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	155299	A. BUILDING 00 B. WING	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	5909 LUTE RD PORTAGE, IN 46368

(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. Survey dates: January 6, 7, 8, 9, and 10, 2025 Facility number: 000196 Provider number: 155299 AIM number: 100267390 Census Bed Type: SNF/NF: 56 SNF: 2 Total: 58 Census Payor Type: Medicare: 24 Medicaid: 27 Other: 7 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/17/24.	F 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Miller's Merry Manor Portage desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on, February 14, 2025. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on observation, record review, and interview, the facility failed to ensure the resident's responsible party was promptly notified after the development of a venous stasis foot ulcer (a wound caused by abnormal or damaged veins) for 1 of 1 resident reviewed for notification of change. (Resident 51) Finding includes:	F 0580	It is this facility's policy to notify a resident's responsible party of any change in condition. **I. <u>Specific Corrective Actions:</u>** The responsible party was immediately notified of the development of the venous stasis foot ulcer for Resident 51. **II. <u>Identification and correction</u>**	02/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rosemary Weeks	Executive Director	01/31/2025

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	During a wound treatment observation on 1/8/25 at 2:00 p.m., Resident 51 was observed lying in bed. At that time, the Assistant Director of Nursing (ADON) and RN 1 were in the room to complete the treatment for a venous ulcer on her foot. The open area on the left great toe was pink and red in color. A new area was identified on the bottom of her foot at that time, which was non-blanchable (an area of redness that does not fade when pressure was applied) and red with no drainage. The record for Resident 51 was reviewed on 1/7/25 at 1:35 p.m. The resident was admitted to the facility on 12/11/24. Diagnoses included, but were not limited to, atrial fibrillation, high blood pressure, and high cholesterol. The 12/18/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and had one venous ulcer. A Nursing-Assess Skilled Assessment, dated 12/15/24, indicated the resident had developed an open area to the left inner great toe that measured 0.8 centimeters (cm) by 0.5 cm. A Physician's Order, dated 12/15/24, indicated to monitor the open area to the left great toe daily until resolved and monitor for signs and symptoms of infection, increased pain, or unusual changes and report to physician. Cleanse the open area to the left great toe with wound cleanser, pat dry and put skin prep around the area and cover with a foam adhesive bandage every 3 days. There was no documentation the resident's family		**of others:** All residents with a change of condition were audited to ensure the responsible parties were notified of any change. **III. Systemic Changes:** All nursing staff will be in-serviced, by the compliance date or before their next shift, on the "Physician & Family Notification of Condition Change" policy. (Attachment A). **IV. Monitoring:** The DON or designee will audit: New/worsening wounds or changes in treatment via a QA Tool developed for monitoring (Attachment 1); 5 days a week x 4 weeks, then weekly for 4 weeks, then monthly for 4 more months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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	was notified on 12/15/24 of the development of the ulcer on the left great toe. During an interview on 1/9/25 at 4:00 p.m., the Director of Nursing (DON) indicated the staff nurse assessed the resident's open area on 12/15/24 and there was no documentation the resident's family was notified. The DON indicated the ADON, who was the Wound Nurse, notified the resident's family on 12/19/24 when she first assessed the wound and new orders were obtained. The 5/14/24 and current "Physician and Family Notification of Condition Changes" policy, provided by the DON on 1/10/25 at 11:08 a.m., indicated notify the resident and responsible party of any change in condition that may or may not warrant a change in treatment plan, including critical lab values, abnormal radiology, or diagnostic testing results. 3.1-5(a)(2)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances Based on record review and interview, the facility failed to file a grievance form for multiple complaints regarding pain, care, dignity, and room location that were reported by the resident to the Administrator for 1 of 1 resident reviewed for grievances. (Resident 32) Finding includes: During an interview on 1/7/25 at 9:48 a.m., Resident 32 indicated he had multiple complaints when he first arrived at the facility regarding pain medication, his bed, and how a nurse said to him	F 0585	It is this facility's policy to file a Concern/Grievance Record for any resident who has a concern that needs to be investigated and results reported back to the resident. **I. <u>Specific Corrective Actions:</u>** Resident 32's concerns were immediately placed on a Concern/Grievance Record form and given to the appropriate departments. **II. <u>Identification and correction</u>**	02/14/2025

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	"you ugly." The resident indicated he reported all of his concerns to the Administrator, but did not know if an official grievance had been written up for him. The record for Resident 32 was reviewed on 1/8/25 at 11:25 a.m. The resident was admitted to the facility on 12/6/24 and diagnoses included, but were not limited to, fracture of the right tibia, end stage renal disease, dependence on renal dialysis, heart failure, high blood pressure, type 2 diabetes, diabetic neuropathy, major depressive disorder, and anxiety. The 12/13/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. During an interview on 1/9/25 at 10:10 a.m., the Administrator indicated the resident had some concerns and she wrote them down on yellow ledger paper. He had concerns about his pain medication and not being able to have it, a nurse calling him "ugly", wanting his door closed and wanting to move to the other bed in his room. The Administrator indicated she investigated all his concerns, however, failed to document them on a grievance form. There was also no follow up documentation regarding a resolution with the resident. The current 11/17/16 "Grievance Procedure" policy provided by the Administrator on 1/9/25 at 1:00 p.m., indicated residents were encouraged to speak to any staff member whenever their expectations of care and service were not met so immediate action could be taken. The facility would investigate, act upon, and resolve to the best of their ability the resident or family concern.		**of others:** All Concern/Grievance Records were reviewed for proper follow through. **III. Systemic Changes:** All staff will be in-serviced, by the compliance date or before their next shift on the “Grievance Procedure” (Attachment B) and the “Concern/Grievance Record” (Attachment C). **IV. Monitoring:** The Social Service Director or designee will audit the Concern/Grievance forms (Attachment 2) for proper follow through 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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F 0677 SS=D Bldg. 00	3.1-7(a)(2) 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 not providing showers twice a week for 3 of 4 residents reviewed for ADLs (Residents 24, 40, and 8), and not providing oral care for 2 of 2 residents with a feeding tube reviewed for ADLs. (Residents 24 and 40) Findings include: 1. During an interview on 1/6/25 at 11:24 a.m., Resident 24 indicated she was supposed to be getting showers twice a week, but was not. She had a feeding tube (a tube inserted through the abdominal wall into the stomach) and no one had brushed her teeth (dentures) or helped her clean her mouth since she was admitted to the facility on 12/8/24. During an interview on 1/7/25 at 1:30 p.m., the resident indicated not getting a shower had been an ongoing problem. She wanted to shower and brush her teeth. At that time, she appeared disheveled, wearing the same clothing as observed on 1/6/25. On 1/8/25 at 11:04 a.m., the resident was observed resting in bed. Her hair appeared greasy and uncombed, and she was wearing the same clothing as on 1/6/25 and 1/7/25. The record for Resident 24 was reviewed on 1/7/25 at 3:08 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease	F 0677	It is this facility's policy to provide ADL care for dependent residents per their preference to maintain good nutrition, grooming, and personal and oral hygiene. **I. Specific Corrective Actions:**: Showers were immediately provided for the residents who missed their showers and oral care was provided to the residents with a feeding tube. **II. Identification and correction of others:** All residents were reviewed for showers and oral care and provided for any residents who missed a shower or oral care. **III. Systemic Changes:** All nursing staff were reeducated regarding following the shower schedule and providing oral care to all residents (Attachment D "Bath Shower" and Attachment E "Oral Care"). **IV. Monitoring:** The DON or designee will audit the shower schedule and oral care (Attachment 3 and 4) 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking.	02/14/2025

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	(COPD), diabetes, heart disease, cancer of the stomach, and chemotherapy. The 12/15/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, required supervision/touching assistance with oral hygiene, maximal assistance with shower/bathing, and moderate assistance with transferring. A Care Plan, dated 12/8/24, indicated the resident required moderate to maximum assistance with ADLs due to hospitalization for nausea, pancreatic mass, and weakness. The Care Plan indicated the resident had a feeding tube and full dentures. The approaches included encouraging oral care twice a day and assisting as needed. The facility's shower schedule indicated the resident was to receive showers on Tuesday and Friday. The Task List indicated the resident did not receive or refuse a bath or shower on 12/24/24, 12/31/24, and 1/7/25. A Physician's Order, dated 12/8/24, indicated the nurse was to provide mouth care every shift. During an interview on 1/9/25 at 11:25 a.m., LPN 1 indicated he documented on the treatment record that he provided mouth care which meant he looked in the resident's mouth for broken or missing teeth, and would offer oral swabs if needed, but the resident hadn't needed anything. He indicated the CNAs should brush the residents' teeth. During an interview on 1/9/25 at 1:50 p.m., the Director of Nursing (DON) indicated the resident		After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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	should have received a shower every Tuesday and Friday, but she did not. Mouth care should include cleaning or swabbing the mouth and/or brushing the teeth, and the CNAs and nurses should have completed or assisted the resident with this task. 2. During an interview on 1/6/25 at 2:08 p.m., Resident 40 indicated she was not getting bathed twice a week. She had a feeding tube (a tube inserted through the abdominal wall into the stomach) and the staff had not been cleaning her mouth. On 1/7/25 at 2:22 p.m., the resident was observed resting in bed. Her hair was uncombed, and she was wearing the same clothing as on 1/6/25. On 1/8/25 at 1:55 p.m., the resident was observed resting in bed, appeared disheveled with crumbs on her shirt, uncombed hair, and was wearing the same clothing as on 1/6/25 and 1/7/25. At that time, she indicated she wanted a bath and still had not been offered assistance with mouth care. During an interview on 1/10/25 at 10:20 a.m., the resident indicated the staff finally cleaned her up on 1/9 and helped her clean her mouth for the first time, and it felt good. The record for Resident 40 was reviewed on 1/8/25 at 2:29 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness on one side of the body) following a stroke, dysphagia (difficulty swallowing), feeding tube, rheumatoid arthritis, and gout. The 11/30/24 Admission Minimum Data Set (MDS) assessment indicated the resident was			

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	cognitively intact for daily decision making, required moderate assistance with oral hygiene, dependent/total assistance with showering/bathing, and maximal assistance with transferring. A Care Plan, dated 11/30/24, indicated the resident required maximum/total assistance with ADLs due to a stroke resulting in left-sided weakness. The Care Plan indicated the resident had a feeding tube. The approaches included encouraging oral care twice a day and assisting as needed. The facility's shower schedule indicated the resident was to receive showers on Tuesday and Friday. The Task List indicated the resident did not receive or refuse a bath or shower on 12/17/24, 12/24/24, and 1/7/25. The record lacked documentation of mouth care. During an interview on 1/9/25 at 1:50 p.m., the Director of Nursing (DON) indicated the resident should have received a shower every Tuesday and Friday, but she did not. The CNAs and nurses should have completed or assisted the resident with mouth care, but she was not sure where or if the CNAs documented mouth care. No further information was received. 3. During an interview on 1/6/25 at 11:10 a.m., Resident 8 indicated she was not getting showers as frequently as she should. During an interview on 1/9/25 at 8:40 a.m., the resident indicated she was supposed to get a shower the previous day, but they did not have enough staff.			

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	The record for Resident 8 was reviewed on 1/9/25 at 10:46 a.m. Diagnoses included, but were not limited to, heart failure, type 2 diabetes, dementia, and depression. The 11/11/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, required moderate assistance with showering/bathing, and moderate assistance with transferring. A Care Plan, dated 11/22/24, indicated the resident required moderate assistance with ADLs due to heart failure, aortic stenosis, and anemia. A Nurse's Note, dated 11/22/24, indicated the resident was not on the shower schedule, and stated she had not had a shower. The facility's shower schedule indicated the resident was to receive showers on Wednesday and Saturday. The Task List indicated the resident did not receive or refuse a bath or shower on 12/11/24, 12/14/24, 12/18/24, 12/21/24, and 1/8/25. During an interview on 1/9/25 at 1:50 p.m., the DON indicated the resident should have been getting showers twice a week, and she was not informed the resident told a nurse she was not getting them. 3.1-38(a)(3) 3.1-38(a)(3)(C)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure signs and symptoms of constipation were addressed for 1 of	F 0684	It is the policy of this facility to provide quality care in relation to all treatments and care provided to	02/14/2025

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	1 resident reviewed for constipation, residents were transported and arrived to physician visits on time and heels were floated for non-pressure ulcers for 2 of 6 residents reviewed for non-pressure skin conditions, and insulin was administered as ordered for 1 of 5 residents reviewed for unnecessary medications. (Residents 7, 32, and 51) Findings include: 1. During an interview on 1/6/25 at 2:10 p.m., Resident 7 indicated she had issues with constipation. The record for Resident 7 was reviewed on 1/8/25 at 10:30 a.m. The resident was admitted to the facility on 5/24/24. Diagnoses included, but were not limited to, stroke, chronic kidney disease, Alzheimer's disease, high blood pressure, anxiety, and constipation. The 11/29/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and was always incontinent of bowel, but not on a bowel program. A Care Plan, dated 5/24/24, indicated the resident had the potential for constipation. The interventions were to administer laxatives and/or stool softeners as ordered and monitor for signs and symptoms of constipation. A Physician's Order, dated 6/19/24, indicated Polyethylene Glycol 3350 Powder (a laxative), give 17 grams by mouth every 24 hours as needed for constipation. The resident's bowel movement flow sheet indicated the resident had no documented bowel		our Residents and in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. **I. <u>Specific Corrective Actions:</u>** Resident 7's constipation was treated per policy. Resident 32's physician visit was rescheduled and completed. The residents' heels were immediately floated. The insulin was administered as ordered for Resident 32. **II. <u>Identification and correction of others:</u>** All residents on the BM list were reviewed for proper treatment. Residents with scheduled physician visits were reviewed for timely completion. Residents with non-pressure ulcers were reviewed for proper floating of heels. No other residents were on insulin. **III. <u>Systemic Changes:</u>** The "Bowel Elimination" policy (Attachment F) and Insulin Administration protocol (Attachment G – Injection-Subcutaneous) was reviewed with nursing. A dedicated van driver was hired and the process to ensure physician visits occurred timely was reviewed with this driver and the back up Maintenance assistant. The policy regarding floating of heels (Attachment H – Skin Mngt Program) was reviewed with nursing and blue square heel devices will be purchased to help	

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	movements on 10/26-10/29/24, 11/28-12/1/24, 12/29/24-1/1/25, and 1/3-1/5/25. A Nursing Note, dated 10/29/24 at 1:30 p.m., indicated the Polyethylene Glycol powder was administered to the resident for complaints of constipation. A Nursing Note, dated 10/30/24 at 1:36 a.m., indicated the resident's results for the complaints of constipation were unknown. A Nursing Note, dated 11/28/24 at 10:15 p.m., indicated the Polyethylene Glycol Powder was administered for complaints of constipation. A Nursing Note, dated 11/29/24 at 6:57 a.m., indicated the resident's results for the complaints of constipation were unknown. A Nursing Note, dated 12/5/24 at 11:27 a.m., indicated the Polyethylene Glycol Powder was administered for complaints of constipation. A Nursing Note, dated 12/5/24 at 10:24 p.m., indicated the resident's results for the complaints of constipation were ineffective. A Nursing Note, dated 1/1/25 at 9:46 a.m., indicated the Polyethylene Glycol Powder was administered for complaints of constipation. A Nursing Note, dated 1/2/25 at 9:39 a.m., indicated the resident's results for the complaints of constipation were ineffective. During an interview on 1/9/25 at 3:00 p.m., the Director of Nursing had no additional information to provide.		trigger the proper floating of heels. **IV. <u>Monitoring:</u>** The DON, Administrator or designee will review the BM list (Attachment 3), and residents with non-pressure ulcers (Attachment 1) for proper treatment/administration; and the physician visit schedule will be reviewed for timely visits (Attachment 5); 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. There are no other residents on insulin. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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	The current 1/3/2001 "Bowel Elimination" policy, provided as current by the DON on 1/9/25 at 2:34 p.m., indicated if a resident complained of constipation or at least on the third day with no bowel movement, an ordered bowel aide or stool softener would be administered. If within eight hours of administering the bowel aide or softener, the resident has not had a bowel movement, another bowel aide would be administered. If within another 8 hours the resident has not had a bowel movement, the nurse will do an abdominal assessment, and notify the physician. 2. During an interview on 1/7/25 at 10:02 a.m., Resident 32 indicated he had arrived at his orthopedic surgeon's appointment late so he was unable to see him as the doctor had left for surgery. The record for Resident 32 was reviewed on 1/8/25 at 11:25 a.m. The resident was admitted to the facility on 12/6/24 and diagnoses included, but were not limited to, fracture of the right tibia, type 2 diabetes, and diabetic neuropathy. The 12/13/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Nursing Transfer to Appointment Form, dated 12/19/24 at 2:10 p.m., indicated the resident left per facility van to (physician name) orthopedic appointment. A Nursing Note, dated 12/19/24 at 3:35 p.m., indicated the resident had returned from the scheduled appointment per the facility van. During an interview on 1/9/25 at 10:20 a.m., a			

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	maintenance associate indicated he was hired to drive the residents to appointments part time and also to work in maintenance the rest of his time. On 12/19/24, he had to take another resident to an appointment around the same time as Resident 32 needed to be at an appointment. His plan was to take the other resident a little bit earlier and then be back in enough time to get Resident 32. The resident's appointment was at 2:10 p.m., they arrived at 2:30 p.m. (20 minutes late) and the physician had already left the office for surgery, so he missed the appointment. He indicated there was no back up plan and he did not call his supervisor to let him know he was not going to make it back in time to get Resident 32 to the appointment on time. During an interview on 1/9/25 at 1:10 p.m., the Director of Nursing (DON) indicated she was aware the resident missed his appointment for the orthopedic surgeon on 12/19/24. The facility van was used to transport the residents to their appointments. A Physician's Order, dated 12/7/24, indicated Insulin Lispro Injection, inject 10 units subcutaneously (delivers medication into the fatty tissue beneath the skin) three times a day for diabetes. The 12/2024 and 1/2025 Medication Administration Records, indicated the Lispro Insulin administration times were 7:30 a.m., 11:30 a.m., and 4:30 p.m. On the resident's dialysis days of Monday, Wednesday, and Friday a "2" was coded (LOA without meds) for the 11:30 a.m. administration. During an interview on 1/9/25 at 4:00 p.m., the DON indicated the Lispro insulin times should not			

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	have conflicted on dialysis days. The current 11/2/16 "Van Transportation Program" policy, provided by the Administrator as current on 1/9/25 at 11:00 a.m., indicated the facility would offer transportation services for residents of the facility to include, but not limited to, physician appointments. The facility would work with local transportation companies for back up transportation services. 3. During random observations on 1/7/25 at 1:31 p.m. and on 1/8/25 at 9:45 a.m. and 10:27 a.m., Resident 51 was observed in bed. At those times, both of her heels were laying flat on the bed and not floated. On 1/8/25 at 2:00 p.m., the resident was in bed and her heels were not floated. The Assistant Director of Nursing and RN 1 performed the wound treatment to her left great toe. The open area on the left great toe was pink and red in color. A new area was identified on the bottom of her foot at that time, which was non blanchable (an area of redness that does not fade when pressure was applied) and red with no drainage. After the completion of the treatment, they covered the resident with the bed linens and left the room. Both of her heels were observed flat on the bed and not floated. At 3:30 p.m., the resident was observed in bed and both heels remained flat on the bed. The record for Resident 51 was reviewed on 1/7/25 at 1:35 p.m. The resident was admitted to the facility on 12/11/24. Diagnoses included, but were not limited to, atrial fibrillation, high blood pressure, and high cholesterol.			

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	The 12/18/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and had one venous ulcer. A Care Plan, dated 12/17/24, indicated the resident developed an arterial wound to the left great toe. The approaches were to float heels off of the bed. A wound measurement, dated 12/30/24, indicated the left great toe venous ulcer measured 0.5 centimeters (cm) by 0.5 cm. and was stable. A Nursing Note, dated 1/8/25 at 2:38 p.m., indicated the physician was notified of a non-blanching red area with some maceration (skin softening) that measured 1.4 cm in length by 2.2 cm in width over the bunion area. The new area was not present on the last assessment. During an interview on 1/9/25 at 1:10 p.m., the Director of Nursing had no additional information to provide. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review, and interview, the facility failed to assist a resident with eating, monitor nutritional intake for meals, obtain readmission and post dialysis weights, and provide breakfast before dialysis for residents with a history of significant weight loss for 2 of 2 residents reviewed for nutrition. (Residents 19 and 32) Findings include:	F 0692	It is the policy of this facility to provide assisted nutrition and hydration to maintain acceptable parameters of nutritional status, offer sufficient fluid intake and offer a therapeutic diet where indicated. **I. Specific Corrective Actions:** Resident 19 was immediately offered assistance at subsequent meals. Nutritional intake is now being monitored for resident 19.	02/14/2025

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	1. During a random observation on 1/6/25 at 1:52 p.m., Resident 19 was observed in bed. Her lunch tray was in front of her and untouched. There was a spoon in her pudding and nothing else had been touched on the tray. There was no staff in the area assisting the resident. On 1/9/25 at 8:29 a.m., the resident was observed in bed and her breakfast tray was delivered to her and placed on the over bed table. The resident's eyes were closed, and CNA did not attempt to wake her up or assist her to eat. She just left the meal on the tray table and left the room. The resident was served cold cereal, one serving of scrambled eggs, one piece of raisin toast, and apple juice. At 8:39 a.m., the Admission Coordinator entered the room and closed the door. Upon leaving the room, the resident was awake and was observed holding a spoon in her hand. At 9:00 a.m., the resident had not eaten any of her breakfast meal. The resident indicated she was hungry, however, there was no staff in the area to help her eat. On 1/9/25 at 1:04 p.m., the resident was observed in bed with her eyes closed and her lunch tray in front of her on the over bed table. No staff were observed in or around the room to assist the resident to eat. No food had been eaten as it was untouched. The record for Resident 19 was reviewed on 1/7/25 at 2:10 p.m. The resident was admitted to the facility on 8/20/24 and diagnoses included, but were not limited to, stroke, hemiplegia, aphasia, dysphagia (difficulty swallowing), and peg tube (a tube inserted directly into the stomach for nutrition). The resident was admitted to the hospital on		Resident 32 discharged prior to receiving these results. Resident 32 received breakfast prior to dialysis until discharge. Readmission weights are being obtained. Resident 32 discharged prior to these results regarding post dialysis weights. **II. <u>Identification and correction of others:</u>** All residents are being monitored for the need of assistance during meals. Nutritional intake is being monitored for any resident with significant weight loss. Weights are being obtained for any readmission. Any new residents on dialysis will have post dialysis weights obtained from the Dialysis Company and meals will be coordinated based on his/her dialysis schedule to avoid missing meals. **III. <u>Systemic Changes:</u>** Nursing will be in-serviced regarding assisting residents with meals as needed, monitoring intake, obtaining readmission weights and the protocol for residents on dialysis regarding meals and post dialysis weights. (Attachment I – Point of Care Documentation & Legends). **IV. <u>Monitoring:</u>** The DON, Administrator or designed will ensure: Rounds at mealtime occur to ensure residents who need assistance are being helped (Attachment 6); nutritional intake logs are	

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	12/23/24 and returned to the facility on 12/31/24. She was sent out to the hospital on 1/2/25 and returned on 1/3/25. A new Significant Change Minimum Data Set (MDS) assessment was currently in progress. The 11/14/24 Significant Change MDS assessment indicated the resident was not cognitively intact for daily decision making and weighed 316 pounds, with no significant weight loss. The resident had a peg tube and only needed set up or clean up assistance for eating. A Care Plan, dated 8/27/24, indicated the resident was at nutritional risk related to tube feeding, recent hospitalization and weight fluctuations. The approaches were to serve double protein at breakfast and monitor weights and intakes. A Physician's Order, dated 9/19/24, indicated the resident was to receive a mechanical soft carb controlled diet. The weight record indicated the following weights: - 11/5/24 the resident weighed 317 pounds - 12/8/24 the resident weighed 280 pounds - 12/16/24 the resident weighed 272 pounds. There were no other weights documented for the rest of 12/2024 and on 1/3/25. A Registered Dietitian (RD) Narrative Note, dated 12/11/24, indicated the resident had a significant weight loss in the last 30 days. The note recommend resuming the enteral feeding and running it through the night. A Physician's Order, dated 12/13/24, indicated		monitored (Attachment 3); readmission weights are obtained (Attachment 6); and any new dialysis residents are monitored for receiving meals and having post dialysis weights (Attachment 3). This monitoring will occur 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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	Glucerna 1.583 milliliters (ml) times 12 hours, on at 6:00 p.m. and off at 6:00 a.m. Flush the peg tube with 120 ml of water three times a day. There were no other RD notes available for review. The meal consumption log indicated there was no documentation on 1/6/25 for dinner, 1/7/25 and 1/8/25 for breakfast and lunch. Hospital discharge notes, dated 12/31/24, indicated the resident weighed 314 pounds before leaving the hospital. A weight obtained on 1/7/25 indicated the resident weighed 302 pounds. During an interview on 1/9/25 at 1:04 p.m., CNA 3 indicated the resident was able to feed herself. The CNA was questioned about that statement, as the resident had been observed not eating or able to feed herself. The CNA indicated again she was able to feed herself. During an interview on 1/9/25 at 3:00 p.m., the Director of Nursing (DON) indicated there were no readmission weights documented after the resident returned from the hospital. There had been no assessments by the RD since the hospital returns and 12/11/24 was the most recent. The resident was in need of assistance during meals. The 3/2/16 "Enteral/Parental Nutrition" policy provided by the DON on 1/9/25 at 2:34 p.m., indicated for existing enteral nutrition orders, the Dietary Manager (DM) would review the weight at least monthly and notify the consultant dietitian of concerns. The DM would report any other pertinent concerns to the dietitian. The dietician			

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	would review and evaluate all residents receiving enteral nutrition for adequacy. 2. During an interview on 1/7/25 at 9:57 a.m., Resident 32 indicated he only sometimes received breakfast prior to dialysis on Monday, Wednesday, and Friday. He did not take a lunch and was not given a snack before he left. His chair time was at 9:00 a.m. He usually left the facility around 8:30 a.m. and arrived back to the facility between 2:30 p.m. and 3:00 p.m. He indicated he was very hungry when he returned to the facility. The record for Resident 32 was reviewed on 1/8/25 at 11:25 a.m. The resident was admitted to the facility on 12/6/24 and diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, and type 2 diabetes. The 12/13/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident received dialysis while at the facility and weighed 208 pounds with no significant weight loss. A Care Plan, dated 12/7/24, indicated the resident was at nutritional risk related to hemodialysis. The approaches were to serve double protein at breakfast and monitor weights and intakes. The resident's current weight as of 12/28/24 was 209 pounds. A Physician's Order, dated 12/6/24, indicated to serve a 3 to 4 gram sodium carb controlled diet with no orange juice, bananas, tomatoes, and potatoes.			

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	A Registered Dietitian (RD) Assessment, dated 12/10/24, indicated the resident's weight was stable but she suggested weekly weights, same day, post dialysis. There were no other RD notes available for review. There were no post dialysis weights available for review on 12/20/24, 12/30/34 and 1/8/25. The meal consumption log indicated there was no total food consumption for breakfast and lunch on 1/5/25, 1/7/25, and 1/8/25. There was no dinner food consumption documented on 12/22/24, 12/28/24, 12/31/24, and 1/6/25. During an interview on 1/9/25 at 10:20 a.m., a maintenance associate indicated he was hired to drive the residents to appointments part time and also to work in maintenance the rest of his time. He transported the resident to dialysis every Monday, Wednesday and Friday. He usually went down to the resident's room by 8:15 a.m. to make sure the resident was up because he wanted to leave at 8:30 a.m. to make sure he got there on time. The majority of the time, he had not eaten breakfast and did not get breakfast before they left. During an interview on 1/9/25 on 10:43 a.m., the Dietary Food Manager indicated she had a board in the kitchen and his name was on it for early breakfast. His breakfast was prepared every Monday, Wednesday and Friday, but the CNA did not come and pick it up. She has told nursing that a CNA had to come and pick up the tray to serve it to him. During an interview on 1/9/25 at 1:10 p.m., the			

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	Director of Nursing (DON) indicated she was not aware the resident was not receiving his breakfast tray. Food consumption totals were to be completed after every meal and post dialysis weights were not documented on post dialysis sheets from the dialysis center. 3.1-46(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 1 of 1 resident reviewed for oxygen. (Resident 36) Finding includes: On 1/7/25 at 9:46 a.m. and 1:19 p.m., Resident 36 was observed in his room in bed with oxygen by the way of a nasal cannula in use. The oxygen concentrator was set at 3 liters. On 1/8/25 at 8:17 a.m., 11:35 a.m., and 2:04 p.m., the resident was again observed in his room in bed. His oxygen was in use and the oxygen concentrator was set at 3 liters. On 1/9/25 at 8:28 a.m., the resident was in his room eating breakfast. His oxygen was in use and the oxygen concentrator was set at 3 liters. At 8:37 a.m., the Nurse Case Manager confirmed the oxygen concentrator was set at 3 liters. The record for Resident 36 was reviewed on 1/8/25 at 11:29 a.m. Diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease (COPD).	F 0695	It is the policy of this facility to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards, the person-centered care plan and the resident's goals and preferences. **I. Specific Corrective Actions:** Resident 36's oxygen liter flow was immediately adjusted to the correct liter flow when it was observed to be at an incorrect flow rate. **II. Identification and correction of others:** All residents on oxygen were reviewed to ensure their oxygen was set at the correct flow rate per the physician's order. **III. Systemic Changes:** All nursing staff were in-serviced to ensure any resident on oxygen is set at the correct liter flow; erasable stickers will be utilized to indicate what the liter flow should be to make it easier to check. **IV. Monitoring:** The DON or designee will do	02/14/2025

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	The Quarterly Minimum Data Set (MDS) assessment, dated 10/18/24, indicated the resident was cognitively intact for daily decision making and he received oxygen therapy. A Care Plan, dated 10/19/24, indicated the resident had intermittent congestion. Interventions included, but were not limited to, administer oxygen as ordered. A Physician's Order, dated 4/16/24 and listed as current on the January 2025 Physician's Order Summary (POS), indicated the resident was to receive oxygen at 2 liters per minute per nasal cannula continuously for chronic respiratory failure. During an interview on 1/9/25 at 1:35 p.m., the Director of Nursing indicated the resident's oxygen concentrator was set at the incorrect flow rate. 3.1-47(a)(6)		rounds to ensure oxygen liter flows are set correctly (Attachment 4) 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, record review and interview, the facility failed to ensure a resident's pain was managed and monitored for 1 of 1 resident reviewed for pain. (Resident 32) Finding includes: During an interview on 1/7/25 at 9:44 a.m., Resident 32 indicated he went four days without pain medications when he first was admitted to the facility. The record for Resident 32 was reviewed on 1/8/25	F 0697	It is the policy of this facility to provide pain management to our residents in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. **I. <u>Specific Corrective Actions:</u>** Resident 32 has discharged from the facility. **II. <u>Identification and correction of others:</u>**	02/14/2025

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	at 11:25 a.m. The resident was admitted to the facility on 12/6/24 and diagnoses included, but were not limited to, fracture of the right tibia, high blood pressure, diabetic neuropathy, and anxiety. The 12/13/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident received an opioid medication in the last 7 days. He received PRN (as needed) pain medication and had pain almost constantly in the last 5 days that had frequently affected his sleep, interfered with therapy, and day to day activities. The resident rated his pain a 10 out of 10. A Care Plan, dated 12/11/24, indicated the resident was at risk for complications related to healing from right tibia fracture. The approaches were to monitor for pain and give pain medications as ordered. A Care Plan, dated 12/7/24, indicated the resident had the potential for pain and discomfort related to right tibia fracture. The goal was for the resident's pain to be controlled at an acceptable level. The approaches were to notify the physician as needed, administer pain medications as ordered, acknowledge the presence of pain and discomfort, and listen to the resident's concerns. A hospital note, dated 11/25/24, indicated the patient was brought in by his sons for a change in mental status. The patient had gone to an urgent care the previous day and was found to have a tibia/fibula (lower leg bones) fracture, placed in a splint, and was sent home with Norco (a narcotic pain medication). The family did not know how much he took or how he fractured his foot. The resident was given Narcan (temporarily reverse the effects of an opioid medicine) while in the		All residents were reviewed for complaints of pain to ensure appropriate management. **III. <u>Systemic Changes:</u>** All nursing staff were in-serviced on the “Pain Management Program” policy (Attachment J). **IV. <u>Monitoring:</u>** The DON or designee will monitor residents for pain and appropriate management per a developed QA Tool (Attachment 7); 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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	emergency room, as a blood test indicated he had opiates in his system. On 12/3/24, the resident had surgery for an open reduction internal fixation of the right distal tibia and distal fibula fractures with repair of the medial collateral ligament (ligament in the knee that connects the thigh bone to the shin bone). During his hospital stay he received Dilaudid (a narcotic used for severe pain) intravenously (IV) and also received Norco 7.5-325 milligrams (mg) 1 or 2 tablets every 4 hours. A Physician's Order, dated 12/6/24, indicated Acetaminophen Tablet 325 mg, give two tablets by mouth every 4 hours as needed for mild pain. The resident's pain levels (on a scale from 1-10 with 10 being the highest) were as follows: - 12/7/24 at 11:16 p.m. an 8 - 12/8/24 at 3:30 a.m., a 6 - 12/8/24 at 9:46 a.m., and 12:53 p.m. an 8 - 12/9/24 at 8:21 a.m., 3:41 p.m., and 11:45 p.m., a 7 - 12/10/24 at 10:04 a.m., an 8 A Nursing Note, dated 12/8/24 at 8:38 a.m., indicated Acetaminophen Tablet 325 mg, 2 tablets was administered to the resident for complaints of pain. A follow up assessment at 9:46 a.m., indicated the pain medication was ineffective as his pain level was an 8. There was no communication with the physician in regards to the resident's complaints of severe pain with levels between 6-8 from 12/7-12/10/24. A Nursing Note, dated 12/10/24 at 2:29 p.m., indicated the physician was finally notified of the resident's pain level and Norco 5-325 mg every 6 hours PRN for pain was ordered for the resident.			

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	During an interview on 1/9/25 at 1:10 p.m., the Director of Nursing (DON) indicated the resident, as well as his sons, came to her and spoke about his pain medication on 12/10/24. She notified the physician (Medical Director) and asked him for the Norco, however, the physician was hesitant because of the condition he was brought into the ER and having to have Narcan. She was not made aware the resident was having a lot of pain prior to 12/10/24 and the nursing staff should have notified the physician over the weekend or before 12/10/24. The current 4/10/24 "Pain Management Program" policy, provided by the DON on 1/9/25 at 2:34 p.m., indicated it was the goal of the facility to assist residents in achieving their optimal level of comfort by providing an effective pain management program. Assess pain by using the following scale, mild pain 1-3, mild moderate pain 3-5, moderate severe 5-7, severe to unbearable 7-9, and worst pain ever a 10. 3.1-37(a)			
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 ensure each resident's medication regimen was managed and monitored related to not monitoring the resident's blood pressure for medications with blood pressure parameters for 2 of 5 residents reviewed for unnecessary medications. (Residents 21 and 29) Findings include: 1. The record for Resident 21 was reviewed on	F 0757	It is this facility's policy to ensure each resident's drug regimen is free from unnecessary drugs. **I. <u>Specific Corrective Actions:</u>** Both residents' orders were reviewed and it was ensured parameters were checked and followed to avoid unnecessary medications were given. **II. <u>Identification and correction of others:</u>**	02/14/2025

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	1/9/25 at 2:07 p.m. Diagnoses included, but were not limited to, dementia and hypertension. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 12/8/24, indicated the resident had severe cognitive impairment. A Physician's Order, dated 12/1/24, indicated to give Midodrine (a medication that treats low blood pressure) 2.5 milligrams (mg) two times a day, hold for blood pressure greater than 120/80. The record lacked any documentation of blood pressure monitoring for 12/4/24, 12/5/24, 12/6/24, 12/10/24, 12/14/24, 12/16/24, 12/24/24, 12/25/24, 1/3/25, 1/6/25, and 1/7/25. Blood pressures were only documented once per day on 12/1/24, 12/7/24, 12/9/24, 12/11/24, 12/12/24, 12/13/24, 12/15/24, 12/17/24, 12/18/24, 12/19/24, 12/20/24, 12/21/24, 12/22/24, 12/23/24, 12/26/24, 12/27/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/2/25, 1/4/25, 1/5/25, and 1/8/25. During an interview on 1/10/25 at 10:30 a.m., LPN 1 indicated the resident's blood pressure should be checked before each dose of a medication with a parameter, but he did not always document the blood pressure unless he was holding the medication because the unit was so heavy. 2. The record for Resident 29 was reviewed on 1/8/25 at 11:25 a.m. Diagnoses included, but were not limited to, dementia, heart attack, and atrial fibrillation (irregular heart rhythm). The Significant Change Minimum Data Set (MDS) assessment, dated 11/7/24, indicated the resident had moderate cognitive impairment.		All residents were reviewed for orders with parameters to ensure medication was administered per criteria. **III. <u>Systemic Changes:</u>** All nursing staff were in-serviced on the “New Order Transcription” policy (Attachment K). **IV. <u>Monitoring:</u>** The DON or designee will monitor residents for orders with parameters and that they are being followed, per a developed QA Tool (Attachment 8); 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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	A Physician's Order, dated 7/24/24, indicated to give Metoprolol Tartrate (a blood pressure medication) twice a day, hold if the blood pressure was below 100/60. The record lacked any documentation of blood pressure monitoring for 12/1/24, 12/2/24, 12/3/24, 12/4/24, 12/6/24, 12/7/24, 12/8/24, 12/9/24, 12/10/24, 12/11/24, 12/13/24, 12/14/24, 12/15/24, 12/16/24, 12/17/24, 12/18/24, 12/20/24, 12/21/24, 12/22/24, 12/23/24, 12/24/24, 12/25/24, 12/27/24, 12/28/24, 12/29/24, 12/30/24, 12/31/24, 1/1/25, 1/3/25, 1/4/25, 1/5/25, and 1/6/25. Blood pressures were only documented once per day on 12/5/24, 12/9/24, 12/12/24, 12/19/24,12/26/24, 1/2/25, and 1/7/25 During an interview on 1/10/25 at 10:42 a.m., the Director of Nursing indicated vitals should be taken and documented with each scheduled dose of a medication with parameters. 3.1-48(a)(3)			
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 8 residents observed during medication pass. Three errors were observed during 25 opportunities for errors during medication administration. This resulted in a medication error rate of 12%. (Residents 6 and 1) Findings include: 1. During medication administration on 1/8/25 at 8:37 a.m., LPN 2 was observed preparing medications for Resident 6. The LPN dispensed	F 0759	It is this facility's policy to ensure the medication error rates are less than 5 percent. **I. <u>Specific Corrective Actions:</u>** Both resident 6 and 1 had their medication orders reviewed and LPNs 1 and 2 were re-educated to ensure proper administration of medications in future. **II. <u>Identification and correction of others:</u>** All residents were reviewed for proper administration of medication.	02/14/2025

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	one Potassium Chloride 20 milliequivilant (meq) Extended Release tablet into the medication cup. The LPN added four more medications to the medication cup and then proceeded to place another Potassium Chloride tablet into the cup, the LPN locked the medication cart and computer screen and proceeded to the resident's room. Prior to giving the medications, the LPN was asked to check the resident's Potassium Chloride order. The LPN indicated the resident was to receive 20 meq of Potassium Chloride. When asked how many pills the resident should be receiving, she indicated 11. When the pills were counted, 12 pills were present in the medication cup. During an interview at that time, LPN 2 indicated the resident was to receive only one Potassium Chloride tablet and an extra pill was included in the resident's roll of AM medications. 2. On 1/9/25 at 8:45 a.m., LPN 1 was observed preparing Resident 1's medications. The LPN poured 7.5 milliliters (ml) of Potassium Chloride into a medication cup. The LPN then prepared Omeprazole (a medication used to treat gastric reflux disease) 20 milligram (mg), Acidophilus (a probiotic) capsule, Baclofen (a muscle relaxer) 10 mg, Glucosamine capsule (a joint medication), and Levothyroxine (a thyroid medication) 75 microgram (mcg). Each pill was crushed into a separate medication cup and diluted with water. The Potassium Chloride liquid was not diluted. The LPN proceeded to Resident 1's room to administer the medications. The resident's medications were going to be given by the way of a gastrostomy tube (a tube inserted through the abdominal wall into the stomach). One of the		**III. Systemic Changes:** All nursing staff were in-serviced on the "Enteral - Medication Administration" policy (Attachment L). **IV. Monitoring:** The DON or designee will observe 3 medication passes per day (Attachment 8); 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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	medication cups which contained a diluted medication was knocked over. The LPN placed the cup upright and stated, "it was mostly water that spilled." During an interview at that time, the LPN indicated he did not know which medication was spilled because they were all diluted. He then proceeded to administer each medication separately. The resident's Potassium Chloride was not diluted prior to administering. During an interview on 1/10/25 at 11:30 a.m., the Director of Nursing indicated Resident 1's Potassium Chloride should have been diluted and it couldn't be ensured the resident received the correct dose of the medication that was knocked over. She also indicated medication rolls should be reviewed to make sure extra pills weren't included. 3.1-48(c)(1)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to food not labeled and dated for 1 of 1 kitchen. (The Main Kitchen) This had the potential to affect all residents receiving food from the kitchen. Findings include: During the Initial Kitchen Sanitation Tour on 1/6/25 at 8:57 a.m., with the Assistant Kitchen Manager, the following was observed: a. There was a tray of individual cups of pickles and mayonnaise in the refrigerator which were not labeled.	F 0812	It is this facility's policy to store, prepare, distribute and serve food in accordance with professional standards for food service safety. **I. Specific Corrective Actions:** All undated, unlabeled opened items were disposed of immediately. **II. Identification and correction of others:** All residents have the potential to be affected; all opened items in the kitchen were reviewed to ensure proper dates and labels. **III. Systemic Changes:** All dietary staff received a Hand	02/14/2025

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	b. There was an undated, opened bag of sweet corn nuggets in the freezer. c. There was an undated, unlabeled, opened bag of white powder in a cabinet in the food preparation area. During an interview on 1/6/25 at 8:58 a.m., the Assistant Kitchen Manager indicated all items should be labeled with the date they were received, the date they were opened, and contents if removed from their original container. She threw away the cups of pickles and mayonnaise and indicated the bag of white powder was food thickener that had been taken from a larger container in the storage room. During an interview on 1/8/25 at 9:13 a.m., the Kitchen Manager indicated all food items should be labeled when received and when opened, and that she already started re-educating staff. A policy titled, "Food Protection and Storage", received as current on 1/10/25, indicated, " ... The Dietary Manager will check the food storage area for: ... open boxes, containers of food should are securely enclosed, labeled, and dated ... food not in original containers are clearly labeled for contents, dated, and stored in food rated containers with tight fitting lids ..." 3.1-21(i)(3)		Out titled Cover, Label and DATE Food Items and completed a Skill Check (Attachment M). **IV. <u>Monitoring:</u>** The Dietary Manager or designee will monitor the kitchen for opened food items to ensure proper labeling and dating (Attachment 9); 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	
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 complete and accurately documented related to meal	F 0842	It is this facility's policy to ensure complete, accurate medical records.	02/14/2025

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	consumption for 1 of 1 resident reviewed for ADL (activities of daily living) decline. (Resident 42) Finding includes: The record for Resident 42 was reviewed on 1/8/25 at 9:56 a.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), and dementia without behavior disturbance. The Annual Minimum Data Set (MDS) assessment, dated 12/13/24, indicated the resident was cognitively impaired for daily decision making and she required supervision with eating. A Care Plan, dated 9/20/24 and reviewed on 12/12/24, indicated the resident was at a nutritional risk related to cognitive impairment and a mechanically altered diet. Interventions included, but were not limited to, monitor weights and intakes. On 12/4/24, the resident weighed 141 pounds. On 1/8/25, the resident weighed 136 pounds. The Food Consumption Log for December 2024, indicated the resident's dinner intake was not documented on 12/10/24, 12/13/24, 12/15/24, and 12/24/24. The Food Consumption Log for January 2025, indicated the resident's lunch intake was not documented on 1/2/25. During an interview on 1/9/25 at 1:35 p.m., the Director of Nursing indicated the resident's food consumption should have been documented for each meal.		**I. Specific Corrective Actions:** Resident 42's Food Consumption Log was immediately brought up to date for the current date. **II. Identification and correction of others:** All residents' Food Consumption Logs were reviewed for completion. **III. Systemic Changes:** All nursing staff were in-serviced on documentation related to food consumption (Attachment I …Documentation…). **IV. Monitoring:** The DON or designee will monitor the Food Consumption Logs, per a developed QA Tool (Attachment 3); 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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F 0880 SS=E Bldg. 00	3.1-50(a)(1) 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 and implemented related to staff failing to perform hand hygiene after glove removal and prior to donning personal protective equipment (PPE) for 1 of 8 residents observed during medication administration, enhanced barrier precautions (EBP) not followed, and glove use in the hallway during random infection control observations. (Residents 1, 51, and 13) Findings include: 1. On 1/9/25 at 8:45 a.m., LPN 1 was observed preparing medications for Resident 1. The LPN donned a pair of gloves to place medications into a medication cup. After placing the medications in four separate cups, he removed his gloves. He did not sanitize his hands after removing his gloves. The LPN proceeded to enter the resident's room. The resident's medications were going to be given by the way of a gastrostomy tube (a tube inserted through the abdominal wall into the stomach). The LPN donned a gown, gloves, mask, and a face shield. The LPN did not sanitize his hands prior to donning the personal protective equipment (PPE). During an interview on 1/9/25 at 1:35 p.m., the Director of Nursing (DON) indicated the LPN should have sanitized his hands after removing his gloves and prior to donning the PPE.	F 0880	It is the facility's policy to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections. **I. Specific Corrective Actions:** LPN1, CNA2, the ADON and RN1, and CNA1 were re-educated regarding hand hygiene, PPE, EBP, glove wearing and soiled linen handling related to each of his/her mistakes during surveyor observation. **II. Identification and correction of others:** There were no other observed failed practices at this time. **III. Systemic Changes:** All nursing staff were in-serviced on the proper procedure related to hand hygiene, PPE, EBP, glove use and linen handling. **IV. Monitoring:** The DON or designee will do rounds and monitor that proper IC practices are being followed, per a developed QA Tool (Attachment 10); 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report	02/14/2025

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	2. During a random observation on 1/8/25 at 10:56 a.m., CNA 2 was observed walking out of a resident's room wearing gloves to both hands and carrying uncontained soiled linens in her arms. There was another resident yelling "help me" over and over again, so the CNA walked over to her room, still carrying the uncontained linen and told the resident "I have to get rid of these soiled linens he had a huge bm (bowel movement)." She then walked into the soiled utility room with the dirty linens. During an interview on 1/8/25 at 11:00 a.m. CNA 2 indicated she "knew better" and was not supposed to walk out of the room with the uncontained soiled linens but heard a resident calling for help and just left that other resident's room carrying all of the linen. During an interview on 1/9/25 at 2:15 p.m., the Director of Nursing (DON) indicated the CNA should not have walked out of the resident's room with uncontained soiled linens. The current 11/10/16 "Linen Handling" policy, provided by the DON on 1/9/25 at 2:34 p.m., indicated linens and laundry were handled or transported in a manner to prevent the spread of infection. 3. During a wound treatment observation on 1/8/25 at 2:00 p.m., the Assistant Director of Nursing (ADON) and RN 1 were observed preparing to do the bandage change for Resident 51. At that time, they both performed hand hygiene and donned clean gloves to both hands. Neither one of them donned an isolation gown prior to the treatment change. The wound was cleaned and a new bandage was placed over the		findings to QAPI committee monthly for review, recommendations, and tracking. After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	

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	open area. After the treatment was completed they both doffed their gloves and performed hand hygiene. During an interview at that time, the ADON indicated she would only don a gown if the resident had draining wounds. The record for Resident 51 was reviewed on 1/7/25 at 1:35 p.m. The resident was admitted to the facility on 12/11/24. Diagnoses included, but were not limited to, atrial fibrillation, high blood pressure, history of falling and high cholesterol. The 12/18/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and had one venous ulcer. A Physician's Order, dated 12/20/24, indicated enhanced barrier precautions (EBP) During an interview on 1/9/25 at 1:10 p.m., the Director of Nursing indicated the resident was on EBP and staff were to don gloves and a gown prior to having any contact with the resident. 4. During an observation on 1/7/25 at 2:44 p.m., Agency CNA 1 entered Resident 13's room and was going to assist her to bed. At that time, the CNA performed hand hygiene and donned a pair of clean gloves to both hands. She assisted the resident into bed by placing her arms around her waist and holding onto her pants. The CNA then removed the resident's pants and provided incontinence care. At that time, there was a bandage on the resident's coccyx area with a date of 1/6/25. The CNA did not donn an isolation gown prior to making contact with the resident.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 1/7/25 at 2:54 p.m., Agency CNA 1 indicated she was not aware the resident had a pressure ulcer and was informed by the nurse if there was an EBP sign on the door she was supposed to go into the oxygen room and get a gown. During an observation on 1/8/24 at 2:20 p.m., CNA 1 answered the resident's call light, and the resident wanted to go to bed. The CNA performed hand hygiene and donned clean gloves to both hands. She then asked the resident how she transferred to bed and the resident motioned by lifting up her arms as to go around the CNA's neck. The CNA told the resident she would go and get help to get her into bed. RN 1 and CNA 1 both came back to the room and performed hand hygiene and donned clean gloves to both hands. Neither one of them donned an isolation gown. The resident was transferred to bed by both staff members and RN 1 left the room after the transfer. CNA 1 proceeded to provide incontinence care to the resident. Again there was a bandage on the resident's coccyx area that was almost falling off. The CNA cleaned the resident without wearing an isolation gown. The record for Resident 13 was reviewed on 1/8/25 at 10:00 a.m. Diagnoses included, but were not limited to, fracture left lower leg, adult failure to thrive, anemia, type 2 diabetes, osteoarthritis, and peripheral vascular disease. The 12/6/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. The resident needed substantial to max assistance for the ability to come to a standing position from sitting in a chair to the side of the bed and had 1			

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	155299	A. BUILDING 00 B. WING	01/10/2025

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	stage 3 pressure ulcer that was not present on admission. A Care Plan, dated 9/9/24, indicated the resident required enhanced barrier precautions during high contact care due to a wound. A Physician's Order, dated 9/9/24, indicated Enhanced Barrier Precautions during high contact resident care every shift for a wound. During an interview on 1/8/25 at 3:10 p.m., the Infection Control Nurse indicated the resident was in EBP and there was a sign on her door before, however, the sign was removed. A gown and gloves should have been worn to perform incontinence care and the transfer. During an interview on 1/9/25 at 1:10 p.m., the Director of Nursing indicated the resident was in EBP and staff were to wear a gown and gloves when providing incontinence care. The current 4/6/23 "Enhanced Precautions for novel and targeted MDRO's" policy, provided by the Infection Preventionist on 1/10/25 at 10:25 a.m., indicated enhanced precautions were used to prevent the spread of MDRO's (multi drug resistant organisms) from one resident to another via health care workers' hands and clothing and to protect vulnerable residents. EBP was targeted use of gown and gloves during high contact resident care activities for residents with wounds, feeding tubes, indwelling catheters, and central lines. Examples of high contact resident care include but were not limited to, dressing, bathing, transferring, changing briefs, and performing wound care. 3.1-18(b)			

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F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to provide a sanitary, comfortable environment for staff, residents, and the public related to the strong odor of urine on 1 of 3 halls. (The 100 hall/ICF) This had the potential to affect all residents residing on the ICF wing. Finding includes: During multiple random observations throughout the day on 1/6/25 and 1/7/25, a pungent odor of urine was present upon entering and throughout the ICF hall. During an interview on 1/6/25 at 2:20 p.m., a resident's family member indicated the whole wing (ICF) constantly smelled of urine. During an interview on 1/8/25 at 11:02 a.m., LPN 1 indicated the smell may be coming from garbage in the dirty utility room. He took bags of garbage out of the room and sprayed air freshener around the unit. On 1/9/25 at 9:33 a.m., the urine odor was less, but still present. During an interview on 1/9/25 at 2:35 p.m., the Maintenance Director indicated he definitely noticed the odor over the last few weeks, but thought it was from a resident, and he didn't know anything about them. During an interview on 1/9/25 at 2:40 p.m., the Administrator was informed of the findings and indicated she would look into finding the source of the odor and get the carpets cleaned.	F 0921	It is this facility's policy to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **I. <u>Specific Corrective Actions:</u>** Upon learning of the concern from the surveyor, staff were immediately asked to empty the trash and soiled linen holding areas. To check any residents with a foley bag for leaks. And to clean the carpeting on the unit in case any spills had occurred. **II. <u>Identification and correction of others:</u>** All resident rooms and halls were checked for unpleasant odors. **III. <u>Systemic Changes:</u>** The floor in the dirty hold will be replaced due to its age and seeming to hold unpleasant odors. The carpeting on that hall will be cleaned at least monthly and more often if needed. **IV. <u>Monitoring:</u>** The Administrator or designee will round to ensure no unpleasant odors exist and that carpets are being cleaned by maintenance as per schedule (Attachment 11); 5 days a week x 4 weeks, then weekly x 4 weeks, then monthly for another 4 months. The Administrator/designee will report findings to QAPI committee monthly for review, recommendations, and tracking.	02/14/2025

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	3.1-19(f)		After 6 months of auditing, QAPI committee will review the need and/or frequency of ongoing auditing and use of this tool.	