STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Terre Haute	3150 N Seventh St Terre Haute, IN 47804

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 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. 35317 Based on observation, record review, and interview, the facility failed to ensure proper storage of respiratory equipment, and the facility failed to ensure a physician order was obtained for nebulizer treatments for 2 of 4 residents reviewed for respiratory care (Residents 22 and 4). Findings include: 1. On 8/23/24 at 3:03 p.m., Resident 22's unbagged nebulizer mouthpiece and tubing were observed on the resident's side table, there was a clear liquid in the medication chamber (small plastic bowl where medication is placed). The nebulizer machine was observed on the resident's bed. Resident 22's record was reviewed on 8/26/24 at 11:00 a.m. The profile indicated the resident diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems) and acute respiratory failure with hypoxia (acute or chronic impairment of gas exchange between the lungs and the blood causing hypoxia [inadequate supply of oxygen] with or without hypercapnia [too much carbon dioxide in your blood]). An admission Minimum Data Set (MDS) assessment, dated 6/19/24, indicated the resident was cognitively intact and was not on oxygen therapy at the time. A care plan, dated 6/13/24, indicated the resident was at risk for respiratory distress related to chronic respiratory failure. Interventions included but were not limited to, administer medication as ordered and oxygen as ordered. A physician order, dated 8/16/24 with a discontinue date of 8/21/24, indicated ipratropium-albuterol inhalation solution (a medication that can help people with lung problems, like asthma or obstructive pulmonary disease, breathe easier); 0.5-2.5mg (milligrams) 3 ml (milliliters). Order was to administer 1 vial inhale orally four times a day for pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid) for 5 days. The record lacked a physician order for a nebulizer treatment beyond 8/21/24. During an interview, on 8/27/24 at 9:38 a.m., Resident 22 indicated she was getting breathing treatments for a few days due to her having pneumonia. She was also using oxygen at night per nasal cannula (a device that delivers extra oxygen through a tube and into your nose). (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/28/24 at 9:15 a.m., Qualified Medication Aide (QMA) 8 indicated she had given Resident 22 a nebulizer treatment on the morning of 8/28/24. During an interview, on 8/28/24 at 9:20 a.m., Resident 22 indicated she had received a breathing treatment this morning. During an interview, on 8/28/24 at 9:36 a.m., the Director of Nursing (DON) indicated Resident 22 did not have an order currently for routine or as needed breathing treatments and staff should not administer a medication without a physician order. During an interview, on 8/28/24 at 9:57 a.m., Licensed Practical Nurse (LPN) 4 indicated nebulizer equipment should be placed in a dated bag for storage while not in use. 34525 2. On 8/23/24 at 9:05 a.m., a nebulizer unit (a machine that turns liquid medicine into a mist that can be inhaled through a mouthpiece or mask) was observed sitting on Resident 4's bed side table. At the same time, the resident indicated she had as needed (PRN) breathing treatments. The nebulizer mouthpiece and tubing were unbagged. During a random observation, on 8/26/24 at 12:02 p.m., the resident's nebulizer remained on the bed side table. The nebulizer mouthpiece and tubing were unbagged. During a random observation, on 8/27/24 at 9:12 a.m., the resident's nebulizer remained on the bed side table. The nebulizer mouthpiece and tubing were unbagged. Resident 4's record was reviewed on 8/27/24 at 8:56 a.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems). A quarterly Minimum Data Set (MDS) assessment, dated 7/17/24, indicated the resident had no cognitive deficit, had shortness of breath or trouble breathing when lying flat, and was not on oxygen therapy at the time. A care plan, dated 6/23/23, indicated the resident was at risk for respiratory distress related to COPD and was unable to lie flat due to it causing shortness of breath. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 6/22/23, indicated to administer 2 puffs of albuterol sulfate (a medication that treats and prevents breathing problems caused by lung diseases like asthma and COPD) HFA inhalation aerosol solution (a type of propellant spray) 108 (90 base) micrograms (mcg), every 4 hours as needed for shortness of breath or oxygen saturation (the amount of oxygen circulating in the blood) less than 95%. A historical review of the physician orders lacked documentation of an order for nebulizer treatments. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's progress notes from January 2024 through August 2024 lacked documentation that any nebulizer treatments had been administered or that the resident had any order for nebulizer treatments. During an interview, on 8/27/24 at 9:00 a.m., Licensed Practical Nurse (LPN) 3 indicated she had never given the resident a nebulizer treatment because she did not believe the resident had an order for a nebulizer. She did have a PRN inhaler ordered, but she rarely requested it. During an interview, on 8/27/24 at 9:18 a.m., Resident 4 indicated she had an inhaler that she would usually use. There had been a day, a couple months ago, that she had a very difficult time breathing and the nurse brought in the nebulizer and gave her a breathing treatment. She was unable to remember what nurse had administered the nebulizer treatment for her. During an interview, on 8/27/24 at 10:17 a.m., the Director of Nursing (DON) indicated she was not aware that the resident had a nebulizer treatment ordered. The nebulizer should not be at the bedside if the resident did not have an order for it and the resident should never be given a nebulizer treatment if there was no order for it. The proper storage of a nebulizer was to ensure the mouthpiece and tubing were stored in a plastic bag when not in use. On 8/27/24 at 10:46 a.m., the Executive Director (ED) provided a document, dated 12/12/23, titled. Medication Administration, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: Medications are administered .as ordered by the physician .Procedure: .10. Review MAR to identify medication to be administered. 11. Compare medication source .with MAR to verify resident name, medication .14. Administer medications as ordered .,17. Sign MAR after administration On 8/27/24 at 10:55 a.m., the ED provided a document, dated 12/12/23, titled, Oxygen Administration, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: .5 .e. Keep delivery devices covered in plastic bag when not in use 3.1-47(a)(6)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49068 Based on observation, interview, and record review, the facility failed to follow physician orders for 1 of 4 residents observed for medication administration (Resident 126). Findings include: During an observation of medication pass, on 8/27/24 at 9:48 a.m., observed Licensed Practical Nurse (LPN 5) confirm Resident 126's order and prepared a Lidocaine patch (patch wore on the skin for pain relief) by initialing and dating it. When the LPN went to apply the new patch, she had to remove an undated Lidocaine skin patch that was located on the resident's back, then she applied the new one. During an interview on 8/27/24 at 9:50 a.m., LPN 5 indicated that the patch she removed from the resident's back before placing the new one was not labeled, did not have a date on it, and should have been removed last night. The patch was only to be left on for 12 hours at a time then left off for 12 hours. She reviewed the medication administration record and determined that the last patch was documented as being applied on 8/26/24 at 8:54 a.m. There was not a place in the MAR to document that patches were removed. On 8/29/24 at 9:02 a.m., a record review for Resident 126 was completed. Her diagnoses included, but were not limited to, osteoporosis (a disease that causes bones to become fragile and more likely to break), and pain. A physician's order, dated 8/22/24, indicated to apply Lidocaine 5% patch, 1 patch to low back daily, every morning for pain. On for 12 hours then off for 12 hours. A Medicare 5-day Minimum Data Set (MDS) assessment, dated 6/8/24, indicated the resident had a brief interview for mental status (BIMS) score of 12, indicating she had moderate cognitive impairment. On 8/27/24 at 10:46 a.m., the Executive Director (ED) provided and identified a document as current facility policy titled, Medication Administration, dated 1/2/24. The policy indicated, .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .10. Review MAR to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, frequency, rout, and time .14. Administer medication as ordered 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on record review and interview, the facility failed to ensure pharmacy recommendations were reviewed, addressed, and dated in a timely manner and failed to ensure documented rationale of pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications (Resident 45). Finding includes: Resident 45's record was reviewed on 8/16/24 at 2:16 p.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems), chronic diastolic congestive heart failure (occurs when left ventricle of the heart becomes still and can't relax properly. This prevents the heart from filling with enough blood between beats, resulting in several symptoms), and end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids). An annual Minimum Data Set (MDS) assessment, dated 6/17/24, indicated the resident received medications which included, but were not limited to, insulin injections (medication use to lower blood sugar), anti-depressants (used to treat depressive symptoms), anti-coagulants (used to prevent or reduce blood clots from forming in the bloodstream), diuretics (increase the amount of urine produced in the kidneys) and opioid (prescription pain relief medication). a. A pharmacy recommendation, dated 8/6/23, recommended to reduce midodrine (a medication used to treat low blood pressure that causes severe dizziness or fainting) dose to 2.5 milligrams (mg) three times a day or discontinue if possible. The pharmacy recommendation was not signed, dated, or addressed by the physician. The resident's record lacked documentation of the pharmacy recommendation being accepted or denied and the rationale for the decision. A current physician order, dated 4/5/24, indicated to administer midodrine 5 mg, give one tablet by mouth three times a day. b. A pharmacy recommendation, dated 8/6/23, recommended to discontinue the medication Hiprex (used to treat bladder and kidney infections) because the medication was contraindicated with any degree of renal impairment. The pharmacy recommendation was not signed, dated, or addressed by the physician. The resident's record lacked documentation of the pharmacy recommendation being accepted or denied and the rationale for the decision. A current physician order, with an original start date of 2/7/23, indicated to administer Hiprex 1 gram, give one tablet twice a day. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. A pharmacy recommendation, dated 8/6/23, recommended to obtain lab work for the following drugs: atorvastatin (used to treat high cholesterol and triglyceride levels) obtain lipid profile (lab test that measures level of cholesterol and other fats in your blood) every 6 months, insulin obtain Hgb (hemoglobin) a1c (lab test that measures a person's blood sugar level over the past two to three months) every 3 months, furosemide (diuretic medication) obtain BMP (basic metabolic panel [a blood sample test that measures eight different substances in your blood]) every 6 months, cholecalciferol (vitamin D) obtain vitamin D every 6 months, cyanocobalamin (vitamin b12) obtain vitamin b[AGE] yearly, and a CBC (complete blood count [medical test that measures the number and types of cells in your blood]) The pharmacy recommendation was not signed, dated, or addressed by the physician. Review of a physician progress note, dated 8/21/23, indicated to continue medication as prescribed. The record lacked documentation of which medications the doctor reviewed to continue or a rationale behind continuing the medications. d. A pharmacy recommendation, dated 11/5/23, recommended to reduce the dose or attempt to hold the dose for 2 weeks and if no gastrointestinal symptoms occur, discontinue the medication. The resident was currently on Protonix (used to treat acid reflux and a damaged esophagus) 40 mg twice a day. The physician signed and dated the recommendation on 12/20/23 to reduce the medication to 40 mg daily. A current physician order, dated 12/23/23, indicated to administer Protonix 40 mg, give one tablet by mouth daily. e. A pharmacy recommendation, dated 6/6/24, recommended to attempt a dose reduction of Cymbalta (antidepressant medication). The physician signed and dated the recommendation on 8/9/24 to discontinue the Cymbalta. A social service note, dated 6/11/24 at 9:02 a.m., indicated a behavior meeting was conducted due to gradual dose reduction was due on Resident 45's Cymbalta. Social Service Director (SSD) indicated the facility would request the medication to be discontinued. A physician order, with a discontinued date of 8/13/24, indicated to administer Cymbalta 30 mg, give one capsule by mouth daily. f. A second request pharmacy recommendation, dated 6/7/24, recommended labs to be obtained. These were the same labs as advised above. The physician signed and dated the recommendation on 8/9/24. He agreed with recommendation. During an interview, on 8/26/24 at 2:49 p.m., the Director of Nursing (DON) indicated she was not aware of how long it took for some physicians to respond to pharmacy recommendations but should be timely. During an interview, on 8/26/24 at 2:52 p.m., the SSD indicated they had one physician that did not respond to pharmacy recommendations in a timely manner. During an interview, on 8/26/24 at 3:15 p.m., the DON indicated she understood the pharmacy recommendations were not addressed timely, and they may had to involve the Medical Director when physicians were not addressing them in a timely manner. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 9:48 a.m., the Administrator provided a document, with a revised date of 2/8/19, titled, Pharmacy Products and Services, and indicated it was the policy currently being used by the facility. The policy indicated, .iii) .For those issues that require provider intervention, the provider must identify whether they accept or reject part or the whole of the recommendation and must document rationale of why they recommendation is rejected in the resident's medical record .iv) The responsible provider will respond to the identified irregularities/recommendations within the time frame listed in the facility's policy or at most 30 days 3.1-48(a)(5)

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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 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. 49068 Based on observation, interview, and record review, the facility failed to ensure multi-dose bottle of eye drops and multi-dose vial of tuberculin solution were dated when opened for 1 of 2 medication carts, and 1 of 1 medication rooms observed for medication storage (Resident 126). Findings include: 1. On 8/27/24 at 10:00 a.m., the 200-hall medication cart contained a multi-dose bottle of Latanoprost (treats high pressure in the eye, also known as glaucoma) eye drops for Resident 126. The bottle was opened and not dated. During an interview on 8/27/24 at 10:01 a.m., Licensed Practical Nurse (LPN) 5 indicated that the bottle and the container both should be dated when opened in case they get separated. On 8/29/24 at 9:02 a.m., a record review for Resident 126 was completed. Her diagnoses included, but were not limited to, glaucoma (a chronic eye disease that can cause vision loss and blindness by damaging the optic nerve). A physician's order, dated 8/21/24, indicated to administer Latanoprost solution 0.005%, one drop in both eyes at bedtime for glaucoma. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:53 a.m., she indicated that the Latanoprost eye drops were only good for 6 weeks after opening. 2. On 8/27/24 at 10:06 a.m., the 200-hall medication storage room refrigerator contained a multi-dose vial of Tuberculin Aplisol solution (injectable medication used to test for tuberculosis) that was opened and not dated. On 8/27/24 at 10:07 a.m., LPN 5 indicated that normally the box was dated when opened and the vials had recently been delivered. The package indicated that medication was ordered on 6/5/24, the lot number was 77298. She did not know when the vial could have been opened. During an interview with the Director of Nursing (DON) on 8/29/24 at 11:53 a.m., she indicated that the Tuberculin solution was only good for 30 days after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 10:46 a.m., the Executive Director (ED) provided and identified a document as current facility policy, titled, Medication Administration, dated 5/20/2022. The policy indicated, .To ensure that the facility, in coordination with the licensed pharmacist, provide for accurate labeling to facilitate safe administration of medications and consideration of precautions in accordance with the currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable .1. Medication labeling must be typed or printed and clearly indicate .3. Multi-dose medication vials/devices .a. should be labeled with date opened/accessed .ii. Once opened/accessed the vial/device should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for vial/device after opened/accessed On 8/29/24 at 1:54 p.m., the DON provided and identified a document as current facility policy, titled, Drug Expiration Dating, dated 2/22/2022. The policy indicated, .**ALL medication(s) with shortened expiration dates after opening must be marked with the date opened** .Aplisol/Tubersol .Expiration date * .28 days from date opened** On 8/29/24 at 2:12 p.m., the DON provided and identified a document as the manufacturing package insert from Pfizer for Resident 126's Latanoprost eye drop solution with a revised date of August 2011. The package insert indicated, .Package insert for the 2.5 mL fill - package of 1 bottle: Xalatan, latanoprost ophthalmic solution 0.005% .Storage .Once a bottle is opened for use, it may be stored at room temperature up to 25 degrees C (77 degrees F) for 6 weeks 3.1-25(j) 3.1-25(k)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on observation, interview, and record review, the facility failed to ensure food was prepared in a sanitary manner for 1 of 2 kitchen observations. This had the potential to affect 35-38 residents who ate meals from the kitchen. Finding includes: During a continuous kitchen observation of the puree (a smooth, crushed, or blended food that has the consistency of a creamy paste or liquid) food preparation, on 8/27/24 at 10:31 a.m. to 10:50 a.m., [NAME] 11 washed her hands at the sink for less than 20 seconds and began to scoop vegetables into a plastic container to puree them. She proceeded to scoop chicken broth into the container as well. [NAME] 11 turned on the puree blender and then went over to the steam table to scoop roasted potatoes and chicken broth into another plastic container to puree that was drying on the counter, she grabbed a paper towel to dry it further. She turned on the potatoes and then went back to the vegetables to see if they were completed. The cook had to add thickener to the vegetables because they were too runny. She went back to the potatoes and emptied them into a pan and took the plastic container they were pureed in and began to clean it at the three-compartment sink (manual procedure for cleaning and sanitizing dishes in commercial settings) along with a spatula. She went back to the other counter to check on the vegetables. She grabbed the spatula that was still wet from where she had washed it and used it to place the vegetables in another container and place in oven. [NAME] 11 took the container that she pureed the vegetables and washed in the 3-compartment sink, she then grabbed a paper towel and dried the container with the paper towel. The cook went back to the steam table and obtained 4 slices of ham and 4 slices of bread with a glove on one hand. The cook finished the ham and placed it into another container and placed in oven. During this entire observation the cook washed her hands at the start of the puree process and no other hand hygiene was observed. During a kitchen observation, on 8/27/24 at 10:55 a.m., Dietary Aide 10 was preparing lemonade into a [NAME] pitcher by using lemonade powder and water. The dietary aid placed his ungloved finger on the inside of the pitcher rim to remove a small particle and in doing so he touched the inside of the pitcher along with the lemonade as it began to splash out. He then placed a lid on the pitcher along with a sticker that contained a date of when it was prepared. The lemonade was being prepared for the lunch meal service. During an interview, on 8/27/24 at 11:00 a.m., the Dietary Manager indicated staff should not touch the inside of a drink pitcher with ungloved hands and she would be throwing out the lemonade that was contaminated this morning. The Dietary Manager indicated staff should be performing hand hygiene during the puree process when they go from a dirty to clean environment. [NAME] 11 would have cross contaminated the food going from the clean utensils to dirty utensils to clean again. She further indicated the utensils should be left to air dry and not used if still wet to puree with. On 8/27/24 at 12:28 p.m., the Dietary Manager provided a document, dated 12/12/23, titled, Dietary Personnel, and indicated it was the policy currently being used by the facility. The policy indicated, .The dietary department will employ sufficient and qualified staff to prepare and serve meals and maintain a sanitary environment (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 12:28 p.m., the Dietary Manager provided a document, dated 12/12/23, titled, Food Production, and indicated it was the policy currently being used by the facility. The policy indicated, .4. Bare hands should never touch raw or ready to eat food directly .Gloves will be worn for single task preparation then removed and hand hygiene performed On 8/27/24 at 1:55 p.m., the Administrator provided a document, dated 12/23/23, titled, Hand Hygiene, and indicated it was the policy currently being used by the facility. The policy indicated, .1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice .c. rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers 3.1-21(i)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Terre Haute	3150 N Seventh St Terre Haute, IN 47804

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 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. 49068 Based on observations, interviews, and record review, the facility failed to accurately document medication administration for 1 of 1 resident reviewed for peritoneal dialysis (Resident 43). Findings include: On 8/23/24 at 3:03 p.m., observed a peritoneal dialysis (PD) machine (a treatment for kidney failure that uses the lining of your abdomen, or belly, to filter your blood inside your body), on Resident 43's bedside table. On 8/27/24 at 11:41 a.m., a record review was completed for Resident 43. His diagnoses included, but were not limited to, chronic kidney disease stage 5 (end stage kidney failure), and dependence on renal dialysis (treatment that helps people whose kidneys are no longer able to filter blood properly). A current physician's order, updated 4/25/24, indicated to follow PD orders through the dialysis center. The physician orders were ongoing and could change daily based on clinical assessments reported to the provider. A physician's order, dated 8/16/24, indicated to administer PD treatment: 1.5 (yellow) x 2 (6 Liter) bags (dialysis solutions) via cycler (PD machine) at bedtime. A quarterly Minimum Data Set (MDS) assessment, dated 8/17/24, indicated the resident had a primary medical condition, chronic kidney disease, stage 4, severe. Had an additional diagnosis of dependence on renal (kidney) dialysis, and received dialysis while a resident. On 8/27/24 at 12:16 p.m., a review of the June 2024 Medication Administration Record (MAR) indicated that on 6/9/24, QMA 17 documented that the PD had been administered. On 6/21/24, QMA 18 documented that the PD had been administered. On 8/27/24 2:44 p.m., a review of the July 2024 MAR indicated that on 7/16/24, QMA 16 documented that the PD dialysis had been administered. On 7/18/24, QMA 18 documented that the PD had been administered. On 7/19/24 QMA 16 documented that the PD had been administered. On 7/20/24, QMA 15 documented that the PD had been administered. During an interview on 8/27/24 at 3:11 p.m., QMA 12 indicated that as a QMA he was not trained to administer PD, so the nurse came and set it up for him at night. He was not allowed to get certified. The nurse must call the dialysis center every day to give them an assessment report and receive new orders based on outflow and recorded vitals. Only someone who was certified was allowed to hook up and administer the PD. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/24 at 3:20 p.m., Licensed Practical Nurse (LPN) 5 indicated that the dialysis company came to train nursing staff on every new resident who received PD, the training included parameters they wanted them to follow. It was mandatory training to be able to give PD to that patient. During an interview on 8/29/24 at 9:32 p.m., QMA 15 indicated that Resident 43 received PD every day. To her knowledge, QMA's were not allowed to be trained to do it. When the nurse came to set up the PD, it was the nurse's responsibility to chart that it was completed. When asked about the MAR dated 7/20/24 where she had charted the PD as being completed, she confirmed that they were her initials documented that day. She was not sure if she just accidently clicked the button. Then indicated she thought that it was possible that she did not sign out of the computer on the medication cart that they parked outside of the resident's room they were working in. She indicated that it was possible that the nurse did not realize that it was logged in under someone else's credentials before going in to sign off that the PD was completed. It had happened before with insulin, and they had to go back and strike it out in an addendum. During an interview on 8/29/24 at 9:46 a.m., when asked about the dates the PD was documented by a QMA, the Director of Nursing (DON) indicated that it was likely that the computer was still logged in under the QMAs when the nurse came and hooked up the PD. QMA 17 and QMA 18 no longer work at the facility. During an interview on 8/29/24 at 11:34 a.m., the Unit Manager indicated that staff should not leave themselves logged into the computers and unlocked to leave it up to possible give access to information or for someone to potentially get in and document something that you did not do. Staff should never document something that they did not do. Staff should not document under someone else's login, it was their credentials, they should not give anyone their login or password information. Everyone had their own access information. If something like that did happen, they should let someone know as soon as they realize it happened so they could amend it. She was not sure what happened on the days that the QMAs signed off on the PD but they know their scope and what they should and should not sign off on. A QMA cannot do assessments of bruit and thrill, cannot do before and after treatment assessments, and only nurses were trained to administer PD. On 8/27/24 at 10:46 a.m., the Executive Director (ED) provided and identified a document as current facility policy, titled, Medication Administration, dated 5/20/2022. The policy indicated, .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection 3.1-50(a)