STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155178	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Fountainview Care Center	609 W Tanglewood LN Mishawaka, IN 46545

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49994 Based on record review and interview the facility failed to ensure resident grievances were responded to promptly and acted upon for 4 of 21 residents reviewed for grievances. (Residents 52, 30, 70 & 128) Findings include: Review of 21 resident grievance forms, on 7/12/2024 at 9:38 A.M., indicated there was no documentation of response and outcomes for 4 of the 21 grievances reviewed. 1. During an interview, on 07/12/2024 at 10:49 A.M., Resident 52 indicated he had waited about an hour on every shift to get care and he has had staff come in, turn the call light off and never came back. The grievance discussed his concerns related to having to wait an hour every shift to get the care he needed, staff turning his call light off, without meeting his care needs and never coming back to give him care. Resident 52 indicated he had not received any response, written or verbal regarding his grievances. On 6/7/2024 Resident 52 filed a personal grievance indicating he had asked for help to use the bathroom and had to wait over 40 minutes for help. The grievance was reviewed by the Executive Director and resolved on 6/10/2024. 2. During an interview, on 7/12/2024 at 10:54 A.M., Resident 30 indicated he had waited 2 hours for care, he had pressed his call light and staff would turn it off and not come back to provide care. Resident 30 filed a personal grievance and had never been told the outcome of any of his grievances or received a written copy. On 6/30/2024, Resident 30 filed a personal grievance indicating it took too long for care and was specifically complaining about the care he received on 6/29/2024. The grievance was reviewed by the Executive Director and resolved on 7/13/2024 3. During an interview, on 7/12/2024 at 11:05 A.M., Resident 70 indicated she had waited approximately 20 minutes for her call light to be answered, staff would come in and turn her call light off and then leave. She stated most of the time staff did not come back after turning off the call light. Resident 70 indicated she had filed a grievance and had never received any outcome or response to her grievances or a written copy. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER: Brickyard Healthcare - Fountainview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 609 W Tanglewood LN Mishawaka, IN 46545	

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/8/2024 Resident 70's significant other filed a grievance indicating the resident was not receiving care as soon as she asked for help. The grievance was reviewed by the Executive Director and resolved on 6/10/2024. During an interview, on 7/12/2024 at 1:10 P.M., the Administrator indicated the facility never provided residents with written responses to their grievances and they should have provided responses. 44111 4. During an interview, on 7/9/2024 at 9:49 A.M., Resident 128 indicated he was missing $20.00 from his wallet. This had occurred sometime between midnight and 4 A.M. on a date near the end of June 2024. A staff member had filled out a grievance form but he had not been informed of the outcome. Review of the grievance log indicated there was an entry, dated 6/27/2024, for Resident 128 regarding missing money. The report indicated he was missing $20.00 out of his wallet. A record review was completed on 7/9/2024 at 3:02 P.M., for Resident 128. An admission Minimum Data Set (MDS) assessment, dated 6/28/2024, indicated he had no cognitive impairment. During an interview, on 7/10/2024 at 10:55 A.M., the Administrator indicated the grievance process included the following: once the facility heard a complaint from a Resident, the concern/grievance was assigned to a department head and they were responsible to interview and resolve the complaint/grievance. She indicated the Admissions Director had been assigned Resident 128's grievance. During an interview, on 7/10/2024 at 11:04 A.M., the Admissions Director indicated she had been assigned to Resident 128's grievance. She had spoken to the resident and asked him if he had possibly spent the money or had given it to his family. She had left a telephone message for his family but had not received a return call. The resident did have some take out food, undated from a local delivery service in the pantry refrigerator at the time of the investigation. The Admissions Director indicated she had not gone back to follow up on the grievance, nor did she inform the resident of any outcome In addition, she had not documented any resolution to the complaint/grievance. She preferred to have the forms completed within 24 hours after she received them. On 7/10/2024 at 11:10 A.M., the Administrator provided a policy titled, Resident and Family Grievances, dated 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated .10. Procedure: c. Forward the grievance form to the Grievance Official as soon as practicable. e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: i. The date the grievance was received. ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concerns(s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility as a result of the grievance. vi. The date the written decisions was issued . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-3(2)(l)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 47419 Based on interview and record review, the facility failed to ensure residents were made aware of the facility's bed hold policy upon transfer to a hospital for 2 of 2 residents reviewed for hospitalization s. (Residents 28 and 64) Findings include: 1. A record review for Resident 28 was conducted on 7/9/2024 at 3:04 P.M., Diagnoses included, but were not limited to, type 2 diabetes mellitus and anxiety disorder. An Annual Minimum Data Set (MDS) assessment, dated 5/8/2024, indicated Resident 28 had moderate cognitive impairment. Nursing Progress Notes, dated 4/22/2024, indicated Resident 28 was admitted to the hospital due to a methicillin resistant staph aureus infection. The record indicated her family had been notified but did not indicate the bed hold policy was explained and/or a copy given to the resident. 2. A record review for Resident 64 was conducted on 7/11/2024 at 9:32 A.M. Diagnoses included, but were no limited to, acquired absence or right and left leg below the knee and type 2 diabetes mellitus. An Admission Minimum Data Set assessment, dated 5/9/2024, indicated Resident 64's cognition was intact. A Nursing Progress Note, dated 5/16/2024, indicated the resident was transferred to the hospital for congestive heart failure. The family was notified of the resident's transfer but the record did not indicate the resident or the resident's family was made aware of, or given a copy of the facility's bed hold policy. During an interview on 7/10/2024 at 1:42 P.M., LPN 11 indicated copies of the Advance Directive, face sheet, current order summary, bed hold policy, and any pertinent labs or x-rays were given to EMS personnel when residents were transferred to the emergency room . A copy of the bed hold policy given to the resident should have been placed in the medical record. During an interview on 711/2024 at 1:40 P.M., the ED (Executive Director) indicated there was no documentation of bed hold policies being given to Residents 28 and 64 when they were transferred to the hospital. On 7/11/2024 at 1:50 P.M., the Regional Nurse 14 provided a current, undated, policy titled, Transfer and Discharge (including AMA). The policy indicated, .Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-12(a)(25)(26)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48145 Based on observation, record review and interview, the facility failed to provide nail care for dependent residents for 3 of 5 residents who were reviewed for activities of daily living needs. (Residents 35, 5, & 28) Findings include: 1. During an observation on 7/8/2024 at 10:06 A.M., Resident 35's right hand was contracted and his fingernails were long and curled downward on both hands. During an observation on 7/9/2024 at 11:30 A.M., Resident 35's right hand was contracted and his nails were long and curled downward on both hands. During an observation on 7/11/2024 at 10:04 A.M., Resident 35's right hand was contracted and his nails were long and curled downward on both hands. Resident 35's record review was completed on 7/11/2024 at 10:40 A.M. Diagnoses included, but were not limited to, conversion disorder with seizures and convulsions, diabetes insipidus, bipolar disorder, dysphagia, anxiety, and dementia. A Quarterly Minimum Data Set (MDS) assessment, dated, 5/8/2024, indicated Resident 35 was severely cognitively impaired and was dependent on staff for bathing and personal hygiene needs. A June 2024 TAR (Treatment Administration Record) indicated Resident 35 was given a full bed bath on: 6/13/2024, 6/17/2024, 6/20/2024, 6/21/2024, 6/23/2024, and 6/24/2024. Resident 35 received a shower on 6/27/2024 and 6/29/2024. He refused a shower on 6/12/2024, 6/16/2024, 6/19/224, 6/22/2024, 6/26/2024, and 6/29/2024. A July 2025 TAR indicated Resident 35 received a partial bed bath every day from 7/1/2024 through 7/12/2024 and refused a shower on 7/3/2024 and 7/5/2024. Resident 35's record lacked the documentation to indicate he was offered nail care after refusing baths or showers. Resident 35 did not have a current Care Plan to address the rejection of care. A Care Plan, dated, 2/10/2020, indicated the resident had a physical functioning deficit related to self care impairment. He had a goal of maintaining his current level of physical functioning. Interventions included, but were not limited to, personal hygiene assistance and nail care. During an interview on 7/10/2024 at 1:09 P.M., CNA 2 indicated nail care was included in shower and bath care. If a resident refused care, care was to be attempted at a later time. If the resident still refused care, the nurse was notified and a third attempt was made. Refusals were to be documented in the resident's Electronic Medical Record (EMR). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 10:42 A.M, the Unit Manager indicated Resident 35's fingernails were too long on both hands but she was not able to provide any documentation indicating why nail care had not been provided during his baths or showers. 47419 2. During an observation on 7/9/2024 at 8:59 A.M., Resident 5's fingernails were long with dark yellowish/brown matter under them and his toenails were very long. During a record review conducted on 7/9/2024 at 1:48 P.M., a Quarterly Minimum Data Set assessment, dated 5/3/2024, indicated Resident 5's cognition was moderately impaired. No behavior issues were noted. He was dependent for bathing, transfers, and toileting. He required supervision or touch assist for personal hygiene. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and type 2 diabetes mellitus. A record review for Resident 5 was completed on 7/9/2024 at 1:48 P.M. Diagnosis, included but were not limited to, chronic obstructive pulmonary disease and type 2 diabetes mellitus. A Quarterly Minimum data Set (MDS) assessment, completed on 5/3/2024, indicated Resident 5's cognition was moderately impaired, he had not exhibited any behavioral issues, was dependent on staff assistance for bathing, transferring and toileting needs and required supervision and/or touch assistance from staff for personal hygiene needs. The current care plan and facility documentation regarding activities of daily living lacked any reference for nail care. During an observation, on 7/10/2024 at 10:58 A.M., Resident 5's toenails had been trimmed but his fingernails remained long and had dark yellowish/brown matter under them. During an observation and interview, on 7/10/2024 at 2:28 P.M., QMA 10 indicated that Resident 5's fingernails should have been clean and trimmed. 3. During an observation on 7/8/2024 at 11:40 A.M., Resident 28's fingernails were very long and had dark yellow matter under them. The record for Resident 28 was reviewed on 7/9/2024 at 3:04 P.M. Diagnoses, included but were not limited to, generalized osteoarthritis, firbromyalgia and type 2 diabetes mellitus. An Annual Minimum Data Set (MDS) assessment, completed on 5/8/2024, indicated Resident 28 had moderate cognitive impairment, had not exhibited any behavioral issues and required substantial to maximal assistance from staff for toileting, bathing and personal hygiene needs. The current care plan and facility documentation regarding activities of daily living needs lacked any reference for nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/10/2024 at 1:30 P.M., CNA 16 indicated a shower should include hair washing and nail care. If the resident was diabetic, she would soak their fingernails and clean under them with an orange stick. If their fingernails or toenails need to be trimmed she would notify the nurse. She indicated shaving was done if the resident agreed and/or requested it. If they did not want to be shaved, she would document it as a refusal on the shower sheet and in the chart and report it to the nurse. During an observation and interview, on 7/10/2024 at 2:28 P.M., QMA 10 indicated Resident 28's fingernails should have been cleaned and trimmed. During an interview, on 7/10/2024 at 2:35 P.M., the Unit Manager indicated fingernails should be cleaned and trimmed. Nurses provided nail care for diabetics. On 7/11/2024 at 1:36 P.M. the ED provided a current, undated, policy titled, Activities of Daily Living (ADLs). The policy indicated, .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care 3.1-38(a)(3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48145 Based on interview, observation and record review, the facility failed to follow the physician's orders for 1 of 17 residents whose physician's orders were reviewed (Resident 11), and failed to accurately assess and document a wound for 1 of 7 residents reviewed for non pressure skin conditions. (Resident 5). The facility failed to obtain treatment orders for a new admission (Resident 127) and failed to transcribe and administer prescribed treatment orders from a follow-up post operative appointment. (Resident 63) for 1 of 17 residents reviewed for quality of care. Findings include: 1. During an interview and observation, on 7/8/2024 at 2:18 P.M., Resident 11 indicated he had problems with water retention in both of his lower legs and feet, and was not on a fluid restriction and was given as much to drink as he wanted. He indicated he did not wear any devices to help with the fluid retention. The resident had a full 20 ounce cup of water,dated 7/8/2024 and his lower legs and feet were observed to be swollen. During an observation, on 7/9/2024 at 11:05 A.M., Resident 11 had a 20 ounce cup of water, dated 7/9/2024, on his bedside table and his lower legs and feet remained swollen. During an observation, on 7/10/2024 at 9:55 A.M., Resident 11's lower legs and feet remained swollen. He had a 20 ounce cup of water, dated 7/10/2024, that was half empty and a second 20 ounce cup full of water without a date. A record review was completed on 7/10/2024 at 1:11 P.M. for Resident 11. Diagnoses included, but were not limited to, dementia, stage 3 chronic kidney disease, hypertension, post traumatic stress disorder, anxiety disorder, major depressive disorder, glaucoma and benign prostatic hyperplasia. A current Physician's Order, indicated the resident was on an 1800 mL (milliliter) fluid restriction. Dietary was to offer 1080 mLs a day and nursing staff could offer 240 mL per shift. A Quarterly MDS (Minimum Data Set), dated, 6/26/2024 indicated Resident 11's cognition was intact. A current Care Plan, dated 6/25/2021, indicated Resident 11 had history of significant weight gain and losses throughout his stay and was on daily diuretic medication which could contribute to weight changes. The goal was to have no significant undesirable weight changes. Interventions to the Care Plan included, but were not limited to, provide fluid restriction as ordered and diet as ordered. An interview was completed on 7/11/2024 at 9:43 A.M. CNA 2 indicated she was responsible for taking care of Resident 11. Water should be passed at the beginning of every shift and then refilled as needed. CNA 2 was not aware the resident had a fluid restriction and gave him a full cup of water. Staff typically knows a resident is on a fluid restriction because fluid restrictions were posted on a list in the kitchenette, but Resident 11 was not on the fluid restriction list. The cups that were used to pass water contained 20 ounces or 591 mL. Resident 11 should not have been given a cup of water with 591 mLs. (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 7/11/2024 at 9:45 A.M., CNA 2 indicated she was assigned to care for Resident 11. Water was to be passed at the beginning of every shift and then refilled as needed. CNA 2 was not aware Resident 11 had a fluid restriction and had given him full cup of water. She indicated staff were notified of any fluid restrictions from a list posted in he kitchenette and Resident 11 was not on he list of residents with fluid restrictions. The water cups used to pass ice water were 591 ml and residents on fluid restrictions were not to have full cups of ice water. On 7/11/2024 at 9:50 A.M., the Regional Nurse Consultant provided an undated policy, titled, Fluid Restriction, and identified it as the policy currently used by the facility. The policy indicated, .It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders . 2. The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes . 4. Water will not be provided at the bedside unless calculated into the daily total fluid restriction 47419 2. During an observation of Resident 5, on 7/8/2024 at 10:11 A.M., dark reddish/brown scabs were noted on Resident 5's left foot 2nd and 3rd toes. A record review was completed on 7/9/2024 at 1:48 P.M. for Resident 5. Diagnoses, included but were not limited to, peripheral venous insufficiency and type 2 diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 5/3/2024 indicated the resident was moderately cognitively impaired, had not exhibited any behavioral issues, was dependent on staff for bathing, transferring and toielting needs, was frequently incontinent of his bladder and always incontinent of his bowels, was at risk for pressure ulcers but had none, had a pressure reducing mattress and cushion for his wheelchair and had creams and ointments applied to his skin other than his feet. The Physician's Order Summary's included the following orders: elevate legs and float heels while in bed. A current Care Plan problem, initiated on 8/27/2019, indicated the resident was at risk for pressure ulcers. The interventions included, but were not limited to, conduct a weekly skin inspection and check skin during bathing. A Weekly Skin Assessment, dated 7/8/2024, indicated his skin was intact and there were no orders for wound care. During an interview, on 7/11/2024 at 2:58 P.M., the Unit Manager indicated she did not think Resident 5 currently had any wounds. After the Unit Manager was made aware of Resident 5's wounds, she indicated the wounds should have been noted during the weekly assessment. During an interview, on 7/11/2024 at 2:59 P.M., LPN 4 indicated he did not know about any wounds for Resident 5. On 7/1//2024 at 8:30 A.M., the Executive Director provided a current, undated, policy titled, Skin Integrity-Skin Tears. The policy indicated, .a. Licensed nurses will conduct skin assessments in accordance with facility policy (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44111 3. During an interview on 7/8/2024 at 2:56 P.M., a family member indicated Resident 63 had back surgery on 6/13/2024. On 6/26/2024 following a post-operative visit, she returned with treatment orders and the orders did not get initiated for a couple days afterwards. A record review was completed on 7/12/2024 at 7:45 A.M. for Resident 63. Diagnoses included, but not limited to, status post lumbar decompression/discectomy tube based right L 2-3, low back pain and type 2 diabetes with chronic kidney disease. A Physician Progress Note, dated 6/26/2024, indicated to see wound care and betadine was tot be applied daily with a light dressing. A Treatment Administration Record (TAR), dated 6/1/2024 - 6/30/2024, indicated an order was initiated on 6/28/2024 on the evening shift to cleanse the surgical wound, pat dry and apply betadine twice a day. During an interview on 7/11/2024 at 2:42 P.M., the Wound Nurse indicated Resident 63 had returned from her post operative appointment on 6/26/2024 with an order for betadine and a dressing. During an interview on 7/12/2024 at 11:00 A.M., the Regional Nurse Consultant indicated she did not know why the order was not written until 6/28/2024. On 7/12/2024 at 1:14 P.M., a policy was requested, the Regional Nurse Consultant indicated the facility did not have one. 4. During an interview and observation on 7/8/2024 at 11:23 A.M., Resident 127 indicated his right hip surgical site dressing had not been changed every day and the staff just peeked under his skin tear dressing to the right wrist and layed the dressing back down. The hip dressing had visible bloody drainage and was undated, and the right wrist dressing was undated. A record review was completed on 7/10/2024 at 9:46 A.M., for Resident 127. Diagnoses included, but were not limited to, fracture of unspecified part of neck of right femur and initial encounter for closed fracture. He was admitted to the facility on [DATE]. During an observation on 7/9/2024 at 1:26 P.M., Resident 127 indicated his dressings had been changed, and he had told them to date the hip dressing, but they did not date the wrist. A Nursing Admission General Note, dated 7/3/2024, indicated there was a skin issue to the right anterior wrist and redness and bruising to the right hip. There was no mention of the surgical wound to Resident 127's right hip. The current Physician's Order Summary, for July 2024, indicated there were no treatment orders for the right wrist skin tear nor the right hip surgical site. During an interview on 7/10/2024 at 1:08 P.M., the Wound Nurse indicated the treatment orders for the skin tear and the right hip surgical site should have been obtained upon admission and when a dressing was changed, it should be dated with the nurse's initial. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/2024 at 1:44 P.M., the Wound Nurse provided a policy titled, Wound Treatment Management, undated, and indicated the policy was the one currently used by the facility. the policy indicated, .Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Policy Explanation and Compliance Guidelines: 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse . 3.1-37(a)

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

44111

Based on observation, interview and record review the facility failed to ensure a catheter was anchored to prevent excessive tension on the catheter for 1 of 1 resident reviewed for urinary catheters. (Resident 128)

Finding includes:

During an interview, on 7/9/2024 at 9:58 A.M., Resident 128 indicated he had asked multiple times for several days on all three shifts for a catheter strap. He had an issue with blood in his catheter and was fearful of it getting pulled out.

A record review was completed on 7/9/2024 at 3:02 P.M., for Resident 128. Diagnosis included but not limited to: paraplegia, osteomyelitis of vertebra in the sacral and sacrococcygeal region, residual foreign body in soft tissue, pressure ulcer of unspecified site, unspecified stage, and unstageable pressure ulcer of sacral region.

An Admission Minimum Data Set (MDS) assessment, dated 6/28/2024, indicated the resident had no cognitive impairment.

During an observation of Resident 128's urinary catheter, on 7/10/2024 at 10:23 A.M., 7/11/2024 at 1:25 P.M. , there was no catheter strap in place.

A current Care Plan, dated 7/3/2024, indicated the resident had a foley catheter related to a stage 4 sacral wound. Interventions, included but were not limited to, anchor catheter to avoid excessive tugging on the catheter during transfers and delivery of care.

During an interview, on 7/11/2024 at 1:27 P.M., LPN 3 indicated, to avoid excessive tugging on a urinary catheter during care and transfers, staff should make sure the urinary collection bag and tubing was unhooked from the bed and chair and fastened down with a catheter strap. If the tubing was not secured, the catheter could get pulled out and cause trauma to the urethra. LPN 3 indicated the physician's orders batched for the care of urinary catheters did not have a specific order regarding providing catheter straps, but it would help Resident 129 if a catheter strap was provided and applied.

On 7/11/2024 at 1:01 P.M., the Regional Nurse Consultant provided a policy titled, Indwelling Catheter Use and Removal, undated, and indicated the policy was the on currently used by the facility. The policy indicated .7. Additional care practices include: d. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter .

3.1-(2)

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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. 48145 Based on observation, record review and interviews, the facility failed to ensure physician orders regarding tube feeding orders were followed for 1 of 1 residents with tube feeding. (Resident 53) Finding includes: During an observation, on 7/11/2024 at 10:45 A.M., Resident 35 had a container of Jevity 1.5 (Brand of food used in feeding tubes) with 350 mL of formula remaining in the bag. The bag was still connected to a feeding tube pump that was turned off. Resident 35's record review was completed on 7/11/2024 at 11:40 A.M. Diagnoses included, but were not limited to, conversion disorder with seizures and convulsions, diabetes insipidus, bipolar disorder, dysphagia, anxiety, and dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 5/8/2024, indicated Resident 35 was severely cognitively impaired and had a feeding tube. A current Physicians Order indicated the resident was to receive 1050 mL (milliliters) of Jevity 1.5 daily. A July 2024 Medication Administration Record (MAR) indicated the resident had received the full amount of Jevity 1.5 on 7/11/2024. A current Care Plan, indicated Resident 35 was dependent on tube feeding. The goals of the care plan were to have no undesirable weight changes, be free from discomfort, and be free from dehydration. Interventions included, but were not limited to, enteral formula and feedings as ordered, monitor ins and outs, and water flush. During an interview, on 7/11/2024 at 2:06 P.M., the Unit Manager indicated Resident 35 did not get all of his prescribed tube feed that day. On 7/11/2024 at 1:36 P.M., Regional Nurse 14 provided an undated policy, titled, Care and Treatment of Feeding Tubes, and identified it as the policy currently used by the facility. The policy indicated, . e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders 3.1-44(a)(2)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 44111 Based on observation, record review and interviews, the facility failed to ensure physician orders regarding dressing changes were followed for 1 of 1 residents reviewed for intravenous fluids. (Resident 128) Finding includes: During an observation and interview on 7/9/2024 at 10:14 A.M., Resident 128 indicated his peripheral inserted central catheter (PICC) line dressing had only been changed once since he was admitted . The date on the dressing was 6/29. The dressing had gauze tape applied around the edges of the dressing. A record review was completed on 7/9/2024 at 3:02 P.M., for Resident 128. Diagnosis included but not limited to, paraplegia, osteomyelitis of vertebra, sacral and sacrococcygeal, region, residual foreign body in soft tissue pressure ulcer of unspecified site, unspecified stage, pressure ulcer of sacral region, unstageable. An Admission Minimum Data Set (MDS) assessment, dated 6/28/2024, indicated he had no cognitive impairment. A Physician's Order, dated 6/21/2024, indicated to the PICC line dressing was to be changed upon admission, then weekly and as needed, on the night shift every Sunday. A Medication Administration Record (MAR), dated 6/1/2024-6/30/2024, indicated the dressing was changed on 6/23/2024, and 6/30/2024. A Medication Administration Record, dated 7/1/2024 - 7/31/2024 indicated the dressing was changed on 7/7/2024. A Nursing Progress Note, dated 6/29/204 at 7:28 P.M., indicated the Access RN was in the building and the PICC line dressing changed was completed. A Care Plan, dated 6/21/2024, indicated the resident had a potential risk for infection at the PICC line site with an intervention for dressings to be changed as ordered. During an interview on 7/9/2024 at 3:30 P.M., LPN 15 indicated the date on the PICC line dressing was 6/29. She indicated it looked like someone re-enforced the dressing with tape and it was not ok to leave the dressing on that long. During an interview on 7/12/2024 at 12:47 P.M., the Infection Preventionist (IP) Nurse indicated that the dressing was not changed and the MAR was inaccurately signed on 7/7/2024. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2024 at 10:16 A.M., the IP (Infection Preventionist) Nurse indicated she could not find any documentation the dressing had been changed upon the resident's admission to the facility. She could not find that it was required in the facility policy and did not know why it was ordered to be changed upon admission. On 7/10/2024 at 8:25 A.M., the IP Nurse provided a policy titled, PICC/Midline/CVAD Dressing Change, undated, and indicated the policy was the one currently used by the facility. The policy indicated . Policy: It is the policy of this facility to change peripherally inserted central catheter (PICC), midline or central venous access device (CVAD) dressing weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type and frequency of changes . 3.1-47(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47419 Based on observation and interview the facility failed to ensure reconciliation of controlled drugs was completed for 3 of 3 carts reviewed for narcotic counts. (B-Wing Hall 1 medication cart, C-Wing Hall 1 medication cart, and C-Wing Hall 2 medication cart) Findings include: 1. During an observation of the B-Wing Hall 1 medication cart on 7/12/2024 at 9:48 A.M., with LPN 11, the narcotic reconciliation sheets were missing signatures between 6/17/2024 and 7/11/2024. During an interview, on 7/12/2024 at 9:58 A.M., LPN 11 indicated narcotics should be counted by the off going nurse with the oncoming nurse and the reconciliation sheet should be signed by both nurses every shift. 2. During an observation, of the C-Wing Hall 1 medication cart on 7/12/2024 at 10:34 A.M., with QMA 9, the narcotic reconciliation sheets were missing signatures between 6/13/2024 and 7/11/2024. During an interview, on 7/12/2024 at 10:35 A.M., QMA 9 indicated the reconciliation of narcotics should be done every shift and both the off going and oncoming nurses should sign the sheet. 3. During and observation of the C-Wing Hall 2 medication cart on 7/12/2024 at 10:20 A.M., with QMA 9, the narcotic reconciliation sheets were missing signatures between 5/30/2024 and 6/12/2024. During an interview, on 7/12/2024 at 10:21 A.M., the Infection Preventionist (IP) Nurse indicated the narcotic reconciliation sheets should be signed by both the off going and oncoming nurses after counting the narcotics. On 7/12/2024 at 12:42 P.M., the Regional Nurse Consultant provided a current, undated policy, titled, Controlled Substance Administration & Accountability. The policy indicated, .The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure .a. The entire amount of controlled substances obtained or dispensed is accounted for 3.1-25(n)

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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. 47419 Based on interview and observation the facility failed to properly store medications in 1 of 3 carts reviewed for storage. (C-Wing Hall 1 medication cart) Finding includes: 1. During an observation of the C-wing Hall 1 medication cart on 7/12/2024 at 10:34 A.M. the following was noted: A. A bottle of Lantus insulin for Resident 176 was found unopened in the cart. It had a label which indicated t was to be refrigerated until opened. During an interview, on 7/12/2024 at 10:36 A.M., the IP nurse indicated the insulin should have been in the refrigerator until it was opened. B. A bottle of Timolol eye drops and Brimondine eye drops, both for Resident 177, were found opened but undated. During an interview, on 7/12/2024 at 10:34 A.M., QMA 9 indicated the eye drops should have been dated when opened. On 7/12/2024 at 12:42 P.M., the Regional Nurse Consultant provided a current, undated, policy titled, Medication Storage. The policy indicated, .All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room 3.1-25(j)

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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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48145 Based on observation, record review and interview, the facility failed to dispose of leftovers timely in the walk-in cooler of the kitchen. This had the possibility to affect 2 of 2 resident with altered diets who received their meals from the kitchen. Finding includes: During the initial kitchen tour with the Registered Dietician (RD) on 7/8/2024 at 9:45 A.M., three tray, dated 7/2/2024, were observed in the refrigerator and held 8 glasses of milk, 2 glasses of water, 3 glasses of cranberry juice and 2 glasses of orange juice. The RD indicated the drinks were all thickened for residents who had altered liquid diet orders and the date on the tray was the date the drinks were prepared. During an interview, on 7/8/2024 at 10:15 A.M., the Regional Certified Dietary Manager (RCDM) indicated left overs were good for three days and prepared food should containing a made on date and a discard date. On 7/9/2024 at 1:27 P.M., the RCDM provided an undated policy, titled, Storage of Refrigerated Foods, and identified it as the policy currently used by the facility. The policy indicated, .The dining services department will store refrigerated foods .Foods Storage/Leftovers .All items not stored in original container must be labeled and noted with use by date according to storage chart, used or discarded within allowed days per manufacturer directions. Recipe prepared items should be discarded 3 days from preparation if not used 3.1-21(a)(3)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44111 Based on interview and record review the facility failed to ensure the Medical Director or his designee attended the quarterly Quality Assurance and Performance Improvement (QAPI) meeting during the past year. Finding includes: During an interview on 7/12/2024 at 1:56 P.M., the Administrator indicated the Medical Director had not attended the quarterly meetings, but she reviewed them with him or sent the minutes from the meeting to the Medical Director via an e-mail. The Nurse Practitioner attended some facility meetings, such as the nutrition at risk/wound, behavior, morning meeting or stand down meetings, but the QAPI signature log did not indicate she had attended any QAPI meetings during the past year. On 7/12/2024 at 2:00 P.M., the Administrator provided a policy titled, Quality Assurance and Performance Improvement, undated and indicated the policy was currently the one used by the facility. The policy indicated, .Policy Explanation and Compliance Guidelines: 2. The QAA Committee shall be Interdisciplinary and shall: a. Consist at a minimum of: i. The Director of Nursing Services ii. The Medical Director or his/her designee iii.At least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other Individual in a leadership role; and iv. The Infection Preventionist. b. Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program,such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary . 3.1-52(a)

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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. 44111 Based on observation, interview and record review, the facility failed to ensure infection control practice was maintained regarding glove use and hand washing during a sterile procedure for 1 of 1 residents observed during a dressing change procedure. (Resident 128) Finding includes: During an observation of a peripheral inserted central catheter (PICC) line dressing change on 7/9/2024 from 4:03 P.M. to 4:10 P.M., LPN 15 placed the dressing kit on the Resident's nightstand without a barrier or disinfecting the surface prior to placing the kit on the nightstand. Then she opened the dressing kit, donned sterile gloves and removed the old dressing. Without changing her gloves, she took the antimicrobial sponge disk and cleaned an area below the insertion site, then did a circular motion to clean around the insertion site. She then applied skin prep on the whole area and then patted it with gauze, applied transparent dressing, removed her gloves and performed hand hygiene. The resident was not offered a mask or asked to turn his head away from the insertion site. His head was not turned away from his chest and he was talking to the nurse while the dressing was changed. During an interview on 7/9/2-24 at 4:12 P.M., LPN 15 indicated nothing had touched the table as everything was inside the packet so she thought she did not need a barrier or needed to clean the surface prior to placing the kit on the nightstand. During the dressing change, her left gloved hand held down the tubing and used her right hand with the sterile glove to remove the dressing. She did not think she needed to remove the gloves and perform hand hygiene and donn sterile gloves to clean the site and apply new dressing. She did not feel the area she touched first with the antimicrobial sponge was contaminated since it was under the old dressing. She did indicate that she should have offered the resident a mask On 7/10/2024 at 8:25 A.M., the Infection Preventionist Nurse provided a policy titled, PICC/Midline/CVAD Dressing Change, undated, and indicated the policy was the one currently used by the facility. The policy indicated .Policy Explanation and Compliance Guidelines: 3. Perform hand hygiene. a. Put on mask. b. Place mask on resident if they cannot keep their head turned away. c. Perform hand hygiene. d. Set up clean field on the overbed table with needed supplies for the dressing change. If the table is soiled, wipe clean before setting up clean field. e. Place a disposable cloth or linen saver on the overbed table. 4. Wash hands and put on clean gloves. 5. Position resident with arm extended away from the body and below the heart level or if a CVAD, have resident turn head away from the insertion site or have them wear a mask. 7. Remove old dressing at the devoice beginning at the device hub and gently pull the dressing perpendicular to the skin toward the insertion site. 8. If the resident has a chlorhexidine -impregnated sponge dressing at the insertion site, remove and discard into the appropriate receptacle. 11. Remove and discard gloves. 14. Clean the insertion site with an antiseptic following manufactures' instructions. a. Apply chlorhexidine (if present in kit) with an applicator using a side-to-side motion for at least 30 seconds. Allow to dry completely . 3.1-18(b)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 49994 Based on record review and interview, the facility failed to document declination forms for COVID immunizations for 3 of 5 residents reviewed for immunizations. (Residents 1, 3, & 24) Finding includes: On 7/11/2024 at 1:06 P.M., a record review was completed for Residents 1, 3 & 24. The records lacked documentation of signed declination forms for the covid vaccine. During an interview, on 7/11/2024 at 2:55 P.M., the Infection Prevention Nurse indicated she did not have signed declination forms for residents 1, 3, or 24 and she should have had each resident sign a declination form. On 7/12/2024 at 11:17 A.M., the Regional Nurse provided the policy titled, COVID Vaccination, no date, and indicated it was the policy currently in use by the facility. The policy indicated, .The resident's medical record will include documentation of the following: If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49994 Based on observation, interview and record review, the facility failed to maintain a temperature log for a resident's personal refrigerator for 1 of 2 residents reviewed for personal refrigerators. (Resident 9) Finding includes: During an observation, on 7/11/2024 at 12:30 P.M., Resident 9's personal refrigerator did not have a thermometer or a temperature log. During an interview, on 7/11/2024 at 3:05 P.M., the Unit Manager indicated there should have been a thermometer in the fridge and temperature log record sheet for the refrigerator. On 7/11/2024 at 1:25 P.M., the Administrator provided the policy titled, Resident Refrigerators, no date, and indicated it was the policy currently in use by the facility. The policy indicated, . 2. Staff shall record refrigerator temperatures weekly on a temperature log. a. A thermometer shall remain in the refrigerator. It shall be calibrated prior to use and periodically thereafter. 3. Nursing/housekeeping staff shall clean the refrigerator weekly and discard any foods that are out of compliance. 4. Residents and staff shall comply with safe food handling and storage principles: c. Foods with use by dates shall be discarded accordingly 3.1-19(f)