STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155094	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary Healthcare Center	2201 Cason St Lafayette, IN 47904

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49891 Based on interview and record review, the facility failed to include a seizure disorder diagnosis or monitoring for seizure medication side effects in the care plan for 1 of 1 resident reviewed for comprehensive care plans. (Resident 29). Finding includes: The clinical record for Resident 29 was reviewed on 4/25/24 at 11:40 a.m. The diagnoses included, but were not limited to, epilepsy without status epilepticus, dementia with other behavioral disturbance, delusions disorder, depression, anxiety disorder, and insomnia. A physician's order, dated 2/20/24, indicated to give lamotrigine (an anticonvulsant) 100 milligrams (mg) twice a day for epilepsy. A care plan, dated 3/15/24, did not include the risk for seizures with an epilepsy diagnosis. There were no approaches for monitoring seizure activity or safety measures for seizures. A care plan, dated 3/15/24, did not include the resident receiving an anticonvulsant medication for epilepsy. There were no approaches for monitoring for seizure medication side effects. During an interview, on 4/26/24 at 2:35 p.m., the Clinical Support Nurse indicated the Nurse Practitioner included a history of seizures for Resident 29. During an interview, on 4/29/24 at 3:09 p.m., the Director of Nursing (DON) indicated the facility had not included monitoring for seizures in the care plan for Resident 29. A current policy, titled Comprehensive Care Plan Guideline, dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/26/24 at 4:30 p.m., indicated .Care plan interventions should be reflective of risk area(s) or disease processes that impact the individual resident .The comprehensive care plan should be .revised to reflect changes in the resident's condition as they occur .Comprehensive care plans need to remain accurate and current 3.1-35(a) 3.1-35(b)(1)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48525 Based on observation, interview and record review, the facility failed to administer medications within the ordered time frame, assess and accurately document a resident's dental status and communicate with hospice and provide a positioning chair to meet the residents care planned needs for 6 of 6 residents reviewed for quality of care. (Residents 40, 47, 1, 20, 46 and 27) Findings include: 1. The clinical record for Resident 40 was reviewed on 4/24/24 at 3:45 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, heart failure, edema, and chronic kidney disease stage 3. A current physician's order, with a start date of 12/21/23, indicated the resident was to take buspirone (an antianxiety medication) 5 milligrams (mg) 3 times per day. Administer the first dose from 6:00 a.m. to 10:00 a. m., administer the second dose from 11:00 a.m. to 1:30 p.m., and administer the third dose from 6:00 p.m. to 10:00 p.m. A medication administration record (MAR) indicated the following administration times for buspirone: a. On 4/1/24 at 3:07 a.m. b. On 4/6/24 at 3:02 a.m. c. On 4/7/24 at 3:00 a.m. d. On 4/8/24 at 3:01 a.m. e. On 4/13/24 at 3:06 a.m. f. On 4/14/24 at 3:01 a.m. g. On 4/17/24 at 4:36 a.m. h. On 4/20/24 at 3:10 a.m. i. On 4/21/24 at 3:00 a.m. j. On 4/22/24 at 3:20 a.m. There was no documentation to show the physician was notified about administering the medications early. During an interview, on 4/26/24 at 11:57 a.m., the DON (Director of Nursing) indicated she was not sure why the medications were given outside of the ordered times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The clinical record for Resident 47 was reviewed on 4/24/24 at 3:54 p.m. The diagnoses included, but were not limited to, dependence on renal dialysis, diabetes mellitus, depression, and end stage renal disease. A physician's order, dated 1/18/24, indicated to give Eliquis (an anticoagulant) 2.5 mg tablet twice a day. Administer the first dose from 6:00 a.m. to 10:00 a.m., and the second dose from 7:00 p.m. to 10:00 p.m. A MAR indicated the following administration times for Eliquis: a. On 4/1/24 at 3:07 a.m. b. On 4/6/24 at 3:02 a.m. c. On 4/7/24 at 3:00 a.m. e. On 4/8/24 at 3:01 a.m. f. On 4/13/24 at 3:07 a.m. g. On 4/14/24 at 3:02 a.m. h. On 4/17/24 at 4:46 a.m. i. On 4/20/24 at 3:10 a.m. j. On 4/21/24 at 3:01 a.m. k. On 4/22/24 at 3:21 a.m. There was no documentation to show the physician was notified of the early medication administration. During an interview, on 4/24/24 at 11:15 p.m., QMA 6 indicated the time she checked medications off in the computer was the time she gave the medication. 3. The clinical record for Resident 1 was reviewed on 4/24/24 at 3:57 p.m. The diagnoses included, but were not limited to, cerebral palsy, diabetes mellitus, depressive disorder, and anxiety disorder. A physician's order, dated 2/15/24, indicated to give baclofen (a muscle relaxant medication) 10 mg tablet three times a day. Administer the first dose from 6:00 a.m. to 10:00 a.m., the second dose from 11:00 a.m. to 1:30 p.m., and the last dose from 6:00 p.m., to 10:00 p.m. A MAR indicated the following administration times for baclofen: a. On 4/1/24 at 3:08 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 4/6/24 at 3:09 a.m. c. On 4/7/24 at 3:01 a.m. d. On 4/8/24 at 3:02 a.m. e. On 4/14/24 at 3:05 a.m. f. On 4/20/24 at 312 a.m. g. On 4/21/24 at 3:03 a.m. h. On 4/22/24 at 3:23 a.m. There was no documentation to show the physician was notified of the early medication administration. 4. The clinical record for Resident 20 was reviewed on 4/26/24 at 9:44 a.m. The diagnoses included, but were not limited to, dysphagia (difficulty swallowing), chronic kidney disease, anxiety disorder, and major depressive disorder. A physician's order, dated 12/28/23, indicated to give lansoprazole oral suspension liquid (a medication used to treat indigestion, acid reflux, heartburn, and other stomach issues) 3 mg/ml, take 10 ml's by gastric tube twice a day. Administer the first dose from 6:00 a.m. to 12:00 p.m., and the second dose from 6:00 p.m. to 10:00 p.m. The MAR indicated the following administration times for lansoprazole: a. On 4/6/24 at 3:05 a.m. b. On 4/7/24 at 3:02 a.m. c. On 4/8/24 at 3:03 a.m. d. On 4/13/24 at 3:12 a.m. e. On 4/14/24 at 3:07 a.m. f. On 4/20/24 at 3:14 a.m. g. On 4/21/24 at 3:05 a.m. h. On 4/22/24 at 3:25 a.m. There was no documentation to show the physician was notified of the early medication administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 4/25/24 at 11:18 a.m., the DON indicated the facility had extended medication times. The nurses had one hour before and one hour after the scheduled times to pass the medication. During an interview, on 4/26/24 at 11:57 a.m., the DON indicated the time the medications were charted was most likely the time the nurse gave the medications. She did not know why the nurses gave the medication early. 36454 5. During an observation, on 4/23/24 at 12:46 p.m., Resident 46 was sitting up in a chair in the dining room. The resident did not look like she had any teeth as her mouth and cheeks were sunk in. During an observation, on 4/23/24 at 1:18 p.m., Resident 46 was standing in the dining room, she had no top teeth and had several natural teeth on the bottom which were observed while the resident was talking and smiling. The clinical record for Resident 46 was reviewed on 4/25/24 at 9:51 a.m. The diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, osteoarthritis, anxiety disorder, and depression. A Minimum Data Set (MDS) assessment, dated 8/23/23, indicated the resident was edentulous (had no teeth). A Personal Inventory Form, dated 8/21/23, was blank. A care plan profile guide, dated 8/22/23, indicated the resident was edentulous. A care plan, dated 8/29/23, indicated the resident was at risk for mouth pain related to the edentulous status. The approaches included, but were not limited to, assessing the condition of the oral cavity as needed and a dental evaluation and interventions as needed. A Nutrition note, dated 2/22/24, indicated the resident had upper and lower dentures. A Dental Note, dated 4/9/24, indicated the resident had a full removable upper appliance. The upper denture was cleaned and inspected and appeared to be okay. The resident had 9 natural teeth on the bottom. During an interview, on 4/25/24 at 11:49 a.m., QMA 2 indicated the resident would not put in her upper dentures. QMA 2 was not sure if the resident had natural bottom teeth. There was a denture cup in the resident's room and no dentures. During an interview, on 4/25/24 at 3:03 p.m., the Unit Director observed a denture cup in the resident's room, and it was empty. The resident had lost her dentures at the previous facility and the Unit Director did not know why the dentures had not been replaced. During an interview, on 4/25/24 at 3:50 p.m., the Clinical Support Nurse did not know if the resident had dentures when she arrived at the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 4/26/24 at 11:00 a.m., the Clinical Support Nurse indicated there was conflicting information in the resident's record about her teeth. The Registered Dietitian had reported the resident had upper and lower dentures and the MDS indicated the resident was edentulous. During an interview, on 4/26/24 at 11:56 a.m., the DON indicated there was a note from the previous facility which indicated the resident's upper dentures were missing. The resident's admission inventory list was not in the electronic health record, and she did not know if dentures were checked on the admission inventory. During an interview, on 4/29/24 at 3:19 p.m., the DON indicated the notes from the dentist could have been copied and pasted from dental notes at the previous facility. The resident did have natural lower teeth and no dentures. The resident had been non-compliant with wearing the upper dentures previously although this was not documented. There was conflicting information in the electronic health record about the resident's dental status. 6. During an observation, on 4/23/24 beginning at 12:17 p.m., Resident 27 was sitting up in a short Broda chair (a chair for positioning) with no leg rests or foot supports. Her head was even with the table and not at the normal height for eating. The resident was using her fingers to eat and had to reach up to the table. When she tried to pick up her silverware her hands would shake and then she would put the silverware down and use her fingers again. Her legs were dangling, and her feet were touching the floor. During an observation, on 4/23/24 at 1:01 p.m., Resident 27 was sitting up in a Broda chair in her room. Her legs were dangling, and her feet were touching the floor. During an observation, on 4/25/24 at 2:52 p.m., the resident was sitting up in a Broda chair in the dining area. Her legs were dangling, and her feet were touching the floor. During an observation, on 4/26/24 at 12:30 p.m., the resident was in the dining room in a different Broda chair with her feet on the foot rests of the chair. The chair was at a regular height for sitting at a dining table. The staff were cueing the resident, and she was eating the French fries and chicken with her fingers. The clinical record for Resident 27 was reviewed on 4/24/24 at 4:40 p.m. The diagnoses included, but were not limited to, Alzheimer's disease with late onset, adult failure to thrive, generalized anxiety disorder, and low back pain. A physician's order, dated 11/25/23, indicated to admit to hospice with a diagnosis of chronic kidney disease stage 3, dementia, failure to thrive, and hypertension. A hospice progress note, dated 4/10/24 at 9:28 p.m., indicated the resident was seated in a wheelchair. The hospice staff talked to the facility about this and even among the staff, they did not know why the resident was in a wheelchair. The resident could still walk although had been voluntarily sitting in the wheelchair more often. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A hospice progress note, dated 4/17/24 at 11:44 a.m., indicated the resident was seen sitting in a Broda chair in the common area. The resident was no longer able to ambulate independently. The facility was using the resident's wheelchair for another resident, so they had the resident in a broken Broda chair. The hospice staff placed an order for a Broda chair. A care plan profile guide indicated to encourage the resident to elevate her legs when sitting up. There was no care plan for a Broda chair and no physician's order for the Broda chair. During an interview, on 4/25/24 at 3:06 p.m., Qualified Medication Aide (QMA) 2 indicated the Broda chair was ordered for the resident by hospice. During an interview, on 4/26/24, the Clinical Support Nurse indicated a Broda chair was ordered by hospice. The short Broda chair was from the facility since the Broda chair from hospice had not arrived yet. The care planned profile guide which indicated the resident was to be encouraged to keep her legs elevated when up was old and not a current concern for the resident. The Profile Guide has not been updated. During an interview, on 4/29/24 at 3:01 p.m., the Director of Nursing (DON) indicated the facility tried to get hospice to order a Broda chair and the chairs were on back order. The facility had plenty of wheelchairs. During an interview, on 4/30/24 at 10:18 a.m., the hospice Registered Nurse (RN) 3 indicated the facility had not communicated with the hospice the resident was no longer ambulatory. The resident was sitting in a Broda chair with the armrest on the left side broken. The staff told RN 3 the resident's wheelchair was needed for another resident, so they put the resident in the Broda chair. The resident was comfortable in the Broda chair, so the hospice staff ordered one for the resident on 4/17/24 and it was on back order until 4/26/24. The resident was still able to stand and transfer and physically had the ability to walk although with her dementia her mind was not letting her walk. The Broda chair ordered by hospice had leg and footrests for positioning. 44598 A current hospice contract, received at entrance, indicated .subsequent to the initial assessment, a plan of care is developed together with the primary physician, facility professionals and the patient and family A current policy, titled Medication Administration Times Procedural Guidelines, dated as revised on 12/1/21 and received from the Director of Nursing Services on 4/26/24 at 9:11 a.m., indicated .To ensure medication is administered in resident centered fashion and documented in medical records A current policy, titled Admission Policy, dated as revised on 1/19/17 and received from the Clinical Support Nurse on 4/26/24 at 4:30 p.m., indicated .The facility will not request or require residents or potential residents to waive potential facility liability or losses of personal property (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current policy, titled Program Guidelines: Restorative Mobility Program, dated as revised on 12/31/22 and received from the Clinical Support Nurse on 4/26/24 at 4:30 p.m., indicated .To encourage increased independence and maintain mobility through services that promotes circulation stimulates and strengthens muscle, reduces the potential of falls and increases self-esteem .Analyze interdisciplinary assessments to determine need for restorative mobility interventions. Assessments may include but are not limited to: MDS . Nursing Assessments .Therapy screens and/or evaluations .Fall Event .Determine resident specific needs to enhance mobility by analyzing the assessments and communication .Determine the type of mobility program required and establish a baseline through the assessment. Mobility interventions include but are not limited to .Wheelchair mobility: using a wheelchair for independent mobility A current policy, titled Dental Services Including Repair, Replacement, dated as revised on 11/8/17 and received from the Clinical Support Nurse on 4/26/24 at 4:30 p.m., indicated .Clinical staff will assess teeth and gums upon admission, with each comprehensive assessment and as needed to identify pain, lost or broken teeth, visible signs of tooth decay and other chewing and swallowing problems .The facility will ensure the delivery of emergency dental services to meet the resident needs .The Admissions team (CSR, CSS or Guest Relations) will be responsible for getting the Dental consent form signed upon admission, if the resident chooses to us the contracted dental service 3.1-37(a)

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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. 36454 Based on interview and record review, the facility failed to ensure post fall interventions were evaluated for effectiveness and a rationale was documented prior to removing the interventions from the comprehensive care plan for 2 of 3 residents reviewed for accidents. (Resident 23 and 54) Findings include: 1. The clinical record for Resident 23 was reviewed on 4/25/24 at 3:42 p.m. The diagnoses included, but were not limited to, malignant neoplasm of the pancreas, unspecified dementia with other behavioral disturbance, and chronic kidney disease stage 3. A fall event, dated 9/24/23 at 5:53 p.m., indicated the resident was ambulating back from the dining room toward her room using a walker. The resident's legs became weak, and she was lowered to the ground. An interdisciplinary team (IDT) note, dated 9/25/23 at 9:46 a.m., indicated the new intervention was for hospice to re-evaluate the use of ambulatory device and weakness. The intervention for hospice to re-evaluate the use of ambulatory device and weakness was not on the current care plan and the progress notes did not include a resolution of this intervention. A Facility Reported Incident (FRI), dated 12/27/23, indicated Resident 23 was attempting to ambulate and fell . The injury was an acute metatarsal (a bone of the foot). The care plan was reviewed and updated accordingly. The new intervention was for staff to toilet the resident in the morning between 6:00 a.m. and 8:00 a.m. The new intervention for the staff to toilet the resident in the morning between 6:00 a.m. and 8:00 a.m., was not on the current fall care plan. 2. The clinical record for Resident 54 was reviewed on 4/24/24 at 2:59 p.m. The diagnoses included, but were not limited to, unspecified dementia with anxiety, heart failure, type 2 diabetes mellitus, chronic kidney disease stage 3, repeated falls, and difficulty in walking. A Fall Event, dated 2/27/24 at 2:39 p.m., indicated the resident was found on the floor in his room between beds. The IDT indicated the new intervention was to encourage and offer activities after lunch. The fall care plan, dated 6/1/23 and last updated on 4/24/24, did not include the intervention to offer activities after lunch. The electronic record did not include a resolution of this intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/29/24 at 3:22 p.m., the Director of Nursing (DON) indicated if the root cause of the fall changed then the intervention implemented from the IDT would be removed. The progress notes did not indicate if hospice had evaluated Resident 23 for the use of ambulatory devices. Both interventions were removed from the care plan and there was no documentation to indicate if the intervention was effective or no longer applied to the resident. The documentation for Resident 54 did not include if the intervention for offering activities was effective or no longer applied to the resident. A current policy, titled Fall Management Program Guidelines, dated as reviewed 12/31/23 and received from the Clinical Support Nurse on 4/26/24 at 4:30 p.m., indicated .strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures .The fall risk assessment is included as part of the Admission and Quarterly Nursing Observation and other Events/Observation in EHR [electronic health record] .Should the resident experience a fall the attending nurse shall complete the 'Fall Event. This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors, interventions to reduce risk of repeat episode and a review by the IDT to evaluate thoroughness of the investigation and appropriateness of the interventions . The resident care plan should be updated to reflect any new or change in interventions .Discuss risks and interventions with resident and/or responsible party and communicate interventions during shift report 3.1-45(a)(2)

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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. 44598 Based on interview and record review, the facility failed to ensure a resident on a fluid restriction was monitored for 1 of 1 resident reviewed for a fluid restriction related to dialysis. (Resident 47) Finding includes: The clinical record for Resident 47 was reviewed on 4/24/24 at 3:54 p.m. The diagnoses included, but were not limited to, dependence on renal dialysis, diabetes mellitus, depression, and end stage renal disease. A care plan, dated 10/27/21, indicated the resident had a potential for weight fluctuations and alterations in labs due to receiving dialysis treatments. The interventions included, but were not limited to, limit fluid intake if a fluid restriction was ordered. A care plan, dated 10/27/21, indicated the resident had a diagnosis of renal failure. The interventions included, but were not limited to, treatment to dialysis site per physician's order, observe catheter site per orders, and fluid restriction per orders. A physician's order, dated 12/28/23, indicated to encourage a 1200 milliliters (ml's) daily fluid restriction. The order indicated to give 240 ml's with meals and nursing was to provide 240 ml's every dayshift, and 120 ml's on the evening and nightshift. A facility vitals report, from 4/1/24 to 4/25/24, indicated 17 out of 25 days the resident went over her daily fluid restriction. During an interview, on 4/29/24 at 10:44 a.m., CNA 4 indicated she was not aware the resident was on a fluid restriction. The information would be on the resident's care plan, and she had not recently looked at the care plan. During an interview, on 4/29/24 at 10:54 a.m., the Director of Nursing (DON) indicated the resident was on a fluid restriction. When the order said to encourage a fluid restriction, the facility would like to see the resident stay around the 1200 ml's a day. During an interview, on 4/29/24 at 10:58 a.m., Resident 47 indicated she was on dialysis and was not supposed to drink a lot. During an interview, on 4/29/24 at 11:17 a.m., the DON indicated the resident did not have a care plan for being noncompliant with fluids. (continued on next page)

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St Mary Healthcare Center	2201 Cason St Lafayette, IN 47904

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, titled Guidelines for Fluid Restrictions, dated as revised 12/1/21 and received from the DON on 4/29/24 at 11:55 a.m., indicated .To ensure fluids are provided within the physician order guidelines .Upon receipt of a physician's order for fluid restriction the Director of Health Services and Director of Food Services shall be notified of the order. Intake monitoring shall be initiated up receipt of the order .The Dietary Department shall record established breakdown by meal on tray card. The Nursing Department shall record established breakdown by shift and document in the EHR. Fluid consumption shall be reviewed by shift to determine adjustments necessary in the fluid intake of the resident on the restriction in order to meet their established fluids needs .Should the resident .chose not to comply with the recommended fluid restriction a Self Determination of Care or Informal Refusal and Non-Compliance observation should be completed explaining the risk(s) of noncompliance .The resident should be periodically assessed for appropriateness and continued need for fluid restriction 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. 49891 Based on interview and record review, the facility failed to include monitoring for seizure medication side effects and seizure activity and to review a resident's history for 1 of 5 residents reviewed for unnecessary medications. (Resident 29). Finding includes: The clinical record for Resident 29 was reviewed on 4/25/24 at 11:40 a.m. The diagnoses included, but were not limited to, epilepsy without status epilepticus, dementia with other behavioral disturbance, delusions disorder, depression, anxiety disorder, hyperlipidemia, insomnia, and deficiency of other specified B group vitamins. A psychiatric unit after visit care note, dated 12/14/23, indicated lamotrigine was for mood stabilization related to diagnoses of dementia with behavior disturbance, major depressive disorder, and anxiety disorder. A physician's order, dated 2/20/24, indicated to give lamotrigine (an anticonvulsant) 100 milligrams (mg) twice a day for epilepsy. The original physician's order indicated related diagnosis dementia, seizures? A care plan, dated 3/15/24, did not include risk for seizures with an epilepsy diagnosis. There were no approaches for monitoring seizure activity or safety measures for seizures. A care plan, dated 3/15/24, did not include the resident receiving an anticonvulsant medication for epilepsy. There were no approaches for monitoring for seizure medication side effects. The clinical record did not include order sets for seizures, monitoring for seizure activity, or for monitoring for side effects of anticonvulsant medication. During an interview, on 4/26/24 at 2:35 p.m., the Clinical Support Nurse indicated the Nurse Practitioner included a history of seizures for Resident 29. During an interview, on 4/26/24 at 3:35 p.m., the DON (Director of Nursing) indicated the diagnoses are not added by this facility, rather a Louisville home office coder provided this service. She indicated the facility would need to determine which diagnosis the lamotrigine was being given for and if the resident had a seizure disorder diagnosis. During an interview, on 4/29/24 at 3:09 p.m., the DON indicated the facility had not included monitoring for seizures in the care plan for Resident 29. She indicated there was not a clear reason for the lamotrigine prescription according to the facility documentation. She indicated she was trying to call the family to confirm the seizure diagnosis. She indicated a question mark should not be on the physician orders. (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 4/29/24 at 4:18 p.m., the DON indicated she had concluded the resident did not have a diagnoses of seizure disorder. She indicated she went back through all the records and decided Resident 29 did not have a seizure disorder. The clinical record did not include any gradual dose reduction attempt for the lamotrigine when given for mood disorder rather than seizure disorder. A current policy, titled Psychotropic Medication Usage and Gradual Dose Reductions, dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/29/24 at 4:00 p.m., indicated .To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team . Regular monthly review of antipsychotics in CAR [clinically at risk] for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted 3.1-48(a)(3) 3.1-48(a)(4)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 36454 Based on interview and record review, the facility failed to ensure the assessments for side effects for antipsychotic medications were completed timely for 1 of 5 residents reviewed for unnecessary medications. (Resident 54) Finding includes: The clinical record for Resident 54 was reviewed on 4/24/24 at 2:59 p.m. The diagnoses included, but were not limited to, unspecified dementia with anxiety, major depressive disorder, anxiety disorder, and a cognitive communication deficit. A physician's order, dated 5/25/23 through 10/27/24, indicated to give olanzapine (an antipsychotic) 5 milligram (mg) at bedtime. There was no diagnosis with the order. A physician's order, dated 10/27/23 through 1/13/23, indicated to give olanzapine 2.5 mg at bedtime. There was no diagnosis with the order. An Abnormal Involuntary Movement Scale (AIMS) was completed on 6/21/23. This was 27 days after the medication was ordered. A physician's order, dated 1/25/24 and open ended, indicated to give Risperdal (an antipsychotic) 0.5 mg once a day. An AIMS assessment was completed on 1/25/24. This was 7 months and 4 days after the initial AIMS assessment was completed on 6/21/24. A care plan, dated 1/30/24, indicated the resident was at risk for adverse reactions related to receiving an antipsychotic medication. The approaches included, but were not limited to, AIMS test according to guidelines. During an interview, on 4/29/24 at 2:53 p.m., the Director of Nursing (DON) indicated the AIMS was not completed initially and every 6 months according to the facility policy. A current Nursing Drug Handbook indicated the adverse reactions for olanzapine and Risperdal included, but were not limited to, extrapyramidal events (involuntary movements including tremors, facial movements which are caused by antipsychotic medication) and tardive dyskinesia (a feeling of restlessness and not being able to sit still with the urge to tap fingers, fidget or jiggle the legs). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, titled Guidelines for: Abnormal Involuntary Movement Scale [AIMS], dated as reviewed on 12/31/23 and received from the DON on 4/29/24 at 10:20 a.m., indicated .Guidelines for: Abnormal Involuntary Movement Scale .To assess residents that have prescribed antipsychotic medications to identify symptoms that may indicate the presence of Tardive Dyskinesia; a neurologic disorder characterized by abnormal involuntary movements which may occur as an undesired effect of dopamine blocking medications . A licensed nurse will complete an AIMS scale assessment on all residents on antipsychotic medications and or other medications known to cause Tardive Dyskinesia .The AIMS assessment will be completed if possible, prior to the resident beginning this type of medication, or at the earliest possible time, either after admission; after medications listed above are prescribed; and with dosage changes .The AIMS assessment will be repeated for residents taking antipsychotic medications every six [6] months A current policy, titled Psychotropic Medication Usage and Gradual Dose Reductions, dated as reviewed on 12/31/23 and received from the Clinical Support Nurse on 4/29/24 at 4:00 p.m., indicated .To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team . Regular monthly review of antipsychotics in CAR [clinically at risk] for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted 3.1-48(a)(3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46961 Based on observation, interview and record review, the facility failed to ensure the facility was free of strong odors, the walls, doors, and carpet were maintained, and the trash was disposed of in 2 of 3 units observed for environment. (200 hall and 100 hall) Finding includes: During an observation, on 4/23/24 at 11:00 a.m., the back hallway had a strong odor. The odor was stronger near the riser room. During an observation, on 4/23/24 at 12:07p.m., the lower portion of the walls in the dementia unit dining room had brown paint with gouges in the corners and white paint showing through. The lower half of the doors throughout the hallway had black marks. The carpet in the hallways had faded areas and dark stains. During an observation, on 4/23/24 at 2:44 p.m., an odor of urine was noted in the bathroom of room [ROOM NUMBER]. A urine-soaked brief was observed in the trash can. During an observation, on 4/23/24 at 1:27 p.m., the carpet in room [ROOM NUMBER] was very wet and slick. A resident was walking on the wet carpet with nonskid socks and the socks were wet. During an observation, on 4/24/24 at 10:30 a.m., the back hallway had a strong odor. The odor was stronger near the riser room. During an observation, on 4/24/24 at 4:38 p.m., the front hallway had a strong odor noted. During an observation, on 4/25/24 at 2:01 p.m., with the Plant Operations Director, room [ROOM NUMBER] was observed to have black marks on the room entry door. room [ROOM NUMBER] had paint missing around the bathroom sink. The bathroom wall was yellow with white gouging around the wall by the sink. room [ROOM NUMBER] had two gouges on the right side of the bathroom wall the size of baseballs. There were paint chips all over linoleum towards the right side of the bathroom. room [ROOM NUMBER] had paint peeled around the sink. During an observation, on 4/26/24 at 2:29 p.m., a very strong odor was noted in the back hallway towards the chapel, the chapel had a very strong smell. During an observation, on 4/29/24 at 1:54 p.m., the front hallway had a very foul unidentifiable odor. The odor was not urine or bowel movement. During an interview, on 4/29/24 at 2:30 p.m., the Maintenance Director indicated the areas around the sinks were due to someone repairing the counter tops around the sinks and putting painters tape up. When the tape was removed, it peeled the paint. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/25/24 at 11:20 a.m., the Maintenance Director indicated there have been problems with the sewage system. They had a quote and would have to bust concrete to replace some sewer lines, and quotes to fix the main water lines. There was a pipe rebuilt which was back in the riser room, the drain line had to be rebuilt, they saddled on to a different drain line, it drained from the water heater, water softeners and laundry room, they had to seal it up. The facility had a sewer gas smell usually in the shop or laundry room. There were multiple sewer lines, it was wet but not an active leak. The problem was in the shop, the water was not draining. He worked at the facility 2 and 1/2 years and they have had problems with the sewer line off and on the whole time. They are getting money to get some things updated. During an interview, on 4/26/24 at 10:00 a.m., the Executive Director indicated the wet carpet was extracted again and walk off mats (absorbs water from feet) were placed on the linoleum floors. The smells in the front hall and back hall were probably sewer, the back hall especially. The clean-out drain was located at the back of the building. When it rained, it could smell more. A current policy, titled Walls Preventative Maintenance, dated 2/18/2018 and received from the Executive Director, on 4/29/24 at 3:20 p.m., indicated . it is the policy to inspect common area and corridor walls monthly resident room walls are inspected during routine semi-annual preventative maintenance .survey the wall for any pain or wallcovering that needs repair .protect floor with a drop cloth while painting, touch up painting requires painting walls from break point to break point . Touching up spots on the walls is not an acceptable practice .glue lose vinyl wallcovering seams .inspect handrails for splintering and make sure they are tightly secured 3.1-19(f)(5)