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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsburg Health Care Center	1010 Hornaday Rd Brownsburg, IN 46112

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46414 Based on record review and interview, the facility failed to code a pressure ulcer correctly on the Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed (Resident 72) and failed to code Preadmission Assessment and Resident Review (PASARR) correctly on the MDS for 1 of 1 resident reviewed (Resident 14). Findings include: 1. On 10/24/24 at 11:39 a.m., a record review was completed for Resident 72. He had the following diagnoses which included but were not limited to paraplegia, pressure ulcer of sacral region stage 3 (a full-thickness wound that extends through the skin and into the subcutaneous fat, but not into the muscle, tendon, or bone), essential hypertension (HTN), and type 2 diabetes mellitus. Resident 72 had a wound care assessment dated [DATE]. It indicated he had three pressure ulcers. A stage 3 to his sacrum, a stage 3 to his left medial (middle) knee and a stage 3 to his right medial knee. His MDS, dated [DATE], indicated he had two stage 3 pressure ulcers and one unstageable (a full-thickness tissue loss that is covered by eschar, slough, or a non-removable dressing, making it difficult to determine the extent of the wound) pressure ulcer. His care plan, dated 10/14/24, indicated he had pressure ulcers to his sacrum, left and right medial knee. On 10/28/23 at 12:35 p.m., during an interview with the Regional MDS Coordinator, she indicated she would correct the MDS from one unstageable pressure and two stage 3 pressure ulcers to three stage 3 pressure ulcers. She indicated they have a new MDS coordinator starting. 2. On 10/28/24 at 10:11 a.m., a record review was completed for Resident 14. She had the following diagnoses which included but were not limited to dementia, anxiety disorder, major depression, and difficulty walking. Resident 14 had an MDS, dated [DATE], which indicated she did not require a level 2 assessment. She had a level 2 assessment dated [DATE]. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She had a care plan, dated 3/27/24, that indicated she had a positive PASSR due to diagnosis of major depressive disorder. On 10/28/24 at 12:35 p.m., the Regional MDS Coordinator indicated the MDS would be corrected. On 10/28/24 at 1:00 p.m., a policy was requested. The policy was not received by the time of exit.

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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. 51296 Based on observations, interviews, and record review, the facility failed to ensure a comprehensive resident centered care plan was implemented for two residents related to their indwelling urinary catheters for 2 of 3 residents reviewed for urinary catheters (Residents 68 and 1). Findings include: 1. On 10/21/2024 at 10:39 a.m. Resident 68 was observed. He was propped up on his left side in his bed. There was a sign on his door which indicated he was in enhanced barrier precautions. A urinary collection bag was hung on the side of the bed. On 10/23/2024 at 12:32 p.m., Resident 68's medical record was reviewed. He was a long term care resident who's diagnoses included but were not limited to, retention of urine and neuromuscular dysfunction of the bladder (a condition where the muscles and nerves of the bladder do not work together properly). He had a current physician's order for placement and securement of a urinary foley catheter. Resident 68's comprehensive care plans were reviewed and lacked documentation of a plan of care to address his need for a catheter. 38768 2. On 10/21/24 at 2:03 p.m., Resident 1 was observed. She sat up in bed and indicated she had a catheter and it bothered her from time to time. On 10/24/24 at 2:43 p.m., Resident 1's medical record was reviewed. She was a long-term care resident with a diagnosis of neurogenic bladder. She had current physician's order for a foley catheter placement and securement. Resident 1's comprehensive care plans were reviewed and lacked documentation of a plan of care to address his needs for a catheter. On 10/23/2024 at 1:25 p.m., the Administrator provided a copy of a current facility policy titled, Care Planning dated 10/24/2022. The policy indicated .The facility's interdisciplinary team(IDT) will develop a baseline and/or a comprehensive care plan for each resident in accordance with OBRA and MDS guidelines . A licensed nurse will initiate the care plan, and the plan will be finalized in accordance with OBRA/MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems and as deemed appropriate by clinical assessment and judgement on an as needed bases 3.1-35(a)

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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. 51296 Based on observations, interviews and record review, the facility failed to coordinate treatments and services with hospice after new skin impairment areas were discovered on the bilateral lower extremities (BLE) for 1 of 2 residents reviewed for change of condition (Resident B). Findings include: On 10/22/2024 at 9:50 a.m., Resident B was observed as she laid in bed. Here eyes were closed and she was positioned on her back. On 10/22/2024 at 10:12 a.m., Certified Nursing Aide (CNA) 23 and an unidentified CNA were observed as they changed Resident B's brief. During her care, Resident B's BLE were observed to be reddened and edematous which extended from below her knees to the top of her ankles. Both CNAs indicated Resident B was totally depended on staff for all care. On 10/22/2024 at 10:23 a.m., Registered Nurse (RN) 120 indicated she changed Resident Bs' dressings in the morning and any time the dressing was soiled or loose. RN indicated that the resident had stopped eating, and that the hospice nurse came in more frequently to check on the resident and to do wound care since the significant change in the residents' condition began. During a confidential interview, Resident B's family member indicated they were very unhappy with the nursing care that the Resident had received. The family member indicated there was a lack of quality of care being provided which they felt had contributed to the rapid decline in the residents' condition. During a confidential interview, RN 15 indicated after a hospice nurse visited their patient, if any new areas of concerns had been noted, they would check in to let the floor nurse of the facility know. If there were any need for new orders, the hospice nurse would notify the nurse or contact the doctor themselves to request new orders. On 10/23/2024 at 10:00 a.m., Resident B's medical record was reviewed. She was a long-term care resident with diagnoses which included but were not limited to, hypertension (high blood pressure), congestive heart failure, and Lymphedema (a chronic condition that causes swelling due to a buildup of lymph fluid in the body). On 10/23/2024 at 10:30 a.m., Resident B's skin assessments were reviewed and indicated there were no new open areas. She had an active physician's order, dated 8/29/2024, to cleanse BLE from the knees down with wound cleanser, apply silicone cream to BLE from the knees down twice daily and may apply telfa (non-stick dressing pad) and sleeve if drainage occurred. A nursing progress note, dated 10/3/2024 at 6:21 p.m., indicated the Director of Nursing (DON) spoke with the Resident's hospice provider about BLE blisters, and that an RN from the hospice company would be out to evaluate the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hospice visit narrative note, dated 9/9/2024, indicated that Resident B showed signs of continued disease progression as evidence by plus 4 pitting edema in bilateral lower extremities with new open wounds. A hospice visit narrative note, dated 9/12/2024, indicated Resident B had deep purple bruising on her BLE from laying on pillows and she was at risk for infection due to new wounds as evidence by compromised skin integrity on bilateral posterior (the back of) lower extremities and new open sores on bilateral anterior (the front of) lower extremities compared to 9/9/24 when sores were not open. A hospice narrative note, dated 9/23/2024, indicated that Resident B had a new wound on their right leg from skin peeling off. During an interview on 10/28/24 at 3:28 p.m., the Regional Nurse Consultant (RNC) indicated they did not have the hospice narrative notes mentioned above. Hospice had not sent the notes, and he did not know if hospice told the floor nurse. He was unable to find anything in the facility records related to the wounds on her legs and the physician was not notified. When asked why the facility did not have the hospice narrative notes, he indicated hospice had not provided the notes, but the facility had also not reached out to hospice to request them. On 10/23/2024 at 1:25 p.m., the Administrator provided a copy of a current facility policy titled, End of Life Care dated 08/2020. The policy indicated that .Social services staff will coordinate with hospice staff to ensure that the residents needs are communicated to hospice . This citation relates to Complaint IN00445712. 3.1-37

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 Based on interview and record review, the facility failed to ensure all tube feedings were completed according to physician's orders for 2 of 2 residents reviewed for tube feeding (Resident 74 and 134). Findings include: 1. On 10/25/24 at 12:28 p.m., Resident 134's record was reviewed. Her diagnoses included but were not limited to the after-effects of cerebral infarction (stroke) including hemiparesis (weakness and paralysis) on her right dominant side, gastrostomy (g-tube for consuming nutrition), and diabetes mellitus (blood sugar disorder). A progress note, dated 10/17/24 at 9:28 p.m., indicated Resident 134 arrived at the facility after suffering an acute cerebral vascular accident (CVA, stroke). She was to have nothing by mouth (NPO) and had a gastric tube (g-tube). Her sister indicated all medications and Glucerna were provided via her g-tube. Her admission weight was 243 pounds. On 10/23/24, her weight was 235.4. She lost 7.6 pounds in 6 days. Her physician's orders, dated 10/18/24, included but were not limited to: Resident 134's diet order, dated 10/18/24, was nothing by mouth (NPO). Resident 134's enteral feedings (per g-tube feedings), started on 10/17/24 at 5:35 p.m., and discontinued on 10/18/24 at 11:21 a.m., indicated to provide a 237 mL (milliliter) bolus of Glucerna 1.5 three times a day for supplement. No free water was indicated. Resident 134's enteral feedings, dated 10/18/24 at 2:00 p.m., indicated to provide a 300 mL (milliliter) bolus of Glucerna 1.5 five times a day with 120 mL free water flush before and after each feeding. Resident 134 was at risk of malnutrition, dated 10/18/24, related to being a new admission and her diagnosis of cerebral infarction with the registered dietician to consult as needed. Her baseline care plans were reviewed. Her dietary/nutritional stats indicated she was dependent and required tube feedings. The resident's goal was to maintain her current weight. The dietary risk was weight loss. The Treatment Administration Record (TAR), dated 10/17/24, indicated she was provided with 237 mL of Glucerna 1.5 via her g-tube in the evening. The TAR indicated she was not provided with nutritional supplements on 10/18/24 for the 8:00 a.m. or the 11:00 a.m. tube feeding times. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 1:15 p.m., a carton of Glucerna 1.5 was noted on top of 300 hall med cart. It was observed to be 237 mL and provided 356 calories per carton. The tube feedings provided by RN 72, on 10/24/24 equaled 1780 calories for the day. 2. On 10/23/24 at 1:47 p.m., Resident 74's record was reviewed. He was admitted on [DATE]. His diagnoses included, but were not limited to, gastric ulcer with hemorrhage (bleeding sore in the stomach lining), schizophrenia (mental illness that affects a person's thoughts, feelings, and behaviors), and diabetes mellitus (blood sugar disorder). His physician's orders included, but were not limited to: An order, dated 10/1/24 and still active, indicated to provide enteral feeding four times a day with 100 cc (mL) of free water flush via g-tube four times a day. An order, dated 10/10/24 and still active, indicated to provide Glucerna 237 mL three times a day for nutrition support. On 10/25/24 at 2:26 p.m., Resident 74's September Treatment Administration Record (TAR) was reviewed. The tube feeding order on the TAR, started on 8/6/24 and discontinued on 10/1/24, indicated the enteral feeding order was to provide Glucerna 1.5 carton (237 mL) five times per day with 70 mL of water before and after each tube feeding. On 9/2/24 and 9/3/24, he was not provided with his tube feeding at 2:00 p.m., limiting his calories for the day to 1424. On 9/22/24, he was not provided with his tube feedings at 8:00 a.m., 11:00 a.m., and 2:00 p.m., limited his calories for the day to 712 calories. A current policy, titled, Tube Feeding/TPN, dated 12/2020, was provided by the Executive Director (ED), on 10/28/24 at 10:16 a.m. A review of the policy indicated, .To ensure that the Facility meets the nutritional guidelines and resident's nutritional requirements per physician's orders. A physician order is required to administer tube feeding .The physician order .should include type of formula, amount of formula and fluid and frequency and amount of feeding .it is recommended that commercial tube feedings not be less than 1500 calories per day for females and 1800 calories per day for males 3.1-44(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46414 Based on record review and interviews, the facility failed to ensure a resident, (Resident 82) who was newly admitted from the hospital, received appropriate and timely interventions to assess and treat her pain, which resulted in her choice to discharge from the facility against medical advice (AMA) for 1 of 1 resident reviewed for pain. Findings include: On 10/25/24 at 12:40 p.m., a closed record review was completed for Resident 82. She had the following diagnoses which included but were not limited to, multiple sclerosis (MS, a chronic disease that damages the central nervous system and often causes pain), and pain in right arm due to compartment syndrome, (a serious condition that occurs when pressure increases in a muscle compartment, which can restrict blood flow and cause pain). A nursing progress note, dated 8/10/24 at 12:50 p.m., indicated Resident 82 admitted to the facility, from a local hospital and she was alert and oriented to person, place, time and situation. On 8/10/24 at 2:49 p.m., a pain assessment was completed. It indicated her pain intensity in the past 24 hours was a 9 out of 10 in her right arm that was aching. This would occur when her pain medication wore off. A nursing progress note, dated 8/10/24 at 3:19 p.m., indicated Resident 82's physician order for HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen- a narcotic pain medication) with instructions to give 2 tablets by mouth every 6 hours as needed for pain was entered into the system. A nursing progress note, dated 8/10/24 at 6:51 p.m., (more than three hours later), indicated the nurse attempted to call pharmacy for an authorization code for access to the EDK (emergency drug kit), and waited for a call back. A nursing progress note, dated 8/10/24 at 7:45 p.m., indicated the facility was still waiting for a call back from the pharmacy for an authorization code to the EDK. A nursing progress note, dated 8/10/24 at 8:54 p.m., indicated the facility was still waiting for a call back for an authorization code to the EDK. Resident 82 was informed, but she remained upset. A nursing progress note dated 8/10/24 at 10:47 p.m., indicated Resident 82 was upset and chose to discharge herself AMA and refused to sign AMA form. The record lacked documentation of additional and/or ongoing pain assessments as Resident 82 continued to complain of pain. The record lacked documentation of an AMA form, with indication to the reason for her wish to discharge AMA, and/or a nurses and witness's signature of her refusal to sign out AMA. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observations, interviews and record review, the facility failed to ensure specialized dementia care programming was implemented to provide meaningful, engaging and diverse activities and/or opportunities for residents with a diagnosis of dementia for 5 of 15 residents who resided in the specialized secured memory care (MC) unit, (Residents 21, 37, 38, 50 and 63). Findings include: Activities, events, and opportunities for MC unit residents were observed throughout the survey week. Those observations were reconciled with the posted Activity Calendar and special events hosted by the facility that week. While all residents were periodically observed, special focus was directed to Residents 21, 37, 38, 50 and 63. Observations and interviews below are organized by days ,d+[DATE], with morning, afternoon, or evening activities specified, as well as two special events hosted by the facility. Day 1, [DATE] scheduled activities for MC unit: 9:30 a.m., Morning Social 10:00 a.m., Coffee & Snax 10:30 a.m. Current Events 11:00 a.m., Trivia 11:30 a.m., Sittercise 12:00 p.m., Dining Music 1:00 p.m., Cleaning Crew 2:00 p.m., Snax/Bingo 3:30 p.m., Afternoon Sitcoms Afternoon Observations: At 12:32 p.m., the Memory Care Unit (MC) was observed. There were 8 residents seated in the only common area, which served as the dining room and activity room. An announcement whiteboard was blank. The T.V. was on, but unable to be heard. There was no music, and there were no activities. There was one Certified Nursing Assistant (CNA) who assisted residents at a time to the restroom. There was one Licensed Practical Nurse (LPN) who was seated at a computer in the nurses' station, out of sight from the common area. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 21 was seated in a recliner in her room. She read a piece of paper out loud to herself. Resident 37 was seated in a blue cushioned recliner chair. The chair was covered with a white sheet, and Resident 37's head was lowered, and her eyes were closed. She was covered by a sheet. Resident 38 was seated in a wheelchair (wc) at a table. She rested her elbow on her table, with her head in her hand. Her eyes were closed. Resident 50 was observed as she independently walked in and out of the common area. She would sit, but then got back up and walked through the hall, then come back and sit. Resident 63 was seated in a Broda chair (a specialized high-back wheelchair). There were no activity and/or sensory materials to engage with. She made occasional faces by squinting her face and gritted her teeth. Her eyes were open but unseeing as she looked at the ceiling and around the room. An 8.5 (inch) by 11 Activity Calendar was posted on a bulletin board in the MC hallway. The Calendar was observed to have very small print and was not eye level for anyone who would be seated in a wheelchair. The Activities scheduled for [DATE] at 12:00 p.m. was Dining Music and at 1:00 p.m., was Cleaning Crew. Neither were observed. From 1:45 p.m. until 2:15 p.m.: At 1:45 p.m., upon entrance to the MC unit, there were 7 residents in the common area. The T.V. was on and played County Gospel music. Resident 21 was seated in a recliner in her room. She read a piece of paper out loud to herself. She held a baby doll, and spoke as if someone else was in the room, but no one was with her. Resident 37 was seated in a blue cushioned recliner chair. The chair was covered with a white sheet, and Resident 37's head was lowered, and her eyes were closed. She was covered by a sheet. She occasionally opened her eyes. She did not engage in the activity around her. Resident 38 was seated in her WC at a dining room table. Here eyes were open and she watched out the glass window as people occasionally passed by in the hallway. Resident 50 independently walked in and out of the common area, then up and down the hall. She would sit for in a dining room chair for a period at a time, but then returned to the hallway. Resident 63 was observed in bed after lunch. The lights were off. There was no music on. No T.V. on. She laid on her left side and faced the bare wall which she picked at. Pieces of paint were observed to be chipped away from the wall where her hand tapped and picked at the wall. At 1:45 p.m., An Activity Assistant (AA) 7, entered the unit with a [NAME] Mouse coloring book. She pulled some pages out and asked if some of the residents would like to color. They declined. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:52 p.m., the Activity Director (AD) entered the unit and invited the residents to Bingo. Several residents were assisted off the unit for the activity. At 2:00 p.m., the AD returned to the unit and wrote the day's date and some trivia questions on the announcement whiteboard then left the unit. At 2:15 p.m., as the scheduled activity, Snax /Bingo took place off the unit, no alternative activity was offered for the resident who remained in MC. The Activities scheduled for [DATE] at 1:00 p.m., had been Cleaning Crew, which did not take place. Coloring was a scheduled activity, and no alternative activity/opportunity was offered for the residents who remained on the unit during Bingo. Day 2, [DATE] scheduled activities for MC unit: 9:30 a.m., Coffee & Snax 10:00 a.m., Today in History 10:30 a.m., Trivia 11:00 a.m., Adult Coloring 11:30 a.m., Sensory Table Games 12:00 p.m., Dining Music 1:00 p.m., Cleaning Crew 2:00 p.m., Flip It 2:15 p.m., Snax Morning observations: From 9:10 a.m., until 11:00 a.m.: Upon entrance to the MC unit at 9:10 a.m., the activity calendar was observed. A new note had been thumb tacked to the bottom of the calendar which indicated, Activities Subject to Change. At 9:11 a.m., nine residents were observed in the common area. 6 residents had their eyes closed. The T.V. was on. There was no music and no activity. A housekeeper was observed as she finished mopping the common area floor. At 9:13 a.m., AA 47 entered the unit with a rolling cart of snacks and passed out small snacks to some residents who wanted them. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:29 a.m., AA 7 entered the unit and gave pumpkin coloring pages to AA 47 who placed them on the bottom of her cart. At 9:34 a.m., AA 47 began to read aloud from the Daily Chronicle. Residents 37, 38, 50 and 63 were present as the activity occurred, but were not engaged. Resident 21 remained in her room talking/reading to herself. At 10:08 a.m., AA 47 led some of the residents in acappella singing and read some simple trivia questions. At 10:27 a.m., AA 47 and AA 7 circled up several residents for an unscheduled Ball-Toss game. Resident 21 was not invited and remained in her room. Resident 63 could not participate and was not provided an alternative activity/oppurtunity. Resident 37 remained in the recliner chair with her eyes closed and did not participate. At 10:45 a.m., AA 47 and 7 passed out the pumpkin coloring pages and an unnamed resident threw her page across the table and indicated, this is stupid. Afternoon observation: At 11:00 a.m., the T.V. was on and played some quiet music while several residents colored. Resident 21 remained in her room. Resident 37 remained in the recliner in the common area with her head lowered and her eyes closed. Resident 50 came and went independently, she would sit momentarily but then got up and paced up and down the hallway. She was not offered and alternative activity/opportunity. Day 3, [DATE] scheduled activities for MC unit: 9:30 a.m., Coffee and Snax 10:15 a.m., Current Events 10:30 a.m., Bible Study 11:30 a.m., Dining Set-Up 12:00 p.m., Dining Music 1:00 p.m., Cleaning Crew 2:00 p.m., Snax/Bingo 3:30 p.m., Sittercise 4:00 p.m., Arm Massages Morning Observations: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon entrance at 9:25 a.m., AA 47 was observed as she passed out some snacks while a children's move, Nanny [NAME] played on the T.V. Resident 21 was in her room, in her recliner and read/talked to herself. Resident 63 was seated in her broad chair, at the same table place as the previous days, she was positioned directly under the T.V. and did not have very good line of sight to the screen. She was not offered a snack. Resident 37 was seated in the blue recliner, and her eyes opened on and off. She was not offered a snack. At 9:39 a.m., AA 47 began to read trivia quotes, which were repeated from the previous days. Residents 21, 37, 38, 50 and 63 could not/did not participate. At 10:27 a.m., AA 47 was seated as she read out loud more trivia and finish the line sayings. Afternoon Observations: At 1:23 p.m., six residents were in the common area. 3 residents were coloring the same pumpkin pages from the day before. 3 residents were not coloring and just watched, or had their eyes closed. Resident 63 had been laid down after lunch. Her lights were off, there was no music playing, the T.V. was not on. Her eyes were open as she laid on her left side and picked at the bare wall. Resident 50 sat in a chair and stared blankly. Resident 38 was seated in her WC at a table spot and her eyes were closed. On [DATE] at 1:54 p.m., several MC residents were invited and assisted off the unit for Snax/Bingo. No alternative activity/opportunity was offered for the residents who remained in MC. Day 4, [DATE] scheduled activities for MC unit: 9:30 a.m., Coffee and Snax 10:15 a.m., Chronicle Review 10:30 a.m., Catholic Rosary 11:30 a.m., Dining set up 1:00 p.m., Cleaning Crew 2:00 p.m., Flip It 2:15 p.m., Snax & Social 3:30 p.m., Sing-A-Longs Afternoon observations, from 11:03 a.m. until 12:19 p.m.: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:03 a.m., several residents returned from Catholic Rosary. An unnamed resident indicated, I'm not Catholic, I'm protestant, I don't know anything about Rosary or why I went. AA 33 turned the T.V. to an Elvis music channel and began to pass out coloring pages. An unnamed resident indicated, are we coloring again? During an interview on [DATE] at 11:07 a.m., AA 33 indicated, she was new and still training. She was not sure exactly what the activities Dining Music and Cleaning Crew were. She indicated, she thought it was mostly having music on during lunch and watching staff clean up lunch. When asked if any of the residents were asked/invited to help as an act of service type of activity, AA 33 indicated, no. When asked what Dining Set Up meant, AA 33 indicated, it was probably the same as cleaning crew, where the residents would watch as staff set up lunch. When asked what Set up included, AA 33 indicated it would probably be setting up lunch trays after the cart arrived on the unit. When asked if there were acts of service opportunities for the residents to fold napkins, or lay table clothes, or roll silver wear etc. she indicated, no. At 11:10 a.m., Resident 50 was seated at a table with 5 other table mates. Resident 63 was in her broad chair beneath the T.V. Resident 21 was in her room and talked/read out loud to herself. Resident 38 was seated at a table with two table mates and stared blankly out the glass window into the hallway. AA 33 indicated, we are surely going to do an activity and have some fun. At 11:13 a.m., no Dining Set Up activity was observed as AA 33 led the group in some unscheduled acepello singing. She attempted a first song, but did not know the tune, and the residents did not participate. Then she attempted to find music to sing along to on the T.V. on a YouTube channel and started a nursey rhyme Twinkle Twinkle Little Star. It was an unfamiliar version/tune and the video displayed images of dancing stars and babies. At 11:49 a.m., Resident 63's family member came for a visit. During an interview, he indicated, he did not have any nursing concerns, but there did not seem to be any dementia activities especially for some of the folks like [Resident 63] who really could not participate in most of the group activities. They did things like bingo, card games, and trivia, but all that was way beyond Resident 63's abilities at that point. He suggested it might be nice to sit outside in the courtyard, or have certain familiar smells, or different kinds of music that wasn't played off a T.V., but an old stereo like some of those folks might remember. At 12:19 p.m., the AD entered the MC unit common area to fill a water jug at the sink. In passing she indicated to the AAs and residents, it's a lot cooler today, I like it, its really nice outside. Going outside was not offered during any survey observation. At 1:52 p.m., several residents finished a ball-toss game, where a beach-ball was rolled across the table tops back and forth. At that time, Resident 21 was observed in her room, seated in her recliner and read out loud to herself. Resident 37 was seated in the recliner in the common area and watched some, but then closed her eyes. Resident 38 sat at a table away from the activity and did not participate. At 1:57 p.m., the AD and AA 47 entered the MC unit and invited/assisted several residents off the unit to play Bingo. Resident 63 and 37 as well as one other unnamed resident remained in the MC common area. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:02 p.m., AA 33 indicated she would try to help them with a puzzle but changed her mind, sat down and continued reading the Daily Chronicle. Resident 37's eyes remained closed. Shortly after AA 33 began to read, a CNA came to assist Resident 63 to go lay down. At 2:05 p.m., Resident 50 entered the dining room. AA 33 handed her a Daily Chronicle, but Resident 50 just held the paper and smiled. She walked away, out of the common area and dropped the page to the floor. At 2:09 p.m., a Floor Technician entered the MC and began working a machine on the hallway floors. The machine was very loud. AA 33 attempted to continue reading Trivia questions for one remaining resident, but it was too loud and she indicated they could finish later. Evening Observation: Throughout the survey week, an announcement T.V. at the front of the building advertised a Halloween Party and Trick-or-Treating event to take place on [DATE] from 6:00 - 8:00 p.m. No posts or announcements were observed for the Special Event in the MC unit. No activity/opportunity was schedule as an alternative for MC residents during the party. From 6:16 p.m., until 7:13 p.m., the Halloween Party & Trick-or-Treat Special Event was observed. Upon entrance into the facility, at 6:16 p.m., staff, visitors and children were dressed in costumes and participated in the event which took place up and down the main hallway of the facility, and in the long-term care dining rooms. Upon entrance to the MC unit, at 6:33 p.m., the lights remained on, and the unit was brightly lit. Resident 37 was observed in the blue recliner chair, with her eyes closed and covered with a blanket. Resident 50 walked up and down the hallway, in and out of her room, and through the common area. She paced without purpose or redirection. Most residents were in bed. During an interview on [DATE] at 6:58 p.m., LPN 121 indicated, she was not sure if any residents had gone to the Halloween party. She did not think any of them had since no one had come in to invite them or assist them to the party, because most of the residents had already been put to bed. During an interview on [DATE] at 7:08 p.m., CNA 34 indicated, only 2 residents had participated in the Halloween party since they were still awake. Everyone else had been put to bed. She indicated, Resident 50 sun-downed and would restlessly pace up and down the hall until it was time for her to go to bed, but then she would get back up. By 7:13 p.m., both resident who had gone to the party returned to the unit and were assisted to bed. Day 3, [DATE] scheduled activities for MC unit: 9:30 a.m., Coffee & Snax (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:15 a.m., Chronicle Review 10:30 a.m., Sittercise At 11:00 a.m., Sensory Table Games At 12:00 p.m. Dining Music 1:00 p.m. Cleaning Crew 2:00 p.m., [Special event Guest Musician] October Birthday Party Celebration . Morning observations: Upon entrance to the MC unit at 9:50 a.m., AA 47 was observed as she attempted to read Trivia questions and the Daily Chronicle overtop of the noise of the T.V. At 10:00 a.m., Resident 38 was observed with 2 visitors who stood beside her and talked over the ongoing activity at that time. There were no empty chairs in the common area, and no staff offered to escort them to a more private or quiet place to visit. Resident 38's visitors agreed to an interview, and moved to Resident 38's room on their way out of the unit. They indicated, they had no concerns with Resident 38's nursing care and always found her to be neat and clean, but wondered if there could be opportunities for her to participate in different activities. Resident 38 would often get overstimulated in larger groups, with loud noises and lots of commotion. Overall, she was sweet and calm but could flip like a switch. When she was younger, Resident 38 was a very talented needle-worker and enjoyed stitching. During a recent hospital stay, the staff there had some kind of lap blanket which had buttons, strings, Velcro, zippers and other tactile-type items. She was fascinated by it and it kept her occupied for hours. They had not seen anything like that for Resident 38 in the MC unit. They also suggested, Resident 38 might benefit from more natural lights throughout the day, maybe by going to sit outside, instead of always sitting in the same room under florescent lights and starring into the hallway. At 10:03 a.m., AA 47 entered the common area and asked the resident who were there, did you guys see all those cute trick-or treaters last night? They indicated, no. At 10:15 a.m., (the scheduled activity was Chronicle Review) AA 47 indicated to AA 7, she should take over leading the activity until 10:30. AA 7 indicated, what should I do? AA 47 indicated, maybe she should try getting them to sing. AA 7 led the group to sing God Bless America accopello. At 10:19 a.m., CNA 9 brought a sensory fidget toy, (a squishy, liquid filled rubber tube) for Resident 63. CNA 7 attempted to put it in the Resident's hand, but she was unable to hold it by herself. CNA 7 left the fidget in Resident 63's hand and walked away. Resident 63 dropped the toy, and it fell to the floor. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:20 a.m., AA 47 facilitated Sittercise and three resident actively participated. Resident 37 was seated in the recliner in the common area with her eyes closed, and a blanket over her lap. Resident 21 was in her room talking to herself, and had not been invited to participate in Sittercise. Resident 63 was unable to participate. Resident 38 kept her back turned to the activity and did not participate. At 10:50 a.m., Sittercise was over, and AA 47 and AA 7 moved two tables together to play a [NAME] toss game. 6 residents actively participated. Resident 21 remained in her room and was not invited. Resident 37 was seated in the recliner in the common area with her eyes closed. Resident 38 was seated at a separate table and did not participate. A black plastic basket with another resident's name was placed on the table in front of Resident 63. She was unable to engage with the materials. Afternoon Observations: At 1:18 p.m., AA 47 read Trivia questions out loud. (The Trivia facts were the same that had been shared throughout the week). She read out loud overtop of the T.V. which was on. As she read, an unnamed resident attempted to stand up form her wheelchair several times. Each time, AA 47 called to the Resident, Sit down, and continued reading. This was observed 4 times. The resident was not offered an alternative activity/opportunity. At 1:30 p.m., Resident 38 had a visitor who sat in a chair at the table with her in the common area. At that time, AA 47 continued to read Trivia questions out loud and other residents conversed with each other over the T.V. Resident 38 leaned forward to her visitor several times with her hand on her ear and indicated she couldn't hear her friend. Resident 38, and her visitor, were not offered or assisted to a more quiet or private place to finish their visit as the activity continued. At 1:34 p.m., AA 47 moved from Trivia questions, to Finish the Phrase, prompts. At 1:58 p.m., 2 residents were assisted off the unit to attend the Special Birthday Party Event. Resident 21 was not invited and remained in her room. Resident 63 had been laid down in bed. Resident 50 had a Happy Birthday paper posted on her bedroom door which indicated she had an October Birthday. She was not invited or assisted to the Special Event. At 2:01 p.m., an unnamed resident continued to attempt to stand up from her WC and was repeatedly told to sit back down. CNA 34 indicated to AA 47 she would take the resident to the restroom and lay her down. She was not invited to the Special Event or provided an alterative activity/opportunity. All other residents who remained on the MC unit, were not offered an alternative activity or opportunity. On [DATE] at 10:30 a.m., the Executive Director (ED) provided a copy of the AD's annual ongoing dementia-specific training. The ED indicated, the AD was both the Activity Director for the whole building and the Memory Care Facilitator (MCF). The training provided was an untitled, 36 page PowerPoint print off. The training did not include a specified number of hours it qualified for ongoing trainings. (continued on next page)

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F 0744

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on [DATE] at 10:34 p.m., with the ED present, the AD indicated, she became the MCF when the new company took over. The Dementia-Specific training provided, was called, Mosaic Moments, and the power point was her training on the new program requirements. The ED and AD indicated, activities for the MC residents were similar to the main activities with modifications related to the resident's abilities. Overall the MC was different because it was a secured unit to provide a safe environment and prevent elopement, but should also offer specialized programming to engage the residents. When asked about the Categories mentioned in the training information, the AD indicated, it was something she meant to do, but had not gotten to yet. The AD indicated she also enjoyed and tried to implement programming and activities based off her education and training via Teepa Snow.

During an interview on [DATE] at 12:40 p.m., the ED indicated, the purpose of the specialized MC unit should be more than just a locked door for safety. Programming should be specialized and individualized to meet the needs and preferences of the those residents who have a diagnosis of dementia.

On [DATE] at 1:00 p.m., Resident 21, 37, 38, 50 and 63 were reviewed.

1. Resident 21 was a long-term care resident who had diagnoses which included but were not limited to, vascular dementia.

An Admission minimum data set (MDS) assessment dated [DATE] indicated, the following activity preferences were very important reading, listening to music, being around animals, do things with groups of people, going outside to get fresh air when the weather is nice.

A Social History assessment dated [DATE] indicated, some of her hobbies and past interests included, enjoying sweets, liked to watch CNN, and enjoyed dogs and music.

An Initial Activity assessment dated [DATE] indicated, she usually accepted any activity but required reminders and cues to attend activities.

A quarterly Activity assessment dated [DATE] indicated, she preferred to be out of her room and preferred to be with people.

A comprehensive care plan, revised [DATE] indicated, Resident 21 required reminder and cues to participate in activities related to her dementia and confusion. Interventions included, but not limited to, her preferred activities were watching CNN, pet visits, watching animal movies/shows, food/beverages/socials and Lutheran religious practices.

Resident 21's activity participation logs were reviewed for the survey week from [DATE] - [DATE] and indicated the following:

She had actively engaged with Games/Trivia and religious programs every day. Parties and Special events were blank.

2. Resident 37 was a long-term care resident who had diagnoses which included but were not limited to, Alzheimer's dementia and unspecified dementia.

(continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Annual MDS assessment dated [DATE] Staff Assessment for customary routines and preferences included, but were not limited to the following applicable items, spending time outdoors, religious activities, reading, listening to music and being around animals. A Social History assessment dated [DATE] indicated, information had to be obtained from family as she was unable to give answers. Some of her hobbies and past interests included, being involved with her church, watching Westerns, and being around animals. She had been a stay-at-home mom for her adopted children and loved gardening flowers. A quarterly Activity assessment dated [DATE] indicated, she preferred to be with people and initiated conversations. A comprehensive care plan revised [DATE] indicated, Resident 37 had decreased activity involvement due to her dementia and she required reminders and cues to participate in activities. Interventions included, but not limited to, offer resident to attend activities that occur off the MC unit, offer refreshments daily and supplies for independent leisure in her room. Resident 37's activity participation logs were reviewed for the survey week from [DATE] - [DATE] and indicated the following: She had actively listened to movies/T.V., actively participated in discussions and actively participated in sensory stimulation groups. 3. Resident 38 was a long-term care resident who had diagnoses which included but were not limited to, unspecified dementia and mild cognitive impairment. A Significant Change MDS assessment dated [DATE] indicated the following routines and preferences as very important, reading, listening to music, being around animals, keeping up with the news, doing things with groups of people, doing her favorite activities and going outside for fresh air when the weather was nice. A Social History assessment dated [DATE] indicated, she was widowed with one daughter who was deceased , but had very good support from neighbors and friends. She had been an accounting bookkeeper with business and secretarial skills. A quarterly Activity assessment dated [DATE] indicated, she preferred to be with people and was an active participant in activities. An undated comprehensive care plan indicated, Resident 38 was dependent on staff for cognitive stimulation, social interaction and activity participation related to her dementia. Interventions included, but not limited to, offer out of room and off the unit activities, compatible with know interests and preferences such as large print books, puzzles and age appropriate. Resident 38's activity participation logs were reviewed for the survey week from [DATE] - [DATE] and indicated the following: She had actively participated in current events, exercise, discussion, religious programs, sensory stimulation groups and games/trivia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 50 was a long-term care resident who had diagnoses which included but were not limited to, unspecified dementia. An Annual MDS assessment dated [DATE] Staff Assessment for customary routines and preferences included, but were not limited to the following applicable items, participating in religious programs, going outside to get fresh air when the weather is nice, spending time away from nursing home, being around animals, reading and listening to music. A Social History assessment dated [DATE] indicated, she had been a stay at home mom of 3 children who enjoyed baking and loved dogs. A quarterly Activity assessment dated [DATE] indicated, she preferred to be with people and was an active participant in activities. Resident 50's activity participation logs were reviewed for the survey week from [DATE] - [DATE] and indicated the following: She had actively participated in discussions, religious programs, sensory stimulation groups and games/trivia. 5. Resident 63 was a long-term care resident who had diagnoses which included but were not limited to, Alzheimer's dementia. An Annual MDS assessment dated [DATE] Staff Assessment for customary routines and preferences included, but were not limited to the following applicable items, participating in religious programs, going outside to get fresh air when the weather is nice, being around animals, reading and listening to music. A Social History assessment dated [DATE] indicated, she had been a factory worker who enjoyed hiking and camping. An undated comprehensive care plan indicated, Resident 63 was dependent on staff for cognitive stimulation, social interaction and activity participation related to her dementia. Interventions included, but not limited to, offer out of room and off the unit activities, and prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as sensory activities, music, arts and crafts. Resident 63's activity participation logs were reviewed for the survey week from [DATE] - [DATE] and indicated the following: She had actively participated in sensory stimulation groups. MC unit Activity calendars for the previous months of July, August and September were reviewed. There were no scheduled pet/animal visits. There were no scheduled/designated days to enjoy fresh air outside. There were no specification of small vs. large group activities. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:40 p.m., the ED provided a copy of current facility policy titled, Secure Care neighborhood Activity Program, revised ,d+[DATE]. The policy indicated, The Secure Care Neighborhood will provide a therapeutic activity program to enhance the ability to express feelings, maintain social skills, develop a sense of belonging, improve self-esteem, self-confidence and quality of life for the residents who reside in the neighborhood . Creative Expression Activities provide the resident the opportunity to express feelings and thoughts through arts and crafts, and other creative mediums. Creative Expression Activities include but are not limited to: Arts and crafts, yarn crafts, wood crafts, paper crafts, Holiday decorating, poetry, puppetry, coloring or painting, photography . Service Activities will five the resident the opportunity to develop roles in the environment which may parallel to past roles. Service Activities are offered in a variety of ways to include a wide range of residents regardless of function abilities. Service Activities include but are not limited to, baking, washing dishes, folding towels, plant care, dusting, coupon clipping, sorting socks, bed making, stuffing envelops . Activities outside the secure neighborhood is encouraged when appropriate . Physical activities will provide the resident with a physical/exercise program which is restorative in nature and is individualized to meet the needs of each resident may include but not limited to, exercise groups, bowling, balloon volleyball, horseshoes, shuffleboard, toss games, walks, dances, golf, gardening On [DATE] at 12:40 p.m., the ED provided the Alzheimer's/Dementia Special Care Unit Disclosure Form. The mission/philosophy statement was blank. The disclosure form required specification of the resident census and number of full time equivalent direct care staff for each shift of the dementia care program/unit but was not specified. The disclosure form indicated, the special unit provided a secured outdoor area accessible to residents, the unit used sensory cues such as things to see, smell, hear touch and taste to assist with wayfinding and orienta [TRUNCATED]

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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. 46414 Based on record reviews and interviews, the facility failed to ensure an alternative or additional emergency pharmaceutical services were available to obtain an authorization code for a resident, (Resident 82) when she began to experience pain and needed medication from the emergency medication kit (EDK) for 1 of 1 residents reviewed for pharmacy services. Findings include: On 10/25/24 at 12:40 p.m., a closed record review was completed for Resident 82. She had the following diagnoses which included but were not limited to, multiple sclerosis (MS, a chronic disease that damages the central nervous system and often causes pain), and pain in right arm due to compartment syndrome, (a serious condition that occurs when pressure increases in a muscle compartment, which can restrict blood flow and cause pain). Resident 82 was admitted to the facility from a local hospital on 8/10/24 at 12:50 p.m. A physician's order for a narcotic pain medication had been entered into the medical record at 3:19 p.m., but by 10:47 p.m., more than 7 hours later that night, she still had not received pain relief and chose to discharge herself against medical advice (AMA). On 10/25/24 at 3:20 p.m., an email was received from the pharmacist who had been on call the evening of 8/10/24. The pharmacist indicated, she received three text messages from the facility regarding Resident 82, for the request of a EDK code. Her phone had been in silent mode as she tended to some personal tasks which caused a 1 hours and 20-minute delay in her response. On 10/28/24 at 11:07 a.m., the Regional Nurse Consultant (RNC), provided a copy of a procedure guideline titled, Pharmcare USA. The procedure indicated, .The E-kit (emergency drug dispensing machine) should always be checked to see if the medication is already in the building . after business hours if the drug is not in the E-kit, call the pharmacy, leave a message and a pharmacist will call you back. Cross Reference F697. 3.1-25(a) 3.1-25(b)(1) 3.1-25(c)

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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. 37981 Based on observation, interview, and record review, the facility failed to ensure staff provided lunches according to policy for enhanced barrier precaution residents (Resident 17 and 77). Findings include: 1. On 10/21/24 at 12:38 p.m., Qualified Medication Aide (QMA) 6 was observed removing Resident 77's lunch from the lunch cart. She did not perform hand hygiene before entering or after leaving her room. Resident 77 was on enhanced barrier precautions (EBP) due to g-tube (for long-term nutrition) and pressure ulcer (skin injury caused by prolonged pressure on an area of the body). On 10/21/24 at 12:39 p.m., QMA 6 was observed removing Resident 17's lunch from the lunch cart. She did not perform hand hygiene before entering or after leaving her room. Resident 17 was on EBP due to her indwelling catheter and wound. On 10/21/24 at 12:45 p.m., QMA 6 was observed entering Resident 17's room with an additional lunch item. She did not complete hand hygiene before entering or upon exiting her room. On 10/21/24 at 1:53 p.m., Certified Nursing Aide (CNA) 8 indicated when staff members provide lunch to residents in EBP rooms, they need to hand sanitize before entering and after leaving the resident's room. A sign on the EBP rooms indicated, .Everyone must clean their hands, including before entering and when leaving the room A current policy, titled, Hand Hygiene, dated 6/2020, was provided by the Executive Director (ED) on 10/21/24 at 2:21 p.m. A review of the policy indicated for alcohol-based hand rubs, .apply product to palm of hand and rub hands together. Cover all surfaces of hands and fingers until hands are dry 3.1-18(a)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) role was filled for 6 of 12 months reviewed, and all new residents were screened to control infections for tuberculosis (TB) for 5 of 7 newly admitted residents reviewed for implementation of TB screenings (Resident 133, 134, 135, 136, and 184) and one previously admitted resident who did not receive TB screenings for 1 of 3 previously admitted residents (Resident 72). Findings include: 1 During the entrance conference, on 10/21/24, the Executive Director (ED) indicated the Infection Preventionist (IP) was their Regional Director of Operations (RDO). During an interview, on 10/28/24 at 11:08 a.m., the RDO indicated, although he had his IP certification from the CDC, he was not the IP for this facility but their RDO. He assisted with their survey readiness. He indicated he had asked all leadership members, including the Director of Nursing (DON) to get their IP certifications. He indicated this facility did not have a IP person. During an interview, on 10/28/24 at 11:12 a.m., the ED indicated the facility did not have an IP person, and no one working in the building had their IP certification. During an interview, on 10/28/24 at 2:52 p.m., the ED indicated their last IP person left the faciity on [DATE]. She hired a new Assistant Director of Nursing (ADON) and gave her 2 months to complete the IP certification. She did not complete the IP certification and her last day was 9/4/24. She hired another ADON on 10/2/24. She was told to stay on orientation until she finished her CDC IP certification. She only stayed 3 days and left on 10/5/24. On 10/21/24, she hired a new ADON who had not yet completed the CDC IP certification. But, after talking with her RDO, he indicated she could hire a dedicated IP nurse. She indicated she was in the process of facilitating a floor nurse to become their full-time IP nurse and would be getting her IP certification. She would be giving her 2 weeks to complete the IP certification program. On 10/23/24 at 11:21 a.m., newly admitted residents were found to have incomplete tuberculosis (TB) screenings. 2. During an interview, 10/23/24 at 12:17 p.m., the Regional Nurse Consultant (RNC) indicated Resident 72 had not received any TB screening. On 10/28/24 at 12:22 p.m., Resident 72's record was reviewed. He was admitted on [DATE]. On 10/25/24 at 7:22 a.m., a physician's order was added to inject 0.1 mL (milliliter) for a one-time only tuberculin skin test and to be read within 48-72 hours. Administer another tuberculin skin test in 1-3 weeks after the first injection had been read and read within 48-72 hours of administration. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 72's October Medication Administration Record (MAR) was reviewed. No tuberculin skin tests were observed to be injected or read. 3. On 10/28/24 at 1:02 p.m., Resident 135's record was reviewed. She was admitted on [DATE]. On 10/13/24 at 12:27 a.m., a physician's order indicated to inject 0.1 mL for a one-time only tuberculin skin test and to be read within 48-72 hours. According to her October MAR, she received her TB screening injections on 10/13/24 and 10/15/24. After reviewing Resident 136's MAR and TAR, it was observed that it was not read within 48-72 hours but read on 10/22/24. 4. On 10/28/24 at 12:42 p.m., Resident 134's record was reviewed. She was admitted on [DATE]. On 10/17/24 at 6:35 p.m., a physician's order indicated to inject 0.1 mL for a one-time only tuberculin skin test and to be read within 48-72 hours. According to her October MAR, she received her TB screening injection on 10/17/24. After reviewing Resident 134's MAR and TAR, it was observed that it was not read within 48-72 hours. 5. On 10/28/24 at 12:52 p.m., Resident 136's record was reviewed. She was admitted on [DATE]. On 10/20/24 at 4:04 p.m., a physician's order indicated to inject 0.1 mL for a one-time only tuberculin skin test and to be read within 48-72 hours. According to her October MAR, she received her TB screening injection on 10/19/24. After reviewing Resident 136's MAR and TAR, it was observed that it was not read within 48-72 hours but read on 10/20/24. 6. On 10/28/24 at 1:12 p.m., Resident 133's record was reviewed. She was admitted on [DATE]. On 10/19/24 at 8:17 a.m., a physician's order indicated to inject 0.1 mL for a one-time only tuberculin skin test and to be read within 48-72 hours. Resident 133's October MAR and TAR were reviewed. She received the TB screening injection on 10/17/24. The results were still pending. 7. On 10/28/24 at 12:42 p.m., Resident 184 record was reviewed. He was admitted on [DATE]. He did not have physician's orders to receive initial or subsequent TB screenings. After reviewing his October TAR, no record was found of him receiving TB screenings. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 12:17 p.m., the RDO provided a document from another facility indicating he was tested on [DATE] with a negative result. The document did not indicate where it was from, when the resident was injected and by whom and when it was read and by whom. A current job description, titled, Infection Control Preventionist - RN, dated December 2023, was provided by the ED, on 10/28/24 at 11:21 a.m. A review of the job description indicated, .Responsible for assuming the responsibility for the Infection Control Program of the facility in accordance with accepted standards of practice, state and federal regulations and licensing requirements A current policy, titled, Tuberculosis - Screening of Residents, dated 6/2020, was provided by the ED, on 10/25/24 at 10:22 a.m. A review of the policy indicated, .To ensure that residents are screened for Tuberculosis upon admission, readmission, and as indicated thereafter .Any resident who admits to the facility receives a baseline (two-step) TST [tuberculin skin test] upon admission. When the first TST is negative, a follow-up TST is administered 1 to 3 weeks after the initial test is read 3.1-18(a)