 milligrams (mg) to give 1 tablet in the evening every Monday, Wednesday, and Friday. The medication was to be held for systolic less than 110 and/or pulse less than 60. The Medication Administration Record (MAR) indicated Resident 196 was given the medication on 2/3/25 when his blood pressure was 102/83, on 2/5/25 when his blood pressure was 110/68, and on 2/7/25 when his blood pressure was 93/58. On 2/17/25, 2/19/25, 2/21/25, and 2/24/25 metoprolol was administered without obtaining a blood pressure prior to administering. 2. On 2/26/25 at 1:00 p.m., a record review was completed for Resident 59. She had the following diagnoses which included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, dementia, anxiety, and depression. She had an order for midodrine (a blood pressures medication) oral tablet 10 mg to give 1 tablet orally every 8 hours as needed for systolic blood pressure less than 110. The MAR indicated she did not receive the medication when her blood pressure was below 110 on the following days. On 10/17/24 her blood pressure was 108/68. 3. On 2/26/25 at 10:25 a.m., a record review was completed for Resident 195. He had the following diagnoses which included end stage renal disease, heart failure, and muscle weakness. Resident 195 had an order for hydralazine (a blood		**deficient practice and corrective action taken:** All residents have the potential to be affected by the alleged deficient practice. No residents were found to be affected by the alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:** **Education was provided for all nurses using the Physician's Orders policy with emphasis on following parameters with medication administration on 3/20/25** ="" span="">
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How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: DON/Unit Manager/designee will conduct audits pf medication administration records to ensure medications are given within the proper parameters 1x weekly x 4 weeks and every-other-week x 3months, then 1x per month x 6 months. Any discrepancies will be immediately corrected and education will be provided as needed. ="" span="">="" p="">
The results of the audits observations will be reported,	

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	pressure medication) 25 mg to be given by mouth three times daily for hypertension, hold for systolic blood pressure less than 110. The MAR indicated on 2/19/25, 2/20/25, 2/21/25, 2/22/25, and 2/24/25, Resident 195 received the medication without having his blood pressure obtained. On 2/27/25 at 1:30 p.m., during an interview with the Vice President of Risk Management, she indicated staff did not understand the orders. On 2/27/25 at 10:34 a.m., a policy titled, "Physician Orders" was provided by the Vice President of Risk Management. It indicated, " ...The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse ...." 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-38(a)(6)		**reviewed and trended for compliance through the facility QA committee for 6 months and sporadically as needed thereafter.**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to date multi-dose vials of tuberculin serum and failed to remove expired insulins from the medication cart for 2 of 3 refrigerators observed for medication storage and 1 of 3 medication carts observed for medication storage. Findings include: On 2/25/25 at 10:22 a.m., the Health unit	F 0761	**Corrective action for residents found to be affected by deficient practice:** No residents were found to have adverse outcomes as a result of alleged deficiency. Expired solution destroyed and replaced per policy and procedure. **Identification of residents**	03/24/2025

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	medication room refrigerator was observed. A vial of Aplisol (tuberculin serum) was in the refrigerator with no date to indicate when it was opened. Health unit medication cart number 2 contained 2 insulin pens belonging to Resident 26. One insulin pen Semglee (insulin) 100 unit/ml opened on 1/20/25 and the other was Lispro (insulin) 100 unit/ml opened on 1/16/25. Heritage unit medication room refrigerator had a vial of Tubersol (tuberculin serum) 5 unit/0.1mg with no date to indicate when it was opened. During an interview with Licensed Practical Nurse 7, she indicated the insulin pens were only good for 30 days. A policy titled, "Storage of Medications," was provided by the Vice President of Risk Management on 2/27/25 at 9:08 a.m. The policy indicated, " ...Expiration dates (beyond use dates) of dispensed medications shall be determined by the pharmacist at the time of dispensing. Drugs dispensed in the manufacturer's original container will be labels with the manufacturer's expiration date. Certain medications or package types, such as intravenous solutions (IV), multiple dose injectable vials, ophthalmic, nitroglycerin tablets, and blood sugar testing solution and strips require and expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency ...." 3.1-25(j) 3.1-25(m) 3.1-25(n)		**having the potential to be affected by the same alleged deficient practice and corrective action taken:** All residents have the potential to be affected by the alleged deficient practice. Full-house audit completed on 3/15/25 to ensure all Medication carts, Treatment carts and Medication rooms and refrigerators to ensure all medications were labeled appropriately and that there were no medications labeled that had past due expirations. No residents were found to be affected by the alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:** Education was provided on proper medication labeling utilizing the Storage of Mediations Policy to all nurses on 3/20/25 **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DON/Unit Manager/Designee will conduct audits of medication carts, treatment carts, medication room and refrigerator 1x weekly x4 weeks and every-other-week x 3 months, then 1x per month for 6 months ="" span="">="" span="">The results of the audits observations will be reported, reviewed and trended for	

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			compliance through the facility QA committee for 6 months and sporadically as needed thereafter.	