STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valparaiso Care & Rehabilitation	606 Wall Street Valparaiso, IN 46383

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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 residents received the necessary treatment and services related to the lack of assessment and monitoring of skin discolorations for 1 of 2 residents reviewed for non-pressure related skin conditions. The facility also failed to ensure residents received medications as ordered by the physician for 1 of 1 resident reviewed for dialysis, 1 of 2 residents reviewed for constipation/diarrhea, and 1 of 1 resident reviewed for insulin administration. (Residents 10, 8, 3, and 18)Findings include:1. On 12/11/25 at 3:19 p.m., Resident 10 was observed sitting on a couch in the lounge area. There were purple discolorations observed to the tops of both hands. On 12/15/25 at 9:04 a.m., Resident 10 was observed sitting at a dining room table. The discolorations were still observed. On 12/16/25 at 10:08 a.m., Resident 10 was observed sitting at a dining room table. The discolorations were still observed. There were also 2 small scabbed areas observed to the top of his left hand and a discoloration to his left forearm. The discoloration to his left forearm was not entirely visible and unable to observe the size due to him wearing a long sleeve shirt. Record review for Resident 10 was completed on 12/15/25 at 9:15 a.m. Diagnosed included, but were not limited to, atrial fibrillation, hypertension, and dementia. The Significant Change Minimum Data Set (MDS) assessment, dated 11/6/25, indicated the resident was cognitively impaired. The resident required partial moderate assistance with bed mobility, transfers, and walking. A Weekly Skin Assessment, dated 12/15/25, indicated there were no alterations in the resident's skin including bruising. During an interview on 12/16/25 at 11:46 a.m., the Wound Care Nurse indicated she was unaware of the residents' discolorations, and they had not been assessed or monitored. A policy titled, Skin Management Program, and received as current from the facility on 12/17/25, indicated, .6. Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises. 2. Record review for Resident 8 was completed on 12/17/25 at 2:04 p.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and obstructive uropathy. The admission MDS assessment, dated 11/11/25, indicated the resident was cognitively intact. The resident received antidepressant, diuretic, and antiplatelet medications. The resident received (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dialysis services. A Physician's Order, dated 11/4-12/15/25, indicated to administer calcitriol (synthetic active form of vitamin D3 primarily used to manage low blood calcium levels and bone diseases in patients with kidney failure) 0.25 micrograms (mcg) every day for end stage renal disease. The November 2025 Medication Administration Record (MAR) indicated the calcitriol was not administered on the following dates due to the drug item not being available and or waiting on arrival: 11/5, 11/12, 11/14, 11/15, 11/16, 11/18, 11/24, 11/25, and 11/27/25. During an interview on 12/17/25 at 4:03 p.m., the Director of Nursing (DON) indicated the medication was in the emergency drug kit (EDK) and the staff could have pulled the medication from there while waiting for pharmacy arrival. 3. Resident 3's record was reviewed on 12/16/25 at 3:48 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 10/22/25, indicated the resident was severely cognitively impaired. She had received insulin injections daily for the last seven days. A Care Plan, dated 4/1/25, indicated the resident was at risk for adverse effects of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) related to the diagnosis of diabetes mellitus. Interventions included, but were not limited to, diet as ordered, provide medications as ordered, and monitor blood sugars as ordered. The December 2025 Physician's Order Summary indicated insulin lispro insulin pen 100 unit/milliliter (ml) four time a day per sliding scale and insulin glargine insulin pen 100 unit/ml 20 units subcutaneous daily. The November and December 2025 Medication Administration Records indicated the insulin lispro medication was not signed out as administered on 11/3/25 at 12:00 p.m., 11/16/25 at 6:00 p.m., 11/30/25 at 6:00 p.m., and 12/9/25 at 9:00 p.m. The insulin glargine medication was not signed out as administered on 11/2 at 9:00 a.m. and 11/19/25 at 9:00 a.m. During an interview on 12/17/25 at 8:57 a.m., the Director of Nursing (DON) indicated both nurses working during those shifts ran their EMAR Compliance which shows if there were any medications that were not marked as administered. The nurses indicated they did not have any of the medications show up as missed. The DON had no further information to provide. 4. Resident 18's record was reviewed on 12/16/25 at 1:43 p.m. Diagnoses included, but were not limited to, lung and bone cancer. The admission Minimum Data Set assessment, dated 11/28/25, indicated the resident was cognitively intact. She received antianxiety and opioid medications. The December 2025 Physician's Order Summary indicated buspirone (antianxiety medication) 5 milligram tablet three times a day, lactulose (laxative) 10 gram/15 milliliter solution 30 milliliters three times a day, ipratropium-albuterol nebulizer solution 0.5 milligram-3 milligram, 3 milliliter inhalation, oxycodone (narcotic pain medication) 20 milligram tablet every 12 hours, and lidocaine 5% (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cream four times a day to the lower back and knees. The November and December 2025 Medication Administration Record indicated the buspirone was not signed out as administered on 12/6/25 at 8:00 a.m., and 12/11/25 at 8:00 a.m. and 2:00 p.m. The lactulose solution was not signed out as administered on 12/6/25 at 8:00 a.m., and 12/11/25 at 8:00 a.m. and 2:00 p.m. The ipratropium-albuterol nebulizer was not signed out as administered on 11/15/25 at 8:00 p.m., 11/27 at 8:00 am., and 11/28/25 at 11:00 a.m. The oxycodone was not signed out as administered on 12/6/25 at 8:00 a.m. The lidocaine cream was not signed out as administered on 11/21/25 at 4:00 p.m., 11/24/25 at 8:00 a.m., and 11/25/25 at 4:00 p.m. During an interview on 12/17/25 at 8:57 a.m., the Director of Nursing indicated she had no further information to provide. 3.1-37(a)

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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. Based on observation and interview, the facility failed to ensure a clean and sanitary kitchen related to dirty shelves, carts and the walk in refrigerator in the main kitchen. This had the potential to affect the 109 residents who received meals prepared in the kitchen.Findings include:During the initial kitchen tour on 12/11/25 at 9:15 a.m. with the Kitchen Manager, the following was observed:a. In the walk-in refrigerator, there was a white powdery substance build up on the motor fan, and patches of whitish substance on the ceiling and walls. There was a musty odor present in the refrigerator.b. There were two carts near the door to the dining room that had crumbs, dried liquid and food substances spilled on the shelves.c. The shelves below the counter had crumbs, liquid spillage and food substances.During an interview with the Dietary Manger during the kitchen tour, she indicated they cleaned the shelves weekly and she had tried to get the substance off the refrigerator walls and ceiling but was unable to remove it.During an interview on 12/11/25 at 10:15 a.m., the Maintenance Director indicated he was unaware of the white substance in the walk in refrigerator but would go look at it. During a follow up interview, the Maintenance Director indicated it had been cleaned off and was no longer there.3.1-21(3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain a sanitary, safe, and homelike environment related to accident hazards observed to the hallway on the dementia unit during construction, and dirty resident care equipment on both units. (Cottage, East Unit, [NAME] Unit) Findings include:1. On 12/11/25 at 10:30 a.m., the Cottage Dementia Unit was observed. There were multiple residents and staff observed in the dining area and lounge area. The hallway to the resident rooms had two fire doors closed. The door did not have windows to see into the hallway. Upon opening the door to the hallway, there was someone standing on a ladder. The door was then closed and staff were asked if people were able to go back there. The Memory Care Support Specialist (MCCS) indicated anyone could go back into the hallway. The facility staff were keeping the doors closed due to the dust coming from the construction that was taking place in the hallway. Upon entering the hallway, there were multiple construction workers in the hallway. There were drop cloths observed on the ground with multiple ladders. Not all the ladders were being used by the construction workers at that time. There were power tools observed on the floor. There were 4 residents who were observed in their rooms with the doors closed. The MCCS indicated 3 out of the 4 residents observed in their rooms were mobile and could walk unassisted or with a walker. There were no staff observed in the hallway or in the resident rooms. During an interview at the time of the observation, the MCCS indicated the staff had gotten the residents up and into the dining/lounge area earlier, but a few of the residents did not want to come out of their rooms yet. She did not have any staff stationed in the hallway to make sure if the residents did decide to come out of their rooms and into the hallway, that they had assistance to walk down the hallway safely with the drop cloths, ladders, and power tools in the hallway. Going forward, she would make sure a staff member was always stationed in the hallway if there were residents in their rooms and the hallway fire doors were shut during the construction. 2. During the group resident council interview on 12/16/25 at 2:02 p.m., the residents indicated the sit to stand lifts needed to be cleaned. The wheels were dirty and had hair stuck in them. During the environmental tour on 12/17/25 at 2:35 p.m. with the Maintenance Supervisor, the following was observed:-The East Wing sit to stand lift had a dried brown substance and crumbs on the bottom rails. There was hair and debris built up in the wheels.-The [NAME] Wing sit to stand lift had hair and debris built up in the wheels. During an interview with the Maintenance Supervisor at the time of the tour, he indicated the CNAs would clean the lifts in between uses but were probably focused on the handles and high touch areas. This citation relates to Intake 2653024. 3.1-19(e)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to restraints, antipsychotic medication, and tube feeding for 3 of 26 MDS assessments reviewed. (Residents 59, 11, and 79) Findings include:1. Record review for Resident 59 was completed on 12/16/25 at 10:58 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety disorder, and type two diabetes mellitus. The Quarterly MDS assessment, dated 10/22/25, indicated the resident had not received any antipsychotic medication since the prior assessment. The prior MDS assessment was dated 8/1/25. The Physician's Order Summary, dated 12/2025, indicated Risperdal Consta (an antipsychotic medication) 25 milligrams (mg)/2 milliliters (ml), give 25 mg intramuscular injection every 2 weeks. The Medication Administration Record, dated10/2025, indicated the resident had received a Risperdal injection on 10/9/25. During an interview on 12/17/25 at 11:39 a.m., the MDS Coordinator indicated there was a data entry error regarding the antipsychotic medication. 2. On 12/12/25 at 10:57 a.m., Resident 11 was observed sitting in her wheelchair. There were no restraints observed to the wheelchair that would prevent the resident from rising. Record review for Resident 11 was completed on 12/15/25 at 10:56 a.m. Diagnoses included, but were not limited to, dementia, type two diabetes mellitus, and general anxiety disorder. The Quarterly MDS assessment, dated 11/3/25, indicated a chair restraint to prevent rising was used less than daily. There was a lack of any Physician's Orders or assessments to indicate a chair restraint had been used. During an interview on 12/17/25 at 11:39 a.m., the MDS Coordinator indicated the facility was restraint free and there had been a data entry error. 3. On 12/12/25 at 9:44 a.m., Resident 79 was observed sitting up in bed. The resident indicated she had a gastrostomy tube used for tube feedings and it had been bleeding for the last two months. The gastrostomy tube was observed with a split gauze that was soiled with drainage from the insertion site. Resident 79's record was reviewed on 12/15/25 at 2:52 p.m. Diagnoses included, but were not limited to, gastrostomy and tracheostomy status. A Physician's Order, dated 4/1/25, indicated cleanse the gastrostomy site with soap and water, pat dry, and apply gauze every shift. A Care Plan, dated 12/2/24, indicated the resident was at risk for complications related to tube feeding. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 12/4/25, indicated the resident was cognitively intact. Tube feeding was not marked. During an interview on 12/17/25 at 11:38 a.m., the MDS Coordinator indicated it was a data entry error and would be corrected immediately. 3.1-31(i)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to ensure a resident's care plan was updated related to a suprapubic urinary catheter and enhanced barrier precaution isolation use for 2 of 26 residents whose care plans were reviewed. (Resident 2 and 79) Findings include:1. On 12/17/25 at 9:50 a.m., Resident 2 was observed in his bed while the Wound Nurse changed pressure ulcer dressings. Resident 2 had a suprapubic catheter that was draining clear yellow urine to gravity. Resident 2's record was reviewed on 12/12/25 at 3:17 p.m. Diagnoses included, but were not limited to, obstructive and reflux uropathy (blockage in the urinary system that prevents normal urine flow and urine flowing backward from the bladder to the kidneys) and acute and chronic respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 10/22/25, indicated the resident was severely impaired for daily decision making. The resident had an indwelling urinary catheter. A Physician's Order, dated 9/30/25, indicated the resident had a Foley catheter size 18 Fr with a 30 milliliter bulb. A Care Plan, dated 6/12/24, indicated the resident required an indwelling catheter related to obstructive uropathy. Interventions included, but were not limited to, change catheter per the Physician Order, use a 16 Fr, 10 milliliter catheter per the Physician's Order. A Progress Note, dated 9/27/25 at 1:10 p.m., indicated the resident arrived at the facility. A head-to-toe assessment was completed. The resident had a gastrostomy tube and an 18 Fr, 30 milliliter suprapubic catheter draining clear yellow urine. During an interview on 12/17/25 at 1:45 p.m., the Director of Nursing indicated she was unsure when the resident had the suprapubic catheter placed and the care plan would be updated to reflect the use of a suprapubic catheter. 2. On 12/12/25 at 9:44 a.m., Resident 79 was observed sitting up in bed. She had a tracheostomy and a gastrostomy tube. There was a sign on the door that indicated she was in enhanced barrier precautions. There was a bin nearby the door for personal protective equipment. Resident 79's record was reviewed on 12/15/25 at 2:52 p.m. The December 2025 Physician's Order Summary indicated the resident was in enhanced barrier precautions (EBP). There was no care plans related to the resident being in enhanced barrier precautions. During an interview on 12/17/25 at 4:25 p.m., the Infection Preventionist indicated there should have been a care plan initiated for the resident being in enhanced barrier precautions. 3.1-35(d)(2)(B)

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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. Based on observation, record review and interview, the facility failed to ensure a hand splinting device was in place as ordered and restorative nursing care was provided as ordered for 1 of 2 residents reviewed for range of motion. (Resident 81)Finding includes: On 12/11/25 at 11:12 a.m. and 12/15/25 at 9:39 a.m., Resident 81 was observed in his bed. There was no hand splint or carrot in the resident's hand left hand which was contracted. On 12/15/25 at 1:27 p.m., the resident was in bed and there was no splint in place to the left hand. The resident indicated he was not receiving restorative nursing services but would like to.The resident's record was reviewed on 12/15/25 at 9:50 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis affecting one side of the body) left side, heart failure and unspecified mood disorder.The Quarterly Minimum Data Set (MDS) assessment, dated 11/14/25, indicated the resident was cognitively intact and was dependent for bed mobility, transfers and toileting. The resident had not received any therapy or restorative nursing services during the assessment period.A Physician's Order, dated 7/24/25, indicated palm protectors to the left hand, on in the morning, off in the evening.The December 2025 Treatment Administration Record (TAR) indicated the palm protectors were signed out every shift as on, no refusals were noted.A Care Plan, dated 6/25/25, indicated the resident required passive range of motion (ROM) to the left upper extremity for weakness and to decrease contractures. Approaches included passive ROM program 5-7 days a week. Resident will tolerate 10 repetitions x 2 sets of passive ROM to left upper extremity, one time daily.The Restorative Nursing Tasks for December 2025 indicated the resident received ROM one day on 12/7/25. In November 2025, the resident received ROM on 11/3, 11/20, 11/22, 11/26, 11/27 and 11/28. There were no refusals noted.During an interview on 12/15/25 at 1:38 p.m., the Director of Nursing was made aware the palm protectors were not in place as documented on the TAR. No additional information was providedDuring an interview on 12/15/25 at 1:41 p.m. the MDS Nurse indicated she was aware there were no refusals documented in the restorative charting. She indicated the resident refused frequently.3.1-42(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to monitor nutritional intake for meals for a resident with history of weight loss for 1 of 1 resident reviewed for nutrition. (Resident 5) Finding includes:During an interview on 12/11/25 at 12:42 p.m., Resident 5's family member indicated he had weight loss recently and had been having problems eating. Record review for Resident 5 was completed on 12/16/25 at 9:06 a.m. Diagnoses included, but were not limited to, dementia, hypertension, anxiety, tremors, and dysphagia (difficulty swallowing food or liquids). The resident was admitted to the facility on [DATE].The admission Minimum Data Set (MDS) assessment, dated 11/17/25, indicated the resident was severely cognitively impaired. The resident required a setup for eating and had a weight loss of 5% or more. A Care Plan, dated 11/13/25 and revised 12/10/25, indicated the resident was a nutritional risk and had a significant weight loss. An intervention included to monitor the food and fluid intake at meals.A nutrition calculation indicated on 11/11/2025, the resident weighed 191.6 lbs. On 12/02/2025, the resident weighed 179 lbs, which was a 6.58% weight loss.The Intake - Breakfast, Lunch, and Dinner documentation was reviewed for the past 30 days. The following meal consumption amounts were not documented: - Breakfast: 11/22, 11/23, 11/30, 12/8, 12/11, and 12/14/25- Lunch: 11/22, 11/23, 11/24, 11/29, 12/2, 12/8, 12/12, and 12/14/25- Dinner: 11/28, 12/1, 12/3, 12/7, 12/8, 12/9, 12/11, 12/12, and 12/15/25During an interview on 12/17/25 at 11:04 p.m., the Director of Nursing indicated the staff should have been documenting the resident's meal intake amounts or when he refused. A policy titled, Food and Fluid Intake Record-EMR, and received as current from the facility on 12/17/25, indicated, .Upon completion of the meal a member of nursing staff (CNA, QMA or Licensed Nurse) will document the percentage of food and fluid consumption for the meal.3.1-46(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review and interview, the facility failed to ensure a resident with a gastrostomy tube (g-tube, feeding tube) received care and services as ordered by a Physician related to treatment of the area around the insertion site for 1 of 1 resident reviewed for tube feeding. (Resident 79)Finding includes:On 12/12/25 at 9:44 a.m., Resident 79 was observed sitting up in bed. The resident indicated she had a gastrostomy tube used for tube feedings and it had been bleeding for the last two months. The gastrostomy tube was observed with a split gauze that was soiled with dark colored drainage from the insertion site. Resident 79's record was reviewed on 12/15/25 at 2:52 p.m. Diagnoses included, but were not limited to, gastrostomy and tracheostomy status. The Quarterly Minimum Data Set (MDS) assessment, dated 12/4/25, indicated the resident was cognitively intact. Tube feeding was not marked. A Physician's Order, dated 4/1/25, indicated cleanse the gastrostomy site with soap and water, pat dry, and apply gauze every shift. A Care Plan, dated 12/2/24, indicated the resident was at risk for complications related to tube feeding. Interventions included, but were not limited to, cleanse around site as ordered, observe for and document any symptoms of intolerance such as infection at insertion site, pain at site, observe site for signs of infection such as redness, warmth, malodorous drainage, document findings and notify the physician. Resident 79 was observed on 12/17/2025 at 9:23 a.m. with the Director of Nursing present. Resident 79 was observed sitting up in bed. The insertion site of the gastrostomy tube had a buildup of dark colored discharge surrounding it. There was no gauze in place at the time. At the time, the DON indicated the gauze must have fallen off. She would get the insertion site cleaned up and place a new gauze. She was also going to contact the physician and see if there was an ointment to put around the insertion site to help with the irritation. 3.1-44(a)(2)

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	155166	A. Building B. Wing	12/17/2025

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Valparaiso Care & Rehabilitation	606 Wall Street Valparaiso, IN 46383

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. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to medication administration for 1 of 1 resident reviewed for dialysis. (Resident 8)Finding includes:Record review for Resident 8 was completed on 12/17/25 at 2:04 p.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and obstructive uropathy. The admission MDS assessment, dated 11/11/25, indicated the resident was cognitively intact. The resident received antidepressant, diuretic, and antiplatelet medications. The resident received dialysis services.The December 2025 Physician's Order Summary indicated orders for the following medications:-furosemide (to treat fluid retention) 40 mg (milligrams) every day-losartan (manages high blood pressure) 50 mg every day-dialysis at dialysis center on Monday, Wednesday, and Friday at 11:00 a.m.The 2025 November and December Medication Administration Records indicated the medications were not administered on the following dates and times due to dialysis. The medications were ordered to be administered every day at 7:00 a.m.,-11:00 a.m.-losartan not administered on: 11/7, 12/1, 12/3, and 12/8/25 due to dialysis-furosemide not administered on: 12/8/25 due to dialysisDuring an interview on 12/17/25 at 3:40 p.m., the Director of Nursing indicated the medications were not administered due to the resident had refused them. The staff should have written that he refused them and not due to dialysis.3.1-50(a)(1)3.1-50(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155166	A. Building B. Wing	12/17/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control measures were implemented related to an indwelling urinary catheter bag on the floor for 1 of 2 residents reviewed for urinary catheters (Resident 62), glove use during tracheostomy care for 1 of 1 resident reviewed for tracheostomy care (Resident 2) and lack of orders and care plans for enhanced barrier precautions (EBP) for 1 of 3 residents reviewed for transmission based precautions. (Resident 141)Findings include:1.On 12/11/25 at 3:15 p.m. and 12/12/25 at 9:15 a.m., Resident 62 was observed lying in his bed. His indwelling urinary catheter bag was lying on the floor. On 12/12/25 at 9:28 a.m., LPN 1 was standing at the resident's bedside doing nail care. The catheter bag was lying on the floor next to her. When asked if it should be on the floor, the nurse then picked it up and hung it on the side of the bed. The resident's record was reviewed on 12/12/25 at 3:06 p.m. Diagnoses included, but was not limited to, metabolic encephalopathy, neuromuscular dysfunction of the bladder and chronic pain. The Quarterly Minimum Data Set assessment, dated 12/8/25, indicated the resident was cognitively intact, dependent for toileting and needed partial assistance for bed mobility. The resident had an indwelling urinary catheter. The Indwelling Catheter Care Plan, dated 12/13/23, included the approach to not allow tubing or any part of the drainage system to touch the floor. During an interview on 12/12/25 at 10:15 a.m., the Director of Nursing indicated the resident was putting the catheter bag on the floor and was educated not to put the bag on the floor. 2. On 12/17/25 at 1:15 p.m., Respiratory Therapist (RT) 1 was observed doing tracheostomy care for Resident 2. RT 1 cleansed his hands and donned a gown and gloves and then prepared his supplies. He opened the tracheostomy care kit. He removed his gloves and cleaned his hands. He attempted to don the sterile gloves provided in the kit; however, they did not fit his hands, so he removed them and attempted to don another pair. The second pair of gloves ripped and so he removed them. He indicated the sterile gloves provided have never fit his hands and tracheostomy care is really a clean procedure, so he was going to use regular gloves. He moved his gown with his hands and reached into his pants pocket and pulled out a single glove and donned it. He then reached into his pocket again and pulled out another glove and donned it. He proceeded to perform the tracheostomy care. During an interview on 12/17/2025 at 1:45 p.m., the Director of Nursing was notified and had no further information to provide. A facility policy titled, Tracheostomy Care, indicated .7. Using aseptic technique, open trach care kit & empty contents onto the drape. 8. Remove gloves & perform hand hygiene. 9. Aseptically put on sterile gloves & prepare field. 3. On 12/12/25 at 9:42 a.m., there was a sign posted on Resident 141's doorway indicating the resident was in enhanced barrier precautions. There was a bin nearby containing personal protective equipment. Resident 141's record was reviewed on 12/17/25 at 4:21 p.m. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2025 Physician's Order Summary indicated cleanse right heel with betadine cover with bordered gauze. There were no orders for enhanced barrier precautions. There was no care plans related to enhanced barrier precautions. During an interview on 12/17/25 at 4:25 p.m., the Infection Preventionist indicated the resident was in enhanced barrier precautions due to wounds. There should have been orders and a care plan for enhanced barrier precautions. 3.1-18(b)