STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greencroft Healthcare	1225 Greencroft Dr Goshen, IN 46527

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47419 Based on observation, record review, and interview, the facility failed to develop a person-centered care plan for the use and refusal of a splint for 1 of 30 residents whose care plans were reviewed. (Resident 90) Finding includes: During an observation on 5/23/24 at 2:26 P.M., Resident 90's left hand was contracted (a permanent tightening of muscles that prevents normal movement) and she was not able to open it fully without using her right hand to pull her fingers open. A splint was noted on the table next to her bed. She nodded her head yes when asked if she usually wore the splint during the day. A record review was conducted on 5/29/24 at 9:23 A.M. for Resident 90. Diagnoses included, but were not limited to, a cerebrovascular accident with hemiplegia. A Quarterly Minimum Data Set (MDS) assessment, dated 4/30/24, indicated the resident's cognition was severely impaired, she refused care between 1 and 3 days during the assessment period, her range of motion was limited on one side in both upper and lower extremities, and she was dependent on staff for dressing, bathing, and toileting. She did not receive any physical or occupational therapy. Physician Orders on 3/27/24, included, but were for the resident to wear a left hand splint twice a day. A care plan, dated 1/19/24, included a goal for Resident 90's hand not have worsening contractures through the next review. Interventions included, but were not limited to, .wash and dry left hand daily prior to applying the splint, apply the splint in the morning and remove in the evening, and upon removal look for redness or skin breakdown and report any changes to the nurse. The record lacked any interventions to address when the resident refused the splint and what to do when she refused. During an interview on 5/31/24 at 9:12 A.M., the DON indicated the care plan did not address when the resident refused the splint or interventions to encourage her to wear the splint. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 8:30 A.M., the DON provided a policy titled, Comprehensive Care Plans, dated 1/29/24, and indicated the policy was the one currently used by the facility. The policy indicated, 2.All Care Assessment Areas triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preference, will also be addressed in the plan of care 3.1-35(a)(d)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44111 Based on interview and record review, the facility failed to update a care plan regarding the use of a Continuous Positive Airway Pressure (CPAP) machine for 1 of 33 residents reviewed for care plans. (Resident 254) Finding includes: A record review was completed on 5/28/2024 at 1:13 P.M., for Resident 254. Diagnoses included, but were not limited to: interstitial lung disease, and atrial fibrillation. Resident admitted on [DATE]. A Care Plan, dated 2/12/2024, indicated the resident was at risk for respiratory distress related to allergies, cough and COVID. Interventions did not indicate a CPAP machine was in use. During an interview on 5/28/2024 at 1:38 P.M., LPN 5 indicated the care plan should have mentioned the CPAP machine and the settings. On 5/31/2024 at 8:30 A.M., the DON provided a policy titled, Comprehensive Care Plans, revised 1/29/2024, and indicated the policy was the one currently used by the facility. The policy indicated .5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment . 3.1-35(d)(2)(B)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44111 Based on observation, interview, and record review, the facility failed to ensure physician orders were in place for a resident using a Continuous Positive Airway Pressure (CPAP) for 1 of 1 resident reviewed for quality of care. (Resident 254) Finding includes: During an observation on 5/23/2024 at 2:40 P.M., Resident 254's CPAP mask and tubing was hanging over the headboard and a container of distilled water was on the bathroom floor under the sink, opened without an open date. During an observation and interview on 5/28/2024 at 1:03 P.M., Resident 254 indicated the mask and tubing had never been placed in a plastic bag, and the tubing had not been cleaned. The water was kept on the floor in the bathroom under the sink. She did not always get the water put in the machine, there are times she ran it without the water. The mask/tubing was hanging over the headboard and the distilled water was on the bathroom floor undated. She indicated she has been using the CPAP machine for years. A record review was completed on 5/28/2024 at 1:13 P.M., for Resident 254. Diagnoses included, but were not limited to: interstitial lung disease, and atrial fibrillation. There were no physician's orders for the CPAP machine with settings or for the cleaning of the equipment. During an interview on 5/28/2024 at 1:38 P.M., LPN 5 indicated Resident 254 did not have an order with settings for a CPAP machine nor for the cleaning/storage of the equipment. On 5/28/2024 at 3:10 P.M., the DON provided a policy titled, Medication Order Policy, dated 4/9/2019, and indicated the policy was the one currently used by the facility. The policy indicated .1. Medications should be administered only upon the signed order of a person lawfully authorized to prescribe. 4. Documentation of Medication Orders: a. Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR) . On 5/28/2024 at 3:10 P.M., the DON provided a policy titled, CPAP/BIPAP Cleaning Policy, revised 1/31/2024, and indicated the policy was the one currently used by the facility, The policy indicated .It is the policy of this community to clean CPAP/BiPAP equipment in accordance with current CDC guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infection. Policy Implementation: 5. If humidification is required, distilled or sterile water will be used to fill the humidifier chamber. Empty the chamber completely after each use and wipe dry. 6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use. 7. Weekly cleaning activities a. Wash headgear/straps in warm, soapy water and air dry. b. Wash tubing with warm, soapy water and air dry . 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, interview and record review, the facility failed to provide proper G-tube (artificial opening placed in the stomach to provide nutritional support and/or gastric decompression) care per professional standards and facility policy related to G-tube feedings for 1 of 1 resident who was reviewed for G-Tube feeding. (Resident 67) Finding includes: During an observation of a G-Tube feeding on 5/29/2024 at 1:00 P.M., LPN 3 checked the residuals (the quantity left over in the stomach between feedings) of the resident's stomach. She pulled 60 mL (milliliters) of gastric contents from the G-Tube and left the contents in the graduated cylinder on the bedside table. After giving the resident his prescribed tube feeding and flushing the tubing with water, LPN 3 asked the resident if she could perform oral care on him. The resident's gastric content was still in the graduated cylinder on the bedside table. An interview with LPN 3 was completed on 5/29/2024 at 1:08 P.M. LPN 3 indicated she would be dumping the resident's 60 mL gastric residual down the toilet. She was not sure if she should return the resident's residuals back to him but would check before discarding. During an interview on 5/29/2024 at 1:12 P.M., the Director of Nursing (DON) indicated residuals should be given back to the resident through the G-Tube before administering the tube feed. Resident 67's record review was completed on 5/29/2024 at 2:30 P.M. His diagnoses included, but were not limited to: functional quadriplegia, adult failure to thrive, cerebral palsy and major depressive disorder. A current Physicians order, dated 3/13/2024, indicated the resident was to receive 1 carton of Jevity (liquid nutritional supplement to provide a balanced nutrition through a tube feed) 1.5 tube feed three times a day through his G-Tube. A Physician's Order, dated 3/13/2024, indicated the resident's G-Tube placement and residuals were to be checked before any G-Tube feeding. During an interview on 5/30/24 at 2:36 P.M. , LPN 2 indicated gastric residuals are always given back to the resident through the G-tube. During an interview on 5/30/2024 at 3:10 P.M., LPN 4 indicated she checks residuals before any G-Tube feedings and always returns the residuals to the resident. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/2024 at 2:40 P.M. the DON provided a policy titled, Checking Gastric Residual and identified it as the policy currently used by the facility. The policy indicated, .Definitions .Gastric Residual (GDV): Food, liquid, or material from previous feeding left in the stomach at the start of the next feeding .1 . Residents who receive bolus feedings should have residual checks prior to administration of a bolus, per MD order . 3. After measuring, the contents should be replaced (up to 500 mL or per MD order) via the enteral tube 3.1-44(a)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44111 Based on observation, interview, and record review, the facility failed to ensure continuous positive airway pressure (CPAP) equipment was properly stored when not in use, cleaned and the distilled water was dated when opened for 1 of 1 resident reviewed for respiratory care. (Resident 254) Finding Includes: During an observation on 5/23/2024 at 2:40 P.M., Resident 254's CPAP mask and tubing was hanging over the headboard and the distilled water container was on the bathroom floor under the sink, opened without an open date. During an observation and interview on 5/28/2024 at 1:03 P.M., Resident 254 indicated the mask and tubing had never been placed in a plastic bag, and the tubing had not been cleaned. The water was kept on the floor in the bathroom under the sink. She did not always get the water put in the machine, there were times she ran it without the water. The mask/tubing was hanging over the headboard and the distilled water container was on the bathroom floor, undated. Resident 254 indicated she has been using the CPAP machine for years. A record review was completed on 5/28/2024 at 1:13 P.M., for Resident 254. Diagnoses included, but were not limited to: interstitial lung disease, and atrial fibrillation. There were no physician's orders for the CPAP machine or a care plan regarding the use of the CPAP machine. During an interview on 5/28/2024 at 1:38 P.M., LPN 5 indicated the CPAP mask should have been stored in a dated plastic bag when not in use, and the distilled water should have been marked with an opened date and stored on a shelf or cabinet. The mask and the tubing should have been cleaned. On 5/28/2024 at 3:10 P.M., the DON provided a policy titled, CPAP/BIPAP Cleaning Policy, revised 1/31/2024, and indicated the policy was the one currently used by the facility, The policy indicated .It is the policy of this community to clean CPAP/BiPAP equipment in accordance with current CDC guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infection. Policy Implementation: 5. If humidification is required, distilled or sterile water will be used to fill the humidifier chamber. Empty the chamber completely after each use and wipe dry. 6. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use. 7. Weekly cleaning activities a. Wash headgear/straps in warm, soapy water and air dry. b. Wash tubing with warm, soapy water and air dry . 3.1-47(6)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49994 Based on observation, interview and record review, the facility failed to provide ongoing assessment of the resident and monitoring for complications by completing Pre Dialysis Evaluations and Post Dialysis Evaluations assessments for 2 of 2 residents reviewed for dialysis. (Residents 354 & 88). Findings include: 1. Resident 354's record was reviewed on 5/29/24 at 9:11 a.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. Physician's Orders, dated 5/21/24, indicated the following: -. Fresenius Kidney care Dialysis, Monday, Wednesday, and Friday. - Assess dressing to dialysis port every shift. - Weight before dialysis - Weight after dialysis The facility's electronic charting system included a Pre Dialysis and Post Dialysis Evaluation form which was to be completed with the resident name, date, time of assessment, most recent weight and most recent vital signs and placed in the resident's dialysis book. Questions included presence of redness at access site, presence of swelling at access site, presence of bleeding at access site, presence of bruit, presence of thrill and medications given prior to dialysis. Pre and Post Dialysis Evaluations for Resident 354, dated May 2024, were documented and placed in the dialysis book on 5/22, 5/27, and 5/29. The dialysis book lacked documentation of a Pre and Post Dialysis Evaluation form being completed on 5/24. A Care Plan for Resident 354, dated 5/21/24, indicated the resident needed hemodialysis related to end stage renal disease. Interventions included, but were not limited to, resident to attend dialysis as scheduled, notify provider for non-compliance/missed visits, assess dialysis access site as ordered and notify provider for complications, weights and vital signs as ordered. During an interview on 5/29/24 at 2:49 p.m., RN 7 indicated there was not a note showing the resident did not go to dialysis on 5/24, there was not a Pre Dialysis Evaluation or a Post Dialysis Evaluation in the book on that day, and one should have been completed. On 5/29/24 at 2:50 p.m., the Pre and Post Dialysis Evaluation for 5/24/24 was requested but was not provided prior to the survey exit. 48145 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A record review for Resident 88 was completed on 5/30/2024 at 1:07 P.M. Diagnoses included, but were not limited to: chronic kidney disease stage 5, type 2 diabetes, anemia, hypothyroidism, and venous insufficiency. A current Physicians's Order indicated the resident received hemodialysis three times per week on Monday, Wednesday and Friday. Resident 88's dialysis binder lacked documentation the resident's post-dialysis assessment and vitals were completed and recorded on the following dates: -4/26/2024 -4/29/2024 -5/1/20204 -5/3/2024 -5/6/2024 -5/8/2024 -5/13/2024 -5/15/2024 -5/17/2024 -5/20/2024 -5/22/2024 -5/24/2024 -5/27/2024 -5/29/2024 During an interview on 5/30/24 at 2:00 P.M., the DON indicated the dialysis book was used for continuity of care between the facility and the dialysis center and Resident 88's dialysis binder did not have post dialysis assessments and vitals recorded for every day she went to dialysis. An interview on 5/30/24 at 2:36 P.M. LPN 2 indicated Nurses should take a weight and a full set of vitals before and after dialysis and the vitals and weights should be recorded in the resident's dialysis binder. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2024 at 3:10 P.M., LPN 4 indicated residents who received dialysis should have their fistula (dialysis access site) accessed, weight and a full set of vitals checked before and after dialysis treatments. The assessment, their weight and vitals should be recorded in the resident's dialysis binder. On 5/30/2024 at 10:00 A.M. the DON provided a policy titled, Hemodialysis and identified it as the policy currently used by the facility. The policy indicated, .This facility will provide the necessary care and treatment, consistent with professional standards of practice . 3. Interventions will include, but not limited to: . b. Pre- and post weights, c. Assessing, observing, and documenting care of access sites . f. Vital signs 3.1-37(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48145 Based on interview and record review, the facility failed to prevent a significant medication error related to a resident being given an incorrect insulin pen for 1 of 2 residents who were reviewed for insulin use. (Resident 101) Finding includes: During an interview on 5/29/2024 at 9:00 A.M., Resident 101 indicated he was given the wrong insulin pen on 5/28/2024 and had self-injected the insulin before he realized it was another resident's insulin pen. Resident 101 normally self injected 40 units of insulin using a Basaglar Kwick Pen. This was not the first time he was given another resident's insulin pen, but it was the first time he had injected the insulin with another resident's insulin pen. The DON had visited Resident 101 and he was no longer upset with the mistake but did not want it to happen again. Resident 101 understood why the physician ordered blood work but refused the laboratory tests to check for hepatitis and HIV. Resident 101's record review was completed on 5/29/2024 at 9:45 A.M. Diagnoses included, but were not limited to: type 2 diabetes, chronic kidney disease stage 3, benign prostatic hyperplasia, and dysphagia. A Quarterly Minimum Data Set (MDS) assessment, dated 3/12/2024, indicated the resident's cognition was intact. A Self Administration of Medication assessment, dated 10/8/2023, indicated the resident was able to self-administer his own medications. A current Physicians Order, dated 3/24/2024, indicated the resident was to receive 40 units of regular insulin with a Basaglar Kwik Pen, twice a day. A current Physician's order, revised on 5/30/2024, indicated Resident 101 could self-administers his own insulin. During an interview with the DON\ completed on 5/29/2024 at 9:30 A.M., the Director of Nursing (DON) indicated Resident 101 was given the wrong resident's insulin pen and it was discovered after the resident had already injected himself. The nurse who had given the resident the insulin pen was interrupted after pulling the insulin pens and got the insulin pens mixed up when she came back to the medication cart. The insulin pen Resident 101 used was a brand new pen and had never been used by anyone prior to Resident 101 using it. The facility contacted the physician and spoke to the resident's wife. The physician ordered blood work to check for HIV and hepatitis, but the resident refused. The DON educated the resident on why the physician ordered the blood work, but the resident still refused labs. The nurse who made the error was educated and an In-Service titled, Medication Administration was conducted with staff by the DON on 5/28 and 5/29/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN 2 completed on 5/30/24 at 2:36 P.M. , LPN 2 indicated Resident 101 self-administered his own insulin and the Five Rights of Medication Administration were used to ensure medications were given correctly. LPN 2 indicated the five rights were: right resident, right medication, right dose, right route, and right time. It was never appropriate to give a resident another resident's insulin pen. During an interview on 5/30/2024 at 3:10 P.M., LPN 4 indicated residents should never be given another resident's insulin pen for use and the facility used the Five Rights of Medication Administration during medication passes. On 5/30/2024 at 10:00 A.M. the DON provided a policy titled, Medication Administration and identified it as the policy currently used by the facility. The policy indicated, . 11. Compare medication source (bubble pack, vial, etc.) with MAR (Medication Administration Record) to verify resident name, medication name, form, dose, route and time On 5/28/2024 at 3:10 P.M., the DON provided a policy titled, Medication Order Policy, dated 4/9/2019, and indicated the policy was the one currently used by the facility. The policy indicated .1. Medications should be administered only upon the signed order of a person lawfully authorized to prescribe. 4. Documentation of Medication Orders: a. Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR) . This federal tag relates to Complaint IN 00435496. 3.1-48(c)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44111 Based on observation, interview, and record review the facility failed to properly label medications with an open date for 3 of 5 medication carts observed. ([NAME] Vesta cart 2, [NAME] cart 1, [NAME] cart 2) In addition, the facility failed to ensure treatments, and inhaler were separated from oral medication for 2 out of 5 medication carts and 1 out of 3 medication room refrigerators reviewed. Findings include: 1. During an observation of the medication cart for [NAME] Vesta cart 2 with QMA 9 on 5/31/2024 at 8:32 A. M., the following was observed:: -An opened bottle of Fiberwell gummies for Resident 108 without an open date. -An opened bottle of Peg 3350 Powder for Resident 16 without an open date. -An opened bottle of Reguloid 28 grams for Resident 98 without an open date. -An opened bottle of antacid chew 750 milligram (mg) for Resident 57 without an opened date. During an interview on 5/31/2024 at 8:45 A.M., QMA 9 indicated they should have been dated when they were opened. 2. During an observation of the medication cart for [NAME] 1 with LPN 10 on 5/31/2024 at 9:00 A.M., the following was observed: - An opened bottle of Tums smooth chew 750 mg for Resident 96 was without a date. LPN 10 indicated it should have had an opened date. 3. During an observation of the medication cart for [NAME] 2 with LPN 11 on 5/31/2024 at 9:32 A.M., the following was observed: -An opened bottle of brimonidine 0.2% eye drops for Resident 120 without an open date. -An opened bottle of Peg 3350 powder for Resident 48 without an open date. -An opened bottle of liquid protein sugar free without a label and an open date. During an interview on 5/31/2024 at 9:45 A.M., LPN 11 indicated she did not know who opened the liquid protein but it should have had an open date along with the other bottles. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greencroft Healthcare	1225 Greencroft Dr Goshen, IN 46527

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/2024 at 12:10 P.M., the ADON provided a policy titled, Labeling of Medications and Biologicals, revised 5/20/2022, and indicated the policy was the one currently used by the facility. The policy indicated . All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices . 4. During observation of the medication on cart 2 of the [NAME] unit with LPN 11 on 5/31/2024 at 9:23 A.M. the following was observed: - A tube of Aquaphor and capsaicin cream for shingles was on top of the oral medication for Resident 124. During an interview LPN 11 at the time of the cart observation, she indicated she had a treatment cart, and the creams should not have been stored in the medication cart. 5. During observation of the medication cart 1 of [NAME] Vesta unit with LPN 12 on 5/31/2024 at 10:20 A.M. the following was observed: -An inhaler was in the drawer with oral medication for Resident 113. During an interview with LPN 12 at the time of the medication cart observation, she indicated the inhaler should have been kept in a separate drawer. 6. During observation of the medication room refrigerator on Lea Unit on 5/31/2024 at 11:15 A.M., the following was observed: -One unsealed container of yogurt, a clear plastic cup dated 5/31/2024 with PAB (prune, applesauce and bran) mixture, and 3 cartons of Nepro therapeutic nutrition supplement. During an interview LPN 6 indicated food and drinks should not have been in the refrigerator designated for medication. On 5/31/2024 at 12:10 P.M., the ADON provided a policy titled, Medication Storage, revised 10/27/2022, and indicated the policy was the one currently used by the facility. The policy indicated . 3. External Products: Disinfectants and drugs external use are stored separately from internal and injectable medications. 4. Internal Products: Medications to be administered by mouth are stored separately from other formulations (i. e., eye drops, ear drops, injectables) . On 5/31/2024 at 1:01 P.M., the ADON provided a policy titled, Medications Requiring Refrigeration, revised 5/20/2022, and indicated the policy was the one currently used by the facility. The policy indicated . 4. Refrigerators used for the storage of medications and biologicals: a. Used solely for the purpose of storing medications and biologicals that require refrigeration according to manufacturer's instructions. b. Not used for food, blood or blood products or specimen storage . 3.1-25(j)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. Building B. Wing	05/31/2024

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49994 Based on record review and interview, the facility failed to obtain a declination form for a resident who refused the pneumococcal vaccine for 1 of 5 residents reviewed for vaccinations. (Resident 101) Finding includes: On 5/31/24 at 9:06 a.m., Resident 101's record was reviewed for vaccine compliance. An Immunization Report indicated Resident 101 refused the pneumococcal vaccine on 10/10/2023. The record lacked the documentation showing a declination form was signed by the resident and/or their representative. During an interview on 5/31/24 at 12:12 p.m., the IP (Infection Preventionist) Nurse indicated the resident did not have a signed declination form for the pneumococcal vaccine and one should have been obtained. 3.1-13(a)