STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

(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 Complaints IN00436414, IN00437098, IN00437481, IN00440036, IN00440148, and IN00442228. Complaint IN00436414 - Federal/state deficiencies related to the allegations are cited at F921. Complaint IN00437098 - No deficiencies related to the allegations are cited. Complaint IN00437481 - No deficiencies related to the allegations are cited. Complaint IN00440036 - No deficiencies related to the allegations are cited. Complaint IN00440148 - No deficiencies related to the allegations are cited. Complaint IN00442228 - No deficiencies related to the allegations are cited. Survey dates: September 16, 17, 18, 19, and 20, 2024. Facility number: 008505 Provider number: 155580 AIM number: 200064830 Census Bed Type: SNF/NF: 123 Total: 123 Census Payor Type: Medicare: 9	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Frank Bensema	Administrator	10/16/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicaid: 108 Other: 6 Total: 123 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/26/24.			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation, record review, and interview, the facility failed to ensure a resident's privacy was maintained related to staff not knocking on the door prior to entering the resident's room for 2 of 2 residents reviewed for privacy. (Residents 2 and 9) Findings include: 1. During an interview on 9/16/24 at 2:44 p.m., Resident 2 indicated staff do not always knock on her door prior to entering her room. On 9/16/24 at 2:55 p.m., CNA 3 opened the door to the resident's room without knocking. The CNA proceeded to close the door and exit the resident's room. On 9/16/24 at 2:58 p.m., a staff member, partially opened the door and then closed it. The staff member did not knock on the door prior to opening it. The record for Resident 2 was reviewed on 9/19/24 at 9:56 a.m. Diagnoses included, but were not limited to, bipolar, type 2 diabetes, major depressive disorder, and schizophrenia.	F 0583	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Tag number: F583 Personal Privacy** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents 2 and 9 had no adverse reactions related to the alleged deficient practice.** II. How other residents having the	10/14/2024

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/15/24, indicated the resident was moderately impaired for daily decision making. During an interview on 9/18/24 at 4:10 p.m., the Director of Nursing indicated staff should have knocked on the door before entering the resident's room. 2. During an interview on 9/16/24 at 3:00 p.m., Resident 9 indicated staff do not always knock on her door prior to entering her room. On 9/16/24 at 3:03 p.m., Housekeeper 1 entered the resident's room to replace the trash bag. She did not knock on the door prior to entering the room. The record for Resident 9 was reviewed on 9/17/24 at 3:18 p.m. Diagnoses included, but were not limited to, major depressive disorder and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 7/15/24, indicated the resident was cognitively impaired for daily decision making. During an interview on 9/18/24 at 4:10 p.m., the Director of Nursing indicated staff should have knocked on the door before entering the resident's room. 3.1-3(p)(5)		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 to be affected by the alleged deficient practice**. CNA 3 and Housekeeper 1 were educated on resident rights to include knocking on doors prior to entering a residents room.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate all staff on resident rights to include knocking on doors prior to entering a resident room**. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct audits to ensure staff are knocking on residents door prior to entering. Audits will be completed as follows 10 resident rooms a week x 4 weeks, then 5 resident rooms a week x 4 weeks, then 1 resident room a week x 4 months**. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90%	

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			compliance or greater is achieved x4 consecutive weeks. **The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0640 SS=A Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments Based on record review and interview, the facility failed to successfully complete and export the Discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 1 of 28 residents whose MDS assessments were reviewed. (Resident 53) Finding includes: The Record for Resident 53 was reviewed on 9/20/24 at 8:38 a.m. The resident was admitted to the facility on 10/30/23 and discharged with the return anticipated on 7/12/24. The Discharge Return Anticipated MDS assessment, dated 7/12/24, indicated it was completed and accepted on 9/16/24. During an interview on 9/20/24 at 10:00 a.m., the MDS Nurse Consultant indicated the assessment was completed and submitted late. The Centers for Medicare and Medicaid Services "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual," dated October 2024, indicated, "Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14	F 0640	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Tag number: F640 Encoding/Transmitting Assessments** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 53 discharged from the facility.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; Any**	10/14/2024

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	days of the MDS Completion Date (Z0500B + 14 days)."		**resident discharging from the facility has the potential to be affected by the alleged deficient practice. A full house audit was completed on residents discharged in the last 60 days to ensure they had a discharge assessment completed.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **MDS consultant to educate MDS coordinator/assistant on completing discharge assessments timely.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **MDS/designee to audit discharges to ensure a discharge assessment was completed timely. Audits will be completed 3x week x 6 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to dirty and long fingernails and the removal of facial hair for 3 of 10 residents reviewed for ADLs. (Residents 35, 58, and 236) Findings include: 1. During random observations on 9/16/24 at 9:32 a.m., 11:44 a.m., and 2:38 p.m., on 9/17/24 at 9:00 a.m., 1:38 p.m., and on 9/18/24 at 9:09 a.m., 11:15 a.m., and 1:57 p.m., Resident 35 was observed with dirty fingernails on her left hand and long and dirty fingernails on her right hand. On 9/19/24 at 8:15 a.m., the Assistant Director of Nursing (ADON) 2 was asked to observe the resident's fingernails. At that time, ADON 2 indicated her nails were long and dirty. The record for Resident 35 was reviewed on 9/17/24 at 2:05 p.m. Diagnoses included, but were not limited to, stroke, aphasia (a language disorder that makes it difficult to understand or express language), diabetes, hemiplegia (paralysis on one side of the body), heart disease, and high blood pressure. The 6/16/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had a functional limitation of range of motion impairment to one side for both the upper and lower extremities, was dependent on staff for bathing and needed substantial to maximal assistance with personal hygiene.	F 0677	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Tag number: F 677 ADL Care** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 35 had their nails cleaned and trimmed on 9/20/24. Resident 58 was shaven on 9/20/24. Resident 236 had their facial hair shaven on 9/20/24.** II. How other residents 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 to be affected by the alleged deficient practice. **A full house audit was completed on nail care and shaving. Any discrepancies**	10/14/2024

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	The Care Plan, revised on 8/5/22, indicated the resident had an ADL self-care performance deficit related to a stroke. An approach indicated the resident may require staff assistance with personal hygiene. The task section of the EMR (electronic medical record), completed by the CNA, indicated there was no documentation the resident's fingernails had been cleaned or trimmed. During an interview on 8/19/24 at 8:15 a.m., ADON 2 indicated the resident's fingernails were in need of being trimmed and cleaned. 2. During random observations on 9/16/24 at 12:16 p.m., 2:40 p.m., and 3:40 p.m., on 9/17/24 at 9:11 a.m., 1:40 p.m., and 3:00 p.m., and on 9/18/24 at 10:04 a.m. and 2:00 p.m., Resident 58 was observed with long facial hair under her chin and on her neck. On 9/18/24 at 2:45 p.m., the resident was observed sitting in a wheelchair in her room. At that time, CNA 2 was asked to come to the resident's room to observe the facial hair. The CNA indicated she had just shaved the resident 2 days prior, however, she must have missed the facial hair under her chin and neck. She indicated the facial hair was very long. The record for Resident 58 was reviewed on 9/18/24 at 2:55 p.m. The resident was admitted to the facility on 7/19/24. Diagnoses included, but were not limited to, type 2 diabetes, stroke, hemiplegia (paralysis to one side of the body), high blood pressure, urinary tract infection (UTI), obstructive uropathy (occurred when urine		**were immediately corrected.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on ADL care/showering to include nail care and shaving.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an audit on nail care and shaving to ensure it is completed. Audits will be completed on 10 residents a week x 8 weeks, 5 residents a week x 8 weeks then 1 resident a week 2 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks**. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	cannot drain through the urinary tract), dementia, anxiety, and depressive disorder The Admission Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was cognitively impaired for daily decision making and needed supervision with personal hygiene. The 9/8/24 5-day Medicare MDS assessment, indicated the resident was cognitively impaired for daily decision making and now she needed substantial assistance with personal hygiene. A Care Plan, dated 7/25/24, indicated the resident had an ADL self-care performance deficit related to a stroke. The task section of the EMR, completed by the CNA, indicated the had a shower on 8/22, 9/5, 9/12, and 9/16/24. No shaving was documented. During an interview on 9/19/24 at 8:10 a.m., the Assistant Director of Nursing (ADON) 2 indicated the resident should have had the facial hair removed during care. 3. During random observations on 9/16/24 at 10:08 a.m., 12:25 p.m., 2:46 p.m., and 3:43 p.m., on 9/17/24 at 9:08 a.m., 9:57 a.m., and 1:40 p.m., and on 9/18/24 at 9:13 a.m., and 10:50 a.m., Resident 236 was observed with a moderate amount of facial hair on his face and chin area. On 9/18/24 at 2:05 p.m., the resident was observed sitting in the wheelchair in his room. The resident's son was observed sitting on the couch in the room. During an interview on 9/18/24 at 2:25 p.m., the			

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	resident's daughter indicated the resident liked to be clean shaven and her brother was now giving him a shave. The record for Resident 236 was reviewed on 9/17/24 1:48 p.m. The resident was admitted to the facility on 9/11/24. Diagnoses included, but were not limited to, pneumonia, high blood pressure, hearing loss, joint pain, and arthritis. The Admission Minimum Data Set (MDS) assessment was still in progress. The Care Plan, dated 9/12/24, indicated, the resident had an ADL self-care deficit related to mobility and weakness. The task section of the EMR, completed by the CNA, indicated Resident 236 had a bed bath on 9/12/24 and a shower on 9/16/24. No shaving was documented. During an interview on 9/19/24 at 8:10 a.m., the Assistant Director of Nursing indicated she was unaware the resident wanted to be clean shaven. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure non-pressure ulcer treatments were completed as ordered for 3 of 4 residents reviewed for skin conditions and failed to obtain a psychiatric consult as ordered for 1 of 5 residents reviewed for unnecessary medications. (Residents 94 and 107)	F 0684	**The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	10/14/2024

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	Findings include: 1. During a random observation on 9/16/24 at 10:26 a.m., Resident 94 was observed sitting on a couch in the dining/day room. The resident's left lower leg was observed to be scaly, with scabbed and inflamed red areas. There were no bandages on her left lower leg. The record for Resident 94 was reviewed on 9/18/24 at 9:45 a.m. Diagnoses included, buy were not limited to, schizophrenia, morbid obesity, cellulitis, high blood pressure, major depressive disorder, anxiety, osteoarthritis, and bipolar disorder. The 6/15/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. A Care Plan, revised on 3/25/24, indicated the resident was resistive to care and refused wound care. A Care Plan, revised on 7/1/24, indicated the resident had a venous/stasis ulcer to the left lower leg. The approaches were to perform the treatment as ordered. Physician's Orders, dated 7/2/24, indicated Hydrocortisone external cream 0.1 % apply to the left lower leg topically on day shift every Monday, Wednesday, and Friday, and wrap with kerlix. The Treatment Administration Records (TAR), from April 2024 to present, indicated the treatment was blank and not signed out as being completed on the following days:		***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **Tag number: F684 Quality of Care** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 94 had no adverse reactions to related to the alleged deficient practice. Resident 107 had no adverse outcomes related to the alleged deficient practice and will be seen by psych services on 9/20.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident receiving treatments or on psych meds have the potential to be affected by the alleged deficient practice. **A full house audit was completed to ensure any resident with an order for a psych evaluation has one completed or scheduled. Moving forward the**	

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	- 4/2024: blank on 4/10/24 - 5/2024: blank on 5/27/24 - 6/2024: blank on 6/14, 6/21 and 6/28/24 - 7/2024: blank on 7/1, 7/15, 7/17, 7/19, 7/22, 7/24, and 7/26/24 - 8/2024: blank on 8/7 and 8/19/24 During an interview on 9/20/24 at 9:20 a.m., Assistant Director of Nursing (ADON) 2 indicated the treatments to the left lower extremity were not signed out as being completed for the resident. 2. The record for Resident 107 was reviewed on 9/19/24 at 10:55 a.m. Diagnoses included, but were not limited to, Parkinson's disease, high blood pressure, psychotic disorder, major depressive disorder, dementia without behaviors, and type 2 diabetes. The resident transferred to the facility on 1/4/24 from another skilled nursing home. The Quarterly Minimum Data Set (MDS) assessment, dated 7/5/24, indicated the resident was not cognitively intact for daily decision making. The resident had mood problems such as feeling down, feeling tired, poor appetite and trouble concentrating on things. The resident received an antipsychotic, anti-anxiety, and antidepressant medications. Physician's Orders, dated 4/1/24, indicated Lorazepam (an anti-anxiety medication) 0.5 mg every day and evening shifts and a psychiatric evaluation to treat as indicated. Physician's Orders, dated 9/18/24, indicated Olanzapine (an antipsychotic medication) 20 milligrams (mg) 1 tablet at night time. Trazadone (an antidepressant medication) 50 mg at bedtime,		**DON/designee will ensure all treatment are completed as ordered** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee will educate nursing staff on completing and initialing treatments are ordered. SS will be educated on ensuring any resident with an order for a psych evaluation has one completed.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit the MAR/TAR to ensure treatments are completed and initialed as ordered. DON/designee will audit new admissions to ensure everyone with an order for a psych evaluation has one scheduled or completed as ordered. Audits will be completed on 10 residents treatments a week x 8 weeks, 5 residents treatments a week x 4 weeks, then 1 resident treatment a week x 3 months. Audits will be completed on new admissions/readmissions to ensure psych evals are completed/scheduled as ordered. Audits will be completed on all new admission during daily clinical**	

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	and Zoloft (an antidepressant medication) 50 mg at night time. A Nurse Practitioner (NP) Progress Note, dated 9/16/24, indicated the resident had the diagnosis of psychotic disorder with delusions and was on Olanzapine 20 mg with psychiatric services following him. During an interview on 9/19/24 at 1:50 p.m., Assistant Director of Nursing (ADON) 2 indicated the resident was admitted to the locked unit when he first arrived. After his hospitalization in March, he was readmitted to the PCU unit. She had thought the resident was being seen by the outside behavior company for his medications. There was no documentation or consents obtained for the resident to seek outside behavior management. During an interview on 9/20/24 at 1:45 p.m., the Nurse Consultant indicated the psychiatric consult was not obtained in a timely manner. 3.1-37(a)		**meetings x 3 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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 a palm protector was donned as ordered by the physician for 1 of 1 residents reviewed for range of motion. (Resident 35) Finding includes: During a random observation on 9/16/24 at 9:32 a.m., Resident 35 was observed sitting in a geri	F 0688	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	10/14/2024

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	155580	A. BUILDING 00 B. WING	09/20/2024

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	chair, dressed in street clothes and finishing breakfast. At that time, her right hand was clenched like a fist and there was no anti-contracture device in her hand. On 9/16/24 at 11:44 a.m., the resident now was observed with a palm protector in her right hand The record for Resident 35 was reviewed on 9/17/24 at 2:05 p.m. Diagnoses included, but were not limited to, stroke, aphasia (a language disorder that makes it difficult to understand or express language), diabetes, hemiplegia (paralysis on one side of the body), heart disease, and high blood pressure. The 6/16/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making. The resident had a functional limitation of range of motion impairment to one side for both the upper and lower extremities and was dependent on staff for bathing and needed substantial to maximal assistance with personal hygiene. The Care Plan, dated 9/23/22, indicated the resident had hemiplegia due to a stroke with weakness to the right side. The approaches were to provide a palm proctor to the right palm as per order. Physician's Orders, dated 10/19/23, indicated the resident may have a palm protector or rolled wash cloth to the right hand. The Medication and Treatment Administration Records for 6/2024,7/2024, 8/2024 and 9/2024 lacked documentation to indicate if the palm protector was donned or doffed. There was no documentation of any refusals.		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Tag number: F688 Increase/Prevent/Decrease in ROM** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 35's order for the palm protecter was placed on the MAR on 9/19/24 to ensure it is in place as ordered.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who have a device to prevent a decrease in ROM have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure anyone with a device to prevent a decrease in ROM has an order on the MAR to ensure it is being placed as ordered. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on following an order to place any device to prevent a decrease in ROM.**	

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	The task section of the EMR (electronic medical record), where the CNAs document, indicated "Nursing: Splint/Brace: palm protector. Resident to wear palm protector to right hand it is to be on at all times you may use rolled face towels when palm protector is being laundered." From 9/1-9/16/24 the palm protector was signed out as N/A (not applicable). There was no documentation the resident refused to wear the palm protector. During an interview on 9/19/24 at 1:50 p.m., Assistant Director of Nursing 2 indicated there was no documentation to monitor if the palm protector was being donned and doffed. 3.1-42(a)(2)		IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit any resident with a device to ensure it is in place as ordered or any refusal is documented. Audits will be completed 5x a week x 8 weeks, then 3x a week x 8 weeks, then weekly x 2 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure Foley (urinary) catheter bags and tubing were kept off of the floor for 1 of 1 resident reviewed for urinary catheters. (Resident 58) Finding includes: During a random observation on 9/16/24 at 9:30 a.m., Resident 58 was observed in bed. Her anchored catheter bag was on the floor at the side of the bed.	F 0690	**The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or***	10/14/2024

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	During an interview at that time, CNA 1 indicated the catheter bag should not be on the floor. During random observations on 9/18/24 at 9:12 a.m. and 10:04 a.m., the resident was up and dressed and observed sitting in her wheelchair. At those times the catheter bag and tubing was observed on the floor under the wheelchair. On 9/18/24 at 10:29 a.m., the Director of Rehabilitation entered the resident's room and asked if she was ready for therapy. The resident indicated she was, so the director pushed her out of the room to the therapy room. At that time, the catheter bag and tubing remained on the floor while being pushed down the hallway. At 11:10 a.m., the resident was finished with therapy and staff pushed her down the hallway back to her room with the catheter bag and tubing still observed on the floor. During an observation on 9/18/24 at 2:00 p.m., the resident was observed sitting in her wheelchair inside her room. At that time, the catheter bag and tubing remained on the floor under the wheelchair. During an observation on 9/18/24 at 2:45 p.m., the catheter bag and tubing were still on the floor under the resident's wheelchair. CNA 2 was asked to step inside the room to observe the catheter bag and tubing. During an interview at that time, CNA 2 indicated the bars under the wheelchair dip down too low and that was why the catheter bag was on the ground. She was aware the catheter bag and tubing should not be on the floor. The record for Resident 58 was reviewed on 9/18/24 at 2:55 p.m. The resident was admitted to		***conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **Tag number: F690** **Bowel/Bladder, catheter, UTI** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 58 had not adverse outcomes related to the alleged deficient practice.** II. How other residents 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 to be affected by the alleged deficient practice.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on the policy "Urinary Catheter Care" to include keeping a foley bag and tubing off the floor.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit foley**	

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	the facility on 7/19/24. Diagnoses included, but were not limited to, type 2 diabetes, stroke, hemiplegia (paralysis to one side of the body), high blood pressure, urinary tract infection (UTI), obstructive uropathy (occurred when urine cannot drain through the urinary tract), dementia, anxiety, and depressive disorder The Admission Minimum Data Set (MDS) assessment, dated 7/22/24, indicated the resident was cognitively impaired for daily decision making and needed supervision with personal hygiene. The 9/8/24 5-day Medicare MDS assessment indicated Resident 58 was cognitively impaired for daily decision making. She needed substantial assistance with personal hygiene and had a Foley catheter. A Care Plan, revised on 8/6/24, indicated the resident had a Foley catheter. Physician's Orders, dated 9/4/24, indicated Foley catheter 14 French with a 10 cubic centimeters (CC) balloon. Physician Orders, dated 9/4/24 and discontinued on 9/12/24, indicated Ciprofloxacin HCl (an antibiotic) tablet 500 milligrams (mg), give 1 tablet by mouth every day and evening shift for an UTI for 7 days. Meropenem (an antibiotic) Intravenous solution reconstituted 2 grams, give 100 milliliters (ml) intravenously three times a day for UTI for 9 days. During an interview on 9/18/24 at 4:00 p.m., the Director of Nursing indicated the catheter bag and tubing should not be on the floor. The current and revised 2/14/19, "Urinary Catheter		**catheters/tubing to ensure they are kept off the floor. Audits will be completed on 5 residents a week x 8 weeks, then 3 resident's a week x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Care" policy provided by Assistant Director of Nursing 2 on 9/19/24 at 2:30 p.m., indicated urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly. 3.1-41(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, record review, and interview, the facility failed to ensure a tube feeding was infusing at the correct time and treatment orders were obtained for a gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach) site for 2 of 2 residents reviewed for tube feeding. (Residents 10 and 107) Findings include: 1. On 9/19/24 at 8:35 a.m., Resident 10 was observed in his room in bed. His tube feeding pump was turned off and there was no tube feeding hanging from the pole. On 9/20/24 at 8:36 a.m., the resident was seated in his wheelchair and he was being transported to the main dining room. The resident was not connected to his tube feeding at that time. The record for Resident 10 was reviewed on 9/17/24 at 1:34 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), stroke, intestinal obstruction, and dementia with agitation. The Medicare 5-day Minimum Data Set (MDS) assessment, dated 7/24/24, indicated the resident was cognitively impaired for daily decision making	F 0693	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **="" i="">** ***i="">*** **="" i="">** **Tag number: F693 Tube Feeding** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 10 had no adverse outcomes related to the alleged deficient practice. Resident 107 had an order placed to cleanse g-tube**	10/14/2024

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	and he had a feeding tube through which he received 51% or more of his total calories. A Care Plan, dated 8/1/24, indicated the resident required a peg (percutaneous endoscopic gastrostomy tube) tube related to an intestinal obstruction. The resident also received an oral diet. Interventions included, but were not limited to, dependent with tube feeding and water flushes, see physician orders for current feeding orders. A Physician's Order, dated 7/27/24, indicated the resident was to receive a tube feeding of Jevity 1.2 at 95 milliliters (ml) an hour, on at 7:00 p.m. and off at 9:00 a.m. During an interview on 9/20/24 at 9:25 a.m., the 200 Unit Manager indicated the resident's tube feeding was to be turned off at 9:00 a.m. 2. During an observation on 9/18/24 11:05 a.m. Resident 107 had asked to use the bathroom. At that time, he was wheeled out of the dining room by RN 1 and assisted back to his room. The Medical Record Supervisor (who was also a CNA) assisted RN 1 in placing the resident on the toilet. At that time, RN 1 was asked to lift up the resident's shirt so his peg tube (a tube that was inserted directly into the stomach for nutrition) could be observed. The peg tube was intact and there was dried crusty drainage around the stoma site. There was no bandage covering the stoma site. During an interview on 9/18/24 at 11:09 a.m., RN 1 indicated he has flushed the tube on his shift but he has never cleaned around it. After he had checked in the computer, he indicated there were no orders for the peg tube site to be cleaned.		**site on 9/26/24** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **Any resident with a g-tube has the potential to be affected by the alleged deficient practice. A full house audit was conducted to ensure any resident with g-tube has an order to cleanse the site.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee will educate nurses on the policy "Tube Feeding and Care" to include administering the feeding per physicians orders and obtaining an order to cleanse site.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit residents with g-tubes feedings to ensure they are running at the scheduled times. New admissions/readmissions with a g-tube will be audited to ensure they have an order to cleanse g-tube sites . Audits will be completed 5x week for 4 weeks, 3x week for 4 weeks and then weekly x 4 months.**	

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	The record for Resident 107 was reviewed on 9/19/24 at 10:55 a.m. Diagnoses included, but were not limited to, Parkinson's disease, high blood pressure, psychotic disorder, major depressive disorder, dementia without behaviors, and type 2 diabetes. The resident transferred to the facility on 1/4/24 from another skilled nursing home. The Quarterly Minimum Data Set (MDS) assessment, dated 7/5/24, indicated the resident was not cognitively intact for daily decision making. The resident had mood problems such as feeling down, feeling tired, poor appetite and trouble concentrating on things. The resident had no swallowing problems and weighed 160 pounds with no significant weight loss. He had a peg tube and received a mechanically altered diet. A Care Plan, revised on 7/23/24, indicated the resident required tube feeding related to difficulty swallowing. Physician's Orders, dated 4/1/24, indicated flush peg tube with 100 milliliters (ml) of water every shift. Physician's Orders, dated 6/28/24, indicated enteral feed: monitor for tube feeding complications every shift including nausea, vomiting, diarrhea, constipation, abdomen distention, coughing, congestion, choking, cyanosis, frothy sputum, and unusual restlessness. There were no physician's orders to clean around the stoma site. During an interview on 9/18/24 at 11:20 a.m., the Director of Nursing (DON) indicated there was no		The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	order to cleanse around the peg tube. The current 8/3/20 "Tube-Feeding and Care" policy, provided by the DON on 9/18/24 at 11:28 a.m., indicated stoma site care: clean skin with soap and water or antiseptic of choice, begin next to the stoma site, using a spiral pattern moving outward, then clean under the skin disk with a cotton swab. Dry thoroughly and leave open to air, use a dressing only if ordered. 3.1-44(a)(2)			
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 set at the correct flow rate for 2 of 2 residents reviewed for respiratory care. (Residents 236 and 55) Findings include: 1. During random observations on 9/16/24 at 2:46 p.m. and 3:43 p.m., and on 9/17/24 at 9:08 a.m., 9:57 a.m. and 1:40 p.m., Resident 236 was observed wearing oxygen per nasal cannula at 2 liters per minute (lpm) on the room concentrator. During random observations on 9/18/24 at 9:13 a.m., 10:50 a.m., and 2:05 p.m., and on 9/19/24 at 8:10 a.m., the resident was wearing oxygen per nasal cannula at 2.5 liters per minute on the room concentrator. On 9/18/24 at 8:10 a.m., Assistant Director of Nursing (ADON) 2 was in the room and indicated the oxygen was set at 2.5 liters. The record for Resident 236 was reviewed on 9/17/24 1:48 p.m. The resident was admitted to the	F 0695	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **="" i="">** ***i=″″>*** **="" i="">** **Tag number: F695 Resp/Trach Care** I. What corrective action(s) will be accomplished for those residents	10/14/2024

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	facility on 9/11/24. Diagnoses included, but were not limited to, pneumonia, high blood pressure, hearing loss, joint pain, and arthritis. The Admission Minimum Data Set (MDS) assessment was still in progress. The Care Plan, dated 9/12/24, indicated the resident needed oxygen therapy. The approaches were to set the oxygen at 3 liters per minute. Physician's Orders, dated 9/12/24, indicated oxygen at 3 liters per minute via nasal cannula continuously. During an interview on 9/19/24 at 8:10 a.m., ADON 2 indicated the oxygen was set at 2.5 liters and it should have been at 3 liters per minute. 2. On 9/16/24 at 11:18 a.m. and 12:22 p.m., Resident 55 was observed wearing oxygen via nasal cannula. The oxygen flow rate was on at 3 liters. The record for Resident 55 was reviewed on 9/17/24 at 3:11 p.m. The diagnoses included, but were not limited to, anoxic (no oxygen to the brain) brain damage, dysphagia (difficulty swallowing), hypertension (high blood pressure), vegetative state (severe brain damage), and chronic obstructive pulmonary disease (COPD). The Quarterly Minimum Data Set (MDS) assessment, dated 8/12/24, indicated the resident was severely impaired for daily decision making and the resident required oxygen therapy. A Care Plan, dated 2/8/24, indicated the resident required oxygen therapy. Interventions were to monitor signs of respiratory distress and to administer oxygen settings via nasal cannula per oxygen orders.		found to have been affected by the deficient practice; **Resident 55 and resident 236 had no adverse reactions related to the alleged deficient practice. Their oxygen flow rate was set to the ordered flow rate.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **Any resident on oxygen therapy has the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure any resident on oxygen therapy has their concentrator set on the correct flow rate. Any discrepancies will be immediately corrected.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee will educate nursing staff on ensuring residents oxygen is set at the correct flow rate.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit residents on oxygen to ensure their flow rate is set at the ordered amount. Audits will be completed on 5 residents a**	

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	A Physician's Order, dated 12/17/23, indicated to administer oxygen at 2 liters per nasal cannula continuously every shift. The Medication Administration Record (MAR) indicated oxygen was signed out as being given at 2 liters on 9/16/24. During an interview on 9/19/24 at 9:52 a.m., Assistant Director of Nursing (ADON) 1 indicated staff had been auditing the oxygen and the resident's flow rate was corrected. 3.1-47(6)		**week x 4 weeks, then 3 residents a week x 4 weeks, then 1 resident a week x 4 months** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents observed during medication pass. Two errors were observed during 33 opportunities for errors during medication administration. This resulted in a medication error rate of 6.06%. (Residents 3 and 126) Findings include: 1. During an observation of medication pass on 9/18/24 at 4:00 p.m., LPN 1 prepared the insulin Fiasp flex touch pen for Resident 3. She opened the insulin pen, wiped the seal with an alcohol swab, attached the needle, dialed the pen to 10 units, and proceeded to administer the medication to the resident. The LPN did not prime the pen before administration of the insulin. During an interview on 9/20/24 at 9:25 a.m., the 200	F 0759	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Tag number: F759 Free of Med Error rates 5% or more** I. What corrective action(s) will be accomplished for those residents	10/14/2024

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	155580	A. BUILDING 00 B. WING	09/20/2024

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	Unit Manager indicated the insulin pen should have been primed prior to giving the insulin. The facility policy titled, "Insulin Pen Procedure" was reviewed on 9/20/24 at 1:54 p.m. The policy was provided by the nurse consultant and identified as current. The policy indicated the following, "...7. Prime the insulin pen. Priming means removing air bubbles from the needle, and ensures that the needle is open and working. The pen must be primed before each injection. 8. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear. You may need to repeat this step until a drop appears..." 2. On 9/19/24 at 8:41 a.m., LPN 2 was observed preparing medications for Resident 126. The LPN placed an Aldactone (a blood pressure medication) 25 milligram (mg) tablet into the medication cup and administered the pill to the resident. The record for Resident 126 was reviewed on 9/20/24 at 9:00 a.m. A Physician's Order, dated 9/7/24, indicated the resident's Aldactone had been discontinued. During an interview on 9/20/24 at 1:54 p.m., the Nurse Consultant indicated the Aldactone should not have been given if it was discontinued. 3.1-48(c)(1)		found to have been affected by the deficient practice; **Residents 3 and 126 had no adverse outcomes related to the deficient practice.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents receiving medication have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure any discontinued medication was removed from the medication cart.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on the policy "Insulin Pen Procedure" to include priming the pen prior to administering insulin. Nursing staff to be educated on removing a medication from the med cart when it is discontinued and the proper procedure to follow when performing med pass.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee to perform audits on nursing staff**	

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			administering insulin via insulin pen to ensure they are priming pen prior to administration and they are following the correct med pass procedure DON/designee will audit med carts to ensure any discontinued medication has been removed. Audits will be completed 5 times a week x 4 weeks, 3x week x 4 weeks, then weekly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs Based on observation, record review, and interview, the facility failed to ensure a resident had seen the dentist at least yearly for 1 of 2 residents reviewed for dental care. (Resident 88) Finding includes: On 9/16/24 at 10:43 a.m., Resident 88 was observed with missing upper and lower teeth. During an interview at that time, the resident indicated he had not seen the dentist since he arrived at the facility in 2022. The resident expressed he wanted dentures and indicated he had been on the dental list for a long time.	F 0791	**The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the***	10/16/2024

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	The record for Resident 88 was reviewed on 9/18/24 at 8:45 a.m. The diagnoses included, but were not limited to, hypotension (low blood pressure), anemia (low iron), adult failure to thrive, respiratory failure, heart failure, kidney disease, and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 7/28/24, indicated the resident was moderately impaired for daily decision making. There was no dental care plan. A Physician's Order, dated 2/5/24, indicated the resident could receive dental care as needed. During an interview on 9/19/24 at 11:13 a.m., the Social Service Director (SSD) indicated she had not had time to cross reference the previous dental lists to verify which residents had not been seen by the dentist. She indicated Resident 88 had not been seen by a dentist since admission because he was dealing with a deviance with his insurance. The resident had just signed a new senior dental plan application on 8/29/24. During an interview on 9/19/24 at 2:47 p.m., the SSD indicated she was wrong about the resident having a deviance with his insurance. She indicated they recognized the resident had not seen the dentist since admission and had the resident sign a new dental agreement on 8/29/24. The dentist was last in the facility on 9/11/24 and the resident was not on the dental list to be seen. 3.1-24(a)(1)		***provisions of federal and state law.*** **Tag number: F791 Dental Services** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 88 is scheduled to see the dentist on 10/16/2024.** II. How other residents 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 to be affected by the alleged deficient practice. A full house audit was completed to ensure any resident who consented to dental care has been seen by a dentist in the past year.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **SSD educated on scheduling residents who have consented to dental care in a timely manner.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **SSD/designee will complete audit all new admission/readmissions to ensure anyone consenting to dental care has an**	

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			appointment scheduled in a timely manner. Audits will be conducted 5x week x 4 weeks, then weekly x 5 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to 15 minute checks for a resident who had pushed another resident down to the ground for 1 of 1 residents reviewed for abuse. (Resident 94) Finding includes: The record for Resident 94 was reviewed on 9/18/24 at 9:45 a.m. Diagnoses included, buy were not limited to, schizophrenia, morbid obesity, cellulitis, high blood pressure, major depressive disorder, anxiety, osteoarthritis, and bipolar disorder. The 6/15/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. A Care Plan, dated 7/31/24, indicated the resident had the potential to be physically aggressive.	F 0842	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **="" i="">** ***i=″″>*** **="" i="">** **Tag number: F842 Resident Records**	10/14/2024

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	A Social Service Progress Note, dated 7/31/24, indicated the resident had an altercation with her roommate. Resident 94 indicated she was in the bathroom sitting on the toilet and her roommate entered the bathroom and told the her she was going to hit her, so Resident 94 got off the toilet and hit her first and left the room. The other resident had fallen to the ground. Both residents were separated and Resident 94 was moved to a different room and was placed on 15 minute checks. An abuse allegation/incident, received by the Administrator on 9/19/24 at 9:40 a.m., indicated on 7/29/24, Resident 94 pushed another resident down. Both residents were placed on 15 minute checks and they both resided on the behavior unit. The 15 minute checks were completed via the computer in the task section. The following was documented in the clinical record in 15 minute increments: - 8/1/24: 12:00 a.m. to 1:00 a.m., the time documented was 12:02 a.m. - 8/1/24: was blank from 1:30 a.m. to 6:45 a.m. - 8/1/24: 7:00 a.m. to 2:45 p.m., the time documented was 1:57 p.m. - 8/1/24: 3:00 p.m. to 8:30 p.m., the time documented was 7:37 p.m. The time documented for all 15 increments was either before the actual time or way after the time. During an interview on 9/19/24 at 3:45 p.m., ADON 2 indicated the 15 minute checks were time stamped either before or way after the observation of the resident.		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Resident 94 had no adverse outcomes related to the alleged deficient practice.** II. How other residents 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 to be affected by the alleged deficient practice.** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; DON/designee will educate nursing staff on completing 15 minutes checks as scheduled and documenting the checks timely.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit 15 minute checks to ensure they are being completed as scheduled and timely. Audits will be completed 5x week x 4 weeks, 3x week x 4 weeks, then weekly x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90%	

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	3.1-50(a)(2)		compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place related to hand hygiene during glove use for 1 of 1 glucometer blood sugar checks observed, staff failing to donn personal protective equipment (PPE) for a resident who was in enhanced barrier precautions (EBP), and ensuring Foley (urinary) catheter bags were not on the floor during random infection control observations. (Residents 3, 36, and 113) Findings include: 1. On 9/18/24 at 4:00 p.m., LPN 1 was observed completing a glucometer (a test to check the resident's blood sugar) procedure for Resident 3. The LPN entered the resident's room, proceeded to donn a pair of gloves and completed the glucometer check. The LPN sanitized her hands after removing her gloves. She did not wash her hands or use hand sanitizer upon entering the resident's room or before donning the gloves. During an interview on 9/20/24 at 2:28 p.m., the Nurse Consultant indicated hands should be washed and/or sanitized upon room entry so it would be expected for staff to sanitize their hands prior to donning gloves. The facility policy titled "Hand	F 0880	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Tag number: F880 Infection Control** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Residents 3, 36 and 113 had no adverse reactions related to the alleged deficient practices.** II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	10/14/2024

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	Hygiene/Handwashing" was provided on 9/20/24 at 1:54 p.m. by the Nurse Consultant and identified as current. The policy indicated hand hygiene should be completed at room entry. 2. During a random observation on 9/16/24 at 11:07 a.m., CNA 1 was observed wearing gloves and having close contact with Resident 36 by providing incontinence care and pulling up the resident' new brief and pants. There was a sign above the resident's bed that indicated EBP for close contact: required a gown and gloves. During an interview at that time, CNA 1 indicated she thought the EBP was for the resident who resided in the first bed. She did not see the sign above Resident 36's bed. The record for Resident 36 was reviewed on 9/20/24 at 8:18 a.m. Diagnoses included, but were not limited to, peripheral vascular disease and dementia. Physician's Orders, dated 5/14/24, indicated Enhanced Barrier Precautions related to wounds and infection to left lower leg. Physician's Orders, dated 9/13/24, indicated Gentamicin Sulfate External Ointment 0.1 %, apply to left lower extremity for wound healing. The Wound Physician note, dated 9/13/24, indicated the resident had an arterial wound on the left lower leg that measured 9.5 centimeters (cm) by 3 cm and had blue-green drainage. During an interview on 9/19/24 at 1:50 p.m., Assistant Director of Nursing (ADON) 2 indicated the resident was in EBP and the CNA should have donned a gown prior to contact.		action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practices** III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on the policies "Hand Hygiene/Handwashing" and "Urinary Catheter Care" to include washing hands prior to gloving and preventing urinary bags/tubing from touching the floor.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct visual audits to ensure hand hygiene is taking place prior to gloving and that catheter bags/tubing are not touching the floor. Audits will be completed on 5 residents and 5 nurses a week x 8 weeks, then 3 resident's and 3 nurses a week x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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			plan of correction as indicated.	

3. During random observations on 9/16/24 at 3:45 p.m. and on 9/17/24 at 3:07 p.m., Resident 113 was observed in bed and his Foley catheter drainage bag was on the floor.

During random observations on 9/18/24 at 9:10 a.m., 10:51 a.m., 11:10 a.m., and 1:57 p.m., the resident was observed sitting in his wheelchair. At those times, the resident's catheter bag and tubing were observed on the floor under his wheelchair.

The record for Resident 113 was reviewed on 9/19/24 at 12:00 p.m. Diagnoses included, but were not limited to, stroke, chronic kidney disease, obstructive and reflux uropathy, benign prostatic hyperplasia, and retention of urine.

The 8/19/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had an indwelling catheter for urine.

Physician's Orders, dated 11/15/23, indicated Foley catheter 18 French with a 10 cubic centimeters (cc) balloon to gravity drainage.

The resident had no history of an urinary tract infection.

During an interview on 9/18/24 at 4:00 p.m., the Director of Nursing indicated she would be placing a leg bag on the resident to prevent the tubing from touching the floor.

The current and revised 2/14/19, "Urinary Catheter Care" policy provided by Assistant Director of Nursing 2 on 9/19/24 at 2:30 p.m., indicated urinary

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	drainage bags and tubing shall be positioned to prevent either from touching the floor directly. 3.1-18(b)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dirty and discolored floor tiles, marred walls, dirty and missing baseboards, broken mini blinds, dirty and rusty toilet bolts, missing toilet bolt covers, and caulk missing around the toilet for 3 of 3 units observed. (North, South and PCU) Findings include: During the environmental tour with the Maintenance and Housekeeping Supervisors on 9/20/24 at 3:23 p.m., the following was observed: 1. North Unit a. In Room 124, the floor in the room was discolored and had an accumulation of dirt and debris along the baseboard throughout the room. The left closet door was off the track. There was dirt and debris along the track of the closet door. The bathroom floor had dirt and debris along the base board. There was no trash can in the room. b. In Room 124, the entry way trim had build-up of dirt and debris. Behind the entry doorway there was a build-up of dirt and debris. The floor in the room had an accumulation of dust and debris on the floor and along the base board. The floor tile was scuffed.	F 0921	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Tag number: F921 Environmental I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice. Rooms 124, 127, 128, 201, 202, 213, 302, 313, 314, and 318 will have all necessary repairs completed by date of compliance. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	10/14/2024

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	c. In Room 127, the door to the room was marred along the edge, the floor in the room was dirty on left side of bed with dried food spillage and debris on the floor. The bathroom walls were scratched and marred, the floor was dirty and the tile was scuffed. d. In Room 128, the floor was dirty, with scuff marks throughout. The bathroom door was scratched and marred, the floor in the bathroom was dirty with an accumulation of dirt and debris along baseboard. The tiles were discolored and scuffed. The towel rack in the bathroom was broken off of the wall. The toilet bolts were dirty and rusty. The toilet bolt covers were missing. 2. South Unit a. In Room 201, the mini blinds were broken in multiple areas on the blind. b. In Room 202, the blinds were missing and broken. c. In Room 213, the wall next to the bed was marred and had dried spillage on the base of the tube feeding pump. The floor in the room with dirty and had debris present. The door to the bathroom was scratched and marred. The walls in the bathroom was marred. There were no toilet bolt covers for the toilet. The tile strip leading to the room had an accumulation of dirt buildup. 3. PCU a. In Room 302, the floor was scuffed and marred in the room and bathroom. The toilet had rusty toilet bolts, missing toilet bolt covers, and caulk missing around the toilet. The trim was missing to the entrance to the room.		action(s) will be taken; All resident rooms/common areas have the potential to be affected by the alleged deficient practice.The Maintenance Director/Housekeeping Supervisor performed a 100% audit of the facility regarding any needs for wall repair, cleaning of rooms and overall condition of each room. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;Administrator to re-educate Maintenance Director/Housekeeping Supervisor on ensuring Comfortable environment for all residents to include wall repairs, painting, cleanliness. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Maintenance director/designee will audit 5 resident rooms weekly for any necessary repairs. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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	b. In Room 313, the bathroom floor had discolored tile. The walls were marred in the room and bathroom. The toilet bolt covers were missing and the floor was dirty in the room. c. In Room 314, the bathroom were walls marred, the floor in the room was scuffed with black marks, the bathroom ceiling vent was dirty and dusty, the toilet bolts were rusty and missing the toilet bolt covers, there was dried urine by the rusty bolts and adhered dirt on the floor against the baseboard. d. In Room 318, the bathroom ceiling vent was dusty and dirty. During an interview with the Maintenance Director and the Housekeeping Supervisor on 9/20/24 at 3:23 p.m., they indicated they were aware of the issues with the environment and were working on it currently. This Federal tag relates to Complaint IN00436414. 3.1-19(f)			