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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155062 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                         | (X3) DATE SURVEY COMPLETED<br><br>05/14/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brickyard Healthcare - Laporte Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1700 I Street<br>LA Porte, IN 46350 |  |

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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p>48055</p> <p>Based on observation and interview, the facility failed to ensure a resident who required staff assistance for activities of daily living (ADLs) received necessary services related to having the ability to reach the call light when ADL care was needed, for 1 of 1 resident reviewed for accommodation of needs. (Resident 32)</p> <p>Finding includes:</p> <p>During an interview on 5/8/24 at 10:12 a.m., Resident 32 indicated he had waited over 30 minutes to get help off the stool and he could not reach the call light to get help.</p> <p>On 5/8/24 at 10:20 a.m., Resident 32 was observed having attempted to reach for the call light from his wheel chair, but the call light was not within reach. The resident smelled of feces and had attempted to get help from staff.</p> <p>On 5/8/24 at 10:28 a.m., the resident was observed with the Director of Nursing (DON). The resident was seated in his wheelchair and had attempted to reach the call light. The DON witnessed his attempt and realized the call light was not within reach. She then moved the resident's bed several inches, which allowed the resident to pass through the space between the dresser and the bed and reach the call light.</p> <p>Resident 32's record was reviewed on 5/09/24 at 2:40 p.m. Diagnoses included, but were not limited to, hemiparesis (paralysis on one side of the body) following cerebral infarction affecting the right dominant side, chronic kidney disease, and diverticulosis (small pouches in the digestive tract).</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/24, indicated the resident was dependent for toilet assistance and required partial to moderate assistance for toilet transferring.</p> <p>During an interview on 5/08/24 at 10:30 a.m., the DON indicated the resident was not able to reach the call light without his bed being moved, which then allowed the resident's wheelchair to fit through.</p> <p>3.1-38(a)(2)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>48055</p> <p>Based on record review and interview, the facility failed to protect the residents' right to be free from misappropriation of medication related to a staff nurse using a resident's insulin pen for her personal use, for 1 of 1 resident reviewed for misappropriation of medication. (Resident 25)</p> <p>The deficient practice was corrected by 10/31/23, prior to the start of the survey, and was therefore past noncompliance. The facility thoroughly investigated the misappropriation of medication, notified the police, placed the nurse on suspension while the investigation took place, the resident's insulin pen was removed from the medication cart and discarded, a new insulin pen was reordered for the resident to use, the facility provided inservices to the entire staff regarding the misappropriation of medication, and completed random observations on all shifts to ensure compliance of the policy was implemented correctly. The random observations were completed 5 times a week for 4 weeks, weekly for 4 weeks, and then weekly for 4 months. LPN 4 was guilty of misappropriation of medication and was terminated.</p> <p>Finding includes:</p> <p>An IDOH Incident Report, dated 10/30/23, was reviewed on 5/12/24. The report indicated it was reported to the Director of Nursing and the Administrator by QMA 1 on 10/28/23 at 8:01 p.m., that LPN 4 used Resident 25's insulin pen for her own personal use. CNA 2 and CNA 3 had witnessed LPN 4 use the resident's insulin pen on herself. Immediate action was taken by the facility and LPN 4 was placed on suspension pending the investigation. The resident's insulin pen was removed from the medication cart, was re-ordered, and billed to the facility. The preventative measures taken were to provide inservices to the entire staff on resident abuse and misappropriation of medications, an inservice on medication administration guidelines and insulin pen usage, and re-education on insulin pens being a single resident usage and not to be shared. To ensure compliance, random observations were completed that included all units and all shifts. They were completed 5 times a weekly, and then weekly for 4 weeks, and then weekly for 4 months. The follow up was determined after the investigation and the staff member was found guilty of misappropriation of medication and was then terminated. Interviews were conducted with staff members/witnesses on 10/30/23. Staff in-services were completed, and was added to QAPI (quality assurance performance improvement). The QAPI meeting date was 10/31/23 and the facility planned to monitor compliance through the results of audits being brought to QAPI meetings monthly for 3 months.</p> <p>Record Review was completed on 5/9/24 at 1:19 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy.</p> <p>A Quarterly Minimum Data Set assessment, dated 2/28/24, indicated the resident was cognitively intact and required insulin usage.</p> <p>A Care Plan, dated 9/29/24, indicated alteration in blood glucose due to: Insulin Dependent Diabetes Mellitus. Interventions included administer medications as ordered.</p> <p>Medications included Insulin Glargine 100 UNIT/ML Solution pen-injector, Inject 55 unit subcutaneously</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>every 12 hours related to TYPE 2 diabetes mellitus, ordered from 10/5/23 - 4/27/24.</p> <p>During an interview on 5/13/24 at 1:57 p.m., the Director of Nursing (DON) indicated LPN 4 used the resident's insulin pen on herself. The facility removed the insulin pen from the medication cart, discarded the pen in the trash can, suspended the employee, and launched an investigation, which was confirmed for misappropriation and the employee was terminated.</p> <p>A Policy titled, Abuse, Neglect, and Exploitation, provided by the Administrator on 5/8/24 at 11:00 a.m., indicated, .it is the policy of this facility to provide protections for the health, welfare and rights of each residents by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .</p> <p>3.1-28(a)</p> |  |  |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>10770</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependent residents related to nail care and the removal of facial hair, for 3 of 6 residents reviewed for ADL care. (Residents 23, 45, and 11)</p> <p>Findings include:</p> <p>1. During random observations on 5/8/24 at 10:01 a.m. and 1:17 p.m., on 5/9/24 at 9:25 a.m., 11:55 a.m., and 1:08 p.m., and on 5/10/24 at 12:20 p.m., Resident 23 was observed in bed. At those times, the resident was unshaven.</p> <p>The record for Resident 23 was reviewed on 5/9/24 at 2:35 p.m., Diagnoses included, but were not limited to, dementia with behaviors, high blood pressure, heart disease, major depressive disorder, and anxiety.</p> <p>The 2/13/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed substantial/maximal assist with personal hygiene.</p> <p>A Care Plan, revised on 1/18/24, indicated the resident had a physical functioning /self care deficit related to weakness, impaired mobility, and impaired cognition. The approaches were to provide personal hygiene with one assist.</p> <p>A Hospice CNA Progress Note, dated 5/10/24 at 8:30 p.m., indicated a bed bath was provided, however, there was no documentation the resident had a shave.</p> <p>During an interview on 5/13/24 at 11:00 a.m., the Director of Nursing indicated the resident received hospice services. A bed bath was provided 2 times a week from the Hospice CNA, however, there was no documentation the resident received a shave during the care.</p> <p>2. During random observations on 5/8/24 at 9:27 a.m. and 1:10 p.m., Resident 45 was observed sitting in a wheelchair in her room. At those times, the resident had long and dirty fingernails.</p> <p>The record for Resident 45 was reviewed on 5/13/24 9:53 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, high blood pressure, depression , psychotic disorder, and traumatic subdural hemorrhage encounter.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 3/14/24, indicated the resident was not cognitively intact for daily decision making. The resident had no impairment to her upper extremities or lower extremities and needed partial to moderate assistance with personal hygiene.</p> <p>A Care Plan, revised on 6/27/23, indicated the resident had an ADL self care deficit related to Alzheimer's dementia, impaired mobility, impaired cognition, and weakness.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>The resident's shower days were Mondays and Thursdays in the morning. The shower documentation indicated she received a shower on Monday 5/6/24, however, there was no documentation her nails were trimmed.</p> <p>During an interview on 5/13/24 at 10:10 a.m., the Director of Nursing indicated nail care should have been completed as needed.</p> <p>48055</p> <p>3. On 5/08/24 at 10:36 a.m., Resident 11 was observed lying in her room. Her fingernails on her right hand were long and appeared dirty. The resident's hair appeared wet, and she indicated that she would like her nails cleaned.</p> <p>On 5/9/24 at 10:01 a.m., Resident 11 was observed lying in her bed wearing a gown. She indicated she received a shower yesterday. Resident 11's nails continued to appear dirty and unkempt.</p> <p>The resident's record was reviewed on 5/19/24 at 1:19 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) to the left side, mild cognitive impairment, and contracture of the left upper arm.</p> <p>The Quarterly Minimum Data Set assessment, dated 4/11/24, indicated the resident was cognitively intact and required dependent assistance for toileting and bathing.</p> <p>A Care Plan, dated 4/10/24, indicated the resident preferred to keep her fingernails long, as long as they were well-groomed.</p> <p>On 5/9/24 at 1:59 p.m., the resident's nails were observed with CNA 1. During an interview at that time, CNA 1 indicated the resident's nails were still dirty and she would cleaned them right away.</p> <p>3.1-38(3)(E)</p> |  |  |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>10770</p> <p>Based on observation, record review, and interview, the facility failed to ensure an assessment was completed and devices were in place for a resident with limited range of motion for 1 of 1 resident reviewed for range of motion. (Resident 45)</p> <p>Finding includes:</p> <p>During random observations on 5/8/24 at 9:27 a.m. and 1:10 p.m., on 5/9/24 at 9:28 a.m., 11:55 a.m., and 1:06 p.m., and on 5/10/24 at 12:30 p.m., Resident 45 was observed sitting in a wheelchair. At those times, the resident was observed with her left hand clenched and lying against her chest.</p> <p>On 5/13/24 at 11:00 a.m., the Director of nursing assessed the resident's left hand and indicated with passive range of motion, the ring finger could be straightened out, however, the middle finger would only extend up to 75 degrees. She indicated at the time, Occupational Therapy would be completing an assessment of the hand.</p> <p>The record for Resident 45 was reviewed on 5/13/24 9:53 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, high blood pressure, depression , psychotic disorder, and traumatic subdural hemorrhage encounter.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 3/14/24, indicated the resident was not cognitively intact for daily decision making. The resident had no impairment to her upper extremities or lower extremities and needed partial to moderate assistance with personal hygiene.</p> <p>A Care Plan, revised on 7/9/22, indicated the resident had a physical functioning deficit related to mobility impairment and self care impairment. The approaches were to monitor and report changes in physical functioning ability and rehab therapy services as ordered. Date initiated: 7/10/2021</p> <p>A Functional and Abilities Assessment, dated 3/14/24, indicated the resident had impairment to one side for both upper and lower extremities.</p> <p>An Occupational Therapy (OT) Plan and Treatment, dated 3/8-4/6/24 indicated the resident had impaired left upper extremity strength for the shoulder and the elbow/forearm and wrist were all within normal limits.</p> <p>During an interview on 5/13/24 at 11:05 a.m., the Director of Nursing indicated she was unaware the resident had any range of motion limitations to the left hand and had no anti-contracture device for the left hand.</p> <p>A Nurses' Note, dated 5/13/24 at 11:24 a.m., completed by the Director of Nursing, indicated the resident was noted to have a limited extension (75%) of her right hand 2nd digit. The Physician was notified and a new order was received for OT to evaluate and treat.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>An Occupational Therapy Screen, completed on 5/13/24, indicated PIP (Proximal Interphalangeal Joint-knuckle) was 70 degrees. Pain was indicated by facial expressions and sounds, but when asked, patient denied pain.</p> <p>During an interview on 5/13/24 at 2:45 p.m., Certified Occupational Therapist Assistant (COTA) 1 indicated the resident had a limited range of motion at her knuckle of 70 degrees flexion. The resident will be picked up by OT for therapy.</p> <p>3.1-42(a)(2)</p> |

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| <p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide enough food/fluids to maintain a resident's health.</p> <p>10770</p> <p>Based on record review and interview, the facility failed to ensure meal consumption was monitored for a resident with a history of weight loss and/or were at nutritional risk for 1 of 2 residents reviewed for nutrition. (Resident 51)</p> <p>Finding includes:</p> <p>The record for Resident 51 was reviewed on 5/9/24 at 11:00 a.m. Diagnoses included, but were not limited to, pneumonia, diabetes, anemia, acute pancreatitis, and anxiety.</p> <p>The 2/26/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making, had no oral problems and weighed 222 pounds with no significant weight loss. The resident needed setup or clean up assistance with eating.</p> <p>A Care Plan, dated 2/24/24, indicated the resident was at nutritional risk related to obesity, diabetes, and anemia. The approaches were to observe meal intakes.</p> <p>The resident weighed 204 pounds on 2/20/24 and 206 pounds on 3/6/24. A weight obtained on 4/12/24 indicated the resident weighed 189 pounds, which was an 8.25% weight loss in 30 days.</p> <p>Physician's Orders on the current 5/2024 Physician Order Summary, indicated the resident was to receive a controlled carbohydrate diet.</p> <p>The meal consumption intake logs indicated the following:</p> <ul style="list-style-type: none"> <li>- the breakfast meal was not documented on 3/16 and 4/18/24.</li> <li>- the lunch meal not documented on 3/11, 3/16, 3/20, 4/1, and 4/18/24.</li> <li>- the dinner meal was not documented on 3/10, 3/27, 4/13, 4/14, 4/16, 4/17, 4/21, and 4/29/24.</li> </ul> <p>During an interview on 5/13/24 at 1:00 p.m., the Director of Nursing indicated the resident's meal consumption intakes should be documented after every meal.</p> <p>3.1-46(a)(1)</p> |  |  |

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| <p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>48383</p> <p>Based on record review and interview, the facility failed to ensure a newly hired CNA was certified past 120 days of employment for 1 of 44 employees reviewed for licensure and certification. (Employee 1)</p> <p>Finding includes:</p> <p>Review of the employee records was completed on 5/14/24 at 10:02 a.m.</p> <p>Employee 1 was hired on 1/10/24. Employee 1's 120th day of employment was on 5/8/24.</p> <p>The employee's time card was reviewed and indicated she had worked on the following days as a CNA after her 120 days of employment without certification: 5/9/24, 5/13/24, and 5/14/24.</p> <p>During an interview on 5/14/24 at 10:47 a.m., the Payroll Coordinator indicated she was unaware they had only 120 days to work, she thought it was 120 shifts. Employee 1 was working the floor as a CNA today on 5/14/24.</p> <p>3.1-14(e)</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>10770</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was prepared and stored under sanitary conditions related to a greasy deep fryer, improper labeling of food, and dried spillage in refrigerators in 1 of 1 kitchens and 2 of 3 pantries throughout the facility. (The Main Kitchen, A and C wing pantries)</p> <p>Findings includes:</p> <ol style="list-style-type: none"> <li>1. During the Brief Kitchen Sanitation Tour on 5/8/24 at 9:12 a.m. with the Dietary Food Manager, (DFM) the following was observed: <ul style="list-style-type: none"> <li>a. The deep fryer was noted with many food crumbs and was greasy on both sides, with the grease extending to the side of the convection oven.</li> </ul> <p>During an interview at that time, the DFM indicated the deep fryer was cleaned weekly.</p> </li> <li>2. During an observation of the A-Wing pantry refrigerator on 5/9/24 at 9:10 a.m., there was a heavy accumulation of dried pink, orange, and red beverage spillage. The refrigerator housed the resident's food and other beverages.</li> <p>During an interview at that time, LPN 3 had no comment regarding the spillage.</p> <li>3. During an observation of the C-Wing pantry refrigerator on 5/14/24 at 9:25 a.m., there was an open bottle of orange Gatorade with no open date or label on it inside the refrigerator.</li> <p>During an interview at that time, LPN 2 indicated she did not know whose Gatorade it was, and thought maybe it was a resident who recently had a colonoscopy.</p> <p>The current 11/6/16 The Safe Food Procurement: Food from Outside Sources policy, provided by the Administrator on 5/8/24 at 11:00 a.m., indicated food or beverages brought in from the outside will be labeled with the resident's name, room number and dated by nursing with the current date the item was brought in to the facility.</p> <p>3.1-21(i)(3)</p> </ol> |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Brickyard Healthcare - Laporte Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1700 I Street<br>LA Porte, IN 46350 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>10770</p> <p>Based on observation, record review, and interview, the facility failed to ensure clinical records were accurately documented related to weekly skin assessments and nutritional supplements for 1 of 1 residents reviewed for skin conditions and 1 of 2 residents reviewed for nutrition. (Residents 16 and 51)</p> <p>Findings include:</p> <p>1. During a random observation on 5/8/24 at 9:36 a.m., Resident 16 was observed with many bloody and dried scabs all over his upper body including his arms and trunk.</p> <p>The record for Resident 16 was reviewed on 5/10/24 at 12:42 p.m. Diagnoses included, but were not limited to, pulmonary disease and fibrosis, type 1 diabetes, major depressive disorder, high blood pressure, heart disease, anxiety, and stroke.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 4/1/24, indicated the resident was cognitively intact for daily decision making and did receive applications of ointment other than the feet.</p> <p>The Care Plan, revised on 3/25/24, indicated the resident had altered skin integrity, non-pressure related to a rash to bilateral upper and lower extremities including his trunk. The approaches were to conduct a weekly skin inspection.</p> <p>Physician's Orders, dated 1/11/24, indicated Triamcinolone Acetonide External Cream 0.1 %, apply to the trunk, bilateral upper and lower extremities every evening and night shift.</p> <p>The Weekly Skin Review, dated 3/26/24, indicated the resident's skin was intact. The resident still had small scabs to arms and trunk.</p> <p>The Weekly Skin Review, dated 4/9/24, indicated the resident's skin was warm, dry and intact. The comment section indicated the resident does have a chronic rash to his extremities and a treatment was in place.</p> <p>The Weekly Skin Review, dated 4/30/24, indicated the resident's skin was intact.</p> <p>During an interview on 5/13/24 at 1:00 p.m., the Director of Nursing indicated she believed the nurses were thinking his skin was intact because he had no pressure ulcers, however, there was a spot on the weekly skin assessment to check off if the resident had a rash, redness, blisters, or skin tears and if they were pre-existing. The above skin reviews were inaccurately documented.</p> <p>2. The record for Resident 51 was reviewed on 5/9/24 at 11:00 a.m. Diagnoses included, but were not limited to, pneumonia, diabetes, anemia, acute pancreatitis, and anxiety.</p> <p>(continued on next page)</p> |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>The 2/26/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making, had no oral problems and weighed 222 pounds with no significant weight loss. The resident needed setup or clean up assistance with eating.</p> <p>A Care Plan, dated 2/24/24, indicated the resident was at nutritional risk related to obesity, diabetes, and anemia. The approaches were to observe meal intakes.</p> <p>The resident weighed 204 pounds on 2/20/24 and 206 pounds on 3/6/24. A weight obtained on 4/12/24 indicated the resident weighed 189 pounds, which was an 8.25% weight loss in 30 days.</p> <p>Physician's Orders, dated 3/30/24, indicated Ensure (a nutritional supplement) 237 milliliters (ml) at 9:00 a.m. and 6:00 p.m.</p> <p>Physician's Orders, dated 4/5/24, indicated Ensure 237 ml for 30 days at 8:00 a.m. and 4:00 p.m.</p> <p>The Medication Administration Record (MAR) for 4/2024 indicated both Ensure supplements were documented and signed out as being administered 4/5/24 through 4/30/24. The documentation indicated the resident received 4 cans of Ensure and only 1 hour difference in time.</p> <p>During an interview on 5/13/24 at 1:00 p.m., the Director of Nursing indicated the resident was only supposed to receive 2 cans of Ensure a day, not 4 cans. Nursing staff should have discontinued one of the orders so there would be no confusion.</p> <p>3.1-50(a)(2)</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>32582</p> <p>Based on observation, record review, and interview, the facility failed to maintain an infection control program related to incomplete documentation of the infection control program, incomplete mapping of infections and lack of glove use during insulin administration during a medication pass for 1 of 8 residents observed during medication pass. (Resident 51 and LPN 1)</p> <p>Findings include:</p> <p>1. The Infection Control Program was reviewed on 5/9/24 at 9:00 a.m. The January, February, March and April 2024 Infection Surveillance Data Collection Forms included the following:</p> <ul style="list-style-type: none"> <li>- resident's name and room number</li> <li>- infection type</li> <li>- infection onset date</li> <li>- antibiotic name</li> <li>- antibiotic start and stop date</li> <li>- comments</li> </ul> <p>The Infection Control Logs lacked any documentation of diagnostic lab or x-ray results or if criteria for a true infection were met. Five residents in March and ten residents in April lacked documentation of signs or symptoms associated with the infection.</p> <p>During an interview on 5/9/24 at 9:30 a.m. with the Infection Preventionist (IP), she indicated she did not include the infection criteria or diagnostic results on the Infection Log because the information was available elsewhere in the record. She also indicated she was unsure why there were no signs or symptoms documented on some of the entries.</p> <p>The current policy, Infection Surveillance, indicated, ,refers to an ongoing systematic collection, analysis, interpretation and dissemination of infection-related data</p> <p>2. The January 2024 Infection Control Log indicated there were seven residents with urinary tract infections (UTI). The January 2024 map had no residents documented as having a UTI. The March 2024 Infection Control Log indicated there were six residents with respiratory infections. The March 2024 map had no residents documented as having a respiratory infection.</p> <p>During an interview on 5/9/24 at 1:48 p.m., the IP nurse indicated infections were color coded and mapped monthly to identify trends. She indicated some of the missed infections had been carried over from the previous month, but several had been missed on the maps.</p> <p>(continued on next page)</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>The current policy, Infection Surveillance, indicated, .The facility will collect data to properly identify possible communicable diseases or infections among resident and staff before they spread by identifying .The infection site, pathogen (if available), signs and symptoms, and resident location, including a summary and analysis of the number of resident who developed infections ., and, .the identification of unusual or unexpected outcomes, infection trends or patterns</p> <p>3. On 5/8/24 at 11:35 a.m., LPN 1 was observed administering medications. Resident 51 was to receive 3 units of Novolog (insulin). The nurse prepared the insulin pen and administered the medication to the resident. She did not don gloves prior to administering.</p> <p>During an interview following the observation, the LPN indicated she didn't think she was supposed to wear gloves during insulin administration.</p> <p>The current policy, titled Insulin Pen, indicated, .11. Procedure . b. perform hand hygiene. c. don gloves</p> <p>3.1-18(b)(1)</p> |  |  |