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	06/27/2025

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. Based on observation, record review, and interview, the facility failed to ensure residents had physician's orders for medications and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents B and H) Findings include: 1. During random observations on 6/23/25 at 3:07 p.m. and 6/25/25 at 8:41 p.m., a bottle of carboxymethylcellulose sodium ophthalmic solution (an eye lubricant) eye drops and a Ventolin HFA (an inhaled breathing medication) inhaler were observed on Resident H's bedside table. During an interview on 6/25/25 at 8:41 a.m., the resident indicated he self-administered the eye drops and inhaler when he needed them. The resident's record was reviewed on 6/24/25 at 2:59 p.m. Diagnoses included, but were not limited to, heart failure and chronic obstructive pulmonary disease (COPD). The 3/20/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, and required supervision with activities of daily living (ADLs) and transfers. A Physician's Order, dated 10/2/24, indicated carboxymethylcellulose sodium ophthalmic solution 0.5 %, 1 drop in both eyes every 12 hours as needed for dry eyes. A Physician's Order, dated 11/7/24, indicated Ventolin HFA, 2 puffs inhaled orally, every 4 hours as needed for shortness of breath. There was no physician's order or assessment for self-administration. During an interview on 6/25/25 at 2:40 p.m., LPN 3 indicated there should be a self-administration assessment and an order for a resident to keep medications at their bedside, but she did not see either for Resident H. 2. On 6/25/25 at 11:54 a.m., three sealed lidocaine patches (topical pain medication patch) were observed on Resident B's bedside table. At that time, the resident indicated staff left the patches for him to put on himself. He indicated he usually applied them, unless he wanted to use one in a place he could not reach. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 12:27 p.m., Resident B was observed opening a new lidocaine patch and applying it to his left knee. The resident's record was reviewed on 6/25/25 at 12:41 p.m. Diagnoses included, but were not limited to, encephalopathy (damaged brain function), dementia, and opioid abuse. The 6/6/25 Quarterly Minimum Data Set assessment indicated the resident had severe cognitive impairment, and required supervision with activities of daily living (ADLs) and transfers. A Physician's Order, dated 4/28/25, indicated lidocaine pain relief 4% patch, apply one time a day and remove per schedule. There was no order or assessment for self-administration. During an interview on 6/25/25 at 2:40 p.m., LPN 3 indicated Resident B liked to put his own lidocaine patches on, but there was no self-administration assessment or physician's order. During an interview on 6/25/25 at 3:26 p.m., the interim Director of Nursing Services indicated self-administration assessments and physicians' orders were required for a resident to keep medications at their bedside and the staff needed to be re-educated. A policy titled, Resident Self-Administration of Medication, received as current from the Director of Nursing on 6/26/25 at 12:22 p.m., indicated, . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely . This citation relates to complaint IN00460504. 3.1-11(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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to ensure medications were held based on insulin and blood pressure parameters for 1 of 2 residents reviewed for insulin and 2 of 5 residents reviewed for unnecessary medications. (Residents G, E, and H) The facility also failed to ensure discolorations were monitored and treatments were obtained for venous stasis ulcers and frequent diarrhea for 2 of 5 residents reviewed for skin conditions non-pressure related (Residents F and D) and 1 of 3 residents reviewed for constipation and diarrhea. (Resident C) The facility also failed to ensure recommendations were carried out from specialty physicians for 1 of 1 resident reviewed for change in condition. (Resident H) Findings include: 1. The record for Resident G was reviewed on 6/25/25 at 12:57 p.m. Diagnoses included, but were not limited to, type 2 diabetes and Parkinson's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 4/4/25, indicated the resident was cognitively intact and received insulin injections. A Care Plan, reviewed on 4/28/25, indicated the resident had type 2 diabetes without complications. Interventions included, but were not limited to, diabetes medications as ordered by the physician. A Physician's Order, dated 5/13/25, indicated the resident was to receive 22 units of Glargine insulin (a long acting insulin) one time a day at 8:00 a.m. The insulin was to be held if the resident's blood sugar was less than 150. The resident was also to receive 20 units of Glargine insulin at 8:00 p.m. and the resident's insulin was to be held if his blood sugar was less than 150. The May 2025 Medication Administration Record (MAR) indicated the resident received his insulin when his blood sugar was below 150 on the following dates at times: 8:00 a.m.: 5/14, 5/15, 5/18, 5/19 & 5/28/25 8:00 p.m.: 5/29/25 The June 2025 MAR indicated the resident received his insulin when his blood sugar was below 150 on the following dates at times: 8:00 a.m.: 6/2, 6/4, 6/5, 6/9, 6/15, 6/16, 6/19, & 6/23/25 8:00 p.m.: 6/3 & 6/16/25 During an interview on 6/26/25 at 3:20 p.m., the Director of Nursing indicated the resident's insulin should have been held as ordered. 2. The record for Resident E was reviewed on 6/26/25 at 2:38 p.m. Diagnoses included, but were not limited to, mild dementia with anxiety and hypertension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Significant Change Minimum Data Set (MDS) assessment, dated 5/16/25, indicated the resident was moderately cognitively impaired for daily decision making. A Care Plan, reviewed on 5/19/25, indicated the resident had hypertension (high blood pressure) and hyperlipidemia (high cholesterol). Interventions included, but were not limited to, give medications as ordered. A Physician's Order, dated 6/1/25, indicated the resident was to receive Metoprolol Tartrate (a heart medication) 25 milligrams (mg) 1 tablet every morning and at bedtime. Hold and notify the physician of systolic blood pressure (top number) less than 110 or diastolic (bottom number) less than 60. The June 2025 Medication Administration Record (MAR) indicated the resident received the Metoprolol when his systolic blood pressure was below 110 and the diastolic blood pressure was less than 60 on the following dates and times: AM dose: - 6/5/25 blood pressure 98/68 PM dose: - 6/4/25 blood pressure 105/70 - 6/23/25 blood pressure 108/61 - 6/24/25 blood pressure 110/58 During an interview on 6/26/25 at 3:20 p.m., the Director of Nursing indicated the resident's Metoprolol should have been held as ordered. 3. On 6/24/25 at 10:15 a.m., Resident F was observed in his room sitting on the side of his bed. His pants were slightly pulled down and a large area of purplish discoloration was observed on his left hip. The record for Resident F was reviewed on 6/26/25 at 11:42 a.m. Diagnoses included, but were not limited to, fall from bed and history of aneurysm of lower extremity. The Quarterly Minimum Data Set (MDS) assessment, dated 5/29/25, indicated the resident was cognitively intact and he received an anticoagulant (a blood thinner). A Care Plan, dated 3/5/25, indicated the resident was on anticoagulant therapy related to personal history of pulmonary embolism. Interventions included, but were not limited to, daily skin inspections and report abnormalities to the nurse. A Physician's Order, dated 4/8/25, indicated the resident was to receive Apixaban (a blood thinner) 5 milligrams (mg) twice a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse's Notes, dated 6/18/25 at 5:30 a.m., indicated the resident was noted to have bruising on his left hip. A Weekly Skin Review, dated 6/18/25, indicated the resident had a pre-existing bruise to the left hip. A Weekly Skin Review, dated 6/25/25, indicated the resident's skin was intact. There was no documentation related to the bruising to the left hip. During an interview on 6/26/25 at 3:20 p.m., the Director of Nursing indicated the bruising to the resident's left hip should have been documented on the weekly skin review sheet. The current facility policy titled, Skin Assessment, was provided by the Director of Nursing on 6/27/25 at 11:30 a.m. The policy indicated a full body, or head to toe, skin assessment would be conducted by a licensed or registered nurse upon admission, re-admission, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 4. During an interview on 6/23/25 at 11:04 a.m., Resident D indicated she had diarrhea on a regular basis and received no medications for it. The record for Resident B was reviewed on 6/25/25 at 11:40 a.m. Diagnoses included, but were not limited to, vascular dementia, constipation, pain, and stroke. The 5/7/25 Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and was always incontinent of bowel. The bowel incontinence log in the CNA task section indicated the resident had loose/diarrhea on the following days: - 5/27, 5/28, 5/29 times two, 5/30, 6/1, 6/2 times three, 6/3 times two, 6/5, 6/7 times three, 6/9 times two, 6/10, 6/11 times two, 6/12 times two, 6/13, 6/14 times three, 6/15, 6/16, 6/17 times two, 6/18 times four, 6/21 times two, 6/22 times three, 6/23, and 6/24/25 times two. A Nurses' Note by the Infection Preventionist, dated 6/13/25 at 9:39 a.m., indicated the resident had loose stools often. The stools had no characteristics of C-diff, they were not a watery diarrhea, and she had no cramping or tenderness to the abdomen. There were no scheduled or as needed medications ordered for diarrhea. A Physician's Order, dated 4/9/25, indicated Senna (a medication used for constipation) Oral Tablet 8.6 milligrams (mg), give two tablets by mouth at bedtime. During an interview on 6/26/25 at 2:10 p.m., RN 1 indicated she was not made aware of the resident having diarrhea from the morning shift report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/25 at 2:10 p.m., CNA 1 indicated the resident had not had a bowel movement yet that day, but he had taken care of her in the past, and all of her stools were loose like diarrhea. He indicated they had reported the diarrhea to the nurses, they all know about it. During an interview on 6/26/25 at 2:25 p.m., the Unit Manger indicated there was no documentation in nursing notes regarding the diarrhea. During an interview on 6/26/25 at 3:20 p.m., the Director of Nursing indicated there was no documentation regarding the diarrhea in the record and she had no additional information to provide. 5. During an observation on 6/23/25 at 2:15 p.m., Resident C was observed in bed. At that time, there was a large amount of flaking skin on the bed sheets as well as streaks of blood. The resident's right outer shin was observed to be raw, open and red. During an observation on 6/24/25 at 2:54 p.m., the resident was in bed. The right outer shin was red and open with dry flakes of skin noted on the bed sheets. During an observation on 6/25/25 at 10:03 a.m. and 11:49 a.m., the resident was observed in bed. At those times, his right outer shin was observed to be red, open and raw with flakes of skin on the bed sheets. During an interview at that time, the resident indicated his right leg had been that way the last couple of days, it gets worse then it gets better. He indicated there was no treatment being done at the present time. On 6/26/25 at 2:20 p.m., RN 1 was in the resident's room. At that time, there was a bandage that was falling off the resident's right lower leg. The bed sheets were bloody. During an interview at that time, RN 1 indicated the Unit Manager just got a new treatment for his leg as she was made aware of it that day. The record for Resident C was reviewed on 6/25/25 9:23 a.m. Diagnoses included, but were not limited to, COPD, stroke, heart failure, atrial fibrillation, chronic venous hypertension with ulcer of right lower extremity and high blood pressure. The 3/26/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and needed assistance with personal hygiene. The resident had no rashes or open lesions and had an application of ointments other than to the feet. There was no care plan for skin impairment. There were no current Physician Orders for a treatment to the right lower leg. A treatment, dated 6/3/25 and discontinued on 6/17/25, indicated clean right anterior lower leg with wound cleanser, pat dry, apply Xerofoam gauze to wound and wrap with rolled gauze three times a week and as needed. A Nurse Practitioner (NP) Wound Note, dated 6/2/25, indicated the resident had a venous stasis ulcer to the right anterior lower leg that measured 13 centimeters (cm) in length, by 6 cm in width with a scant amount of drainage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A NP Wound Note, dated 6/16/25, indicated the stasis ulcer was resolved. A Weekly Skin Review assessment, dated 6/21/25, indicated there was redness that continued to bilateral lower extremities. The areas were monitored and treated as ordered. During an interview on 6/26/25 at 2:25 p.m., the Unit Manager indicated she was just made aware of the open area this morning and notified the NP, who gave new orders for treatment. During an interview on 6/26/25 at 3:20 p.m., the Director of Nursing had no additional information to provide. 6. During an interview on 6/23/25 at 3:04 p.m., Resident H indicated he was getting emails from his specialists that he had been missing appointments and tests they had ordered. The record for Resident H was reviewed on 6/24/25 at 2:59 p.m. Diagnoses included, but were not limited to, heart failure and chronic obstructive pulmonary disease (COPD). The 3/20/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, and required supervision with activities of daily living (ADLs) and transfers. A 5/2/25 Physician's Order from the resident's nephrologist (kidney doctor) indicated to log the resident's blood pressures for one week and fax them to the doctor's office. The record lacked evidence of a blood pressure log being sent to the doctor. A 5/8/25 Physician's Order from the resident's oncologist (cancer doctor) indicated, . CBC, CMP, Vit B12, Folate, Lactate dehydrogenase, Ferritin, Hepatic Panel, Periph [peripheral] smear pathology review [lab work]. Labs are scheduled at Main Hospital 6-4-25 at 11 a.m . The record lacked evidence of the lab work being completed. A 6/1/25 Physician's Order indicated midodrine HCl (a medication to treat low blood pressure) every 8 hours, hold if systolic (top number in a blood pressure reading) blood pressure was above 125. The June 2025 Medication Administration Record (MAR) indicated: a. The following scheduled midodrine doses were blank on the MAR: 6/5/25 and 6/15/25 at 10:00 p.m., 6/11/25, 6/12/25, 6/13/25, 6/14/25, 6/15/25, 6/16/25, 6/18/25, and 6/19/25 at 6:00 a.m b. The following scheduled midodrine doses were held, but no blood pressure was documented: 6/3/25 2:00 p.m. and 10:00 p.m., 6/11/25 2:00 p.m., 6/22/25 6:00 a.m., and 6/23/25 2:00 p.m. c. The following midodrine doses were administered despite a systolic blood pressure over 125: 6/7/25 at 2:00 p.m.- blood pressure 127/69, 6/7/25 at 10:00 p.m.- blood pressure 126/76, and 6/17/25 at 10:00 p.m.- blood pressure 130/87. The Care Plan, last revised on 4/7/25, indicated the resident had high cholesterol, coronary artery disease, and difficulty breathing. Interventions included administering medications as ordered, documenting and reporting vital signs as ordered, and obtaining/reporting lab work as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/25 11:35 a.m., the DON was informed of the findings and indicated she had no additional information or documentation to provide. This citation relates to complaints IN00460458 and IN00460504. 3.1-37

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure food consumption logs were completed for residents with a history of weight loss for 1 of 1 resident reviewed for nutrition. (Resident 107) Finding includes: The record for Resident 107 was reviewed on 6/24/25 at 3:50 p.m. Diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, dementia, Huntington's disease, Parkinson's disease, bipolar disorder, chronic kidney disease, high blood pressure, depression, and dysphagia (difficulty swallowing). The 5/7/25 Annual Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making, needed supervision with eating and weighed 171 pounds with no current weight loss. A Physician's Order, dated 6/19/25, indicated a regular mechanical soft/easy chew regular thin liquid diet. The recorded weights were: 4/2/25 180 pounds 4/14/25 169 pounds 4/20/25 169 pounds 4/22/25 171 pounds 4/27/25 171 pounds 5/5/25 171 pounds 6/2/25 173 pounds 6/22/25 175 pounds The resident was admitted to the hospital on [DATE] and returned to the facility on 4/12/25. A Registered Dietitian (RD) assessment, dated 4/17/25, indicated the resident's weight was 169 pounds which was a significant weight loss greater than 5% in the last 30 days, a loss of 5.6% related to recent hospitalization. The food consumption logs in the CNA task section indicated there was no documentation of all three meals on the following dates and times: breakfast: 4/14, 4/23, 5/4 5/30, 6/4, 6/17, 6/18, 6/19, and 6/22/25 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lunch: 4/2, 4/14, 4/21, 4/23, 5/4, 5/12, 5/21, 5/26, 5/30, 6/4, 6/5, 6/17, 6/18, 6/19, and 6/22/25 dinner: 4/13, 4/14, 4/16, 4/19, 4/21, 4/28, 4/29, 5/9, 5/16, 5/18, 5/31, 6/5, 6/8, 6/12, and 6/16/25 During an interview on 6/27/25 at 9:00 a.m. the Director of Nursing indicated food consumption logs were to be completed after every meal. 3.1-46(a)(1)

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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. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 1 of 3 residents reviewed for respiratory care. (Resident F) Finding includes: On 6/24/25 at 10:15 a.m. and 3:00 p.m., Resident F was observed in his room seated on the side of his bed. The resident had oxygen in use by the way of a nasal cannula. The resident's oxygen concentrator was set at 3 1/2 liters. On 6/25/25 at 9:10 a.m., the resident was again observed in his room with oxygen per nasal cannula in use. The oxygen concentrator was set at 3 1/2 liters. The record for Resident F was reviewed on 6/26/25 at 11:42 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and dyspnea (difficulty breathing). The Quarterly Minimum Data Set (MDS) assessment, dated 5/29/25, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 2/22/25, indicated the resident had oxygen therapy related to COPD and ineffective gas exchange. Interventions included, but were not limited to, oxygen via nasal cannula at two liters continuously. A Physician's Order, dated 2/23/25 and listed as current on the June 2025 Physician's Order Summary (POS), indicated the resident was to receive 2 liters of oxygen per minute continuously via nasal cannula. During an interview on 6/26/25 at 3:20 p.m., the Director of Nursing indicated the resident's oxygen concentrator should have been set at 2 liters. 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** Based on observation, record review and interview, the facility failed to ensure proper medication storage related to pre-filled saline syringes used to flush PICC (peripherally inserted central catheter) lines not stored securely, an expired insulin vial, and an expired emergency drug kit (EDK) box for 1 of 1 resident observed during medication pass, 1 of 3 medication carts observed and 1 of 2 medication rooms observed. (Resident 109, a Rainbow Unit medication cart and the Memory Unit medication room) Findings include: 1. During medication pass on [DATE] at 7:53 a.m., RN 3 was observed preparing to administer an Intravenous (IV) antibiotic medication through Resident 109's PICC line. The RN entered the resident's room with the IV antibiotic and two 10 cubic centimeters (cc) normal saline pre-filled syringes. She flushed the resident's PICC line with one of the pre-filled normal saline syringes, connected the IV antibiotic and turned on the pump. She told the resident she would be back in 30 minutes to disconnect the IV. At that time, the RN walked out of the room, leaving the other pre-filled normal saline syringe on the resident's over bed table. During an interview on [DATE] at 2:32 p.m., RN 3 indicated she was unaware she should not have left the saline syringe on the over bed table in the resident's room. 2. On [DATE] at 9:10 a.m., RN 2 was observed in the Memory Unit medication room. At that time, inside the locked refrigerator there was an EDK box with an expiration date of 5/25. During an interview at that time, RN 2 indicated the pharmacy comes to the facility weekly and checked the medication room. During an interview on [DATE] at 11:30 a.m., the Director of Nursing indicated pharmacy was supposed to be checking the EDK box in the refrigerator every Thursday during their visit. 3. On [DATE] at 9:23 a.m., LPN 1 was observed by a Rainbow Unit medication cart. At that time, there was one multi-vial of Lispro Insulin with an open date of [DATE] and an expiration date of [DATE]. During an interview on [DATE] at 11:30 a.m., the Director of Nursing (DON) indicated the open vial of insulin should have been discarded after it had expired. The current 2025 Medication Storage policy, provided by the DON indicated all drugs and biologicals will be stored in a locked compartment, cabinet, drawer or refrigerator. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication cart. 3.1-25(m) 3.1-25(o)

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	06/27/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place and implemented related to the storage of wash basins, urinals, and bed pans, the changing of gloves during wound care for 1 of 2 residents reviewed for pressure ulcers, and the lack of personal protective equipment (PPE) during 1 of 1 intravenous (IV) medication administration. (The Memory Unit, Residents 15 and 109) Findings include: 1. During the Environmental Tour on 6/27/25 at 2:12 p.m., with the Maintenance Supervisor and the Administrative Consultant, the following was observed: The Memory Unit a. In the bathroom of room [ROOM NUMBER], there were two urinals hanging from the grab bar located next to the toilet. The closet located in the bathroom had one wash basin and two bed pans stacked on top of each other. The wash basin and bed pans were not contained. Two residents shared the bathroom. b. There was a wash basin on the floor underneath the sink in the bathroom of room [ROOM NUMBER]. Two residents shared the bathroom. c. There was a urinal hanging from the grab bar located next to the toilet in the bathroom of room [ROOM NUMBER]. Two residents shared the bathroom. During an interview on 6/27/25 at the time, the Administrative Consultant indicated the urinals, bedpans, and wash basins should have been placed in bags. The facility policy titled Disinfection of Bedpans and Urinals was provided by the Director of Nursing on 6/27/25 at 2:38 p.m. and identified as current. The policy indicated to store bedpans and urinals in the resident's bedside cabinet or drawer after placing in a plastic bag as per facility policy. 2. Wound care for Resident 15 was observed on 6/26/25 at 9:19 a.m. RN 2 donned a gown and a pair of gloves prior to entering the resident's room. Upon entering the room, the RN removed the top sheet from the resident's bed and placed it on the floor. The resident's heel boots were also removed and placed on the floor. The RN proceeded to remove the dressing to the resident's sacrum. She then cleansed the sacral wound with wound cleanser, packed the wound with Dakin's (a wound disinfectant) soaked gauze, and covered the area with a foam dressing. After completing the treatment to the sacrum, the RN proceeded to reposition the resident and provide incontinence care with the assistance of the CNA. The RN did not change her gloves after completing the treatment to the sacrum. After providing incontinence care, the RN removed a dressing to the resident's chest. She cleansed the area with wound cleanser, tore a calcium alginate pad (a type of wound dressing) in half and placed the pad on the wound bed wearing the same gloves and covered the area with a dry dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RN then proceeded to remove a dressing from the resident's right breast. After removing the dressing, the RN cleansed the area with wound cleanser and packed the wound with Dakin's soaked gauze and covered the area with a dry dressing. The RN was wearing the same pair of gloves that she used to complete the treatment to the sacrum, provide incontinence care, and complete the treatment to the chest and breast areas. During an interview on 6/26/25 at 10:25 a.m., the Infection Preventionist indicated the RN should have changed her gloves going from dirty to clean areas and she should have changed her gloves between each treatment. During an interview on 6/26/25 at 3:20 p.m., the Director of Nursing indicated the RN should have changed her gloves in between treatments and the linen should not have been placed on the floor. The current facility policy titled Clean Dressing Change was provided by the Director of Nursing on 6/27/25 at 11:30 a.m., the policy indicated gloves were to be changed after soiled dressings were removed and in between each dressing change. 2. During medication pass on 6/25/25 at 7:53 a.m., RN 3 was observed preparing to administer an Intravenous (IV) antibiotic medication through Resident 109's PICC line. There was a sign on the resident's room door which indicated he was in Enhanced Barrier Precautions (EBP). Staff that were to come in contact with the resident should don gloves and an isolation gown. The RN entered the resident's room with the IV antibiotic and two 10 cubic centimeters (cc) normal saline pre-filled syringes. She washed her hands with soap and water and donned clean gloves to both hands. She did not don an isolation gown. She flushed the resident's PICC line with one of the pre-filled normal saline syringes, connected the IV antibiotic and turned on the pump. She told the resident she would be back in 30 minutes to disconnect the IV. At 8:56 a.m., RN 3 entered the resident's room to disconnect the IV antibiotic medication from the pump. She washed her hands with soap and water and donned a clean pair of gloves to both hands. She did not don an isolation gown. She removed the IV tubing from the PICC line port, and threw it away. She flushed the PICC line with a pre-filled normal saline syringe and clamped the line. She removed her gloves, performed hand hygiene and walked out of the room. During an interview on 6/25/25 at 2:32 p.m., RN 3 indicated she was aware the resident was in EBP and she should have worn a gown while administering the IV antibiotic medication. During an interview on 6/25/25 at 3:00 p.m., the Director of Nursing (DON) indicated the RN should have worn a gown during the administration of the IV antibiotic during medication pass. The current 2025 Enhanced Barrier Precautions policy provided DON on 6/25/25 at 3:10 p.m., indicated EBP will be followed in high contact resident care activities such as device care or use of PICC lines. 3.1-18(b)