STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155062	A. Building B. Wing	04/04/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review and interview, the facility failed to maintain a resident's dignity related to wearing a hospital gown during the day and not consistently offering pleasure food for 1 of 1 resident reviewed for dignity. (Resident 17) Finding includes: During a random observation on 3/31/25 at 11:21 a.m., Resident 17 was observed in bed wearing a hospital gown. At that time, an enteral tube feeding was infusing into the peg tube (a tube inserted directly into the stomach for nutrition). The resident's roommate was seated in a chair in the room as well. At 11:25 a.m., the roommate received her lunch meal and proceeded to eat in the room. Resident 17 did not receive a tray and was not offered anything to eat. On 3/31/23 at 3:22 p.m., the resident was observed in bed still wearing a hospital gown. During an interview at that time, the resident indicated she did not receive anything to eat for lunch, and sometimes they would bring a pudding for me to eat. During random observations on 4/1/25 at 8:58 a.m., 1:10 p.m. and 2:30 p.m., the resident was observed in bed wearing a hospital gown. During random observations on 4/2/25 at 10:20 a.m. and 11:26 a.m., the resident was observed in bed wearing a hospital gown. During lunch, the resident's roommate received her tray in the room, however, Resident 17 was not offered anything to eat. At 1:30 p.m., the resident remained dressed in her hospital gown. At 5:14 p.m., the resident's roommate received her dinner tray and again Resident 17 was not asked if she wanted anything to eat or served a dinner tray. The record for Resident 17 was reviewed on 4/2/25 at 10:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, hemiplegia (weakness or paralysis on one side of the body), dysphagia (difficulty swallowing), chronic kidney disease, heart failure, peg tube, high blood pressure, and a cardiac pacemaker. The Significant Change Minimum Data Set (MDS) assessment, dated 1/22/25, indicated the resident was not cognitively intact for daily decision making and was dependent on staff for dressing and personal hygiene. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no care plan that indicated the resident preferred to wear a hospital gown during the day. A Physician's Order, dated 3/5/25, indicated enteral feed of Jevity 1.2 Cal at 55 cubic centimeters (cc) per hour for 24 hours. There was no order indicating nothing by mouth. During an interview on 3/31/25 at 12:07 p.m. CNA 1 indicated they would serve the resident pleasure foods only if she requested something. During an interview on 4/3/25 at 10:49 a.m., the Dietary Food Manager indicated they do not normally send the resident any food, they wait to see if the resident requested a pudding or yogurt and then they would send one up. During an interview on 4/3/25 at 11:00 a.m., the Director of Nursing indicated the resident should be offered pleasure foods at every meal and there was no care plan indicating the resident preferred to be dressed in a hospital gown. During an interview on 4/3/25 at 2:00 p.m., CNA 1 indicated they had always dressed the resident in the hospital gown. 3.1-3(t)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. 10326 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medications and had physician's orders to self-administer for 4 of 4 residents reviewed for self-administration of medication. (Residents 44, 52, 20 and 8) Findings include: 1. On 4/1/25 at 9:44 a.m., 1:09 p.m. and 3:50 p.m., a bag of Mucinex throat lozenges was observed in a plastic bin on Resident 44's overbed table. On 4/2/25 at 1:50 p.m., the bag of throat lozenges remained on the resident's overbed table. The record for Resident 44 was reviewed on 4/3/25 at 2:05 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and chronic respiratory failure. The 3/12/25 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The April 2025 Physician's Order Summary (POS) indicated the resident may self-administer her nebulizer treatment and oral medications once prepared by the licensed nurse/QMA. Medications may be left with me to self-administer as long as I am in the room. There was no physician's order for the throat lozenges. The last self-administration of medication assessment was dated 2/9/24. During an interview on 4/3/25 at 2:00 p.m., the Director of Nursing indicated the resident was no longer capable of self-administering her medications and the cough drops were removed from the resident's room. 2. On 4/1/25 at 1:05 p.m., 2:12 p.m. and 3:50 p.m., Resident 52 was observed in her room sleeping. A bottle of Thera Tears was observed on the resident's overbed table. The record for Resident 52 was reviewed on 4/1/25 at 3:22 p.m. Diagnoses included, but were not limited to, neurocognitive disorder with behavior disturbance and cerebral aneurysm. The Quarterly Minimum Data Set (MDS) assessment, dated 2/28/25, indicated the resident was cognitively impaired for daily decision making. The April 2025 Physician's Order Summary (POS), indicated the resident was to receive Refresh Plus Ophthalmic Solution, instill 2 drops in both eyes one time a day for chronic dry eyes. There was no physician's order to self-administer the eye drops. There was no self-administration of medication assessment available for review. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/3/25 at 11:45 a.m., the Director of Nursing indicated the resident did not have an order to self-administer the eye drops and they should not have been in the resident's room. 43293 3. During a random observation on 3/31/25 at 10:36 a.m., a nebulizer machine, a bottle of Biofreeze (a topical pain medication), and a bottle of Fluticasone (an allergy nasal spray) were observed in Resident 20's room. At that time, the resident indicated the staff let him do nebulizer treatments on his own and there was a bag in his closet with the medication for the nebulizer that he got from his own pharmacy. During an observation on 4/1/25 at 9:20 a.m., the Biofreeze, Albuterol, and Fluticasone remained in the resident's room. The resident indicated he used them when he felt like he needed them. The resident's record was reviewed on 4/1/25 at 3:30 p.m. Diagnoses included but were not limited to, amputation of the left leg, COPD (chronic obstructive pulmonary disease), and acute respiratory failure with hypoxia (low oxygen levels). The 2/5/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily incision making, required partial assistance with ADLs (activities of daily living) and was independent with transfers. A Physician's Order, dated 10/6/24, indicated Albuterol Inhaled Solution three times a day. A Physician's Order, dated 12/22/24, indicated Biofreeze Gel to the left hip topically every 3 hours as needed for hip pain. There were no orders for self-administration of Albuterol and Biofreeze or to keep the medications at the bedside. There was no order for Fluticasone. The most recent Self-Administration of Medication Assessment was dated 4/23/24. There was no documentation the resident was capable of administering topical medication. During an interview on 4/3/25 at 11:37 a.m., the Director of Nursing indicated medication self-administration assessments should be performed quarterly and as needed. If a medication was to be self-administered and/or kept at the bedside, it should be written in the medication order. She indicated she was not aware of the bag of medications in the resident's closet, but would look into it. 4. During a random observation on 3/31/25 at 10:49 a.m., a bottle of Astepro (an allergy nasal spray) and Mometasone Furoate (a topical steroid) were observed on Resident 8's bedside table. During an observation on 4/1/25 at 2:33 p.m., both medications remained on the bedside table. At that time, the resident indicated he used both of the medications when he needed them. The resident's record was reviewed on 4/1/25 at 3:35 p.m. Diagnoses included but were not limited to, dependence on renal dialysis, COPD, diabetes and seizures. The 12/24/24 Quarterly MDS assessment indicated the resident was cognitively intact for daily decision making, and required substantial assistance with ADLs and transfers. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Self-Administration of Medication Assessment in the record was dated 5/11/23. During an interview on 4/3/25 at 11:37 a.m., the Director of Nursing indicated medication self-administration assessments should be performed quarterly and as needed. She indicated it was something they were working on correcting. A policy titled, Resident Self-Administration of Medication, received as current from the Director of Nursing on 4/4/25 at 8:30 a.m. indicated, . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely . Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team . 3.1-11

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43293 Based on record review and interview, the facility failed to file a grievance form, thoroughly investigate, and resolve grievances related to a resident representative's complaints for 1 of 1 resident reviewed for grievances. (Resident B) Finding includes: The closed record for Resident B was reviewed on 4/3/25 at 10:43 a.m. Diagnoses included but were not limited to, diabetes, sacral (tailbone area) pressure ulcer, cancer of the large intestine, and dementia. The 1/29/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, and required maximum assistance with ADLs (activities of daily living) and transfers. A Social Services Note, dated 3/3/25, indicated during a meeting with the SSD (Social Services Director), nursing, wound care, and the Administrator, the resident's representative had concerns about the resident's care and made multiple accusations. There was no documentation of the specific concerns, investigation or resolution. A grievance form was not initiated. A Social Services Note, dated 3/6/25, indicated the resident's representative made accusations that a bug was found on the resident when he was at the wound clinic, and that he had bite marks on his skin. The nurse and aide assessed the resident and his room, and found no bugs or bite marks. The note from the wound clinic did not indicate finding a bug or bite marks. The Social Service Note did not indicate a resolution of the complaint. A grievance form was not initiated. During an interview on 4/3/25 at 3:15 p.m., the SSD indicated no grievances had been filled out regarding the representative's concerns because they wanted everything done immediately. She met with the representative regularly and documented this in her notes. The SSD indicated they should have filled out a grievance for each of the resident representative's concerns. A policy titled, Resident and Family Grievances, received as current on 4/4/25 at 12:00 p.m. from the SSD indicated, . The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form . The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form . The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances . This citation relates to complaint IN00455286. 3.1-7(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to shaving and washing hair for 3 of 8 residents reviewed for ADLs. (Residents 17, 37, and 63) Findings include: 1. During random observations on 3/31/25 at 11:21 a.m. and 3:22 p.m., Resident 17 was observed in bed wearing a hospital gown. At that time, she had a moderate amount of facial hair on her chin. During random observations on 4/1/25 at 8:58 a.m., 1:10 p.m. and 2:30 p.m., the resident was observed in bed wearing a hospital gown and had a moderate amount of facial hair on her chin. During random observations on 4/2/25 at 10:20 a.m., 11:26 a.m., 1:30 p.m. and 5:14 p.m., the resident was observed in bed wearing a hospital gown and had a moderate amount of facial hair on her chin. The record for Resident 17 was reviewed on 4/2/25 at 10:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, hemiplegia, dysphagia (difficulty swallowing), chronic kidney disease, heart failure, peg tube, high blood pressure, and a cardiac pacemaker. The Significant Change Minimum Data Set (MDS) assessment, dated 1/22/25, indicated the resident was not cognitively intact for daily decision making and was dependent on staff for dressing and personal hygiene. A Care Plan, dated 11/25/24, indicated the resident had an ADL self-care performance deficit related to a stroke. The resident required assistance of one person with personal hygiene. The CNA task section indicated the resident received a shower on Tuesday and Fridays. There was no documentation the resident had been assisted with the removal of the facial hair on her chin. During an interview on 4/3/25 at 11:00 a.m., the Director of Nursing indicated the resident should be shaved as needed. 2. During a random observation on 3/31/25 at 11:35 a.m., , Resident 37 was observed sitting up in a Broda chair. At that time, he had a large amount of facial hair observed on his face and chin. During random observations on 4/1/25 at 9:00 a.m., 1:14 p.m., and 2:30 p.m., the resident remained with a large amount of facial hair on his face and chin. The record for Resident 37 was reviewed on 4/1/25 at 2:50 p.m. Diagnoses included, but were not limited to, Parkinson's disease, Alzheimer's disease, high blood pressure, delusions, osteoarthritis, depression, and acute kidney failure. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/3/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented and was dependent on staff for personal hygiene. A Care Plan, revised on 12/9/23, indicated the resident had an ADL self-care performance deficit related to Parkinson's and Alzheimer's disease. The resident required assistance of one person with personal hygiene. The CNA task section indicated the resident had completed showers on 3/6, 3/10, 3/17, and 3/20/25, however, there was no documentation the resident was shaved. During an interview on 4/3/25 at 11:00 a.m., the Director of Nursing indicated the resident should be shaved as needed. She has contacted hospice to ensure this was done during his bath days. 3. During random observation on 3/31/25 at 11:25 a.m., 2:20 p.m., and 3:15 p.m., on 4/1/25 at 8:59 a.m., 1:10 p.m., and 2:32 p.m., and on 4/2/25 at 10:20 a.m., 11:30 a.m., and 5:20 p.m., Resident 63 was observed with a large amount of facial hair on his face and chin area. The resident's hair was also observed to be matted and knotted on the back of his head. On 4/3/25 at 9:30 a.m., QMA 1 and the Wound Nurse were observed in the room and were shown the resident's hair and that he was unshaven. During an interview on 4/3/25 at 9:50 a.m., QMA 1 indicated the hospice CNA came at least two times a week to bathe the resident. She indicated he was in need of a shave. During an interview on 4/3/25 at 9:55 a.m., the Wound Nurse indicated the resident's hair was matted and his scalp was dry. The record for Resident 63 was reviewed on 4/2/25 at 11:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure, anxiety, heart disease, osteoarthritis, and heart failure. The 12/24/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was never/rarely understood and was severely impaired for decision making. The resident was dependent on staff for personal hygiene. A Care Plan, revised on 3/4/25, indicated the resident had an ADL self-care performance deficit related to impaired balance and limited mobility. The resident required assistance of one staff with personal hygiene. The CNA task section indicated the resident received a shower or bed bath on Wednesdays and Saturdays. A complete bed bath was last given on 3/29/25. There was no documentation the resident was shaved or had his hair washed. During an interview on 4/3/25 at 11:09 a.m., the Director of Nursing indicated the resident should have been shaved and had his hair washed as needed. 3.1-38(a)(3)(B) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-38(a)(3)(D)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure a resident with signs and symptoms of constipation was treated for 1 of 1 resident reviewed for constipation, and areas of discoloration, and edema were assessed and monitored for 1 of 2 residents reviewed for skin conditions non-pressure related and for 1 of 1 resident reviewed for edema. (Residents 63, 57, and 122) Findings include: 1. The record for Resident 63 was reviewed on 4/2/25 at 11:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure, anxiety, heart disease, osteoarthritis, and heart failure. The 12/24/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was never/rarely understood and was severely impaired for decision making. The resident was dependent on staff for ADL care and was always incontinent of bowel. A Care Plan, revised on 1/19/25, indicated the resident was at risk for constipation related to decreased mobility. The approaches were to follow facility bowel protocol for bowel management and record bowel movements each day. A Physician's Order, dated 12/18/24, indicated Bisacodyl Rectal Suppository, insert 1 suppository rectally every 24 hours as needed for constipation. A Physician's Order, dated 12/20/24, indicated hospice care. A Physician's Order, dated 1/31/25, Morphine Sulfate (Concentrate) Solution 20 milligrams (mg) give 0.25 milliliter (ml) by mouth every 1 hour as needed (prn) for pain. A Physician's Order, dated 2/3/25 indicated Morphine Sulfate (Concentrate) Solution 20 mg give 0.25 milliliter (ml) by mouth every six hours for pain. A Physician's Order, dated 3/14/25, indicated Docusate Sodium Liquid 50 mg, give 10 ml by mouth one time a day for constipation. The resident had no bowel movement on the following days: 1/1/25-1/5/25, 2/16/25-2/21/25, 3/3/25-3/8/25, and 3/22/25-3/25/25. The Medication Administration Record (MAR) for the month of 3/2025 indicated the prn suppository was not signed out as being administered for constipation. During an interview on 4/3/25 at 3:00 p.m., the Director of Nursing indicated they had no policy for constipation. If the resident had no bowel movement after three days, they would give the as needed (prn) medications and if there were no as needed medications, the nurses should be calling the doctor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43293 2. During a random observation on 3/31/25 at 11:10 a.m., bruising was observed to Resident 57's shins and right knee. During subsequent observations on 4/1/25 at 1:33 p.m. and 4/2/25 at 10:05 a.m., the bruising remained present to the resident's shins and right knee. Resident 57's record was reviewed on 4/2/25 at 11:33 a.m. Diagnoses included, but were not limited to, hypertensive heart disease with heart failure and diabetes. The 1/27/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, required substantial assistance with ADLs, and partial/moderate assistance with transfers. A Care Plan, dated 12/14/24, indicated the resident was on anticoagulant therapy (blood thinners). Interventions included monitoring and documenting bruising. A Physician's Order, dated 1/28/25, indicated to observe for signs and symptoms of bleeding including tarry stools, blood in urine, and bruising every shift. The record lacked documentation of assessments of the resident's bruised shins and right knee. During an interview on 4/3/25 at 11:36 a.m., the Director of Nursing indicated bruises should be assessed and documented in the resident's record. During an interview on 4/3/25 on 3:05 p.m., the DON indicated the resident was up and about all of the time, bruised easily and was on blood thinners. 3. During a random observation on 4/1/25 at 9:02 a.m., Resident 122's hands were observed to be swollen. The ring on his left hand was digging into his finger. At that time, the resident indicated his hands were swollen, but he did not know why. During an observation on 4/02/25 at 9:33 a.m., the resident was resting in bed. The swelling to his hands appeared unchanged. The resident's record was reviewed on 4/2/25 at 9:00 a.m. Diagnoses included, but were not limited to, gastrointestinal bleed, heart disease, and chronic kidney disease. The 3/28/25 Skilled Nurse Admission Assessment indicated the resident was cognitively intact for daily decision making, required one person physical assist with ADLs (activities of daily living) and transfers, and had new,1+ pitting edema (1 out of 4 on a scale of severity of swelling that stays indented when pressed with a finger) to his left hand/fingers. A Nurse's Note, dated 3/9/25, indicated the resident had edema (swelling) to both arms/hands. The record lacked any other assessments of the resident's edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan lacked interventions related to monitoring or treatment of the edema. During an interview on 4/3/25 at 9:38 a.m., RN 2 indicated she did not notice the resident's swelling, she only checked his vital signs. During an interview on 4/03/25 at 3:06 p.m., the Director of Nursing indicated edema should be assessed and documented regularly. She was not sure why the resident had edema and would ask the nurse practitioner to see the resident. 3.1-37

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure a resident's toenails were cut, kept trimmed and podiatry care was provided for 1 of 1 resident reviewed for foot care. (Resident 63) Finding includes: During random observations on 3/31/25 at 11:25 a.m. and 4/1/25 at 8:59 a.m., Resident 63 was sitting up in a Broda chair. On 4/2/25 at 10:20 a.m., 11:30 a.m., and 5:20 p.m., the resident was observed reclined in a Broda chair. At those times, the resident was observed with very long toenails. On 4/3/25 at 9:32 a.m., QMA 1 and the Wound Nurse were in the room. At that time, they were both shown the resident's long toenails. During an interview on 4/3/25 at 9:55 a.m., the Wound Nurse indicated the resident received hospice care, so they would have to let hospice know the toenails needed to be trimmed. The record for Resident 63 was reviewed on 4/2/25 at 11:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure, anxiety, heart disease, osteoarthritis, and heart failure. The 12/24/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was never/rarely understood and was severely impaired for decision making. The resident was dependent on staff for personal hygiene. There were no visits by the podiatrist. During an interview on 4/3/25 at 11:08 a.m., the Social Service Director indicated on 2/10/25 hospice deemed podiatry services were not necessary for the resident, therefore he had not seen the podiatrist since admission. During an interview on 4/3/25 at 11:09 a.m., the Director of Nursing indicated the hospice CNA and hospice nurse were in the facility at least three times during the week and provided his baths, so his toenails should have been observed. 3.1-47(a)(7)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 10770 Based on observation, record review, and interview, the facility failed to ensure assistive devices were in place for a resident with a limited range of motion for 1 of 1 resident reviewed for positioning. (Resident 50) Finding includes: During random observations on 3/31/25 at 11:34 a.m. and 12:15 p.m., and on 4/1/125 at 11:32 a.m. and 1:12 p.m., Resident 50 was observed sitting in her wheelchair. At that time, her right arm was elevated on a small bed pillow. There was no arm tray observed on the wheelchair. The record for Resident 50 was reviewed on 4/1/125 at 2:10 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, stroke, right side hemiplegia (weakness or paralysis of one side of the body), vascular dementia, anxiety, high blood pressure, and osteoarthritis. The 2/10/25 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had a limited range of motion impairment to one side for the upper extremity. A Care Plan, dated 12/13/24, indicated the resident had an ADL self-care performance deficit related to a stroke and hemiplegia. The approaches were for the resident to use the right shoulder arm tray to support the right upper extremity while upright in wheelchair for joint protection and proximal support. A Physician's Order, dated 3/29/24, indicated the resident was to use a right shoulder arm tray to support the right upper extremity while upright in wheelchair for joint protection and proximal support. every shift. The 1/2025, 2/2025 and 3/2025 Medication Administration Records (MAR) indicated the right shoulder tray was signed out as being on the wheelchair every day shift. There were no documented refusals of the right shoulder arm tray. During an interview on 4/3/25 at 2:00 p.m., CNA 1 indicated the tray was located in between the dresser and night stand and was to be attached to her wheelchair when she was up. She indicated the resident's daughter may ask for it to be removed sometimes. During an interview on 4/3/25 at 3:00 p.m., the Director of Nursing indicated the tray was to be on the resident's wheelchair. 3.1-42(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure residents with a history of falls had preventions in place to prevent more falls/injuries related to a floor mat beside the bed and keeping the bed in the lowest position for 2 of 3 residents reviewed for falls. (Residents 37 and 63) Findings include: 1. During random observations on 4/1/25 at 9:00 a.m. and 2:30 p.m., and on 4/2/25 at 3:00 p.m., Resident 37 was observed in bed. At those times, the resident's bed was not in the lowest position. The record for Resident 37 was reviewed on 4/1/25 at 2:50 p.m. Diagnoses included, but were not limited to, Parkinson's disease, Alzheimer's disease, high blood pressure, delusions, osteoarthritis, depression, and acute kidney failure. The 3/3/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented and was dependent on staff transfers and bed mobility. The resident had no falls since the last assessment. A Care Plan, revised on 9/20/24, indicated the resident was at risk for falls. The approaches were to keep the bed in the lowest position. A Nurses' Note, dated 12/28/24 at 9:28 p.m., indicated the resident was found on the floor on the floor mat next to the bed. During an interview on 4/3/25 at 3:00 p.m., the Director of Nursing indicated the bed should be in the lowest position. 2. During random observations on 3/21/25 at 2:20 p.m. and 3:15 p.m., Resident 63 was observed in bed. There was no floor mat on the floor next to the bed. The record for Resident 63 was reviewed on 4/2/25 at 11:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure, anxiety, heart disease, osteoarthritis, and heart failure. The 12/24/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was never/rarely understood and was severely impaired for decision making. The resident was dependent on staff for bed mobility and transfers. There was no history of falls since the last assessment. A Care Plan, dated 11/25/24, indicated the resident was at risk for falls. The approaches were to place a floor mat next to the bed at all times while the resident was in the bed. The record indicated the resident was found on the floor next to the bed on 11/22/24 and 11/25/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 11/26/24, indicated to place a floor mat at the bedside at all times while the resident was in the bed, every shift. During an interview on 4/3/25 at 11:00 a.m., the Director of Nursing indicated the mat should have been on the floor next to the bed. 3.1-45(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to ensure food consumption logs were completed for residents with a history of weight loss for 3 of 4 residents reviewed for nutrition. (Residents 14, 39, and 52) Findings include: 1. On 3/31/25 at 11:54 a.m., Resident 14 was seated in her room in her wheelchair. The resident was served noodles, meatballs, peas, and a fruit cup. The resident indicated she wanted nothing to eat. On 4/2/25 at 11:38 a.m., the resident was served grilled cheese and soup for lunch. She was not eating any of her meal. At 11:55 a.m., the resident was observed drinking her milk but not eating any food. The record for Resident 14 was reviewed on 4/1/25 at 1:12 p.m. Diagnoses included, but were not limited to, mild cognitive impairment, adult failure to thrive, and dysphagia (difficulty swallowing). The Significant Change Minimum Data Set (MDS) assessment, dated 1/13/25, indicated the resident had moderate cognitive impairment. The resident had sustained a weight loss during the assessment reference period. A Care Plan, dated 9/30/24 and reviewed on 3/31/25, indicated the resident had a nutritional problem or potential nutritional problem related to hemiplegia and hemiparesis (muscle weakness and/or paralysis), chronic obstructive pulmonary disease (COPD), anxiety disorder, hypertension, recurrent depressive disorder, and adult failure to thrive. The goal was for the resident to maintain adequate nutritional status. A Physician's Order, dated 3/6/25, indicated the resident received a regular diet. A Physician's Order, dated 3/11/25, indicated the resident was also receiving an enteral feeding (a method of providing nutrition directly into the gastrointestinal tract through a tube) of Jevity 1.2, 100 milliliter (ml) bolus five times a day. The resident had sustained a 27% weight loss in the past six months. The March 2025 Food Consumption Log indicated there was no intake documented for all three meals on 3/4/25. No breakfast was documented on 3/25/25 and no dinner was documented on 3/10/25, 3/20/25, and 3/26/25. During an interview on 4/4/25 at 8:45 a.m., the Director of Nursing indicated the resident's food consumption should have been documented for each meal. 2. On 4/2/25 at 11:55 a.m., Resident 39 was observed in his room eating lunch. He was served soup and a grilled cheese sandwich. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident 39 was reviewed on 4/2/25 at 9:57 a.m. Diagnoses included, but were not limited to, stroke, congestive heart failure, and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/25, indicated the resident was moderately impaired for daily decision making and he required set up or clean up assistance with eating. No weight issues were identified during the assessment reference period. A Care Plan, dated 10/18/24 and reviewed on 2/14/25, indicated the resident had a nutritional problem or potential nutritional problem related to being on a therapeutic diet due to end stage renal disease (ESRD) with hemodialysis. The resident would request foods that were restricted on his dialysis diet; weight may fluctuate due to dialysis; meal intakes vary; potential for chewing/swallowing difficulty due to dysphagia (difficulty swallowing). The goal was for the resident to maintain adequate nutritional status as evidenced by maintaining weight with no significant weight changes, no signs and symptoms of malnutrition, and meeting estimated nutrition needs. The resident was hospitalized [DATE]-[DATE] and had a 12% weight loss in one month. A Physician's Order, dated 3/18/25, indicated the resident was to receive a regular diet with no salt packet; no bananas, dried fruit, potatoes, tomatoes, or oranges. Limit to four ounces of milk daily and double protein at meals. The March 2025 Food Consumption Log indicated the resident's dinner intake was not documented on 3/4/25, 3/20/25, and 3/27/25. During an interview on 4/4/25 at 8:45 a.m., the Director of Nursing indicated the resident's food consumption should have been documented. 3. On 3/31/25 at 11:52 a.m. and 12:03 p.m., Resident 52 was observed in her room in bed sleeping. The resident's lunch tray was covered and on the overbed table. On 4/2/25 at 12:02 p.m., the resident was seated in the main dining room. She was served grilled cheese, soup, and jello for lunch. The resident was encouraged to eat by staff and was asked if she would like something else. The resident indicated she didn't want anything else and she would just drink her coffee. The record for Resident 52 was reviewed on 4/1/25 at 3:22 p.m. Diagnoses included, but were not limited to, neurocognitive disorder with behavior disturbance, protein-calorie malnutrition, and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 2/28/25, indicated the resident was cognitively impaired for daily decision making and she required set up or clean up assistance with eating. No weight issues were noted during the assessment reference period. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, dated 10/18/24 and reviewed on 1/19/25, indicated the resident had a nutritional problem or potential nutritional problem related to being at nutritional risk related to low body weight (LBW), a body mass index (BMI) less than 19; meal intake varied, would decline breakfast but would drink coffee; history of receiving a mechanically altered diet due to Barrett's esophagus, dysphagia; abnormal labs due to anemia, LBW; weight may fluctuate due to edema, diuretic; weight gain was desired; diagnoses include depression, protein calorie malnutrition; need for supplements to meet estimated needs. Interventions included, but were not limited to, monitor intake and record every meal. The April 2025 Physician's Order Summary (POS) indicated the resident was to receive a regular diet, mechanical soft/easy to chew texture and nectar thick liquids. The resident was also to be weighed weekly and was receiving an appetite stimulant. The March 2025 Food Consumption Log indicated there was no intake documented for lunch and dinner on 3/4/25. There was no intake documented for dinner on 3/7/25, 3/10/25, and 3/21/25. During an interview on 4/4/25 at 8:45 a.m., the Director of Nursing indicated the resident's food consumption should be monitored for each meal. 3.1-46(a)(1)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure the head of the bed was elevated to at least 45 degrees while a resident's enteral feeding was infusing into the peg tube (a tube inserted directly into the stomach for nutrition) for 1 of 1 resident reviewed for tube feeding. (Resident 17) Finding includes: During a random observation on 4/2/25 at 5:14 p.m., Resident 17 was observed lying completely flat in bed. The head of the bed was flat and not elevated to at least 45 degrees. At that time, the resident had an enteral tube feeding infusing at 55 cubic centimeters (cc) per hour. CNA 2 and RN 1 were immediately notified and asked to reposition the resident in bed. During an interview at that time, CNA 2 and RN 2 both indicated the resident played with the remote control and would lower the head of the bed all the time by herself. RN 1 indicated she had administered her medication at 4:10 p.m., and the head of the bed was elevated at that time. The record for Resident 17 was reviewed on 4/2/25 at 10:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, hemiplegia, dysphagia (difficulty swallowing), chronic kidney disease, heart failure, peg tube, high blood pressure, and a cardiac pacemaker. The Significant Change Minimum Data Set (MDS) assessment, dated 1/22/25, indicated the resident was not cognitively intact for daily decision making, had no oral problems and had a feeding tube through which she received 51% or more of nutrition. A Care Plan, dated 11/24/24, indicated the resident required a tube feeding related to dysphagia. The approaches were to ensure the head of the bed was at least 45 degrees. A Physician's Orders, dated 3/5/25, indicated Enteral Feed every shift of Jevity 1.2 Cal at 55 cc per hour times 24 hours a day. During an interview on 4/3/25 at 11:00 a.m., the Director of Nursing indicated the head of the resident's bed was to be elevated to at least 45 degrees. She was aware of the incident that happened on 4/2/25. The current 2024 Care and Treatment of Feeding Tubes policy provided by the DON on 4/4/25 at 8:30 a.m., indicated the resident's care plan will direct staff regarding proper positioning of the resident consistent with the resident's individual needs. 3.1-44(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 43293 Based on observation, record review, and interview, the facility failed to assess and document a resident's pain in accordance with their care plan for 1 of 1 resident reviewed for pain management. (Resident 20) Finding includes: During an observation on 3/31/25 at 10:36 a.m., Resident 20 winced in pain when moving in bed. He indicated he had pain in his shoulder and hip daily rating 5-8 out of 10. He indicated all the facility was doing for his pain was giving him Tylenol and he did not know why. The resident's record was reviewed on 4/1/25 at 3:30 p.m. Diagnoses included but were not limited to, amputation of the left leg, COPD (chronic obstructive pulmonary disease), and acute respiratory failure with hypoxia (low oxygen levels). The 2/5/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily incision making, required partial assistance with ADLs (activities of daily living) and was independent with transfers. A Physician's Order, dated 12/22/24, indicated Biofreeze External Gel 4 % (a topical pain medication) to the left hip every 3 hours as needed for hip pain. A Physician's Order, dated 12/23/24, indicated Acetaminophen ER Oral Tablet Extended Release 650 MG by mouth every 8 hours for osteoarthritis of the left hip. A Care Plan, revised on 12/13/24, indicated the resident was at risk for pain related to generalized degeneration. Interventions included monitoring and recording pain characteristics: quality, severity, location, onset, duration, aggravating factors, and relieving factors. The record lacked documentation of regular pain assessments. During an interview on 4/3/25 at 11:37 a.m., the Director of Nursing indicated pain should be assessed and documented for a resident taking pain medication or having pain. The EMR (electronic medical record) program got rid of the pain assessment form they had been using, and they would have to figure out something else. A policy titled, Pain Management, received as current on 4/4/25 at 1:20 p.m. from the DON indicated, . In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated . Manage or prevent pain, consistent with the comprehensive assessment and plan of care . 3.1-37(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 10326 Based on record review and interview, the facility failed to ensure a dialysis access site was assessed and monitored as ordered for 1 of 1 resident reviewed for dialysis. (Resident 39) Finding includes: The record for Resident 39 was reviewed on 4/2/25 at 9:57 a.m. Diagnoses included, but were not limited to, stroke, congestive heart failure, and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/25, indicated the resident was moderately impaired for daily decision making and he was receiving dialysis. A Care Plan, dated 12/12/24 and reviewed on 2/14/25, indicated the resident had an alteration in kidney function evidenced by hemodialysis for end stage renal disease (ESRD). Interventions included, but were not limited to, monitor, document, and report as needed (PRN) signs and symptoms of infection to access site: redness, swelling, warmth or drainage. A Physician's Order, dated 5/31/24 and listed as current on the April 2025 Physician's Order Summary (POS), indicated the resident's arteriovenous (AV) fistula (a dialysis access site) to the left upper extremity was to be assessed for patency as well as audible continuous bruit and palpable thrill every shift. The January 2025 Treatment Administration Record (TAR) indicated there was no documentation the AV fistula was assessed for the evening shift on 1/13/25, 1/17/25, and 1/22/25. There was no documentation for the night shift on 1/17/25. The February 2025 TAR indicated there was no documentation the AV fistula was assessed for the day shift on 2/28/25 and the evening shift on 2/1/25 and 2/7/25. The March 2025 TAR indicated there was no documentation the AV fistula was assessed for the day shift on 3/27/25, the evening shift on 3/31/25, and the night shift on 3/23/25. During an interview on 4/4/25 at 8:45 a.m., the Director of Nursing indicated the resident's fistula should have been monitored every shift. The current facility Hemodialysis policy was provided by the Director of Nursing on 4/4/25 at 9:45 a.m. The policy indicated the nurse would ensure the dialysis access site (for example AV shunt or graft) was checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on record review and interview, the facility failed to ensure medications were not used for an excessive duration and an excessive dose for 1 of 1 resident reviewed for antibiotics and 1 of 5 residents reviewed for unnecessary medications. (Residents 44 and 63) Findings include: 1. The record for Resident 44 was reviewed on 4/3/25 at 2:05 p.m. Diagnoses included, but were not limited to, ESBL (extended-spectrum beta-lactamase), neurogenic bladder, sepsis, and urinary tract infection (UTI). The Significant Change Minimum Data Set (MDS) assessment, dated 3/12/25, indicated the resident was cognitively intact. She was dependent with toileting hygiene, always incontinent of bladder, and had received an antibiotic during the last 7 days. A Care Plan, dated 10/17/24 and reviewed on 3/26/25, indicated the resident was on antibiotic therapy related to a history of frequent UTI's. A Physician's Order, dated 10/15/24 and listed as current on the April 2025 Physician's Order Summary (POS), indicated the resident was to receive Macrobid (an antibiotic) 100 milligrams (mg) daily for suppression of ESBL UTI. A Physician's Order, dated 11/21/24, indicated the resident had a 16 french/10 cc (cubic centimeter) Foley catheter. The catheter was discontinued on 12/27/24. A Physician's Order, dated 12/11/24, indicated the resident was to receive Zyvox (an antibiotic) 600 mg twice a day for 10 days for a UTI. A Physician's Order, dated 12/12/24, indicated the resident was to receive Meropenem (an antibiotic) 1 gram intravenously three times a day for 10 days for a UTI. A Nurse's Note, dated 12/26/24 at 12:40 p.m., indicated the resident returned from the hospital with no new orders. She was diagnosed with an acute UTI and to continue the Macrobid. A Physician's Order, dated 12/31/24, indicated the resident was to receive Levaquin (an antibiotic) 250 mg, two tablets daily for 10 days for a UTI. A Physician's Order, dated 1/24/25, indicated the resident was to receive Imipenem-Cilastatin (an antibiotic) 500 mg intravenously every 8 hours for 10 days for a UTI. A Physician's Order, dated 3/6/25, indicated the resident was to receive Meropenem (an antibiotic) 1 gram intravenously every 12 hours for a UTI for 5 days. The resident continued to receive the oral Macrobid while receiving the other antibiotics. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/25 at 8:45 a.m., the Director of Nursing indicated the resident had received numerous rounds of IV antibiotics on top of the oral antibiotic. She indicated the antibiotic was probably not effective any more and the resident was also receiving hospice services. She indicated she would reach out to hospice and see if they still wanted the Macrobid. 10770 2. On 4/3/25 at 9:32 a.m., Resident 63 was observed sitting in a reclined Broda chair. At that time, the Wound Nurse was going to change the resident's bandages to both of his feet. QMA 1 entered the room and administered the resident Morphine Sulfate via a syringe into his mouth. During an interview at that time, QMA 1 indicated the resident was unable to determine his level of pain using a number scale. The record for Resident 63 was reviewed on 4/2/25 at 11:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure, anxiety, heart disease, osteoarthritis, and heart failure. The 12/24/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was never/rarely understood and was severely impaired for decision making. The resident was dependent on staff for bed mobility and transfers. The resident had two unhealed Stage 2 pressure ulcers that were present on admission, received hospice care, and anti-anxiety and opioid medication. A Physician's Order, dated 12/20/24, indicated hospice care. A Physician's Order, dated 1/25/25, indicated Lorazepam 1 mg, give one tablet at bed time at 8:00 p.m. A Physician's Order, dated 1/27/25, indicated Lorazepam (an anti-anxiety medication) 0.5 mg, give 5 mg by mouth every two hours as needed for anxiety. A Physician's Order, dated 1/31/25, Morphine Sulfate (Concentrate) Solution 20 milligrams (mg) give 0.25 milliliter (ml) by mouth every one hour as needed for pain. A Physician's Order, dated 2/3/25 indicated Morphine Sulfate (Concentrate) Solution 20 mg give 0.25 milliliter (ml) by mouth every six hours for pain at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. A Physician's Order, dated 2/27/25, indicated Lorazepam 1 mg, give 1 mg by mouth one time a day for increased agitation at 8:00 a.m. The 1/2025 Medication Administration Record (MAR) indicated the prn Lorazepam and prn Morphine Sulfate were administered simultaneously or very close together on the following dates and times: 1/8/25 at 7:15 a.m. for Lorazepam and 7:16 a.m. for Morphine 1/9/25 at 2:25 a.m for Lorazepam and 2:26 a.m. for Morphine (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/15/25 12:30 a.m. for both Lorazepam and Morphine 1/16/25 3:52 a.m., 9:50 p.m., and 11:52 p.m. for Lorazepam and 3:53 a.m., 9:50 p.m., and 11:52 p.m. for Morphine 1/17/25 11:24 p.m. for Lorazepam and 11:25 p.m. for Morphine 1/18/25 10:53 a.m. for Lorazepam and 10:54 a.m. for Morphine 1/19/25 8:23 p.m. for both Lorazepam and Morphine 1/20/25 6:06 p.m. for both Lorazepam and Morphine 1/21/25 5:04 p.m. for both Lorazepam and Morphine 1/24/25 7:12 p.m. and 9:50 p.m. for both Lorazepam and Morphine The 2/2025 MAR indicated the Lorazepam and Morphine Sulfate were administered simultaneously or very close together on the following dates and times: 2/19/25 9:00 p.m. for Lorazepam and 9:01 p.m., for Morphine 2/22/25 3:22 p.m. for both Lorazepam and Morphine 2/25/25 3:48 p.m. for Lorazepam and 3:47 p.m. for Morphine The 3/2025 MAR indicated the Lorazepam and Morphine Sulfate were administered simultaneously or very close together on the following dates and times: 3/3/25 3:48 p.m. for Lorazepam and 3:47 p.m., for Morphine 3/4/25 4:39 p.m. for Lorazepam and 4:38 p.m., for Morphine 3/5/25 3:29 p.m. for Lorazepam and 3:28 p.m., for Morphine 3/7/25 3:40 p.m. for Lorazepam and 3:41 p.m., for Morphine 3/8/25 4:15 p.m. for both Lorazepam and Morphine 3/9/25 4:15 p.m. for both Lorazepam and Morphine 3/13/25 9:15 p.m. for Lorazepam and 9:14 p.m., for Morphine 3/15/25 3:57 a.m. for both Lorazepam and Morphine 3/17/25 4:43 p.m. for both Lorazepam and Morphine 3/20/25 3:45 p.m. for both Lorazepam and Morphine (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/23/25 3:53 p.m. for both Lorazepam and Morphine 3/25/25 2:12 p.m. and 4:30 p.m. for Lorazepam and 2:13 p.m. and 4:30 p.m. for Morphine 3/30/25 1:26 p.m. for both Lorazepam and Morphine 3/31/25 3:37 p.m. for both Lorazepam and Morphine During an interview on 4/3/25 at 9:50 a.m., QMA 1 indicated depending on the resident's verbal and non verbal actions like how he was moaning, or the position of his legs, was how they scored his pain level. There was a chart in the computer, and based on staff observations, they checked the one he was exhibiting. During an interview on 4/3/25 at 11:00 a.m., the Director of Nursing (DON) indicated she had just reached out to hospice on Monday 3/31/25 to see if they would provide a Fentanyl patch for the resident instead of using the prn Morphine. During an interview on 4/3/25 at 3:00 p.m., the DON indicated nursing staff had a nonverbal pain scale that popped up on the MAR when they gave the Morphine. The Morphine and Lorazepam should not have been given together and Hospice was currently in the facility and was making adjustments to the resident's pain medication. 3.1-48(a)(2) 3.1-48(a)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 10326 Based on observation, record review, and interview, the facility failed to ensure medications were stored correctly for 1 of 7 residents observed during medication administration and 1 of 4 residents reviewed for self-administration of medications. (Residents 23 and 20) Findings include: 1. On 4/2/25 at 4:32 p.m., LPN 1 was observed preparing medications for Resident 23. When the LPN entered the resident's room, a medication cup containing two pills was left on top of the medication cart as well as a Tamsulosin (a medication used to relax the muscles of the bladder and prostate) tablet which was in it's original package. Upon entering the room, the LPN closed the door and the medication cart was out of her view. During an interview on 4/3/25 at 2:00 p.m., the Director of Nursing indicated the pills should not have been left on top of the medication cart. The current facility Medication Storage policy was provided by the Director of Nursing on 4/4/25 at 9:45 a.m. The policy indicated all drugs and biologicals would be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, and medication rooms) under proper temperature controls. 43293 2. During a random observation on 3/31/25 at 10:36 a.m., a nebulizer machine was observed in Resident 20's room. At that time, the resident indicated there was a bag in his closet with the medication for the nebulizer that he got from his own pharmacy and that the facility let him use it sometimes. The paper bag contained 5 boxes of Albuterol (inhaled medication for breathing given via nebulizer) and one box of Fluticasone (an allergy nasal spray). The resident indicated he used them when he felt like he needed them. The resident's record was reviewed on 4/1/25 at 3:30 p.m. Diagnoses included but were not limited to, amputation of the left leg, COPD (chronic obstructive pulmonary disease), and acute respiratory failure with hypoxia (low oxygen levels). The 2/5/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily incision making, required partial assistance with ADLs (activities of daily living) and was independent with transfers. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 10/6/24, indicated Albuterol Inhaled Solution three times a day. There were no orders to use the resident's own medications or to keep the medications at the bedside. There were no orders for Fluticasone. During an interview on 4/3/25 at 11:37 a.m., the Director of Nursing indicated if a medication was to be kept at bedside, it should be written in the medication order and if a resident brought in their own medication, it needed to be evaluated by the facility. She was not aware of the bag of medication in the resident's closet, but she would look into it. A policy titled, Resident Self-Administration of Medication, received as current from the Director of Nursing on 4/4/25 at 8:30 a.m. indicated, . Bedside medication storage is permitted only when it does not present a risk to confused residents . The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents . b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy . 3.1-25(j) 3.1-25(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 10770 Based on observation and interview, the facility failed to serve food under sanitary conditions related to dirty food equipment, dirty floors and dirty PVC pipes under the dish machine for 1 of 1 kitchen observed. (The Main Kitchen) Findings include: During the brief Kitchen Sanitation Tour with the Dietary Food Manager on 3/31/25 at 9:38 a.m., the following was observed: a. There was a large amount of dried grease spillage on top of and on the sides of the deep fryer. The side of the stove next to the deep fryer was also dirty with dried grease. The side of the steamer was observed with dried grease as well as a large amount of food crumbs and dust under the steamer. b. The oven hood vents were dirty and greasy. c. The white PVC pipes under the dish machine were very dirty with a large accumulation of dried food spillage. The floor under the dish machine was dirty with adhered dirt against the wall. d. There were two rusted ceiling vents in the dish room. During an interview on 4/3/25 at 10:45 a.m., the Dietary Food Manager indicated all of the above was in need of cleaning. 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place and implemented related to not donning personal protective equipment (PPE) for residents in enhanced barrier precautions (EBP) and not cleaning multi-use equipment during wound care for 1 of 1 resident with a tube feeding and for 1 of 1 resident with a pressure ulcer. (Residents 17 and 63) Findings include: 1. During a random observation on 4/2/25 at 5:14 p.m., Resident 17 was observed lying completely flat in bed. The head of the bed was flat and not elevated to at least 45 degrees. At that time, the resident had an enteral tube feeding infusing at 55 cubic centimeters (cc) per hour. CNA 2 and RN 1 were immediately notified and asked to reposition the resident in bed. CNA 2 and RN 1 both donned clean gloves to both hands and proceeded to reposition the resident in bed. The RN turned the tube feeding off and lifted up the resident's gown and disconnected the tube. At that time, the resident requested for the surveyor to leave the room. At 5:19 p.m., the door opened and both staff came out of the room. Observation inside the room at that time, indicated there were no used disposable isolation gowns in any of the trash cans in the room. On 4/3/25 at 10:00 a.m., the resident was observed in bed. At that time, there were two hospice CNAs standing on each side of the bed giving the resident a complete bed bath. Both CNAs were wearing gloves to both hands, however, neither one of them wore an isolation gown. The record for Resident 17 was reviewed on 4/2/25 at 10:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, hemiplegia, dysphagia (difficulty swallowing), chronic kidney disease, heart failure, peg tube, high blood pressure, and a cardiac pacemaker. The Significant Change Minimum Data Set (MDS) assessment, dated 1/22/25, indicated the resident was not cognitively intact for daily decision making, had no oral problems and had a feeding tube through which she received 51% or more of nutrition. A Physician's Order, on the 4/2025 Physician Order Summary, indicated the resident was in Enhanced Barrier Precautions. During an interview on 4/4/25 at 11:00 a.m., the Senior Director of Clinical Education was made aware staff were not donning gowns when providing care for the resident and had no additional information to provide. The current 2025 Enhanced Barrier Precautions policy provided by the DON on 4/3/25 at 3:00 p.m., indicated An order for EBP will be obtained for residents with feeding tubes Personal Protective Equipment (gowns and gloves) for enhanced barrier precautions was necessary when performing high contact care activities such as bathing, dressing, changing briefs and device care with feeding tubes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a wound treatment observation on 4/3/25 at 9:32 a.m., the Wound Nurse was observed using her scissors to remove a white kerlix (a rolled gauze) bandage to the left foot. After the treatment was completed, she used the same scissors to cut the new bandage. She did not clean the scissors after removing the dirty bandage. The Wound Nurse then performed the treatment to the right foot. Using the same dirty scissors, she cut the old white kerlix bandage off the foot. After the treatment was completed, she used the same dirty scissors to cut the new bandage to the foot. During an interview at that time, the Wound Nurse was aware she did not clean her scissors in between dirty and clean bandages and between pressure areas. The record for Resident 63 was reviewed on 4/2/25 at 11:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure, anxiety, heart disease, osteoarthritis, and heart failure. The 12/24/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was never/rarely understood and was severely impaired for decision making. The resident had two unhealed Stage 2 pressure ulcers that were present on admission. Physician's Orders, dated 2/21/25 and 3/19/25, indicated to cleanse the right and left heels with wound cleanser, pat dry, apply silver alginate and cover with a bordered gauze. Wrap with rolled gauze and secure with tape daily. During an interview on 4/4/25 at 9:30 a.m., the Director of Nursing indicated the scissors should have been cleaned after each use. The current 2024 Cleaning and Disinfection of Resident Care Equipment policy, provided by the Senior Director of Clinical Education, indicated multiple resident use equipment shall be cleaned and disinfected after each use. 3.1-18(b)