STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155136	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Terrace Care Center	1900 Andrew Ave LA Porte, IN 46350

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48383 Based on observation, record review, and interview, the facility failed to ensure a self-medication administration assessment was completed for residents with medications at the bedside for 2 of 2 random observations. (Residents 105 and 2) Findings include: 1. On 4/15/24 at 9:34 a.m., Resident 105 was observed sitting on the side of her bed. There was a medication cup that contained a small amount of medication solution on top of the bedside table. The record for Resident 105 was reviewed on 4/15/24 at 2:15 p.m. The diagnoses included, but were not limited to, depression, diabetes, traumatic amputation of left foot, hypertension (high blood pressure), and urinary tract infection. The Admission Minimum Data Set (MDS) assessment, dated 1/29/24, indicated the resident was cognitively intact for daily decision making. A Physicians' Order, dated 3/30/24, indicated to give 30 milliliters (ml) of ProT Gold (supplement) once a day. There was no self-medication administration assessment. There was no Physician order to self-administer medications. During an interview on 4/16/21 at 11:20 a.m., the Director of Nursing (DON) indicated she understood the medication should not have been left at the bedside and had no additional information to provide. 2. On 4/14/24 at 11:39 a.m., Resident 2 was observed sitting in her wheelchair eating a snack. There was a bottle of acetaminophen on top of the bedside table. On 4/15/24 at 9:48 a.m., Resident 2 was observed knitting in her wheelchair. There was a bottle of acetaminophen on the bedside table along with 2 tubes of pain-relieving cream. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident 2 was reviewed on 4/16/24 at 9:25 a.m. The diagnoses included, but were not limited to, heart failure, anxiety, depression, hypertension (high blood pressure), muscle weakness, and low back pain. The Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 1/9/24 at 6:45 p.m., indicated to give Tylenol (Acetaminophen) 250 milligrams (mg) by mouth every 4 hours as needed for pain. There was no self-medication administration assessment. There was no Physician's Order to self-administer medications. There was no Physician's Order for topical pain cream. During an interview on 4/16/21 at 11:25 a.m., the Director of Nursing (DON) indicated she understood the medication should not have been left at the bedside and had no additional information to provide. 3.1-7(a)(2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 10770 Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependant residents related to nail care and the removal of facial hair, for 1 of 2 residents reviewed for ADL care. (Resident 41) Finding includes: During an interview on 4/14/24 at 11:40 a.m., Resident 41 indicated his nails were long and dirty and someone usually came in to clean them, but they had not been done in awhile. At that time, the resident's nails were long with a dark colored substance underneath them. The resident was also unshaven. During random observations on 4/15/24 at 1:33 p.m. and on 4/16/24 at 9:00 a.m., the resident was observed in bed. At those times, the resident's nails were long and dirty and he was unshaven. The record for Resident 41 was reviewed on 4/15/24 at 2:40 p.m. Diagnoses included, but were not limited to, senile degeneration, high blood pressure, hallucinations, anxiety, and pain. The 2/6/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making and needed partial to moderate assist with personal hygiene. The Care Plan, revised on 11/27/23, indicated the resident had an ADL self care deficit. The Shower Sheets, dated 4/1 and 4/4/24, indicated the resident's nails were clipped. There was no other documentation his nails had been clipped and/or cleaned since then. There was no documentation indicating the last time the resident had been shaved. During an interview on 4/17/24 at 12:15 p.m., the Director of Nursing indicated the resident received Hospice services and now the CNA was only coming one time a week. She would expect nursing staff to make sure the resident's nails were clipped and cleaned and he was shaved. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)

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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. 10770 Based on observation, record review, and interview, the facility failed to ensure non-pressure skin treatments were completed as ordered and TED (compression support stockings) hose were in use for a resident with edema, for 2 of 4 residents reviewed for non-pressure skin conditions. (Residents 64 and 122) Findings include: During a random observation on 4/14/24 at 1:30 p.m., Resident 64 was observed sitting in his wheelchair. At that time, the resident's lower legs were observed with dry scaly skin and were red in color. The resident indicated staff complete a treatment to them a couple times a week. The record for Resident 64 was reviewed on 4/15/24 at 2:12 p.m. Diagnoses included, but were not limited to, stroke, heart failure, cellulitis, high blood pressure, and atrial fibrillation. The Annual Minimum Data Set (MDS) assessment, dated 3/4/24, indicated the resident was not cognitively intact for daily decision making. The resident was at risk for pressure ulcers, but currently had none. The Care Plan, revised on 3/21/24, indicated the resident had cellulitis. Physician's Orders, dated 3/5/24, indicated Clotrimazole-Betamethasone (a cream used to treat redness and swelling for fungal infections) 1-0.05 % Cream, apply to bilateral lower extremities every day and evening shift for dryness. The Treatment Administration Record (TAR) for the month of 3/2024, indicated the treatment of Clotrimazole-Betamethasone 1-0.05 % Cream was not signed out as being completed on evening shift for 3/5, 3/9, 3/19, and 3/20/24. The TAR for the month of 4/2024, indicated the Clotrimazole-Betamethasone 1-0.05 % Cream was not signed out as being completed on the day shift on 4/9/24 and the evening shift on 4/12/24. During an interview on 4/17/24 at 2:00 p.m., the Director of Nursing indicated there might have been a QMA working on that cart on those days, however, the treatment was in their scope of practice, so she would expected the treatments to be done as ordered. 48383 2. On 4/14/24 at 11:28 a.m., Resident 122 was observed sitting on the side of his bed. His right lower leg was dry, red, and scaly, and his foot was swollen. The resident was wearing sweat pants and there was an indentation on the outside of his leg. The resident was not wearing TED hose. On 4/15/24 at 2:25 p.m., the resident was observed sitting on the edge of the bed. He was not wearing TED hose. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 8:58 a.m., the resident was observed sitting on the edge of the bed. Both lower extremities were dry, scaly, red, and swollen. The resident pushed lightly against both of his legs and demonstrated deep indentations. The resident had 4+ pitting edema (indentation that takes 2-3 minutes for skin to rebound). At 9:00 a.m., the resident's indentation in his legs had not yet rebounded. The resident was not wearing TED hose. On 4/17/24 at 9:32 a.m., Resident 122 was observed sitting up in bed with his sister at the bedside. He was not wearing TED hose and he indicated he had been asking for them for weeks. The record for Resident 122 was reviewed on 4/16/24 at 1:24 p.m. The diagnoses included, but were not limited to, heart failure, respiratory failure with hypoxia, bipolar, anxiety, cellulitis (bacterial infection of the skin) of left and right lower limb and neuropathy (numbness and pain in feet). The Admission Minimum Data Set (MDS) assessment, dated 4/2/24, indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 3/36/24, indicated the resident had congestive heart failure (CHF). Interventions included, elevating lower extremities, observe for signs and symptoms of CHF such as shortness of breath, dependant edema of the legs and feet, and obtain lab/diagnostic work as ordered. A Physician's Order, dated 4/1/24, indicated for the resident to wear bilateral TED hose every day and evening shift and off at night. A Nurse's Note, dated 4/14/24 at 12:38 p.m., indicated the resident had a critical lab result. The resident's brain natriuretic peptide (BNP, a test to indicate heart failure) level was 1107 (normal <100). The Physician and patient were made aware of the results. A Physicians' Note, dated 4/12/24, indicated the resident had a positive cardiovascular assessment with pitting edema in bilateral upper and lower extremities. The Treatment Administration Record (TAR) indicated the TED hose were not signed out as being on from 4/13/24- 4/17/24. During an interview on 4/17/24 at 10:18 a.m., CNA 1 indicated she had not cared for the resident in a while, but she had personally put his TED hose on when she previously provided care for him. During an interview on 4/17/24 at 10:30 a.m., CNA 2 indicated she had been assigned to the resident this week and was unaware the resident wore TED hose. During an interview on 4/17/24 at 2:25 p.m., the Memory Unit Manager indicated she was not aware the resident had not been wearing his TED hose all week and she would follow up immediately. During an interview on 4/17/24 at 3:07 p.m., the Memory Unit Manager indicated they provided a new set of TED hose to the resident and received alternate intervention orders by the Nurse Practitioner (NP) to apply ace wraps to the resident's legs if the resident's TED hose were unavailable. 3.1-37(a)

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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. 10326 Based on observation, record review, and interview, the facility failed to ensure ankle braces were applied as ordered for 1 of 1 residents reviewed for limited range of motion (ROM). (Resident 40) Finding includes: On 4/14/24 at 8:41 a.m., 11:45 a.m., and 2:11 p.m., Resident 40 was observed in his broda chair (a positioning wheelchair). The resident was wearing his shoes and no ankle braces were in use. On 4/15/24 at 1:26 p.m., the resident was again observed in his broda chair. The resident had shoes on and no ankle braces were in use. On 4/16/24 at 8:42 a.m., the resident was seated in his broda chair by the nurses' station. He was wearing shoes and no ankle braces were in use. The resident's right foot was leaning on the right side of the foot rest. At 1:15 p.m., the resident's right foot was again leaning on the right side of the foot rest on the broda chair. No ankle braces were in use. At 3:35 p.m., the resident's left foot was leaning on the left side of the foot rest. Again, no ankle braces were in use. On 4/17/24 at 1:17 p.m., the resident was seated in his broda chair by the nurses' station. He was not wearing shoes and no ankle braces were in use. The record for Resident 40 was reviewed on 4/15/24 at 3:52 p.m. Diagnoses included, but were not limited to, spastic cerebral palsy and intellectual disabilities. The 3/7/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making. He had a limitation in range of motion (ROM) to both sides of his upper and lower extremities. The resident had not received restorative services for splint or brace assistance during the assessment reference period. The resident did not have a current Care Plan related to the use of the ankle braces. A Physician's Order, dated 6/22/23 and listed as current on the April 2024 Physician's Order Summary, indicated the resident was to wear bilateral ankle braces for up to 3-4 hours at a time. Staff were to don/doff (put on and take off) the brace and perform skin checks every shift. Staff were to stop using the brace if any skin issues were noted. The order had not been transcribed onto the June 2023 thru April 2024 Medication or Treatment Administration Records. There was also no indication the ankle braces had been applied under the Task section of the electronic medical record for the last 30 days. During an interview on 4/17/24 at 3:00 p.m., the Director of Nursing indicated therapy was supposed to discontinue the order and the resident no longer wore the ankle braces. 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. 10770 Based on record review and interview, the facility failed to provide adequate supervision for a resident in the shower room which resulted in a fall, for 1 of 3 residents reviewed for accidents. (Resident 34) Finding includes: During an interview on 4/14/24 at 9:44 a.m., Resident 34 indicated she was left alone in the shower room, went to stand up to clean her buttocks, slipped and fell . She indicated the shower chair was not locked, that's why I fell . Staff assisted her into the shower room and they knew she was in there by herself. During an interview on 4/17/24 at 1:30 p.m., the resident was asked again about her fall in the shower room. At that time, she indicated she was helped into the shower room by staff and there were other CNAs in the room talking. One of the CNAs helped her wash her back, and then after she was finished, she did not hear any more talking and indicated she knew was left alone in there, so she continued to wash herself and stood up to wash behind her, went to sit back down and fell to the floor because the wheels on the shower chair were not locked. She screamed out loud and they all came running back in, including the nurse. The record for Resident 34 was reviewed on 4/16/24 at 1:00 p.m. Diagnoses included, but were not limited to, dementia without behaviors, ischemic heart disease, angina, history of falling, osteoporosis, pain, anxiety, and major depressive disorder. The 3/13/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and needed partial to moderate assistance with the task of shower/bathe self. The resident needed supervision or touch assistance with the tasks of tub/shower transfer (the ability to get in and out of a tub/shower) and the task of sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed). The Care Plan, revised on 1/23/24, indicated the resident was cognitively intact. The Care Plan, revised on 1/23/24, indicated the resident was at risk for falls. The approaches were to assist with transfers during showering. A Change of Condition, dated 4/10/24 at 11:00 a.m., indicated the resident was observed sitting on her buttocks in front of the shower chair in the shower room. There were 2 CNAs with the resident and the resident indicated she stood up to wash her bottom, and when she was done, she went to sit down and the shower chair slipped out from under her. The resident indicated the wheels were not locked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Post Fall Evaluation, dated 4/10/24 at 3:28 p.m., indicated the resident's fall in the shower room was not witnessed. The reason for the fall was the wheels on the shower chair were not locked. The bathroom call light was on when the resident was found. The resident was taking a shower, stood up, went to sit back down, and slipped from the shower chair and landed on her buttocks. An IDT (Interdisciplinary Team) Fall Note, dated 4/13/24 at 8:23 a.m. and identified as a late entry, indicated staff noted the resident slipped and fell while attempting to sit on the shower chair. The staff were unable to intervene in time to prevent the fall. The resident was alert and oriented and slipped while attempting to sit on the shower chair. The IDT recommended the resident to be assisted times by 1 staff with transfers in the shower and shower socks upon arrival. There was no investigation regarding the resident's claims she was left alone in the shower room and the fact the wheels on the shower chair were unlocked. During an interview on 4/17/24 at 2:00 p.m., the Director of Nursing indicated she had gone back to speak with the resident regarding the fall. The resident told her a CNA had helped her wash her knees and then pulled the shower curtain around her. After the curtain was pulled, she did not hear anyone else talking any more. The DON asked the resident if it was possible the staff were still in the shower room, and behind the curtain, and the resident told her she did not think anyone was in the room because no one was speaking. She then stood up to continue bathing herself and went to sit down and fell . The DON had no other information to provide. 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48383 Based on observation, record review, and interview, the facility failed to ensure foley (urinary) catheter bags and tubing were kept off the floor, for 1 of 4 residents reviewed for catheters. (Resident 53) Finding includes: On 4/14/24 at 10:58 a.m., Resident 53 was observed sitting in his wheelchair. The foley bag was resting on the ground underneath the resident's wheelchair. On 4/14/24 at 11:25 a.m., the resident was observed sitting in his wheelchair asleep. The foley bag was resting on the floor underneath his wheelchair. On 4/14/24 at 2:16 p.m., the resident was observed sitting in his wheelchair watching his tablet. The foley bag remained resting on the floor beneath his wheelchair. The record for Resident 53 was reviewed on 4/15/24 at 1:44 p.m. Diagnoses included, but were not limited to, cerebral palsy, high blood pressure, urine retention, acute kidney disease, and obstructive uropathy. The Quarterly Minimum Data Set (MDS) assessment, dated 1/17/24, indicated the resident was cognitively intact and had a indwelling catheter. The resident was dependent with toileting hygiene. The Care Plan, dated on 2/19/24, indicated the resident had an urinary tract infection. The Care Plan, dated on 2/19/24, indicated the resident had an alteration in bladder elimination due to having an indwelling catheter. Interventions included, keeping drainage bag off the floor and keep drainage bag of catheter below the level of the bladder at all times. A Physicians' Order, dated 4/11/24, indicated to give Nitrofurantoin Macrocrystal (an antibiotic) 100 milligrams (mg) by mouth two times a day for an urinary tract infection (UTI) for 5 Days A Physicians' Order, dated 4/10/24, indicated to give Cephalexin (an antibiotic) 500 mg by mouth four times a day for an UTI for 7 days. During an interview on 4/16/21 at 11:24 a.m., the Director of Nursing (DON) indicated she understood the concern with the foley bag on the floor and had no additional information to provide. 3.1-41(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate, for 3 of 5 residents reviewed for respiratory care (Residents 228, 37 and 116) Findings include: 1. During random observations on 4/14/24 at 9:10 a.m. and 11:10 a.m., Resident 228 was observed wearing oxygen per nasal cannula. At those times, the flow rate on the room concentrator was set at 2 liters per minute. On 4/15/24 at 9:30 a.m., and 1:25 p.m., the resident was observed wearing oxygen per nasal cannula. At those times the oxygen was above the 2 liter mark but below the 2.5 liter mark. The record for Resident 228 was reviewed on 4/15/24 at 1:50 p.m. Diagnoses included, but were not limited to, respiratory failure, congestive heart failure, heart disease, high blood pressure, and shortness of breath. The 3/27/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and used oxygen while a resident. The Care Plan, dated 3/22/24, indicated the resident required oxygen therapy related to chronic respiratory failure. The approaches were to administer oxygen as needed per Physician's Orders. Physician's Orders, dated 4/8/24, indicated continuous oxygen at 3 liters per minute per nasal cannula. During an interview on 4/17/24 at 2:00 p.m., the Director of Nursing indicated the oxygen should be on as ordered. 48383 2. On 4/14/24 at 11:27 a.m., Resident 37 was observed wearing oxygen via nasal cannula. The flow rate was above 2.5 and under 3 liters. On 4/15/24 at 9:46 a.m., the resident was observed sitting in his wheelchair. He was wearing oxygen at almost 3 liters via nasal cannula. On 4/16/24 at 10:25 a.m., the resident was in his wheelchair, he had oxygen on via nasal cannula. The flow rate on the portable oxygen tank was marked at 3 liters. The record for Resident 37 was reviewed on 4/15/24 at 3:18 p.m. The diagnoses included, but were not limited to, heart failure, stroke, cardiomyopathy, hypertension (high blood pressure), muscle weakness, urinary tract infection, chronic obstructive pulmonary disease (COPD), and anemia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was severely impaired with decision making. A Care Plan, dated 3/29/24, indicated the resident had altered respiratory status/difficulty breathing related to COPD. Interventions included, administer medications as ordered and observe for side effects and effectiveness. There was no care plan for oxygen use. A Physician's Order, dated 4/15/24 at 2:30 p.m., indicated to administer continuous oxygen at 2 liters per minute (lpm) via nasal cannula. There were no orders for the oxygen until 4/15/24. During an interview on 4/16/24 at 11:18 a.m., the Director of Nursing (DON) indicated she understood the oxygen concern and had no additional information to provide. 3. On 4/14/24 at 10:38 a.m., Resident 116 was observed asleep in his wheelchair. The resident was wearing oxygen via nasal cannula at 4.5 liters. During an interview at that time, the resident indicated on 4/13/24 he was having trouble getting air into his lungs. He was then started on oxygen and had been on oxygen therapy continually. On 4/14/24 at 11:18 a.m., the resident was wearing oxygen at 1.5 liters via nasal cannula. On 4/15/24 at 9:42 a.m., the resident was observed watching TV in his wheelchair. He wore oxygen via nasal cannula at 1.5 liters. On 4/15/24 at 1:37 p.m., the resident was observed asleep in his chair, and he wore oxygen via nasal cannula at 1.5 liters. The record for Resident 116 was reviewed on 4/15/24 at 12:56 p.m. The diagnoses included, but were not limited to, osteomyelitis, asthma, diabetes, heart failure, and chronic kidney disease. The Admission Minimum Data Set (MDS) assessment dated [DATE], indicated the resident was moderately impaired with daily decision making. A Care Plan, dated 2/8/24, indicated the resident required oxygen therapy related to ineffective gas exchange. Interventions included, administer oxygen as needed per physician order, monitor oxygen saturations on room air and/or oxygen, and monitor oxygen flow rate and response. A Physicians' Order, dated 4/14/24 at 1:56 p.m., indicated to administer oxygen via nasal cannula at 2 liters per minute as needed. A Nurses Note, dated 4/13/24 at 10:45 p.m., the resident had a change of condition and was short of breath. The resident was placed on oxygen at 3 liters. There were no Physician's Order for oxygen therapy during the 4/14/24 observations. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/24 at 11:23 a.m., the Director of Nursing (DON) indicated she understood the oxygen concern and had no additional information to provide. During an interview on 4/17/24 at 2:17 p.m., the DON indicated the oxygen flow rate should follow Physician's Orders. 3.1-47(a)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure medications were labeled with a date opened and not expired, related to a multi-dose insulin vial and insulin pens, for 2 of 3 medication carts observed. (Rainbow and Reflections medication carts) Findings include: 1. On [DATE] at 10:34 a.m., a medication cart on the Rainbow unit was observed. At that time, there was 1 multi-dose vial of Novolog insulin with an open date of [DATE]. During an interview at that time, the Rainbow Unit Manager indicated it should have been discarded after 28 days. 2. On [DATE] at 10:46 a.m., a medication cart on the Reflections unit was observed. At that time, there was 1 Basaglar and 1 Lantus insulin kwikpens observed with no date opened. During an interview at that time, LPN 1 indicated both pens should have been labeled with a date opened. During an interview on [DATE] at 1:00 p.m., the Nurse Consultant indicated the pens were to be dated when opened and the Novolog multi-dose vial was expired. The current 2024 Labeling of Medications and Biologicals policy, provided by the Nurse Consultant on [DATE] at 1:12 p.m., indicated labels for multi-use vials must include the date the vial was initially opened or accessed and all opened or accessed vials should be discarded within 28 days unless the manufacture specifies a different date. 3XXX,d+[DATE](j) 3XXX,d+[DATE](o)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 48144 Based on record review and interview, the facility failed to provide dental services to a resident requesting dentures, for 1 of 1 resident reviewed for dental care. (Resident 19) Finding includes: During an interview on 4/15/24 at 2:35 p.m., Resident 19 indicated his dentures needed to be tightened up. The resident's upper denture was observed to be loose and flapped when the resident spoke. The record for Resident 19 was reviewed on 4/15/24 at 2:58 p.m. Diagnoses included, but were not limited to, high blood pressure, transient cerebral ischemic attack, type 2 diabetes, major depressive disorder, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 1/22/24, indicated the resident was moderately impaired for decision making and had no oral problems. A Care Plan, updated 2/19/2024, indicated the resident had oral/dental problems. A Dental Visit Note, dated 1/19/23, indicated all the resident's teeth were loose, decayed and broken down. The plan was to extract all remaining teeth and have a complete upper and lower denture made. There were no follow up visits made back to the dentist for the above recommendations, nor were there any follow up conversations documented with the resident if he would like new dentures and to continue with above plan. During an interview on 4/18/24 at 9:11 a.m., the Social Service Director (SSD) indicated the resident had declined dental services on 10/25/20. During an interview on 4/18/24 at 9:47 a.m., the SSD indicated someone added the resident to be seen by the dentist on 1/19/23 without a signed treatment consent, however the resident didn't refuse to be seen at that time. There were no follow up visits from the initial appointment because the resident declined dental services again in 10/2023. 3.1-24(a)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 10326 Based on observation and interview, the facility failed to ensure palatable and attractive food was served for 1 of 2 meals observed and for 2 of 3 residents reviewed for food. (The breakfast meal, Residents 34 and 41) Findings include: 1. During the Resident Council interview on 4/16/24 at 1:57 p.m., 10 residents were in attendance. Over half of the residents in attendance indicated breakfast was not good that morning. They indicated the bacon looked raw and the eggs were discolored. One resident indicated her bacon was raw on one end and burnt on the other. Several of the residents indicated the fried eggs looked green and they didn't want to eat them. One resident stated, the eggs looked like the Dr. Seuss book Green Eggs and Ham. Some of the residents also indicated the sausage patties served for the breakfast meal on 4/14/24 were hard like hockey pucks. During an interview on 4/16/24 at 2:30 p.m., the Administrator indicated the facility had a new Dietary Food Manager and the Resident Council concerns would be addressed. 10770 2. During an interview on 4/14/24 at 9:41 a.m., Resident 34 indicated the food was horrible and overcooked. During an interview on 4/15/24 at 1:30 p.m., the resident indicated the chicken served for lunch was tough and she did not eat. During a random observation on 4/16/24 at 7:30 a.m., the resident was observed in bed and her breakfast tray was on the over bed table with the dome lid on top of it. The lid was removed and an overcooked fried egg (crisp all around the edges) and an under cooked piece of bacon was observed. The resident indicated at that time, the bacon looked raw and she was not eating the overcooked egg. During an interview on 4/17/24 at 1:30 p.m., the resident indicated she had enjoyed the lunch meal, however, she did not eat any of her breakfast because it looked disgusting. 3. During a random observation on 4/16/24 at 10:00 a.m., a resident's breakfast tray was observed on an over bed table. The fried egg was green and light gray in color, there was 1 piece of bacon that was burned and the other piece was looked like it was raw. At 10:10 a.m., the Dietary Food Manager (DFM) was asked to observe the breakfast meal that had been served to a resident. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/16/24 at 10:20 a.m., the DFM indicated she was going to do an inservice on cooking and preparing breakfast food. 4. During an interview on 4/14/24 at 11:40 a.m., Resident 41 indicated the food was overcooked. He stated The sausage patties were so hard you could throw it at a wall and it would make a hole. During an interview on 4/18/24 at 10:00 a.m., the Administrator indicated the dietary staff were contracted and not employed by the facility. She indicated it was time for a change. 3.1-21(a)(2)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 48383 Based on observation and interview, the facility failed to prepare a pureed (blended smooth) diet designed to meet the needs of the residents. This had the potential to affect 10 of 10 residents who received a pureed diet. Finding includes: On 4/17/24 at 11:12 a.m., Cook 1 was observed preparing a pureed cabbage braised recipe. Cook 1 added 10 scoops of cabbage to the mixer and turned on the mix cycle. Cook 1 then added 2 cups of sauerkraut juice. The mixer was turned back on and stirred. The mixture was observed to be watery and Cook 1 added a tablespoon of thickener. The mixer was turned back on and then stirred to review consistency. Cook 1 then added another tablespoon of thickener and turned on the mixer. A total of 7 tablespoons of thickener were added to the recipe. Once the mixture was completed, the pureed meal was appropriate consistency and was free of lumps or chunks. During an interview on 4/17/24 at 11:25 a.m., Cook 1 indicated the cabbage was too watery and she had to add more thickener. During an interview on 4/17/24 at 11:29 a.m., Cook 1 indicated the recipe would not make 10 servings and she would have to make more. During an interview on 4/17/24 at 12:00 p.m., the Director of Nursing (DON) indicated the dietary recipe should have been followed. A recipe titled; Pureed Cabbage Braised was provided by the Dietary Manager on 4/17/24 at 11:10 a.m. This current recipe indicated, . Add water if product needs thinning . 3.1-21)(a)(3)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 10326 Based on observation and interview, the facility failed to ensure meals were served as scheduled for 2 of 2 meal observations. (The lunch meal) Findings include: 1. On 4/16/24 at 12:20 p.m., residents were observed seated at their tables in the main dining room. Staff started passing beverages to the residents at 12:35 p.m. and the first tray served to the residents was at 1:15 p.m. The residents were observed becoming impatient and wanting their food. On 4/17/24 at 1:01 p.m., a food cart was taken to the Memory Lane Unit from the kitchen. At 1:10 p.m., a second cart was sent to Memory Lane. At 1:11 p.m. on 4/17/24, the first tray in the main dining room was served. The posted meal times indicated Memory Lane was to be served lunch at 12:30 p.m. and the Main Dining Room at 1:00 p.m. During an interview on 4/18/24 at 10:00 a.m., the Administrator indicated the dietary staff was a contracted service for the facility and the meals should have been served on time. 2. During the Resident Council interview on 4/16/24 at 1:57 p.m., 10 residents were in attendance. The majority of the residents indicated they ate their meals in the main dining room. The residents in attendance indicated breakfast was served late on Sunday morning (4/14/24) and lunch was late today. They also indicated that dinner was sometimes served late on bingo night. 3.1-21(c)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 10326 Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to sliding scale insulin administration, for 1 of 5 residents reviewed for unnecessary medications. (Resident 107) Finding includes: The record for Resident 107 was reviewed on 4/16/23 at 9:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and mild cognitive impairment. The Significant Change Minimum Data Set (MDS) assessment, dated 2/15/24, indicated the resident had short and long term memory problems and she was severely impaired for daily decision making. The resident had also received insulin during the assessment reference period. A Physician's Order, dated 3/21/24, indicated the resident was to receive Lispro Insulin (a short acting insulin) before meals and at bedtime based on the following sliding scale: 151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units If blood sugar was greater than 400, give 12 units and call the Physician. Notify the Physician if the resident's blood sugar was less than 60. The March 2024 Medication Administration Record (MAR) indicated the resident's sliding scale insulin was not signed out as being given on 3/26 at 8:00 p.m., and on 3/29/24 at 4:00 p.m. and 8:00 p.m. The April 2024 MAR, indicated the resident's sliding scale insulin was not signed out as being given on 4/12 at 4:00 p.m. and 8:00 p.m., and on 4/17/24 at 11:00 a.m. and 8:00 p.m. During an interview on 4/18/24 at 1:30 p.m., the Director of Nursing indicated a QMA had been scheduled on those dates and the Nurse administered the insulin but did not sign it out. 3.1-50(a)(1) 3.1-50(a)(2)