STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Brandywine Care Center	745 N Swope St Greenfield, IN 46140

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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. 45291 Based on interview and record review, the facility failed to promote dignity for 2 of 4 residents reviewed for quality of care. (Resident B and Resident H) Findings include: 1a. The clinical record for Resident B was reviewed on 3/20/2025 at 11:30 a.m. The medical diagnoses included dementia and anxiety. A Quarterly Minimum Data Set assessment, dated 12/20/2024, indicated Resident B was cognitively impaired, did not have behaviors of rejecting care, was incontinent of bowel and bladder, and dependent on staff for toileting needs. An incontinence care plan, revised 2/2/2025, indicated Resident B had functional bladder incontinence. Resident B needed interventions of checking and changing incontinent products as needed. A grievance form, dated 2/26/2025, indicated a concern was filed regarding Resident B being left sitting in his chair for an extended period and regarding the last time he was assisted with toileting needs. 1b. The clinical record for Resident F was reviewed on 3/19/2025 at 2:04 p.m. The medical diagnosis included anxiety disorder. A Quarterly Minimum Data Set assessment, dated 1/7/2025, indicated Resident F was cognitively intact. During an interview on 3/19/2025 at 11:30 a.m., Resident F indicated he was very concerned about how the staff treat Resident B because staff will often get Resident B out of bed, around 9:30 a.m., and do not change Resident B until they lay him down for bed around 9:30 p.m. Resident F recalled a specific time instance that Resident B was taken to sit in front of the television in the common room, at 9:30 a.m., and was not brought back to the room until 9:30-10:00 p.m. Resident B was noted to be soaking wet with urine. Resident F felt it was disrespectful and ridiculous for Resident B to be left up all day and be urine soaked. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The clinical record for Resident H was reviewed on 3/21/2025 at 11:30 a.m. The medical diagnoses included diabetes and chronic obstructive pulmonary disease. An Admission Minimum Data Set assessment, dated 2/10/2025, indicated Resident H was cognitively intact, did not reject care, and was frequently incontinent of bowel and bladder. Care plans, revised 2/24/2025, indicated Resident H had incontinence of bowel and bladder, requiring the need for assistance with incontinence care. During an interview with Resident H on 3/18/2025 at 1:45 p.m., she indicated there were times her call light went off for an extended period. Resident H provided handwritten notes of how long her call light was on before it was answered. During this time frame, Resident H indicated she had episodes of bladder and bowel incontinence, but one specific incident resulted in her becoming incontinent of a bowel movement and sitting in her waste for over an hour. This made Resident H feel disgusting and humiliated. Review of the handwritten notes provided by Resident H indicated the following times she waited over thirty minutes to have her call light answered: 3/10/2025 - call light turned on at 6:20 p.m. and answered at 7:10 p.m., 3/11/2025 - call light turned on at 6:25 p.m. and answered at 7:30 p.m., 3/15/2025 - call light turned on at 1:19 p.m. and answered at 2:25 p.m., 3/16/2025 - call light turned on at 11:00 a.m. and answered at 11:45 a.m., 3/16/2025 - call light turned on at 2:20 p.m. and answered at 3:10 p.m., and 3/16/2025 - call light turned on at 8:15 p.m. and answered at 9:15 p.m. During an interview with the Director of Nursing Services on 3/24/2025 at 2:05 p.m., she indicated it was the expectation for all residents to be treated with dignity and respect. 3.1-3(a) 3.1-3(t)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 45291 Based on interview and record review, the facility failed to timely follow up on a resident's request to be transferred to the hospital for treatment regarding scrotal swelling and pain for 1 of 2 residents reviewed for choices. (Resident J) Findings include: The clinical record for Resident J was reviewed on 3/21/2025 at 12:45 p.m. The medical diagnoses included respiratory failure and diabetes. A Quarterly Minimum Data Set assessment, dated 2/7/2025, indicated Resident J was cognitively intact and did not exhibit behaviors. A care plan, revised 11/15/2023, indicated Resident J had depression and a psychotic disorder. Interventions were listed to allow and encourage choices. During an interview on 3/19/2025 at 12:12 p.m., Resident J indicated earlier this month he had swelling to his scrotum. He requested to go to the emergency room , but the nurse came in and told him to take some pain medicine. He stated he took the pain medicine and then asked to go to the ER [emergency room], but she wouldn't send him. The next day, the pain to his scrotum continued. Around evening into night shift change, on 3/3/2025, per Resident J, he asked to go to theER on ce more, but the nurse wouldn't send him. He stated he waited a few more hours, but the pain was getting too severe, so he asked to be transferred to the ER again, but the nurse wouldn't send him. He indicated he then called emergency services to be transferred to the hospital. A physician order, dated 10/25/2024, indicated for Resident J to utilize Norco (narcotic pain medication) 10/325 mg (milligrams) every six hours as needed for severe pain. A nursing progress note, dated 3/2/2025 at 3:26 a.m., indicated the nurse was called to Resident J's room for scrotal swelling, redness, and pain. The nurse called the on-call provider and received an order to elevate the areas of swelling and administer pain medication. A nursing progress note, dated 3/3/2025 at 2:42 a.m., indicated the nurse was alerted to the police department responding to Resident J's call to emergency services related to wanting to go the hospital for severe groin pain. The nurse notified the on-call provider and placed a call to emergency services. A nursing progress note, dated 3/3/2025 at 2:54 a.m., indicated Resident J was transferred to the hospital via emergency services. Review of the March 2025 Medication Administration Record (MAR) indicated Resident J utilized Norco twice, on 3/2/2025, for pain rated 8 out of 10 (severe pain). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/2025 at 11:09 a.m., Certified Nurse Aide (CNA) 14 indicated she remembered working with Resident J when he had a swollen scrotum. Resident J had requested, around 10:00 - 11:00 p. m., to go the hospital, but she could not remember if it was the first (3/2/2025) or the second (3/3/2025) night she worked with him. She stated she then went and told the nurse, but he was not sent out right away. She doesn't remember the police department coming, but she remembered in the middle of the shift Resident J was transferred to the hospital. During an interview on 3/21/2025 at 1:30 p.m., Registered Nurse (RN) 15 indicated she worked with Resident J on 3/3/2025 and 3/4/2025. She stated she never heard Resident J request to go to the hospital and nothing was unusual with the shift. When progress notes were read back to RN 15, she stated he had requested to go to the hospital, but the on-call provider wanted to give as needed pain medication. She stated she worked with him the next night as well, the lady that works at the end of the hall told her Resident J wanted to go to the hospital, but she was unsure of the time. She went to assess resident, and he had scrotal swelling, continuing from the night before. She did not send him to the hospital. During an interview on 3/20/2025 at 11:30 a.m., the Assistant Director of Nursing indicated he was the one that sent Resident J to the hospital on 3/3/2025. He stated RN 15 told him Resident J wanted to go to the hospital, so he started the transfer, but the police department showed up during that time as well. He had not heard anything prior to this about Resident J wanting to go to the hospital, but it was the expectation of the facility that if a resident was alert, oriented, and made their own decisions, staff would send them to the hospital per their request. During an interview on 3/25/2025 at 11:30 a.m., the Director of Nursing Services indicated she could not locate any assessments or notes other than the listed progress notes for Resident J between 3/2/2025 and 3/3/2025. Hospital paperwork, dated 3/6/2025, indicated Resident J was admitted to the local hospital from 3/3/2025-3/6/2025 for scrotal swelling, urinary retention, and hematuria (blood in the urine). Resident J was treated with continuous bladder irrigation, diuretics (water pills), and antibiotics. A policy entitled, Resident Rights, was provided by the Director of Nursing Services on 3/24/2025 at 9:52 a. m. The policy indicated, .The facility will ensure that all direct care and indirect care staff members .are educated on the right of residents and the responsibility of the facility to properly care for its residents . 3.1-3(n)(3)

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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. 45291 Based on interview, observation, and record review, the facility failed to ensure a grievance was forwarded to the grievance official and failed to implement a resolution of a grievance for 2 of 2 residents reviewed for grievances. (Resident H and Resident B) Findings include: 1a. The clinical record for Resident H was reviewed on 3/21/2025 at 11:30 a.m. The medical diagnoses included diabetes and chronic obstructive pulmonary disease. An Admission Minimum Data Set assessment, dated 2/10/2025, indicated Resident H was cognitively intact, did not reject care, and was frequently incontinent of bowel and bladder. Care plans, revised 2/24/2025, indicated Resident H had incontinence of bowel and bladder and required the need for assistance with incontinence care. During an interview with Resident H on 3/18/2025 at 1:45 p.m., she indicated she filled out two grievances since she had been in the facility. She believed one grievance was filled out at the end of February, the other was filled out about two weeks ago, and both were given to Qualified Medication Aide (QMA) 9. Review of the grievance log, on 3/21/2025 at 12:40 p.m., indicated Resident H had filed a grievance on 2/28/2025. There were no other grievances on file at that time for Resident H. During an interview with Resident H on 3/21/2025 at 1:45 p.m., she indicated no one ever followed up with her about her grievances. She stated, [The Administrator] came down to talk to me about the first one, but she got called away. I don't know what they're supposed to do to help, or anything, but no one ever talked to me about it. 1b. The clinical record for Resident 68 was reviewed on 3/24/2025 at 11:55 a.m. The medical diagnosis included chronic obstructive pulmonary disease. An Admission Minimum Data Set assessment, dated 1/21/2025, indicated Resident 68 was cognitively intact. An interview conducted with Resident 68, on 3/21/2025 at 1:40 p.m., indicated she was present when Resident H provided both grievances to QMA 9. 2a. The clinical record for Resident F was reviewed on 3/19/2025 at 2:04 p.m. The medical diagnosis included anxiety disorder. A Quarterly Minimum Data Set assessment, dated 1/7/2025, indicated Resident F was cognitively intact. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2025 at 11:30 a.m., Resident F indicated he was very concerned about how the staff treat Resident B because staff will often get Resident B out of bed, around 9:30 a.m., and do not change Resident B until they lay him down for bed around 9:30 p.m. Resident F indicated he reported these concerns in the form of a grievance on behalf of Resident B and the staff have not corrected leaving Resident B up for an extended period of time. During an interview on 3/24/2025 at 12:45 p.m., Resident F indicated staff have not been laying his roommate, Resident B, down between meals. He stated if, and it was very rare that they do, the staff lay Resident B down between lunch and supper, then the staff do not get Resident B back up for dinner at all. He stated the staff had laid Resident B down between lunch and supper less than a handful of times since he raised his concern on 2/26/2025. 2b. The clinical record for Resident B was reviewed on 3/20/2025 at 11:30 a.m. The medical diagnoses included dementia and anxiety. A Quarterly Minimum Data Set assessment, dated 12/20/2024, indicated Resident B was cognitively impaired, did not have behaviors of rejecting care, was incontinent of bowel and bladder, and dependent on staff for toileting needs. An incontinence care plan, revised 2/2/2025, indicated Resident B had functional bladder incontinence. Resident B needed interventions of checking and changing incontinent products as needed. A grievance form, dated 2/26/2025, indicated a concern was filed regarding Resident B being left sitting in his chair for an extended period and regarding the last time he was assisted with toileting needs. The resolution entered on the grievance was to place Resident B back to bed after lunch and supper. During an observation on 3/19/2025 at 2:30 p.m., Resident B was noted to be sleeping in his Geri chair in the common room. During an observation on 3/21/2025 at 1:50 p.m., Resident B was noted to be sleeping in his Geri chair in the common room. A policy entitled, Resident and Family Grievances, was provided by the Director of Nursing Services on 3/24/2025 at 9:56 a.m. The policy indicated if a staff receives a grievance, then they are to forward the grievance form to the Grievance Official as soon as practicable, and the Grievance Official will take steps in resolving grievances. 3.1-7(a)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 50436 Based on interview and record review, the facility failed to accurately input medication data into the Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for MDS accuracy. (Resident 70) Findings include: The clinical record for Resident 70 was reviewed on 3/20/25 at 11:41 a.m. The diagnoses included, but were not limited to, diabetes mellitus and dementia. The Admission MDS assessment, dated 2/14/25, indicated Resident 70 was on an anti-coagulant (blood thinner) and an antibiotic. Resident 70's Electronic Health Record (EHR) indicated no current order for an antibiotic or an anti-coagulant. The EHR indicated Resident 70 was on Plavix, which is considered an anti-platelet drug, not an anti-coagulant. During an interview with the MDS Coordinator on 3/20/25 at 12:08 p.m., she indicated she should have marked the anti-platelet tab and not the anti-coagulant tab while entering information into the Resident Assessment Instrument for inputting data. The MDS Coordinator indicated it was her error. The MDS Coordinator also indicated she thought Resident 70 was still on an antibiotic during their seven day look back period, but she was not, and it was entered in error. During an interview with the MDS Coordinator on 3/20/25 at 12:08 p.m., she indicated the Resident Assessment Instrument was used for inputting resident data for the MDS assessment because it had all the tools and information to put into the system.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45291 Based on interview, observation, and record review, the facility failed to establish care plans for refusals of care (Resident H), psychological needs (Resident J), and transfer/ambulation status (Resident 190) for 3 of 8 residents reviewed for care planning. Findings include: 1. The clinical record for Resident H was reviewed on 3/21/2025 at 11:30 a.m. The medical diagnoses included diabetes and chronic obstructive pulmonary disease. An Admission Minimum Data Set assessment, dated 2/10/2025, indicated Resident H was cognitively intact, did not reject care, and was frequently incontinent of bowel and bladder. Review of shower documentation for Resident H indicated she refused nine showers in the last 60 days. No care plan was on file for Resident H's refusals of care. 2. The clinical record for Resident J was reviewed on 3/21/2025 at 12:15 p.m. The medical diagnoses included respiratory failure and diabetes. A Quarterly Minimum Data Set assessment, dated 2/7/2025, indicated Resident J was cognitively intact and did not exhibit behaviors. During an interview on 3/19/2025 at 12:12 p.m., Resident J indicated his roommate exhibited behavior in his room that made him uncomfortable. No care plan indicated Resident J's psychological needs regarding roommate's behavior. 3. The clinical record for Resident 190 was reviewed on 3/24/2025 at 2:30 p.m. The medical diagnoses included pain and anxiety. A nursing assessment, dated 3/13/2025, established Resident 190's functional status at admission. Resident 190 utilized supervision or touch assistance for walking 10 and 50 feet with a walker. During an interview on 3/19/2025 at 10:39 a.m., Registered Nurse (RN) 13 indicated they did not know Resident 190's transfer or ambulation status. During an interview on 3/19/2025 at 10:42 a.m., Certified Nurse Aide (CNA) 11 indicated she believed Resident 190 was able to be up on his own. No care plans were in place to discern Resident 190's transfer or ambulation status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy entitled Comprehensive Care Plans was provided by the Corporate Nurse on 3/21/2025 at 9:50 a.m. The policy indicated it was the goal of the facility to develop and implement a comprehensive person-centered care plans for each resident for all nursing, medical, mental, and psychosocial needs. 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36942 Based on interview and record review, the facility failed to ensure care plan meetings were held quarterly for 4 of 5 residents reviewed for care planning. (Resident G, Resident 22, Resident 39, and Resident 80) Findings include: 1. The clinical record for Resident G was reviewed on 3/19/25 at 2:58 p.m. The diagnoses included, but were not limited to, dementia, anxiety disorder, insomnia, vertigo, and neoplasm of uncertain behavior of skin. An Annual Minimum Data Set (MDS) assessment, dated 1/16/25, indicated Resident G was severely cognitively impaired. An interview conducted with a family member of Resident G, on 3/19/25 at 11:25 a.m., indicated she was the power of attorney (POA) for Resident G and the facility was not good with communication. There had not been a care plan meeting for a long time. A progress note titled Care Plan Meeting Minutes, dated 10/11/24, indicated a quarterly care plan meeting was held with the family member of Resident G. There were no further indications of a care plan meeting being held with the family member of Resident G since 10/11/24. 50436 2. During an interview with Resident 39 on 3/19/25 at 11:02 a.m., they indicated they could not recall having care plan meetings. The clinical record for Resident 39 was reviewed on 3/19/25 at 2:23 p.m. The diagnoses included, but were not limited to, polyneuropathy and major depressive disorder. The Electronic Health Record (EHR) indicated Resident 39 had a care plan meeting on 6/7/24. The EHR indicated no care plan meetings were held after 6/7/24. The Annual MDS assessment, dated 2/26/25, indicated Resident 39 was cognitively intact. The MDS indicated it was very important to Resident 39 to have family, or a close friend involved in discussion about their care. During an interview with the Social Service Director (SSD) on 3/20/25 at 1:10 p.m., they indicated Resident 39 had not had a care plan meeting since 6/7/24. The SSD indicated the facility should have care plan meetings for residents quarterly and as needed. The SSD also indicated it was social services who were responsible for holding care plan meetings for residents and she did not know why the previous SSD did not have any further meetings for Resident 39. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	25054 3. During an interview with Resident 22 on 3/19/25 at 11:13 a.m., he indicated he did not have care plan meetings. Resident 22 indicated last year there was one scheduled and he was sick, and no one rescheduled it. Resident 22 indicated that was the only time he had been invited to one. During an interview with the SSD on 3/20/25 at 1:05 p.m., she indicated the facility was supposed to have care plan meetings with residents every three months and on admission. Review of the clinical record of Resident 22, on 3/20/25 at 1:40 p.m., indicated the diagnoses included, but were not limited to, chronic obstructive pulmonary disease, morbid obesity, diabetes, asthma, pulmonary hypertension, anxiety disorder, atrial fibrillation, agitation, and post-traumatic stress disorder. The Quarterly MDS assessment, dated 1/7/25, indicated the resident was cognitively intact for daily decision making. The resident was reasonable and consistent. A care plan meeting for Resident 22, dated 6/6/24, indicated the resident advised to invite no family and the resident declined to attend. A care plan meeting for Resident 22, dated 12/10/24, indicated the resident declined to come. These were the only two care plan meetings for 2024. The resident had no documented care plan meetings in 2025. 4. During an interview with Resident 80 on 3/19/25 at 11:30 a.m., she indicated she had never been invited to a care plan meeting since she was admitted to the facility. Review of the record of Resident 80, on 3/20/25 at 2:10 p.m., indicated the diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, morbid obesity, hypertension, muscle weakness and insomnia. The Admission MDS assessment for Resident 80, dated 12/26/24, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident was admitted to the facility on [DATE]. The resident's clinical record indicated the resident had not had any care plan meetings since admission to the facility. During an interview with the SSD on 3/20/25 at 1:05 p.m., she indicated the facility was supposed to have care plan meetings with residents every three months and on admission. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care planning resident participation policy provided by the Corporate Nurse, on 3/21/25 at 12:05 p.m., indicated the facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment. The facility would notify the resident and/or the resident representative in advance. The facility would honor the resident's right to participate in establishing the expected goals and outcome of the care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. The facility would discuss the plan of care with the resident and/or the representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility would make an effort to schedule the conference at the best time of the day for the resident and/or resident representative. The facility would obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. 3.1-35(d)(2)(B)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 36942 Based on observation, interview, and record review, the facility failed to ensure a resident was assisted with eating timely that resulted in the resident taking food and drinks from other residents (Resident 67), ensure a resident was assisted with changing his clothes and assisted with shaving (Resident G), ensure a resident was provided showers as preferred (Resident J), and ensure assistance with transfer/ambulation (Resident 190) for 4 of 6 residents reviewed for activities of daily living (ADLs). Findings include: 1. The clinical record for Resident 67 was reviewed on 3/21/25 at 11:49 a.m. The diagnoses included, but were not limited to, schizophrenia, alcohol-induced persisting dementia, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 1/30/25, indicated severe cognitive impairment and supervision with one staff person for eating. An ADL care plan, revised 10/24/24, indicated Resident 67 was able to eat with setup assistance of one staff person. An observation was conducted of lunch meal service in the Alzheimer's Care Unit (ACU) on 3/19/25 from 12:15 p.m. to 12:55 p.m. During the observation, Resident 67 was sitting at a dining table with Resident 21. The Dementia Care Director gave Resident 21 a cup of coffee. Resident 67 then asked for a cup of coffee and the Dementia Care Director stated, hold on. Resident 67 reached for Resident 21's coffee and was redirected by staff not to reach for Resident 21's coffee. Resident 67 reached for Resident 21's coffee, again, and was able to get a hold of the coffee and she drank the remainder of the coffee in Resident 21's cup, that was previously consumed by Resident 21. Resident 21 stated that's mine when Resident 67 got a hold of the coffee cup and proceeded to drink it. Resident 67 later proceeded to reach for Resident 21's food off her tray that was set in front of her. Resident 21 stated to Resident 67 get away from mine. Resident 21 put her hand up while commenting to Resident 67, but no physical contact was made. The nursing staff proceeded to take Resident 67 to another table, at 12:45 p.m., where Resident 82 was sitting and consuming his lunch. Resident 67 still had not received her meal tray at that time. Resident 67 reached over to Resident 82's tray and took a plastic container of cake that was not open and was able to open it. Resident 82 noticed Resident 67 had opened his container of cake and Resident 82 grabbed the plastic container to retrieve the cake. Facility staff intervened and let Resident 67 keep the plastic container of cake and got Resident 82 another piece of cake. While the staff were retrieving another piece of cake for Resident 82, Resident 67 reached towards Resident 82's cup of coffee and proceeded to drink the remainder of the coffee. The facility staff assisted Resident 67 to another table, brought her food tray over, and she proceeded to consume her lunch without any further issues. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted with Certified Nurse Aide (CNA) 2, on 3/20/25 at 9:00 a.m., indicated Resident 67 can be grabby at times with food, especially sweets. The goal was to provide Resident 67 with her entree first and then give her dessert when she finished the entree. If she were to see the dessert first, she would only want to focus on the dessert and not her entire meal. There were times that Resident 67 will just sit there and not even attempt to feed herself and other days she will be fully capable of feeding herself. The staff try to sit Resident 67 places, not by herself, but in positions to where she cannot grab others food. 2. The clinical record for Resident G was reviewed on 3/20/25 at 2:04 p.m. The diagnoses included, but were not limited to, dementia, anxiety disorder, and need for assistance with personal care. An Annual MDS assessment, dated 1/16/25, indicated supervision with set up assistance for shower/bathing, upper and lower body dressing, and personal hygiene. An ADL care plan, revised 1/25/25, indicated Resident G had an ADL self-care performance deficit related to confusion and dementia. The interventions included, but were not limited to, shower with supervision of one staff member, supervision of one staff member for dressing, supervision of one staff member for personal hygiene, and resident prefers long hair and a beard (initiated 10/24/24). An observation was conducted of Resident G, on 3/19/25 at 10:05 a.m., of him wearing a white shirt with brown spots scattered on the shirt. There was stubble to his face. An observation was conducted of Resident G, on 3/19/25 at 12:15 p.m., of him wearing the same white shirt with brown spots scattered on the shirt. Resident B approached the staff and showed them a razor that was broken in half. The resident indicated he wanted to shave but couldn't shave due to the razor being broken. The nursing staff removed the razor and told the resident they will assist with shaving him later. The stubble remained to his face. An observation was conducted of Resident G, on 3/19/25 at 2:50 p.m., of him wearing the same white shirt with brown spots scattered on the shirt. The stubble remained to his face. An observation and interview were conducted of Resident G, on 3/20/25 at 12:08 p.m., of him lying in bed wearing the same white shirt, from 3/19/25, with brown spots scattered on the shirt. Resident G indicated he had not been shaved, and the stubble remained on his face. He indicated the razor he had was broken and he no longer had one to shave himself and indicated I need to put it up, got some marks on it, when asked about his white shirt with brown spots on it. There were no care plans to indicate Resident G refused care. Shower documentation for March 2025 indicated the following showers/baths for Resident G: 3/10/25 - refused, 3/13/25 - shower completed, 3/17/25 - refused shower, and 3/20/25 - shower completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy entitled Activities of Daily Living, dated August 2024, was provided by the Corporate Nurse on 3/21/25 at 9:50 a.m. The policy indicated the facility would provide care and services for bathing, dressing, grooming, oral care, transfer and ambulation, toileting, and eating to include meals and snacks. 45291 3. The clinical record for Resident J was reviewed on 3/21/2025 at 12:45 p.m. The medical diagnoses included respiratory failure and diabetes. A Quarterly Minimum Data Set assessment, dated 2/7/2025, indicated Resident J was cognitively intact and did not exhibit behaviors. A care plan, revised 11/13/2024, indicated Resident J needed assistance of one staff member for showers. A CNA task sheet, provided on 3/21/2025 at 2:00 p.m., indicated Resident J was scheduled for showers every Tuesday and Friday on the evening shift. During an interview on 3/19/2025 at 12:12 p.m., Resident J indicated staff do not shower him as often as he would like. He stated he would like showers every other day, but he was lucky to get one a week. He stated in the last month; he had missed showers more than he received them. Review of the shower documentation indicated Resident J received a partial bed bath, on 2/25/2025, instead of a shower and no refusal was recorded along with no documentation, for 3/7/2025, regarding his scheduled shower. During an interview on 3/21/2025 at 1:57 p.m., Resident J indicated he was given his nighttime care of washing his hands and face, on 2/25/2025, but the staff did not offer him a bath. He stated, on 3/7/2025, the staff did not offer to give him a shower. 4. The clinical record for Resident 190 was reviewed on 3/24/2025 at 2:30 p.m. The medical diagnoses included pain and anxiety. A nursing assessment, dated 3/13/2025, established Resident 190's functional status at admission. Resident 190 utilized supervision or touch assistance for walking 10 and 50 feet with a walker. During an interview on 3/19/2025 at 10:33 a.m., Resident 190 was noted to stand up from his wheelchair in the common room with his walker next to him. Registered Nurse (RN) 13 immediately came to Resident 190 and assisted him in the toilet. Resident 190 was brought back to the common room in his wheelchair. Resident 190's walker was placed out of his reach. Within a few minutes, Resident 190 attempted to stand from his wheelchair. RN 13 and CNA 11 assisted Resident 190 with standing. CNA 11 retrieved Resident 190's walker and gave it to him. CNA 11 stood next to Resident 190 for less than a minute before walking way to attend to another resident. Resident 190 began to walk around the common room without staff assistance. During an interview on 3/19/2025 at 10:39 a.m., RN 13 indicated they did not know Resident 190's transfer or ambulation status. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/2025 at 10:42 a.m., CNA 11 indicated she believed Resident 190 was able to be up on his own. A policy entitled, Resident Showers, was provided by the Director of Nursing Services on 3/24/2025 at 9:52 a.m. The policy indicated, .Residents will be provided showers as per request or as per facility schedule . A policy entitled, Safe Resident Transfer/Handling, was provided by the Director of Nursing Services on 3/24/2025 at 9:52 a.m. The policy indicated, .All residents require safe handling when transferred to prevent or minimize the risk for injury . This citation is related to Complaints IN00454664 and IN00454943. 3.1-38(a)(2)(A) 3.1-38(a)(2)(B) 3.1-38(a)(3)(A) 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. 36942 Based on observation, interview, and record review, the facility failed to ensure a wound dressing remained in place as ordered (Resident G) and weekly skin assessments were conducted per the facility policy (Resident 59) for 2 of 3 residents reviewed for non-pressure skin concerns. Findings include: 1. The clinical record for Resident G was reviewed on 3/19/25 at 2:58 p.m. The diagnoses included, but were not limited to, dementia, anxiety disorder, insomnia, vertigo, and neoplasm of uncertain behavior of skin. An Annual Minimum Data Set (MDS) assessment, dated 1/16/25, indicated Resident G was severely cognitively impaired and had open lesions. A care plan, revised 1/25/25, indicated Resident G had skin impairment related to skin cancer to the right temple. The interventions included, but were not limited to, follow facility protocols for treatment of injury. A physician order, dated 2/18/25, indicated the cleanse the right forehead with wound cleanser, pat dry, apply Vaseline, then cover with foam every other day and as needed for soilage. An interview conducted with a family member of Resident G, on 3/19/25 at 11:25 a.m., indicated she was the power of attorney (POA) for Resident G and the facility was not good with communication. Resident G goes to the cancer center due to skin cancer to the right forehead. The cancer center had expressed concerns recently about the lack of healing and concerns of improper treatment of the wound. The following observations were conducted of Resident G with no treatment in place to the right forehead: 3/19/25 at 10:05 a.m., 3/19/25 at 12:08 p.m., 3/19/25 at 2:50 p.m., and 3/20/25 at 12:08 p.m. 2. The clinical record for Resident 59 was reviewed on 3/21/25 at 12:33 p.m. The diagnoses included, but were not limited to, asthma, Alzheimer's disease, chronic pain, and unspecified psychosis. An Annual MDS assessment, dated 1/8/25, indicated Resident 59 was severely cognitively impaired, supervision with transferring, supervision with walking, and had no skin impairments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan for pressure ulcers, revised 1/12/25, indicated Resident 59 was at risk for pressure ulcers. The interventions included, but were not limited to, follow facility policies/protocols for the prevention/treatment of skin breakdown. The assessments conducted for Resident 59, located in the electronic health record, were reviewed and indicated the last weekly skin assessment was conducted on 2/24/25. 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50436 Based on observation, interview, and record review, the facility failed to ensure a resident had weekly skin assessments for 1 of 4 residents reviewed for pressure injuries. (Resident 39) Findings include: The clinical record for Resident 39 was reviewed on 3/19/25 at 2:23 p.m. The diagnoses included, but were not limited to, polyneuropathy, pain, and anxiety. Resident 39 had a care plan, initiated 1/20/25, for potential for pressure ulcer development with an intervention to follow facility policies/protocols for the prevention/treatment of skin breakdown. The Braden Scale (for predicting pressure ulcer risk evaluation document), dated 2/24/25, indicated Resident 39 had a Braden score of 12, indicating Resident 39 was at high risk for developing pressure ulcers. The Annual Minimum Data Set assessment, dated 2/26/25, indicated Resident 39 was cognitively intact, was dependent on a mechanical lift for transfer, was chairfast, always incontinent of bowel and bladder, and was at risk for pressure injuries. Resident 39's weekly skin assessments indicated they had a skin assessment, completed 2/22/25, with skin intact documented. During review of the Electronic Health Record (EHR), Resident 39 did not have another skin assessment, until 3/12/25, which indicated Resident 39 had a new skin issue to the right gluteus, that was a pressure injury, stage 3 (a full-thickness skin loss, where subcutaneous fat is visible, but bone, tendon, or muscle is not exposed), and was acquired in house. A physician's order, dated 3/13/25, indicated to cleanse the right buttock with wound wash, pat dry, apply collagen to wound bed, and cover with a dry bordered dressing every day shift. During a wound care observation of Resident 39 on 3/21/25 at 10:44 a.m., with Registered Nurse (RN) 6, Resident 39 called out that it hurt and was grimacing when RN 6 removed the previous buttock dressing and began to do wound care. During an interview with Resident 39 on 3/24/25 at 11:00 a.m., they indicated they noticed their bottom hurting for some time and she indicated she was scratching it and had informed the aides that it was bothering her, but they told her it was just red from her scratching. Resident 39 indicated it hurts to sit. During an interview with the Director of Nursing Services (DNS) on 3/20/25 at 2:22 p.m., she indicated floor nurses and unit managers were responsible for completing weekly skin assessments. The DNS indicated they recently did a skin sweep of the facility, and the floor nurse staff did not keep up with them (assessments) and the unit managers were supposed to review them. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin Assessment policy provided by the DNS, on 3/20/25 at 1:15 p.m., indicated .1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter . A Pressure Injury Prevention and Management policy provided by the DNS, on 3/20/25 at 1:15 p.m., indicated .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment .3 . (c) Licensed nurses will conduct a full body skin assessment on all residents weekly 3.1-40(a)(1)

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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. 25054 Based on observation, interview, and record review, the facility failed to develop and implement a Range of Motion (ROM) program and splint program for a resident with limited ROM for 1 of 1 resident reviewed for ROM (Resident 75). Findings include During an interview with Resident 75 on 3/19/25 at 11:29 a.m., he indicated the facility does not provide him with ROM exercises. The resident indicated he was stiff and needed assistance moving all his extremities. The resident indicated he would like to be provided with ROM exercises. Review of the clinical record of Resident 75, on 3/19/25 at 2:00 p.m., indicated the diagnoses included, but were not limited to, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the right dominant side, muscle weakness, difficulty walking, depression and anxiety. The Occupational Therapy evaluation and plan for Resident 75, dated 8/2/24, indicated the goal was for the resident's family and caregivers to be provided with education and training on adaptive hemi-techniques, approach, encouragement, and safest strategies to use with assisting the resident with Activities of Daily Living (ADL), bed mobility, positioning, splinting of the right hand, checking for skin irritation and redness. Passive Range of Motion (PROM), pelvic floor strengthening exercises, and joint protection principles for the right upper and lower extremities. The Occupational Therapy discharge summary for Resident 75, dated 8/23/24, indicated the resident would be provided with a functional maintenance program of ROM and splint/brace program. The plan of care for Resident 75, dated 12/10/24, indicated the resident had an ADL self-care performance deficit related to limited mobility and stroke with right hemiplegia/hemiparesis. The interventions did not include any type of range of motion exercises or right-hand splint application. The most recent Minimum Data Set (MDS) assessment for Resident 75, dated 3/5/25, indicated the resident was moderately impaired for daily decision making. The resident had the ability to be understood and understand others. The resident had impairment of functional range of motion on one side of the upper and lower extremity. During an observation and interview with Resident 75 on 3/21/25 at 1:56 p.m., he indicated he could barely move his right arm, the resident raised his right arm slightly and it was flaccid (hanging loosely), and the resident raised his right leg slightly. The resident indicated it was hard to move his right arm and right leg. The resident indicated he was becoming more stiff. The facility did not provide range of motion exercises. The resident indicated that the CNA's do not provide ROM with care. The resident indicated he would like to be provided with ROM exercises so he could get better. The resident did not have a splint in place on the right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/24/25 at 1:15 p.m., Resident 75 was propelling himself down the hallway in his wheelchair. The resident's right arm was flaccid, and he was not utilizing the right arm to propel himself. The resident was able to move his right leg some to assist in moving himself in the wheelchair. No splint was in place on the right hand. During an interview with Certified Nurse Aide (CNA) 10 on 3/24/25 at 1:16 p.m., they indicated the CNA's do not provide ROM exercises; the restorative aides were responsible for that. CNA 10 indicated they did not know where the facility documented ROM programs for the residents. During an interview with CNA 11 on 3/24/25 at 1:20 p.m., they indicated the CNA's do not provide ROM programs for the residents. The restorative aides were responsible for the ROM programs. During an interview with Restorative Aide 12 on 3/24/25 at 1:25 p.m., they indicated she had been the restorative aide for about a year. There was a binder they documented on and on the computer. Resident 75 was not on a restorative program for ROM exercise. During an interview with the Director of Therapy on 3/24/25 at 1:27 p.m., they indicated Resident 75's family came in the facility every day and provided ROM exercises for Resident 75. During an observation and interview with Resident 75 on 3/24/25 at 1:30 p.m., he indicated his family did not provide ROM exercises for him. The resident's family had their own health issues and was not able to provide ROM exercises for him. The resident indicated he did have a splint for his right hand. The CNAs put the splint on sometimes, but not every day. The resident indicated the splint does not bother him and he had never refused to wear it. The resident did not have a splint in place on the right hand. During an interview with the Director of Therapy on 3/24/25 at 1:33 p.m., they indicated the family, and the CNAs should be providing Resident 75 with ROM exercises and assist with applying the right-hand splint. During an interview with the Director of Nursing Services (DNS) on 3/24/25 at 1:55 p.m., she indicated the facility had restorative aides and they should be providing Resident 75 with the ROM program. During an observation on 3/25/25 at 10:05 a.m., Resident 75 was wheeling himself in a wheelchair within the common area of the facility with his left hand. Resident 75 had a splint in place on the right hand. The prevention of decline in ROM policy was provided by the DNS on 3/24/25 at 10:50 a.m. The policy indicated the facility would provide interventions, exercises, and therapy to maintain or improve ROM. This included, but were not limited to, specialized rehabilitation, restorative, maintenance and braces/splints. 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** 36942 Based on interview and record review, the facility failed to fully conduct a fall follow-up and implement interventions after a fall for 1 of 2 residents reviewed for falls. (Resident 59) Findings include: The clinical record for Resident 59 was reviewed on 3/21/25 at 12:33 p.m. The diagnoses included, but were not limited to, asthma, Alzheimer's disease, chronic pain, and unspecified psychosis. An Annual Minimum Data Set (MDS) assessment, dated 1/8/25, indicated Resident 59 was severely cognitively impaired, supervision with transferring, supervision with walking, and had a fall with injury since the last MDS assessment. A care plan for falls, revised 1/12/25, indicated Resident 59 was at risk for falls related to confusion and psychoactive drug use. The interventions included, but were not limited to, activities that minimized the potential for falls (initiated on 11/18/24) and staff to help when doing rounds (initiated on 2/28/25). A post fall evaluation note, dated 1/24/25 at 10:46 a.m., indicated Resident 59 fell on [DATE] at 12:30 a.m. Resident 59 was startled by a sounding alarm and fell to her knees. The alarm was silenced, and Resident 59 was sent to the emergency room (ER) for evaluation for pain. The note indicated Resident 59's care plan was updated. A post fall evaluation note, dated 1/26/25 at 6:29 a.m., indicated Resident 59 fell on [DATE] at 4:29 a.m. Resident 59 had an unwitnessed fall while attempting to get out of bed. Her bed was in a high position when the fall occurred. Resident 59 had a laceration to her left upper eye with bleeding, hematoma to the left lower eye, and a tear to the lower lip with bleeding. Resident 59 was sent out to the emergency room . A progress note, dated 1/26/25 at 8:48 a.m., indicated Resident 59 returned to the facility from the local hospital emergency room . She received sutures to the left eye. An interdisciplinary team (IDT) fall assessment, dated 1/27/25, indicated Resident 59 was found on the floor beside her bed on 1/26/25 at 5:00 a.m. Resident 59 was attempting to self-transfer and had her bed placed in a high position. The immediate interventions put into place was assessing Resident 59 for injury and assisted resident up and back to bed. Under the question of what additional interventions were put into place, the response was blank. Resident 59's fall care plan did not include an intervention listed for the fall events occurring on 1/21/25 and 1/26/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy entitled Fall Prevention Program, dated 2024, was provided by the Director of Nursing Services on 3/24/25 at 2:00 p.m. The policy indicated when a resident experienced a fall the facility would assess the resident, complete a post-fall assessment, complete an incident report, notify the physician and family, review the resident's care plan and update as indicated, document all assessments and actions, and obtain witness statements in the case of injury. 3.1-45(a)(1) 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. 36942 Based on observation, interview, and record review, the facility failed to ensure residents with weight loss were encouraged to consume supplements as recommended by the Registered Dietitian (RD) for 2 of 4 residents reviewed for nutrition. (Resident D and Resident 46) Findings include: 1. The clinical record for Resident D was reviewed on 3/20/25 at 2:58 p.m. The diagnoses included, but were not limited to, schizophrenia, alcohol-induced psychotic disorder, diabetes mellitus, malnutrition, and major depressive disorder. An Annual Minimum Data Set (MDS) assessment, dated 3/3/25, indicated Resident D had moderate cognitive impairment and was dependent on staff with eating. A physician order, dated 3/18/25, indicated Resident D was on a puree diet with nectar/mildly thick consistency for liquids. A care plan for nutrition, revised 3/16/25, indicated Resident D was on a puree diet, had a history of significant weight loss, and food was to be served in mugs and thinned to nectar consistency. The interventions included, but were not limited to, providing and serve diet as ordered, providing and serve supplements as ordered, and the RD to make diet change recommendations as needed. An observation was conducted of breakfast meal service in the Alzheimer's Care Unit (ACU) on 3/20/25 at 8:55 a.m. A staff member was next to Resident D and assisting him with eating his breakfast. There were four mugs that contained food and a magic cup supplement, in the original packaging, on his meal tray. The staff member removed the lid on each of the four mugs to assist with eating, but the magic cup remained unopened and did not attempt to be given to Resident D. An observation was conducted of lunch meal service in the ACU on 3/20/25 at 12:50 p.m. A staff member was assisting Resident D with eating and there were three mugs that had the lids removed on his tray along with a magic cup supplement in the original packaging. After Resident D was done consuming lunch, the staff member removed his meal tray and placed it on the tray rack. The magic cup remained unopened, and the staff member did not attempt or encourage Resident D to consume the magic cup supplement. 2. The clinical record for Resident 46 was reviewed on 3/21/25 at 11:49 a.m. The diagnoses included, but were not limited to, autistic disorder, anxiety disorder, malnutrition, and muscle weakness. A Quarterly MDS assessment, dated 2/4/25, indicated Resident 46 had severe cognitive impairment and was supervision with one staff member for eating. A physician order, dated 2/10/23, indicated Resident 46 was to be given snacks in-between meals and document the amount consumed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nutrition care plan, revised 1/30/25, indicated Resident 46 had a history of significant weight loss and received and therapeutic diet. The interventions included, but were not limited to, providing and serve diet as ordered and providing and serving supplements as ordered: magic cup at lunch and fortified cereal at breakfast. An observation was conducted of lunch meal service on 3/20/25 from 12:25 p.m. to 1:10 p.m. During the observation, Resident 46 was consuming food from two bowls with a specialized spoon. Her meal tray was located on the kitchen island and contained another bowl of an unknown food item along with a magic cup supplement. When Resident 46 was finished consuming her food within the two bowels, Certified Nurse Aide (CNA) 3 proceeded to take the meal tray from the kitchen island and onto the tray rack. The magic cup was not opened or even placed near Resident 46 for them to consume. A policy entitled Nutritional and Dietary Supplements, dated 2022, was provided by the Director of Nursing Services on 3/24/25 at 9:52 a.m. The policy indicated that the facility would provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs and may be provided by dietitian recommendation as allowed by physician standing order. The care plan would be reflected with the new or modified nutritional interventions. 3.1-46(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50436 Based on observation, interview, and record review, the facility failed to ensure oxygen tubing was dated for 1 of 1 resident reviewed for oxygen administration. (Resident 241) Findings include: During an observation of Resident 241 on 3/18/25 at 2:22 p.m., Resident 241 had oxygen tubing on by nasal cannula. The oxygen tubing did not have a date to indicate when it was last changed. During an observation of Resident 241 on 3/19/25 at 12:48 p.m., Resident 241 had oxygen tubing on by nasal cannula. The oxygen tubing was not dated. The clinical record for Resident 241 was reviewed on 3/19/25 at 2:15 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and respiratory failure. A care plan, initiated on 3/13/25, indicated Resident 241 was on continuous oxygen at two liters per minute via nasal cannula. During an observation on 3/21/25 at 2:21 p.m., Resident 241's oxygen tubing was not dated. During an interview with Registered Nurse (RN) 6 on 3/21/25 at 2:22 p.m., they indicated they did not know why the oxygen tubing was not dated. RN 6 indicated they usually change the tubing once a week and the night shift staff conducts it. The Oxygen Administration policy was provided by the Director of Nursing Services on 3/24/25 at 10:50 a.m. It indicated .5. Change oxygen tubing and mask/cannula weekly and as needed . 3.1-47(a)(6)

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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 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. 36942 Based on observation, interview, and record review, the facility failed to ensure a resident who received scheduled pain medication received follow-up to ensure effectiveness after receiving scheduled pain medication, ensure follow-up after a scheduled appointment pertaining to chronic back pain, and ensure Lidoderm (pain relief) patches were documented when applied and removed after 12 hours for 1 of 2 residents reviewed for pain. (Resident 78) Findings include: 1a. The clinical record for Resident 78 was reviewed on 3/21/25 at 12:39 p.m. The diagnoses included, but were not limited to, chronic back pain, dementia, and hypertension. A Quarterly Minimum Data Set (MDS) assessment, dated 3/13/25, indicated Resident 78 was moderately cognitively impaired, received scheduled pain medication, did not receive as needed pain medication, did not receive non-pharmalogical interventions for pain, had frequent pain in the last five days, and documented the worst pain rating over the last five days as a 5 out of 10. A physician order, dated 8/2/24, was noted for Extra Strength Tylenol 500 milligrams; administer one tablet by mouth three times a day for chronic pain syndrome. A physician order, dated 8/12/24, was noted for Biofreeze gel 4%; apply to left hip and lower back topically every six hours as needed for pain. An interview and observation were conducted with Resident 78 on 3/18/25 at 2:25 p.m. He was sitting in a chair near the dining room. The resident stated his back hurt, and the staff only administered Tylenol, and it was not effective. Resident 78 was observed rubbing his back and grimacing when talking about the pain in his back. The medication administration record (MAR), dated March 2025, indicated eight occasions to where Resident 78's pain was documented greater than five out of ten on the pain scale. There was no indication on the MAR whether the scheduled Tylenol was effective for Resident 78's pain. The MAR for March 2025 indicated the Biofreeze gel was documented, as administered, on 3/7/25. No other administrations were noted. 1b. A physician order, dated 11/7/24, indicated to use Lidoderm External Patch 5%; apply to the lower back one time and day for back pain and remove at 9:00 p.m. There was no documentation in the MAR, dated March 2025, to indicate the removal of the Lidoderm patches. The website Drugs.com at https://www.drugs.com/pro/lidoderm.html, retrieved on 3/24/25 at 1:00 p.m., updated January 15, 2025, indicated the patch should be applied to intact skin for up to twelve hours. Excessive dosing by applying the Lidoderm patch to larger areas or for longer than the recommended wearing time could result in increased absorption of lidocaine and high blood concentrations. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1c. A provider progress note, dated 1/22/25, indicated Resident 78 was seen due to chronic back pain. Resident 78 had an appointment with a neurosurgeon provider, on 2/5/25, for the chronic back pain. The plan was to continue to tizanidine (short-acting muscle relaxer) four milligrams three times daily, continue the Lidoderm patch, continue Tylenol three times daily, and Biofreeze applied to the lower back and hip as needed. A provider progress note, dated 2/19/25, indicated Resident 78 was seen due to chronic back pain. Resident 78 was seen by a neurosurgeon provider, on 2/5/25, and the provider was awaiting notes from that appointment. The plan was to continue to tizanidine four milligrams three times daily, continue the Lidoderm patch, continue Tylenol three times daily, and Biofreeze applied to the lower back and hip as needed. A provider progress note, dated 3/5/25, indicated Resident 78 was seen due to chronic back pain. Resident 78 was seen by a neurosurgeon provider, on 2/5/25, and the provider was awaiting notes from that appointment. The plan was to continue to tizanidine four milligrams three times daily, continue the Lidoderm patch, continue Tylenol three times daily, and Biofreeze applied to the lower back and hip as needed. A provider progress note, dated 3/19/25, indicated Resident 78 was seen due to chronic back pain. Resident 78 was seen by a neurosurgeon provider, on 2/5/25, and the provider was awaiting notes from that appointment. The plan was to continue to tizanidine four milligrams three times daily, continue the Lidoderm patch, continue Tylenol three times daily, and Biofreeze applied to the lower back and hip as needed. There were no notes located in Resident 78's clinical record to indicate he was seen by the neurosurgeon provider or any further instructions from the neurosurgeon provider appointment, dated 2/5/25. There were no current physician orders for the utilization of tizanidine for Resident 78. A physician order, dated 10/1/24, indicated the utilization of tizanidine four milligrams three times a day for a muscle relaxant for 14 days. There was no documentation in the clinical record to show any evaluation after the tizanidine was completed for Resident 78 on 10/15/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy entitled Pain Management, dated February 2025, was provided by the Corporate Nurse on 3/21/25 at 9:50 a.m. The policy indicated the facility was to manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Gather information including, but not limited to, resident's goals for pain management and his/her satisfaction with the current level of pain control. The facility will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. For residents with an addiction history or opioid use disorder (OUD), the facility should use strategies to relieve pain while also considering the OUD or addiction history. These strategies may include continuation of medication assisted treatment (MAT), if appropriate, non-opioid pain medications, and non-pharmacological approaches. Also, referral to a pain management clinic for other interventions that need to be administered under the close supervision of pain management specialists will be considered for residents with more advanced, complex or poorly controlled pain. 3.1-37(a)

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 50436 Based on observation, interview, and record review, the facility failed to ensure 15-minute checks were initiated for a resident with behaviors for 1 of 2 residents reviewed for behavior monitoring. (Resident E) Findings include: The clinical record for Resident E was reviewed on 3/20/25 at 9:42 a.m. The diagnoses included, but were not limited to, diffuse traumatic brain injury and alcohol dependence. The Director of Nursing Services provided a facility incident report on 3/20/25 at 11:33 a.m. It indicated an incident occurred, on 2/18/25, when facility staff alleged Resident E had his hand down another resident's pants. It indicated the facility employee was unaware of the location of Resident E's hands and the two residents were immediately separated. A Quarterly Minimum Data Set (MDS) assessment, dated 12/26/24, indicated Resident E had moderate cognitive impairment. A written statement from Certified Nurse Aide (CNA) 8, dated 2/19/25, indicated, on 2/18/25 after dinner, she saw two residents, one of them being Resident E sitting next to each other. She noticed the two residents laughing so she went over to check on the two. CNA 8 indicated she noticed Resident E's hand was inside of another resident's pants. CNA 8 indicated she was unable to verify if his hand was between the pants and the brief or the brief and the other resident's body. CNA separated the two residents immediately and informed the nurse and Executive Director. A behavioral care plan was provided by the Director of Nursing Services on 3/24/25 at 1:00 p.m. It indicated Resident E had a history of behavioral symptoms directed towards other residents which include attempting to feed other residents and assisting them with care including checking for wet briefs. An intervention for 15-minute checks was initiated on 2/18/25. During an interview with Qualified Medication Aide (QMA) 9 on 3/21/25 at 10:30 a.m., they indicated Resident E was not on 15-minute checks. QMA 9 indicated Resident E acted fatherly over the other resident. QMA 9 indicated Resident E would try and take care of the other resident and staff would re-direct him and Resident E was easily re-directed. During an interview with Corporate Nurse 5 on 3/21/25 at 11:53 a.m., she indicated no documentation could be found to indicate 15-minute checks were ever initiated or being done on Resident E as per the care plan. Corporate Nurse 5 indicated they began behavioral monitoring every shift starting 2/19/25. Corporate Nurse 5 indicated nursing was responsible for 15-minute checks being completed and they should sign off on the 15-minute observation log. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Behavioral Health Services policy was provided by the Director of Nursing Services on 3/24/25 at 1:00 p. m. It indicated .7. (c) Monitor the resident closely .(i) Ensure appropriate follow-up .(k) Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident . This citation relates to Complaint IN00454664. 3.1-37(a) 3.1-43(a)(1)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 45291 Based on interview and record review, the facility failed to timely follow-up on a resident's psychosocial needs regarding his roommate exhibiting inappropriate behavior in front of him for 1 of 4 residents reviewed for behaviors. (Resident J) Findings include: The clinical record for Resident J was reviewed on 3/21/2025 at 12:45 p.m. The medical diagnoses included respiratory failure and diabetes. A Quarterly Minimum Data Set assessment, dated 2/7/2025, indicated Resident J was cognitively intact and did not exhibit behaviors. A care plan, revised 11/15/2023, indicated Resident J had depression and a psychotic disorder. Interventions were listed to encourage activities, provide emotional support, companionship, and to provide opportunities to voice mental health concerns to staff. During an interview on 3/19/2025 at 12:12 p.m., Resident J indicated his roommate (Resident E) will engage in the act of self-pleasure with the door and curtain open. This act made Resident J feel dirty and disgusted. Resident J reported this to staff about a month to six weeks ago per his recall, and the Social Services Director (SSD) came down to tell his roommate to pull the curtain. Since the SSD spoke to his roommate, Resident J reports his roommate continued to do the act with the door and curtains open, as well as being uncomfortable with the noises his roommate makes during said actions. Resident J indicated no staff have followed up with him regarding his concerns since that time. During an interview on 3/21/2025 at 10:51 a.m., the SSD indicated she was made aware of Resident E's behaviors about a month ago during an intradisciplinary team meeting. The SSD spoke with Resident E about pulling the curtain and closing the door before he engaged in said activities, but she had not been back to follow-up on the concerns, nor did she document it in the clinical record. The SSD stated the reason she did not follow-up on the concern or intervention was because she was busy putting out fires. A policy entitled Documentation in Medical Record was provided by the Director of Nursing Services on 3/24/2025 at 9:52 a.m. The policy indicated Each resident's medical record shall contain an accurate representation of the action experience of the resident . A policy entitled Social Services was provided by the Director of Nursing Services on 3/24/2025 at 10:50 a.m. The policy indicated the social worker would assist residents .in voicing and obtaining resolution to grievances about treatment, living conditions . as well as encouraging and promoting each resident's dignity, assure the resident's care plan reflects any ongoing social service's needs, and monitor the resident's progress in improving physical, mental, and psychosocial functioning. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A job description entitled Social Worker was provided by the Director of Nursing Services on 3/24/2025 at 10:57 a.m. The job description indicated the social worker will assist in the identification of and to provide each resident's social, emotional, and psychosocial needs. This citation is related to Complaint IN00454664. 3.1-34(a)(1)

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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. 30344 Based on interview and record review, the facility failed to administer an anticoagulant medication as ordered by the physician, which resulted in receiving the medication for an excessive duration for 1 of 1 resident reviewed for death. (Resident 88) Findings include: The clinical record for Resident 88 was reviewed on 3/24/25 at 11:53 a.m. Her diagnoses included, but were not limited to, a-fib (atrial fibrillation.) The 8/27/24 care plan indicated she was at risk for complications related to anticoagulant medication due to atrial fibrillation. The goal was for her to remain without complications from bleeding or injury. Interventions, initiated 8/27/24, were to observe for adverse reactions such as cramps, diarrhea, hemorrhage, and signs and symptoms of bleeding such as tarry stools and blood in the urine. The December 2024 physician's orders indicated to administer one five mg tablet of apixaban, also known as Eliquis (anticoagulant medication that makes blood flow through your veins more easily), two times a day, effective 8/26/24. The 12/21/24 at 6:02 p.m. change of condition note indicated, Situation: Resident presented with bloody, loose stools Assessment: Resident possesses temp [temperature] of 97.3, respirations of 20, BP [blood pressure] of 103/66, pulse oximetry of 100% on 2L [two liters] NC [nasal cannula.] IS A&OX3 [alert and oriented to person, place, situation.] Abdomen possesses normoactive BS [bowel sounds] X [times] 4, flat, painful upon palpitation. Response: Provider on call [name of provider] called and notified of change in condition, provided order for STAT [immediate] hemoglobin reading for resident's bloody stools, faxed STAT CBC [complete blood count] lab report MD notified: yes. Family Notified: Family called and notified. The 12/22/24 at 12:39 p.m. change of condition note indicated, Situation: Resident was found to have hemoglobin level of 6.5 .Assessment: Is A&Ox3, states has pain in abdomen. Possess BP of 96/56, pulse of 86, respirations of 20, temperature of 96, and pulse ox of 94% on NC. Response: Provider was called and notified of decrease in hemoglobin, was told to send to ED [emergency department.] Resident was informed of her low level hemoglobin, and was told she needs to go the hospital to get a transfusion, resident was hesitant to go, called healthcare representative, was able to convince to be sent out MD notified: yes. Family Notified: yes. Disposition of resident at transfer: Nervous. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/23/24 hospital discharge notes indicated, Features of this condition may have been alarming at the beginning. Severe pain, marked: Distention, greatly elevated white count, recent GI [gastrointestinal] bleeding were very concerning. She did not improve faster than we anticipated Discharge Plan Patient Disposition: Xfer [Transfer] - Skilled Nurse Facility. Condition: Fair. Hospital Course: She had no more bleeding. She did not have any bowel movement normal, much less diarrhea. Her abdomen pain felt much better. We started C.difficile treatment but I will not continue. Her hemoglobin improved. She did have 1 [one] more unit of blood today. Biggest intervention we make, is stopping her blood thinner. I do not think this white count she has represents infection .Acute GI bleeding: Plan: She is on anticoagulation for her A-fib. She has been off and on that before mostly for hematuria and anemia. Will use a PPI (proton-pump inhibitor) and hold her blood thinner .Paroxysmal A-fib: Plan: As before I think she will have to go without her blood thinner, likely long-term. Home Meds [Medications] and New Rx's Prescriptions: Discontinued Eliquis 5 mg tablet 5 mg PO [by mouth] BID [twice daily]. The December 2024 medication administration record (MAR) indicated, after returning from the hospital, she was administered her apixaban (Eliquis) five mg tablet the evening of 12/23/24 and the morning of 12/24/24. An interview was conducted with the Director of Nursing Services (DNS) on 3/25/25 at 12:15 p.m. She reviewed the 12/23/24 hospital discharge orders, the December 2024 MAR, and indicated Resident 88 should not have been administered the two administrations of apixaban after returning to the facility from the hospital. The Unnecessary Drugs policy was provided by the DNS on 3/25/25 at 1:01 p.m. It indicated, It is the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents and/or representatives, other professionals, and the interdisciplinary team. Each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements . b. Duration of use . e. Preventing, identifying and responding to adverse consequences; f. Any combination of the reasons stated above. 3.1-48(a)(2) 3.1-48(a)(5) 3.1-48(a)(6)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 36942 Based on observation, interview, and record review, the facility failed to follow-up on dental recommendations for a tooth extraction for 2 of 3 residents reviewed for dental services. (Resident G and Resident 12) Findings include: 1. An observation conducted of Resident G, on 3/19/25 at 10:05 a.m., noted broken teeth. An interview conducted with a family member of Resident G, on 3/19/25 at 11:25 a.m., indicated she was the power of attorney (POA) for Resident G and the facility was not good with communication. Resident G had a tooth infection back in December of 2024. She was unsure if Resident G's infected tooth had been pulled. She signed consent forms for Resident G to be seen by the dentist. She believed he was seen by the in-house dentist on 2/27/25. She indicated she was told the in-house dentist provider would be able to assist with the tooth extraction for Resident G. The clinical record for Resident G was reviewed on 3/19/25 at 2:58 p.m. The diagnoses included, but were not limited to, dementia, anxiety disorder, insomnia, vertigo, and neoplasm of uncertain behavior of skin. An Annual Minimum Data Set (MDS) assessment, dated 1/16/25, indicated Resident G was severely cognitively impaired and had likely cavities or broken natural teeth. A physician order, dated 12/12/24, indicated to please schedule an appointment with the dentist as soon as possible for possible extraction of tooth. Resident G started on an antibiotic on 12/12/24. A physician progress note, dated 1/2/25, indicated Resident G continued an antibiotic, until 12/22/24, for an infected tooth on the right lower jaw. Resident G was pending a referral to see a dentist. A progress note, dated 1/14/25, indicated the facility contacted the family member of Resident G about him needing to see a dentist. The family member was going to check with insurance on coverage and call the facility back. A care plan for ancillary services, revised 1/25/25, indicated Resident G declined dental services. A care plan for dental, revised 1/25/25, indicated Resident G had teeth in poor repair along with broken teeth. The interventions included, but were not limited to, make an appointment with the dentist (initiated on 12/13/24). A dental evaluation from the in-house dental provider, dated 1/27/25, indicated Resident G had root tips present, red and inflamed tissue, a broken tooth that wasn't restorable, and a decayed tooth that wasn't restorable. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A dental evaluation from the in-house dental provider, dated 2/27/25, indicated Resident G received a cleaning. He had heavy plaque and calculus, tissue inflammation, and poor oral hygiene. There was no indication that a tooth was pulled for Resident G. 2. An observation conducted of Resident 12, on 3/18/25 at 2:25 p.m., noted missing teeth and her front teeth were dark in color. The clinical record for Resident 12 was reviewed on 3/18/25 at 2:49 p.m. The diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, delusional disorder, dementia, and congestive heart failure. An Annual MDS assessment, dated 12/17/24, indicated Resident 12 was rarely understood and had cavities or broken natural teeth. A care plan for dental, initiated on 1/26/25, indicated Resident 12 had teeth in poor repair. The interventions included, but were not limited to, monitor/document/report as needed regarding signs of symptoms of oral/dental problems like pain, abscess, debris in mouth, teeth missing, loose, broken, eroded, decayed, and ulcers in mouth. A dental evaluation by the in-house dental provider, dated 5/10/24, indicated Resident 12 had roots tips present and rampant decay and broken teeth throughout. A recommendation was listed to extract all remaining teeth and fabricate a complete denture. A progress note, dated 9/10/24, indicated Resident 12 was grimacing and rubbing her left cheek. There were broken teeth to the right lower jaw that appeared grey and black in color. The Assistant Director of Nursing (ADON) was notified and indicated Resident 12 was on the list to be seen by the in-house dentist to address the issue. A dental evaluation by the in-house dental provider, dated 9/16/24, indicated a referral was written for Resident 12 to see an oral surgeon for mild sedation and x-rays to diagnose a possible abscess. The x-rays were not able to be taken of Resident 12 unless she was sedated. There was no follow-up in Resident 12's clinical record regarding follow-up for an oral surgeon. A policy entitled Dental Services, dated 2025, was provided by the Corporate Nurse on 3/21/25 at 9:50 a.m. The policy indicated the facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record. 3.1-24(a)(2) 3.1-24(b)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 36942 Based on observation, interview, and record review, the facility failed to ensure the appropriate thickened liquids were provided for 2 of 5 residents observed for dining. (Resident 46 and Resident D) Findings include: 1. An observation was conducted of the lunch meal service in the Alzheimer's Care Unit (ACU) on 3/19/25 from 12:15 p.m. to 12:55 p.m. During the observation, Resident D was assisted with eating by Certified Nurse Aide (CNA) 2. Resident D's food items were a certain consistency and provided in handled cups. Resident D's meal ticket indicated he was on a puree diet with nectar thickened liquids. There was another meal tray located just behind CNA 2 and located on the kitchen island. That meal tray consisted of a meal ticket with Resident 46's name on it with a diet of puree with honey thickened liquids. CNA 2 reached for an orange liquid that was located on Resident 46's meal tray, removed the lid from the cup, and proceeded to assist Resident D with consuming the thickened orange drink. The clinical record for Resident D was reviewed on 3/20/25 at 2:58 p.m. The diagnoses included, but were not limited to, schizophrenia, alcohol-induced psychotic disorder, diabetes mellitus, malnutrition, and major depressive disorder. A physician order, dated 3/18/25, indicated Resident D was on a puree diet with nectar/mildly thick consistency for liquids. A care plan for nutrition, revised 3/16/25, indicated Resident D was on a puree diet, had a history of significant weight loss, and food was to be served in mugs and thinned to nectar consistency. The interventions included, but were not limited to, providing and serve diet as ordered. 2. An observation was conducted of the lunch meal service on 3/20/25 from 12:25 p.m. to 1:10 p.m. During the observation, Resident 46 was feeding herself puree food with a specialized spoon and was approximately 50% done with eating her meal. No drinks were observed on her food tray, that was located on the kitchen island, nor at the table Resident 46 was sitting at. CNA 3 proceeded to go into the kitchen area, open the refrigerator, and retrieved a container of a yellow thickened liquid to pour into a cup for Resident 46 to consume. Resident 46 started consuming the yellow thickened liquid and was about 50% done with drinking it. The container of the yellow thickened liquid was observed to be golden fruit punch and the container indicated it was mildly thickened/nectar thick constancy. Resident 46's meal ticket indicated she was to receive moderate thick/honey thick liquids. CNA 2 was in the kitchen and was asked about Resident 46's fluid consistency. CNA 2 indicated she believed Resident 46 was nectar thickened liquids. CNA 2 observed the container of the golden fruit punch that was labeled as nectar thick, and CNA 2 went to review Resident 46's meal ticket, and the meal ticket indicated honey thickened liquids. Resident 46 finished consuming the golden fruit punch after the interview with CNA 2. The clinical record for Resident 46 was reviewed on 3/21/25 at 11:49 a.m. The diagnoses included, but were not limited to, autistic disorder, anxiety disorder, malnutrition, and muscle weakness. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 4/30/24, indicated Resident 46's diet order consisted of large portion diet, puree texture, and honey thickened/moderately thick consistency for liquids. A nutrition care plan, revised 1/30/25, indicated Resident 46 had a history of significant weight loss and received and therapeutic diet. The interventions included, but were not limited to, providing and serve diet as ordered. A policy entitled Thickened Liquids, revised February 2023, was provided by the Corporate Nurse on 3/21/25 at 9:50 a.m. The policy indicated that thickened liquids are provided only when ordered by a physician/practitioner or when ordered by a dietitian. The use of thickened liquids will be based on the resident's individual needs as determined by the resident's assessment and will be in accordance with the resident's goals and preferences. 3.1-46(a)(2)

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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. 36942 Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during a medication administration observation for 2 of 5 residents observed for medication administration. (Facility) Findings include: An observation of medication administration was conducted, on 3/20/25 from 8:10 a.m. to 8:40 a.m., with Registered Nurse (RN) 4. RN 4 proceeded to prepare morning medications for Resident 246. RN 4 donned gloves prior to taking a bottle of Mirilax, poured the Mirilax medication into water to dissolve, and gave the morning medications for Resident 246 to take. RN 4 proceeded to remove the gloves but did not conduct hand hygiene after glove removal. RN 4 then went to prepare morning medications for Resident 247. RN 4 donned gloves, without conducting hand hygiene, retrieved an insulin pen, used an alcohol wipe to wipe off the hub of the insulin pen, applied the needle, primed the insulin pen with two units, and then administered the insulin to Resident 247's left thigh. RN 4 returned to the medication cart to place the insulin pen back into the medication cart while keeping the same gloves on to administer insulin to Resident 247. RN 4 touched the medication cart keys, the medication cart, opened the medication cart, touched the laptop, and then prepared Resident 247's morning medications while wearing the same gloves. After Resident 247 took her morning medications, RN 4 doffed the gloves and performed hand hygiene. An interview conducted with RN 4, on 3/20/25 at 8:45 a.m., indicated he understood when explained about the lack of hand hygiene and stated, I'll do better next time. A policy entitled Hand Hygiene, dated May 2024, was provided by the Corporate Nurse on 3/21/25 at 9:50 a.m. The policy indicated that the use of gloves does not replace hand hygiene. Perform hand hygiene prior to donning gloves, and immediately after removing gloves. 3.1-18(l)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on interview and record review, the facility failed to obtain a physician's order for administration of the 2024-2025 Covid-19 vaccination and administer or arrange for administration of the vaccination, per policy, for 2 residents who consented to receive it out of 5 residents reviewed for Covid-19 vaccination. (Residents 23 and 50) Findings include: 1. The clinical record for Resident 23 was reviewed on 3/25/25 at 9:45 a.m. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, heart disease, end stage renal disease, and hypertension. He was admitted to the facility on [DATE]. The Covid-19 Vaccine Consent Form, signed by Resident 23 on 10/16/24, indicated he was screened for eligibility, education on the vaccination, and consented to receive the updated Covid-19 vaccine. The immunizations portion of the electronic health record indicated the most recent Covid-19 vaccination for him was administered on 1/26/23. 2. The clinical record for Resident 50 was reviewed on 3/25/25 at 9:45 a.m. His diagnoses included, but were not limited to, Alzheimer's disease and anxiety. He was admitted to the facility on [DATE]. The Covid-19 Vaccine Consent Form, signed by Resident 50's representative on 12/6/24, indicated Resident 50 was screened for eligibility, education on the vaccination was provided, and they consented for Resident 50 to receive the updated Covid-19 vaccine. The immunizations portion of the electronic health record indicated the most recent Covid-19 vaccination for him was administered on 3/14/24. An interview was conducted with the Director of Nursing Services (DNS) on 3/25/25 at 11:20 a.m. She indicated they knew immunizations were a problem, so they focused on influenza vaccinations first and were currently working on Covid-19 vaccinations. Resident 23 consented on 10/16/24, and Resident 50, on 12/6/24, to receive the updated Covid-19 vaccination, but the facility hadn't done them yet. She had a list of which residents needed which vaccinations, but they still needed to obtain orders and get them completed. The Indiana Department of Health Respiratory Illness Line List was provided by the Executive Director on 3/18/25 at 2:30 p.m. It indicated six residents and seventeen staff tested positive for Covid-19 since 1/3/25. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Covid-19 Vaccination policy was provided by the Executive Director on 3/18/25 at 2:30 p.m. It indicated, Policy Explanation and Compliance Guidelines . 11. Covid-19 vaccinations will be offered to residents when supplies are available, as per CDC (Centers for Disease Control) and/or FDA [Food and Drug Administration] guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine. 12. Following assessment for potential medical contraindications, Covid-19 vaccinations for residents may be administered in accordance with physician-approved 'standing orders.' 13. The facility may administer the vaccine directly or the vaccine may be administered indirectly through an arrangement with a pharmacy partner or local health department. 14. The facility will educate and offer the Covid-19 vaccine to residents, resident representatives and staff and maintain documentation of such 17. Residents or their representatives and staff will sign the consent form prior to administration of the Covid-19 vaccine. This information will be retained in the resident's medical record or the staff's medical file.