STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Lakes Healthcare Center	2300 Great Lakes Dr Dyer, IN 46311

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43293 Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to wearing a hospital gown while in bed during the day for 1 of 3 residents reviewed for dignity. (Resident L) Finding includes: On 2/17/25 at 10:24 a.m. and 11:50 a.m., Resident L was observed in the dining room wearing a hospital gown. On 2/18/25 at 10:38 a.m., the resident was observed in his room in a broda chair wearing a hospital gown. On 2/18/25 at 2:35 p.m., the resident was observed in dining area wearing a hospital gown. The record for Resident L was reviewed on 2/19/25 at 3:57 p.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, and adult failure to thrive. The 11/30/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment for daily decision making and he required substantial/maximum assistance with dressing. A Care Plan, revised on 12/4/24, indicated the resident had self-care deficits and required maximum assistance with dressing. There was no care plan related to wearing a hospital gown during the day. During an interview on 2/21/25 at 2:43 p.m., the Director of Nursing (DON) indicated she was aware the resident wore a gown during the day, and that he did not have many clothes, but that should be in a care plan. 3.1-3(t)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43293 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medications and had physician's orders to self-administer for 2 of 2 residents reviewed for self-administration of medication. (Residents 83 and G) Findings include: 1. During observations on 2/17/25 at 11:28 a.m. and 1:20 p.m., a medicine cup containing two chewable antacids was observed on Resident 83's bedside table. During an interview on 2/17/25 at 11:28 a.m., the resident indicated the nurse gave him the antacids because his stomach got upset sometimes, and he took them when he wanted. The record for Resident 83 was reviewed on 2/19/25 at 2:58 p.m. Diagnoses included, but were not limited to, post-laminectomy syndrome (a chronic pain syndrome that can develop after spinal surgery), depression, and anxiety. The 2/4/25 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and required set-up assistance for ADLs and transfers. A Physician's Order, dated 12/18/24, indicated Tums Oral Tablet Chewable 500 MG Calcium Carbonate (Antacid); Give 2 tablets by mouth every 6 hours as needed for GERD (gastro-esophogeal reflux disease). There was no self-administration assessment or a physician's order for the resident to self-administer the medication. During an interview on 2/21/25 at 2:43 p.m., the Director of Nursing (DON) had no additional information to provide. 2. During an observation on 2/17/25 at 10:48 a.m., Resident G was observed holding a tube of Lidocaine cream (a topical numbing agent). At that time, the resident indicated he kept the medication in his room and applied it himself to his left upper arm AV fistula (access port for dialysis) site 40 minutes before dialysis on Mondays, Wednesdays, and Fridays. The record for Resident G was reviewed on 2/19/25 at 9:29 a.m. Diagnoses included but were not limited to, endocarditis, diabetes type 2, and dependence on renal dialysis. The Nursing Admission Evaluation, dated 2/13/25, indicated the resident was cognitively intact for daily decision making, required set-up assistance with ADLs (activities of daily living), and maximum assistance with transfers. There was no self-administration assessment or a physician's order for the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/25 at 2:43 p.m., the Director of Nursing (DON) indicated she was aware the resident kept the lidocaine at his bedside and applied it himself, she did not want to take away what he was used to doing himself, but there should have been an order. A policy titled, Self-Administration of Medications, received as current from the DON on 2/24/25 at 9:47 a.m., indicated, . For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a monthly basis or when there is a significant change in condition . If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted . 3.1-11(a)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to provide reasonable accommodations of needs related to a resident's bed being long enough so his feet were not touching the foot board for 1 of 2 residents reviewed for positioning. (Resident D) Finding includes: During an interview on 2/18/25 at 10:17 a.m., Resident D indicated he stayed in bed most of the time. At that time, the resident was observed high up in his bed and both feet were observed touching the foot board. At 11:28 a.m., the resident was observed lying on his back and positioned high up in the bed and his feet were touching the foot board. On 2/19/25 at 1:42 p.m., the resident was observed lying on his back in bed. Both feet were touching the foot board. On 2/20/25 at 9:52 a.m., and 11:36 a.m., the resident was observed lying flat on his back in bed. At those times, he was positioned high up in the bed, however, both feet were touching the foot board. On 2/21/25 at 8:29 a.m., the resident was observed lying flat on his back in bed and both feet were touching the foot board. During an observation on 2/21/25 at 8:32 a.m., LPN 5 was passing medications to the resident's roommate. At that time, she was asked to observe the resident and his feet touching the foot board. LPN 5 stated, I believe he needs a new bed, that one is too short. During an interview at that time, the resident indicated he could not reposition or pull himself up in the bed as he needed help. The record for Resident D was reviewed on 2/20/25 at 10:21 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Parkinson's disease, history of falling, depressive disorder, anxiety disorder, epilepsy, heart disease, kidney disorder, and stroke. The 2/3/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and needed partial to moderate assistance with rolling to the left and right and the ability to roll from lying on his back. The resident's height was 73 inches lying down, which was last checked on 9/9/24. During an interview on 2/21/25 at 8:36 a.m., the Assistant Director of Nursing indicated both of the resident's feet should not be touching the foot board. During an interview on 2/21/25 at 8:40 a.m., the Administrator indicated he would get the resident a new bed as soon as possible. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/25 at 8:42 a.m., the Maintenance Director indicated he would look to see if they had a bigger bed in the facility for the resident. 3.1-3(v)(1)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to ensure a resident's family received the resident's medical record in a timely manner after the request was processed for 1 of 1 resident reviewed for medical records. (Resident H) Finding includes: The closed record for Resident H was reviewed on 2/20/25 at 3:35 p.m. Diagnoses included but were not limited to, multiple sclerosis, respiratory failure, type 2 diabetes, pressure ulcers, and anxiety. The resident admitted to the facility on [DATE] and discharged home on 5/28/24. The 4/12/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. A Nurse's Note, dated 5/28/24 at 2:30 p.m., indicated the resident left the facility with all of her belongings from the room. Nursing staff spoke with the resident's son regarding her medications and he indicated he would be in later to pick them up. The Release of Information Log, provided by the Administrator on 2/21/25 at 2:30 p.m., indicated on 9/6/24, an IT tech request was sent to request to advise for a medical record release for the resident. The Release of Information Log, provided by the Administrator on 2/21/25 at 2:30 p.m., indicated on 10/30/24, corporate had released the resident's medical records. An email provided by the Administrator on 2/21/25 at 2:30 p.m., indicated the medical records were sent out electronically to the family on 12/2/24. During an interview on 2/21/25 at 11:42 a.m., the Medical Records Supervisor indicated she had only been in the position since 10/2024. The resident's family did have the medical records at this time. During an interview on 2/21/25 at 3:12 p.m., the Administrator indicated the medical records should have been given to the resident's family in a more timely manner. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current and undated Medical Record Request Guide policy, provided by the Medical Records Supervisor on 2/20/25 at 10:00 a.m., indicated The process is as follows from residents and resident families: when you receive a request you immediately forward the complete request and all accompanying papers that came with the request to record requests. We will review the paperwork to determine if it was HIPPA compliant and we can proceed or we need additional paperwork such as a copy of a POA or guardianship. When compliant we will instruct you to scan and email the paper files and billing and generate the PCC charts. Once all documents are received they will be reviewed for HIPPA compliance. Once that review is completed, either legal will release the documents by email or the facility will be emailed the complete record to release depending on the type of request. This citation relates to Complaint IN00446581. 3.1-4(b)(1) 3.1-4(b)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to pressure ulcers and medication use for 4 of 30 MDS assessments reviewed. (Residents 59, 86, D, and F) Findings include: 1. The record for Resident 59 was reviewed on 2/20/25 at 2:34 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic kidney disease, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/25, indicated the resident was cognitively intact and she had two Stage 3 pressure ulcers (full thickness tissue loss but bone, tendon, and muscle are not exposed) which were present on admission. The resident was readmitted to the facility on [DATE]. A Skin and Wound Note, dated 1/2/25 at 12:04 p.m., indicated the resident had new skin concerns for wounds to the sacrum. The wounds were identified as Stage 3 pressure ulcers that had developed in the facility. During an interview on 2/24/25 at 11:22 a.m., the MDS Coordinator indicated the pressure ulcers had developed in the facility and a modification MDS had been completed. 2. The record for Resident 86 was reviewed on 2/19/25 at 9:39 a.m. Diagnoses included, but were not limited to, type 2 diabetes, occlusion and stenosis of the carotid artery, peripheral vascular disease (PVD), and atherosclerotic heart disease. The Admission Minimum Data Set (MDS) assessment, dated 2/5/25, indicated the resident was moderately impaired for daily decision making and he did not receive an antiplatelet medication (a medication that prevents blood clots from forming) during the last seven days. A Physician's Order, dated 1/29/25, indicated the resident was to receive Plavix (an antiplatelet medication) 75 milligrams (mg) in the morning. The January 2025 Medication Administration Record (MAR) indicated the resident received the Plavix on 1/30/25 and 1/31/25. The February 2025 MAR indicated the resident received the Plavix daily 2/1-2/19/25. During an interview on 2/21/25 at 3:25 p.m., the MDS Coordinator indicated the antiplatelet should have been coded and a modification of the MDS would be completed. 10770 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The record for Resident D was reviewed on 2/20/25 at 10:21 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Parkinson's disease, history of falling, depressive disorder, anxiety disorder, epilepsy, heart disease, kidney disorder, and stroke. The 2/3/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and received an antipsychotic medication. The next section under medications was checked with no if the resident received scheduled antipsychotic medications. A Physician's Order, dated 11/20/24 and on the current 2/2025 Physician's Order Summary, indicated Risperidone (an antipsychotic medication) 2 milligrams (mg), give 1 tablet by mouth one time a day. During an interview on 2/21/25 at 4:00 p.m., the MDS Coordinator indicated the Quarterly MDS was coded incorrectly for the use of scheduled antipsychotics. 32664 4. Record review for Resident F was completed on 2/19/25 at 9:11 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation, heart failure, hypertension, Parkinson's, anxiety, depression, and chronic obstructive pulmonary disease. The Admission Minimum Data Set (MDS) assessment, dated 11/15/24, indicated the resident was cognitively intact. The resident had received an insulin injection 1 day and there were 0 orders for insulin checked on the assessment. A Physician's Order, dated 11/11/24, was for Trulicity (glucagon-like peptide-1 [GLP-1] agonist) (medication to treat diabetes); inject 0.5 ml (milliliters) in the morning every Monday. The record lacked any documentation the resident received insulin during the MDS assessment period. During an interview on 2/24/25 at 11:20 a.m., the MDS Coordinator indicated she was unaware the Trulicity was not supposed to be marked as insulin and should have been marked under the section of hypoglycemic medication. 3.1-31(i)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 10770 Based on observation, record review, and interview, the facility failed to ensure professional standards of quality were maintained related to the intent to borrow medications from another resident during medication pass for 1 of 6 residents and 1 of 5 nurses observed during medication pass. (Resident C and LPN 1) Finding includes: During medication pass on 2/18/25 at 8:03 a.m., LPN 1 was observed removing Resident C's medications from the punch cards and then placing all of them into the medication cup. After pouring all of the medications, she entered the resident's room and administered all of the medications to her. At that time, the resident had requested Tylenol for pain. The LPN told the resident she would be back with her Tylenol in just a minute. She walked back to the medication cart, opened the drawer and removed 2 white round tablets into her bare hands from a medication card and placed them into a medication cup and closed the medication drawer. The LPN was asked to remove the card where she had punched the Tylenol from to verify the pills and label. LPN 1 opened the medication cart drawer and started rummaging threw all of the cards. As she kept looking, she stopped and picked up the medication cup of pills and stated, Can I start over? She was then asked where she retrieved the Tylenol tablets from and she stated, I borrowed them from another resident, because she did not have any. The LPN opened the medication drawer again and started rummaging through all of the cards looking for the resident's Tylenol punch card. She was unable to find the card and removed the resident's Tylenol card from which she borrowed the pills. During an interview at that time, LPN 1 indicated she was aware she was not supposed to borrow medications from other residents and there was an emergency drug machine from which she could have obtained the Tylenol. She stated, honestly I have never ran into this problem before with Tylenol. The record for Resident C was reviewed on 2/19/25 at 2:17 p.m. A Physician's Order, dated 2/21/24 and on the current 2/2025 Physician's Order Summary, indicated Acetaminophen 325 milligrams (mg), give two tablets by mouth every 6 hours as needed. During an interview on 2/24/25 at 8:30 a.m., the Director of Nursing (DON) indicted the nurse should not have pulled the Tylenol from another resident's punch card. The current 2013 Medication Administration policy provided by the DON on 2/24/25 at 9:08 a.m., indicated do not touch the medication, either when opening a liquid or dose pack. Do not share or borrow medications from others. 3.1-35(g)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to shaving, washing hair, providing showers, and providing nail care for 6 of 10 residents reviewed for ADLs. (Residents E, D, C, B, F, and L) Findings include: 1. During a random observation on 2/17/25 at 10:46 a.m., Resident E was observed with long and dirty fingernails. During an interview on 2/18/25 at 11:25 a.m., the resident indicated she wanted her fingernails cleaned and cut. She also indicated she did not always receive a bed bath or a shower. During random observations on 2/19/25 at 9:10 a.m. and 2:50 p.m., and on 2/20/25 at 9:45 a.m. and 11:45 a.m., the resident was observed with long dirty fingernails and greasy hair. She indicated she had not received a shower or bed bath. During an interview on 2/21/25 at 8:17 a.m., the resident indicated she received a bed bath the previous day and her hair was finally washed. She was observed in bed at that time, but her fingernails were still long and dirty as she indicated they were not cut on the bath day. The record for Resident E was reviewed on 2/19/25 at 10:50 a.m. Diagnoses included, but were not limited to, multiple sclerosis, quadriplegia, chronic pain, anxiety disorder, and low back pain. The 1/24/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a range of motion impairment to both sides of her upper and lower extremities. Showering and bathing was not attempted due to a medical condition or safety concerns. The resident was dependent on staff for personal hygiene. A Care Plan, revised on 5/13/22, indicated the resident had an ADL self care performance deficit and required assistance with ADLs. A Care Plan, revised on 8/30/24, indicated the resident had a behavior problem related to refused or resisted care. The CNA Task section indicated the resident was to receive a shower every Monday and Thursday during the day shift and lacked documentation that the resident was provided nail care. Shower Sheets indicated the form was blank on 1/16/25 and the resident received a shampoo on 1/27/25. The next and last shampoo was on 2/3/25. During an interview on 2/21/25 at 8:25 a.m., the Assistant Director of Nursing indicated the resident's nails were in need of being cleaned and trimmed. She indicated her hair was washed on 2/20/25 as she got a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/25 at 2:15 p.m., the Director of Nursing indicated if there was no documentation a bed bath was completed then a shower was given. She would instruct the CNAs to complete the bath sheet as far as shampoos were concerned. 2. During an interview on 2/17/25 at 2:34 p.m., Resident D indicated he would like a shower once a week, and right now he was not getting them that often. He also indicated he needed to go to the barber for a haircut and shave. At that time, the resident's fingernails were long and dirty. During random observations on 2/19/25 at 8:53 a.m., 1:42 p.m., and 2:43 p.m., on 2/20/25 at 9:52 a.m. and 11:36 a.m., and on 2/21/25 at 8:29 a.m., the resident was observed in bed. At those times, his fingernails were long and dirty and he was unshaven. During an interview on 2/21/25 at 8:29 a.m., LPN 5 indicated the resident's fingernails were long and dirty. At 8:36 a.m., the Assistant Director of Nursing (ADON) was shown the resident's long and dirty fingernails as well as his facial hair. The record for Resident D was reviewed on 2/20/25 at 10:21 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, Parkinson's disease, history of falling, depressive disorder, anxiety disorder, epilepsy, heart disease, kidney disorder, and stroke. The 2/3/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and needed partial to moderate assistance with bathing, personal hygiene, and rolling to the left and right, the ability to roll from lying on his back, and roll to the left or right. The resident had no behaviors coded. A Care Plan, revised on 11/26/24, indicated the resident had an ADL self care performance deficit and required assistance with ADLs. A Care Plan, revised on 1/6/25, indicated the resident had a behavior problem related to refusing showers and care at times. The CNA Task section lacked documentation of nail care completed and any indications the resident had refused nail care. Shower Sheets, dated 12/2024 through 2/2025, indicated the resident was not shaved. The resident received a shower on 2/3, 2/6, 2/13/25 for the month of February. During an interview on 2/21/25 at 8:36 a.m., the ADON indicated his nails were in need of trimming. During an interview on 2/21/25 at 2:15 p.m., the Director of Nursing indicated she would instruct her staff to complete the bath sheets to indicate if the resident received a shave or shampoo. She also indicated if it did not say bed bath or refused then the resident received a shower. 3. During random observations on 2/19/25 at 8:51 a.m., 1:42 p.m., and 2:39 p.m., and on 2/20/25 at 9:50 a.m. , Resident C was observed in bed. At those times, her fingernails on the left hand were long and digging into her skin, as her fingers were contracted. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/25 at 11:30 a.m., CNA 1 and CNA 2 were observed providing incontinence care for the resident. At that time, CNA 2 was asked to observe the resident's left hand and her fingernails. The CNA indicated her nails were very long and in need of trimming. She indicated nail care was done when needed or if the resident had asked for their nails to be trimmed. On 2/21/25 at 8:30 a.m., the resident was observed with long fingernails on her left hand. The resident indicated at that time, CNA 2 had told her she would come back and cut her nails but she never did. The record for Resident C was reviewed on 2/19/25 at 2:17 p.m. Diagnoses included, but were not limited to, type 1 diabetes, heart disease, heart failure, depressive disorder mood disorder, anemia, and schizophrenia. The 11/28/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and had no functional limitation of range of motion to her upper extremities. She needed partial to maximal assistance with personal hygiene. The Care Plan, revised on 12/9/24, indicated the resident had a behavior problem related to the refusal of care including showers and baths and ADL care. The CNA Task section lacked documentation of nail care or any indications the resident refused nail care. During an interview on 2/21/25 at 8:36 a.m., the Assistant Director of Nursing indicated the resident's fingernails were long and digging into her left hand. 4. The closed record for Resident B was reviewed on 2/21/25 at 11:46 a.m. The resident was discharged home on 12/30/24. Diagnoses included, but were not limited to, type 2 diabetes, schizophrenia, high blood pressure, syncope, major depressive disorder, heart disease, and osteoarthritis. The 12/27/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and needed partial to moderate assist for bathing. The CNA Task section indicated the resident was to receive a shower every Monday and Thursday evening. The Shower Sheets for 10/2024 - 12/1014 indicated the following: - The resident received a shower or bed bath on 10/2/24, 10/4/24, 10/7/24, and 10/9/24 for the month of 10/2024. The resident refused a shower on 10/31/24. - The resident refused a shower or bed bath on 11/7/24, 11/11/24, and 11/14/24. There were no other showers or bed baths documented for the resident in 11/2024. - The resident refused a shower on 12/5/24. There were no other shower sheets or documentation in 12/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/24/25 at 11:00 a.m., the Assistant Director of Nursing indicated the CNAs were not documenting in the point of care task charting when they completed a shower, so the facility had put an order in for the nurse to make sure the resident received a shower on their shower days. The order was discontinued for the resident on 11/22/24 and there was no other order put in for the nurses to monitor and document when the resident received a shower after 11/22/24. There were no other shower sheets available to review after 11/22/24. 32664 5. On 2/17/25 at 1:40 p.m., Resident F was observed lying in bed. His fingernails were long with dark debris underneath them. He indicated he would have liked them cut and cleaned, but the staff had not offered to help him. On 2/19/25 at 8:56 a.m., Resident F was observed lying in bed. His fingernails were still observed to be long with dark debris underneath them. Record review for Resident F was completed on 2/19/25 at 9:11 a.m., Diagnoses included, but were not limited to, diabetes mellitus, Parkinson's disease, anxiety, depression, and chronic obstructive pulmonary disease. The Admission Minimum Data Set (MDS) assessment, dated 11/15/24, indicated the resident was cognitively intact. The resident required a substantial maximal assistance for bathing and personal hygiene. A Care Plan, dated 11/9/24 and revised on 11/11/24, indicated the resident had an ADL self care performance deficit related to a decline in functional status, weakness, and Parkinson's disease. The resident required a substantial maximal assist for personal hygiene. The helper did more than half the effort. The record lacked any documentation the staff had performed fingernail care for the resident. During an interview on 2/19/25 at 2:57 p.m., the Director of Nursing (DON) indicated the CNAs do not document anywhere when they clipped the resident's fingernails. She would have staff clean and cut his nails right away. 43293 6. On 2/17/25 at 10:24 a.m. and again on 2/19/25 at 9:26 a.m., Resident L was observed in the dining room. His fingernails were long and dirty and his face was unshaven. His right wrist was fixed in a hyperextended (bent backwards) position, and was supporting his head. His fingernails were indenting into his face. On 2/18/25 at 10:38 a.m., the resident was observed in a Broda chair in his room. He was in the same position, leaning to his right side, supporting his head with his hyperextended hand. His fingernails remained long and dirty, and his face unshaven. The record for Resident L was reviewed on 2/19/25 at 3:57 p.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, and adult failure to thrive. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/30/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment for daily decision making and he required substantial/maximum assistance with ADLs. A Care Plan, revised on 12/4/24, indicated the resident had self-care deficits, required maximum assistance with ADLs, and refused shaving and nail care. A review of the CNA Shower Sheets from January and February 2025 did not indicate the resident refused care. There was no documentation that nail care was attempted or completed. During an interview on 2/21/25 at 2:43 p.m., the Director of Nursing indicated she would have someone shave the resident and cut his nails. This citation relates to Complaint IN00443889. 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to ensure medications were administered and/or held per blood pressure parameters for 4 of 6 residents reviewed for unnecessary medications. The facility also failed to ensure pre and post respiratory assessments were completed for 1 of 2 residents reviewed for hospitalization , and areas of discoloration, peeling skin, and edema were assessed and monitored for 2 of 9 residents reviewed for skin conditions non-pressure related and 2 of 2 residents reviewed for edema. (Residents 59, M, 65, 87, F, 81, 75, and 24) Findings include: 1. The record for Resident 59 was reviewed on 2/20/25 at 2:34 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic kidney disease, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/25, indicated the resident was cognitively intact. A current Care Plan indicated the resident had altered cardiovascular status related to hypertension, congestive heart failure, and atrial fibrillation (an irregular heartbeat). Interventions included, but were not limited to, administer medications per medical provider's order. A Physician's Order, dated 11/9/24 and listed as current on the February 2025 Physician's Order Summary (POS), indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) 10 milligrams (mg) three times a day. The medication was to be held if the resident's systolic (top number) blood pressure (BP) was greater than 100. The December 2024 Medication Administration Record (MAR) indicated the Midodrine was not held on the following dates and time with the corresponding BP readings: - 9:00 a.m.: 12/9/24 104/63, 12/18/24 106/52, 12/23/24 122/70, and 12/24/24 124/83. - 3:00 p.m.: 12/1/24 101/57, 12/14/24 103/62, 12/23/24 102/63, 12/24/24 112/69, 12/25/24 112/60, and 12/26/24 118/58. - 9:00 p.m.: 12/3/24 116/64, 12/8/24 110/70, 12/9/24 109/60, 12/14/24 118/68, 12/18/24 110/58, 12/19/24 121/60, 12/21/24 128/80, and 12/23/24 101/62. The January 2025 MAR indicated the Midodrine was not held on the following dates and time with the corresponding BP readings: - 9:00 a.m.: 1/6/25 128/72, 1/7/25 117/61, 1/9/25 132/78, 1/13/25 132/76, 1/14/25 128/78, and 1/30/25 132/78. - 3:00 p.m.: 1/3/25 106/54, 1/8/25 112/68, 1/9/25 112/59, 1/14/25 118/68, and 1/31/25 124/68. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9:00 p.m.: 1/1/25 101/67, 1/3/25 106/51, 1/11/ 25 112/50, 1/14/25 122/74, and 1/31/25 124/68. The February 2025 MAR indicated the Midodrine was not held on the following dates and time with the corresponding BP readings: - 9:00 a.m.: 2/5/25 137/80. - 3:00 p.m.: 2/13/25 102/60. - 9:00 p.m.: 2/13/25 102/60, 2/17/25 121/76, and 2/19/25 126/70. During an interview on 2/21/25 at 3:30 p.m., the Director of Nursing indicated the medication should have been held per the parameters. 10770 2. The record for Resident M was reviewed on 2/20/25 at 3:08 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, stroke, atrial fibrillation, heart failure, and high blood pressure. The 1/17/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and received dialysis while a resident. A Care Plan, revised on 8/10/22, indicated the resident had an altered cardiovascular status. The approaches were to administer medications as ordered. A Physician's Order, dated 9/30/24, indicated the resident was to receive Midodrine HCl (a medication used to raise the blood pressure) 5 mg, give 1 tablet by mouth every 6 hours as needed for a systolic blood pressure of less than 100. A Physician's Order, dated 1/27/24, indicated the resident was to receive Metoprolol Tartrate (a medication used to lower the blood pressure and heart rate) 25 milligrams (mg), give 12.5 mg by mouth two times a day every Tuesday, Thursday, Saturday, and Sunday for high blood pressure and hold if the systolic blood pressure (top number) was less than 110. The 12/2024 Medication Administration Record (MAR), indicated the Midodrine was not administered on the following days and the systolic blood pressure was less than 100: - 12/14/24 blood pressure was 98/63 - 12/23/24 blood pressure was 92/57 - 12/24/24 blood pressure was 91/65 - 12/30/24 blood pressure was 85/54 The 12/2024 MAR indicated the Metoprolol was administered on the following days when the systolic blood pressure was less than 110: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 12/23/24 blood pressure was 92/57 - 12/24/24 blood pressure was 91/65 - 12/31/24 blood pressure was 100/61 The 1/2025 MAR indicated the Midodrine was not administered on the following days and the systolic blood pressure was less than 100: - 1/7/25 blood pressure was 94/57 - 1/12/25 blood pressure was 93/62 - 1/17/25 blood pressure was 86/50 - 1/19/25 blood pressure was 97/68 - 1/21/25 blood pressure was 90/60 - 1/30/25 blood pressure was 98/61 The 1/2025 MAR indicated the Metoprolol was administered on the following days when the systolic blood pressure was less than 110: - 1/9/25 blood pressure was 107/61 - 1/30/25 blood pressure was 108/70 The 2/2025 MAR indicated the Midodrine was not administered on the following days and the systolic blood pressure was less than 100: - 2/1/25 blood pressure was 99/61 The 2/2025 MAR indicated the Metoprolol was administered on the following days when the systolic blood pressure was less than 110: - 2/1/25 blood pressure was 99/61 - 2/2/25 blood pressure was 103/86 - 2/13/25 blood pressure was 108/60 - 2/16/25 blood pressure was 104/62 During an interview on 2/21/25 at 2:01 p.m., the Director of Nursing had no additional information to provide. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The record for Resident 65 was reviewed on 2/19/25 at 3:04 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) high blood pressure, anxiety, dehydration, alcohol abuse, wheezing, hypoxemia, pleural effusion, and seizures. The resident was admitted to the hospital on 1/13/25 and returned on 1/29/25. The Admission Minimum Data Set (MDS) assessment, dated 2/5/25, indicated the resident was cognitively intact for daily decision making. A Nurse's Note, dated 1/13/25 at 11:30 a.m., indicated the resident's oxygen saturation was 72% while on oxygen. At that time, the resident was given a breathing treatment and her oxygen saturation was 92%. Approximately 30 minutes later, the resident was complaining of shortness of breath and her oxygen saturation was 74%. The oxygen flow was increased from four liters per minute to five liters per minute and another breathing treatment was administered to the resident. After the treatment, the oxygen was decreased back to four liters and her oxygen saturation was 87%. Per the Nurse Practitioner (NP), no orders to send the resident out to the hospital were received. Will continue to monitor the resident. A Skilled Documentation Note, dated 1/13/25 at 2:34 p.m., indicated the resident was alert and oriented times three and received oxygen per nasal cannula. An NP Note, dated 1/13/25 at 3:00 p.m., indicated the resident had a longstanding history of COPD and she wore oxygen at four liters per nasal cannula. This morning, she indicated she could not breathe well, her pulse oximetry was 79% and I spoke with the nurse and told her to administer nebulizer treatments. After the treatments, the oximetry was 93% and she indicated she felt much better. Returned later, about 1-2 hours and the nurse was concerned. The resident's oximetry for the nurse was 82%, it was rechecked by myself and it was 88% to 91% vacillating [wavering]. The resident indicated she felt good. An assessment of the resident was as follows: 99.1 pounds; 10/25/24 12:29 p.m. Pulse: 98 beats per minute 10/30/24 6:31 a.m. Blood Pressure: 124/76; 10/30/24 10:05 a.m. oxygen Saturation: 92%; 10/30/24 6:31 a.m. Temperature: 98 Fahrenheit; 10/30/24 6:31 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respiratory Rate: 30 Breaths per minute; 10/30/24 6:31 a.m. The resident's lung sounds were with rhonchi and mild wheezing to auscultation bilaterally. All of the above vital signs were from a previous admission and not current. A Nurse's Note, dated 1/13/25 at 7:04 p.m., indicated the resident continued to utilize accessory muscles to breathe. Her respirations were labored and at 36 breaths per minute as she was having difficulty speaking. Her blood pressure was 142/64, pulse 103 beats per minute, temperature was 99 degrees, and her oxygen saturation was 70% on four liters of oxygen. A nebulizer treatment was administered and the oxygen saturation went up to 73%. The resident had requested to be sent out to the hospital. 911 was called and the resident was transported to the hospital. The arrival time to the Emergency Department (ED) was at 7:13 p.m. The resident was admitted for acute hypoxic respiratory failure and tested positive for RSV (Respiratory Syncytial Virus), and was intubated in the ED. She was not responsive and had bilateral rales in both lungs with mild wheezing. She was admitted to the ICU at 11:30 p.m. Physician's Orders, dated 1/9/25, indicated the following: - Albuterol Sulfate HFA Inhalation Aerosol Solution 108 micrograms (mcg) 2 puffs inhale orally every six hours as needed (PRN) for wheezing and shortness of breath. - Budesonide Inhalation Suspension (a steroid inhaler) 0.5 milligrams (mg)/2 milliliters (ml), inhale orally two times a day for COPD. - Albuterol Sulfate Inhalation Nebulization Solution 2.5 mg/3 ml, 1 vial inhale orally via nebulizer four times a day for shortness of breath, wheezing, or chest tightness. The 1/2025 Medication Administration Record (MAR), indicated the PRN inhaler was not signed out at all on 1/13/25. The Budesonide inhaler was signed out for the a.m. shift as well as the Albuterol nebulizer treatments at 9:00 a.m., 1:00 p.m., and 5:00 p.m. Physician's Orders dated 1/10/25 indicated the following: - Yupelri Inhalation Solution (a medication used to treat COPD) 175 mcg/3 ml 1 vial inhale orally one time a day for COPD - Arformoterol Tartrate Inhalation (a medication used to treat COPD) Solution 15 mcg/2 ml, inhale orally in the morning for COPD. - Ipratropium-Albuterol Solution 0.52.5 mg/3 ml, 1 vial inhale orally two times a day for COPD. The 1/2025 MAR indicated all of the above medications ordered on 1/10/25 were signed out as being administered for the a.m. shift on 1/13/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation of pre or post nebulizer assessments that included breath sounds, vital signs or a pulse oximetry. There were no other assessments of lung sounds or oxygen saturations checked between 3:00 p.m. and 7:00 p.m. During an interview on 2/21/25 at 4:00 p.m., the NP indicated he was notified about the resident earlier in the day and told the nurse to give the breathing treatments, and after those, her oxygen saturation was higher. He indicated he came back around 3:00 p.m. and assessed her again. The resident was responsive and her oxygen saturation was between 88% and 90%, so he did not give orders to send her to the emergency room . The NP indicated he was not in a position to determine if the nurse should have assessed the resident's oxygen saturation more frequently and assessed the resident's lung sounds before and after the breathing treatments. During an interview on 2/24/25 at 8:30 a.m., the Director of Nursing had no additional information to provide. 32664 4. On 2/17/25 at 10:25 a.m., Resident 87 was observed lying in bed. The resident had large reddish purple discoloration to the top of his left hand. The resident indicated he had probably bumped it but was unsure. On 2/20/25 at 9:01 a.m., Resident 87 was lying in bed. The discoloration was still observed to the top of his left hand. Record review for Resident 87 was completed on 2/20/25 at 11:49 a.m. Diagnoses included, but were not limited to, anemia, atrial fibrillation (irregular heartbeat), hypertension, and dementia. The Admission Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the resident was moderately cognitively impaired. The resident required a partial moderate assistance for bed mobility and transfers. A Care Plan, dated 12/13/24, indicated the resident was at risk for abnormal bleeding or hemorrhage due to the use of aspirin. An intervention included to monitor for signs and symptoms of bleeding including bruising. A Weekly Skin Assessment, dated 2/14/25, indicated no skin areas were noted. There was a lack of documentation to indicate the resident's discoloration was assessed and being monitored. During an interview on 2/20/25 at 4:24 p.m., the Director of Nursing (DON) indicated there was no documentation to indicate the discoloration had been assessed or was being monitored. 5. On 2/17/25 at 1:46 p.m., Resident F was observed lying in bed. The resident indicated he had been sent out to the hospital a few times since he was admitted . He left the facility last summer and then he was readmitted to the facility in the fall of last year. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review for Resident F was completed on 2/19/25 at 9:11 a.m. Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation (irregular heartbeat), heart failure, hypertension, Parkinson's disease, anxiety, depression, and chronic obstructive pulmonary disease (COPD). The Admission Minimum Data Set (MDS) assessment, dated 7/12/24, indicated the resident was cognitively intact. The resident had received antipsychotic, antidepressant, anticoagulant, antibiotic, diuretic, and antiplatelet medications. The resident discharged to the hospital on 8/13/24 and readmitted to the facility on [DATE]. The After Visit Summary from the hospital, dated 8/21/24, indicated there were no changes made to the resident's medications. The medication list included the following: albuterol inhaler amiodarone (heart rhythm medication) 200 mg (milligrams) daily Abilify (antipsychotic medication) 5 mg daily Lipitor (cholesterol medication) 40 mg every evening Breo Ellipta (inhaler) 200-25 mcg (microgram), 1 puff daily Tums (antacid medication) Plavix (antiplatelet medication) 75 mg daily dapagliflozin propanediol (antidiabetic agent) 10 mg daily docusate sodium (stool softener) 100 mg daily Eliquis (blood thinner) 5 mg every 12 hours Entrestro (heart medication) 24-26 every 12 hours escitalopram (antidepressant medication) 20 mg daily famotidine (heartburn medication) 20 mg daily furosemide (diuretic medication) 20 mg daily Norco (pain medication) 1 tablet every 6 hours as needed metformin (diabetic medication) 500 mg twice a day metoprolol succinate XL (heart medication) 50 mg daily potassium chloride sa (treats low potassium) 20 mEq (milliequivalent) daily (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Flomax (prostate and bladder medication) 0.4 mg every evening Ultram (pain medication) 50 mg every 12 hours. A Pharmacy New Admission Recommendation, dated 8/23/24, indicated, .After review of prior to hospital medications and current active medications upon admission to the nursing home there is a transcribing error. Medication orders can be transcribed incorrectly during a transition period from various healthcare locations. Recommendation: Please review and update the transcription errors. DC summary includes the following orders which are not currently active in PCC: BreoEllipta 200-25 mcg one puff daily Eliquis 5 mg every 12 hours Entresto 24-26 mg every 12 hours Escitalopram 20 mg daily Famotidine 20 mg daily Furosemide 20 mg daily Metformin 500 mg twice a day Metoprolol succinate 50 mg XL daily Potassium Chloride 20 mEq daily. Please clarify if these medications should be resumed The August 2024 Medication Administration Record indicated the following medications were not re-started when the resident readmitted to the facility on [DATE]: escitalopram 20 mg daily BreoEllipta 200-25 mcg, 1 puff daily furosemide 20 mg in the morning metoprolol succinate XL 50 mg daily potassium chloride sa 20 mEq daily famotidine 20 mg daily Eliquis 5 mg twice a day Entresto 24-26 mg twice a day (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	metformin 500 mg twice a day There was a lack of documentation to indicate why the resident's medications had not been re-started after re-admission on 8/21/24 until his discharge home on 8/29/24. During an interview on 2/20/25 at 10:01 a.m., the Director of Nursing indicated she was unsure why the resident's medications had not re-started after his hospitalization . The pharmacy recommendation was not followed up on. The resident discharged home on 8/29/24 with his full medication list. 43293 6. The record for Resident 81 was reviewed on 2/21/25 at 9:07 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), diabetes type 2, hypertension, and Alzheimer's. The 1/10/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment for daily decision making. A Physician's Order, dated 5/1/24, indicated Carvedilol (a medication for heart failure and high blood pressure) oral tablet 6.25 milligrams (mg) by mouth two times a day. Hold for a systolic blood pressure (top number of a blood pressure reading) of 100 or lower or diastolic blood pressure (bottom number of a blood pressure reading) of 60 and lower and notify the physician. The eMAR (electronic medication administration record) indicated the medication was not held per ordered parameters for the following dates: the p.m. blood pressure on 2/3/25 was 147/59, the p.m. blood pressure on 2/12/25 was 128/50, the p.m. blood pressure on 2/15/25 was 141/51, the p.m. blood pressure on 2/16/25 was 137/51, and the p.m. blood pressure on 2/17/51 was 135/58. During an interview on 2/21/25 at 2:43 p.m., when informed of the findings, the Director of Nursing indicated she would need to do an in-service with staff regarding holding medications with parameters. 7. During observation of a bed bath on 2/18/25 at 10:45 a.m., swelling was observed to Resident 75's right arm and hand. The skin on his feet was scaly, peeling and had a dark discoloration. At that time, CNA 5 indicated the resident's arm and hand were swollen, and she did not know or use any treatment for his feet. On 2/19/25 at 1:43 p.m., the resident was observed lying in bed. His right hand and elbow area appeared swollen. During an observation of wound care on 2/20/25 at 10:07 a.m., the Assistant Director of Nursing (ADON) washed the resident's feet and pulled off large pieces of thick, scaly skin. At that time, the ADON indicated there was no current treatment for his feet, but they needed to be treated. The record was reviewed for Resident 75 on 2/19/25 at 11:14 a.m. Diagnoses included, but were not limited to, encephalopathy, alcohol dependence, epilepsy, and vascular dementia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/16/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and dependent for ADLs and transfers. There was no order or Care Plan to monitor or treat the edema. During an interview on 2/20/25 at 3:15 p.m., the ADON indicated she did not know why the resident's hand and arm were swollen, but she would ask the Nurse Practitioner. During an interview on 2/20/25 at 3:28 p.m., the Nurse Practitioner indicated the resident had edema to his right arm and hand, but he did not know why. He indicated they may need to do an MRI to find out why he was swelling, but no interventions were currently in place. 8. On 2/17/25 at 2:08 p.m., Resident 24 was observed lying in bed. His legs appeared swollen and his socks were digging into his skin above his ankles. On 2/18/25 at 10:25 a.m., the resident was observed resting in bed. His legs continued to appear swollen and he complained that they felt numb. On 2/19/25 at 9:05 a.m., the resident was observed resting in a chair in his room. The swelling remained visible to both of his legs. His socks were indented approximately 1/2 inch into each leg. He complained of pain to both legs. On 2/20/25 at 2:46 p.m., the resident was observed sitting in his wheelchair in his room. Again his socks were observed indenting approximately 1/2 inch into each leg. He indicated the socks were uncomfortable. The resident's record was reviewed on 2/20/25 at 1:28 p.m. Diagnoses included, but were not limited to, Alzheimer's, diabetes, atrial fibrillation (heart arrhythmia), and heart failure. The 1/16/25 Annual Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, and was dependent in ADLs and transfers. A Nurse Practitioner (NP) Progress Note, dated 1/29/25, indicated the resident had trace edema. There was no order or Care Plan to monitor or treat the edema. During an interview on 2/20/25 at 3:02 p.m., LPN 6 indicated she did not know of the resident having a problem with edema (swelling) to his legs. During an interview on 2/20/25 at 3:28 p.m., the NP indicated he was going to see the resident, that he might need Lasix (a diuretic) and/or TED hose (compression stockings), and he thought he previously ordered TED hose for the resident. 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 10326 Based on record review and interview, the facility failed to ensure treatments were completed as ordered for 1 of 4 residents reviewed for pressure ulcers. (Resident 59) Finding includes: During an interview on 2/17/25 at 1:53 p.m., Resident 59 indicated she had a sore on her bottom and staff didn't always do her treatment. The record for Resident 59 was reviewed on 2/20/25 at 2:34 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic kidney disease, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/25, indicated the resident was cognitively intact and she had two Stage 3 pressure ulcers (full thickness tissue loss but bone, tendon, and muscle are not exposed). A Care Plan, dated 1/7/25, indicated the resident had an actual alteration in skin integrity related to pressure areas to the left buttock and sacrum. Interventions included, but were not limited to, administer treatments as ordered by the medical provider. A Skin and Wound Note, dated 1/2/25 at 12:04 p.m., indicated the resident had new skin concerns for wounds to the sacrum. The wounds were identified as Stage 3 pressure ulcers that had developed in the facility. A Physician's Order, dated 1/3/25, indicated the resident's sacrum was to be cleansed with soap and water, collagen (a type of dressing) was to be applied, and the wound covered with a border gauze dressing every day shift for wound care. The January 2025 Treatment Administration Record (TAR), indicated the treatment was not signed out as being completed on 1/5/25, 1/19/25, 1/27/25, and 1/30/25. A Physician's Order, dated 2/7/25, indicated the Cygnus (a skin substitute) was to be left in place to the resident's sacrum. The border gauze dressing was to be changed every day shift. The February 2025 TAR, indicated the treatment was not signed out as being completed on 2/9/25. A Physician's Order, dated 2/13/25, indicated the Cygnus was to be left in place to the resident's sacrum. Change border gauze dressing. If the Cygnus dislodged, cleanse the sacrum with wound cleanser, pat dry with gauze, apply collagen, and cover with a border gauze dressing every day shift for wound care. The February 2025 TAR indicated the treatment had not been signed out as being completed on 2/15/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/21/25 at 3:30 p.m., the Director of Nursing indicated the resident's treatments should have been completed as ordered. 3.1-40(a)(2)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 43293 Based on observation, record review, and interview, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 2 residents reviewed for mobility. (Resident L) Finding includes: On 2/17/25 at 10:24 a.m. and again on 2/19/25 at 9:26 a.m., Resident L was observed in the dining room. His right wrist was fixed in a hyperextended (bent backwards) position, and was supporting his head. His fingers appeared contracted (bent or curled). There was nothing in his right hand. On 2/18/25 at 10:38 a.m., the resident was observed in a Broda chair in his room. He was in the same position, leaning to his right side, supporting his head with his hyperextended hand. There was nothing in his right hand. During observations on 2/19/25 at 1:35 p.m., 2/20/25 at 9:26 a.m., and 2/21/25 at 10:29 a.m., the resident was in a similar position, with nothing in his right hand. The record for Resident L was reviewed on 2/19/25 at 3:57 p.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, and adult failure to thrive. The 11/30/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment for daily decision making and he required substantial/maximum assistance with ADLs. A Care Plan, revised on 10/18/23, indicated a washcloth should be placed in the resident's right hand for 4-6 hours a day up to 7 days a week. There was no documentation in the treatment record of a washcloth being placed in the resident's hand. During an interview on 2/21/25 at 2:43 p.m., the Director of Nursing was informed of the findings, nodded, and offered no further information. 3.1-42(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 10326 Based on observation, record review, and interview, the facility failed to ensure smoking materials were secured for 1 of 1 resident reviewed for smoking. (Resident 56) Finding includes: During an interview on 2/17/25 at 2:20 p.m., Resident 56 indicated he was supposed to lock up his cigarettes and lighter when he was done smoking in the mail box located across from the smoking area. The resident indicated he knew he was going to get into trouble, but he rarely locked his cigarettes up because he lost the key to his mail box before and it made him nervous. When asked where his cigarettes were, the resident patted his coat pocket and indicated he had them along with his lighter in his pocket. The resident indicated that he knew better than to smoke in his room. During an interview on 2/19/25 at 1:40 p.m., the resident indicated that his cigarettes and lighter remained in his coat pocket. The record for Resident 56 was reviewed on 2/19/25 at 11:53 a.m. Diagnoses included, but were not limited to, respiratory failure, tracheostomy status, sleep apnea, and nicotine dependence. The Quarterly Minimum Data Set (MDS) assessment, dated 11/15/24, indicated the resident was cognitively intact. A Smoking Assessment, dated 1/31/25, indicated the resident was independent with smoking. A Care Plan, reviewed on 2/13/25, indicated the resident utilized nicotine products. The Resident Smoking Guidelines, provided by the Administrator on 2/24/25 at 8:55 a.m. and identified as current, indicated facility staff would store smoking materials in a secure area when not in use by the resident for both independent and supervised smokers. Smoking safety instructions for all smokers included all smoking materials would be maintained by the facility staff and provided to the resident upon request. Smoking materials were to be returned to the facility staff upon completion of smoking. During an interview on 2/24/25 at 9:10 a.m., the Administrator indicated smoking materials were to be left in the locked mail boxes outside of the smoking area. Each resident had a key and the residents were not to keep their smoking materials. 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 32664 Based on observation, interview, and record review, the facility failed to ensure an indwelling Foley (urinary) catheter collection bag was kept off of the floor and documentation of urinary output was completed for 1 of 1 resident reviewed for urinary catheters. (Resident 73) Finding includes: On 2/17/25 at 10:44 a.m. and 1:54 p.m., Resident 73 was observed lying in bed. The resident's catheter collection bag was lying on the floor next to his bed. During an interview on 2/17/25 at 1:55 p.m., RN 3 indicated the resident's catheter collection bag should not have been laying on the floor. She then went into the resident's room to pick the catheter collection bag off of the floor and hang it so it did not touch the floor. Record review for Resident 73 was completed on 2/21/25 at 9:46 a.m. Diagnoses included, but were not limited to, prostate cancer, end stage renal disease, and obstructive uropathy (obstruction of urine flow). The Quarterly Minimum Data Set (MDS) assessment, dated 12/28/24, indicated the resident was moderately cognitively impaired. The resident had an indwelling urinary catheter. A Care Plan, dated 3/6/24, indicated the resident had an indwelling Foley catheter related to obstructive uropathy. An intervention included to provide catheter care every shift and when necessary. Notify the medical provider if urine was an abnormal color, consistency, or odor. The February 2025 Physician's Order Summary, indicated the resident had an indwelling urinary catheter and to measure and record output every shift. The January and February 2025 Treatment Administration Records lacked documentation urinary output was completed on the following dates and shifts: Day Shift: 2/9/25 and 2/17/25 Evening Shift: 1/24/25 Night Shift: 1/25/25, 1/27/25, 2/3/25, and 2/18/25 During an interview on 2/24/25 at 8:50 a.m., the Director Of Nursing (DON) indicated the staff should be documenting the resident's urinary output every shift. She could not provide any documentation the urinary output had been documented on the above dates and shifts. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Catheter Care and received as current from the DON on 2/24/25, indicated, .III. Catheter care: .V. Check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back to the bladder. VI. Document and report any adverse findings to nurse . 3.1-41(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure food consumption logs were completed for residents with a history of weight loss for 2 of 2 residents reviewed for nutrition. (Residents 65 and 67) Findings include: 1. During an interview on 2/17/25 at 10:57 a.m., Resident 65 indicated she had a recent weight loss. The record for Resident 65 was reviewed on 2/19/25 at 3:04 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) high blood pressure, anxiety, dehydration, and alcohol abuse. The Admission Minimum Data Set (MDS) assessment, dated 2/5/25, indicated the resident was cognitively intact for daily decision making, held food in her mouth, and had complaints of pain when she swallowed. The resident weighed 85 pounds, received a mechanically altered diet, and has had a significant weight loss. The Care Plan, revised on 2/10/25, indicated the resident had the potential for an altered nutrition status. The approaches were to monitor meal intake. The resident's weight was 91 pounds on 1/10/25 and 85 pounds on 2/12/25, which was a 6.59% weight loss in one month. A Physician's Order, dated 2/11/25, indicated a two gram sodium puree texture diet with nectar thick liquids and double portions at all meals for weight gain. The meal consumption log indicated there was no breakfast documented on 2/12/25, 2/13/25, 2/17/25, and 2/18/25. There was no lunch documented on 2/12/25, 2/13/25, 2/17/25, 2/18/25 and no dinner documented on 2/6/25, 2/11/25, 2/16/25 and 2/17/25. During an interview on 2/21/25 at 2:30 p.m., the Director of Nursing indicated the resident had gained weight since 2/12/25 and meal consumptions were to be documented after each meal. 32664 2. On 2/18/25 at 9:17 a.m., Resident 67 was observed lying in bed. He indicated he didn't like to eat much and had lost weight. Record review for Resident 67 was completed on 2/21/25 at 12:00 p.m. Diagnoses included, but were not limited to, stroke, heart failure, hypertension, seizure disorder, and depression. The resident had an impairment on one side of his upper and lower extremities for a functional limitation in range of motion. The resident required supervision for eating. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, dated 6/14/24 and revised on 12/26/24, indicated the resident had the potential for altered nutrition related to left hemiplegia (muscle weakness), depression, and weight loss. An intervention included to monitor meal intake. The resident's weight on 8/8/24 was 136.8 pounds. On 2/10/24, the resident weighed 127.6 pounds. This was a weight loss of 6.73% in 6 months. The Task Nutrition-Amount Eaten Logs were documented with percentage of meals eaten. The last 30 days lacked documentation for the following meals: - breakfast: 1/26/25, 2/7/25, 2/10/25, 2/12/25, 2/13/25, 2/15/25, 2/16/25, and 2/17/25 - lunch: 1/26/25, 2/7/25, 2/10/25, 2/12/25, 2/13/25, 2/15/25, 2/16/25, and 2/17/25 - dinner: 2/11/25 and 2/19/25 During an interview on 2/24/25 at 8:50 a.m., the Director of Nursing indicated she was unable to provide any documentation related to the resident's percentage eaten for meals on the above dates. 3.1-46(a)(1)

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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. 10770 Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube (a tube surgically inserted into the stomach that allows for the delivery of food and medication) water flushes and medications were instilled via gravity, and enteral feedings were started at the correct time for 2 of 2 residents reviewed for tube feeding. (Residents 147 and 58) Findings include: 1. On 2/19/25 at 4:21 p.m., LPN 5 was observed preparing a medication for Resident 147. The resident received his medications by the way of a gastrostomy tube. Upon entering the room, the LPN donned gloves and an isolation gown and placed the cups containing the medication on the over bed table. The LPN checked for placement by pulling back any residual in the peg tube. She then proceeded to flush the resident's gastrostomy tube by plunging (pushing) 30 milliliters (mls) of water rather than instilling the water via gravity. She diluted all of the medications with 10 ml of water and added them one at time, and rather than administering them completely via gravity, she pushed most of the medication with the plunger. After the last medication, she plunged another 30 ml of water through the peg tube. During an interview on 2/19/25 at 4:36 p.m., LPN 5 indicated she was aware she was to administer the medications and water flush via gravity and not by plunging them. During an interview on 2/19/25 at 4:38 p.m., the Director of Nursing (DON) indicated medications and water were to be administered via gravity through the peg tube. The current and undated Enteral Tube Medication Administration policy, provided by the DON, indicated the plunger was to be removed from the 60 milliliter (ml) syringe and connect the syringe to the clamped tubing using the appropriate port. Administer each medication separately and flush the tubing between each medication. Place 30 ml of water in syringe and flush tubing using gravity flow and pour dissolved or diluted medication in the syringe allowing medication to flow by gravity. 32664 2. On 2/17/25 at 3:20 p.m., Resident 58 was observed in bed with her eyes closed. The resident had a feeding pump machine next to the bed. The machine had a bottle of tube feeding hanging up with the tubing wrapped around the bottle. The tubing was not connected to the resident and the machine was not turned on. During an interview on 2/17/25 at 3:22 p.m., RN 2 indicated they had just changed shift and she was unaware the resident's tube feeding had not been started. She would go down to the resident's room and start the tube feeding. Record review for Resident 58 was completed on 2/19/25 at 1:42 p.m. Diagnoses included, but were not limited to, stroke, diabetes mellitus, and adult failure to thrive. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, indicated the resident was cognitively intact. The resident had an impairment on one side of the upper and lower extremities for a functional limitation in range of motion. The resident had a feeding tube. A Care Plan, dated 7/17/24, indicated the resident had an activities of daily living self care performance deficit related to a decline in functional status, and received enteral nutrition. The resident was totally dependent on staff for eating. The February 2025 Physician's Order Summary, indicated an enteral feed order for Jevity (fortified liquid nutrition) 1.5 at 50 ml (milliliters) an hour via G-tube (gastrostomy tube, tube inserted into abdomen to deliver nutrition to the stomach). The enteral feed was to start at 2:00 p.m. and stop at 6:00 a.m. every day. 3.1-44(a)(2)

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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. 10326 Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 1 of 4 residents reviewed for oxygen. (Resident 59) Finding includes: On 2/17/25 at 1:56 p.m. and 2:30 p.m., Resident 59 was observed with oxygen in use by the way of a nasal cannula. The resident's portable oxygen tank was set at three liters. At 3:52 p.m., the resident was observed in her room in bed. The resident's oxygen remained in use and her oxygen concentrator was set at three liters. On 2/18/25 at 10:27 a.m. and 11:55 a.m., the resident was observed with her oxygen per nasal cannula in use. The resident's portable oxygen tank was set at three liters. On 2/19/25 at 1:35 p.m., the resident was observed in her room in bed. Her oxygen was in use and the oxygen concentrator was set at three liters. On 2/20/25 at 9:57 a.m. and 2:14 p.m., the resident was observed in her recliner with her oxygen per nasal cannula in use. The portable oxygen tank was set at three liters. On 2/21/25 at 9:18 a.m., the resident was observed in her room in bed. The resident's oxygen was in use and the oxygen concentrator was set at three liters. At 9:20 a.m., LPN 3 observed the resident's oxygen concentrator and indicated it was set at three liters. The record for Resident 59 was reviewed on 2/20/25 at 2:34 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic kidney disease, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 1/30/25, indicated the resident was cognitively intact and she was receiving oxygen while a resident of the facility. A Care Plan, dated 11/8/24, indicated the resident received oxygen therapy related to ineffective gas exchange. A Physician's Order, dated 10/25/24, and listed as current on the February 2025 Physician's Order Summary (POS), indicated the resident was to receive two liters of oxygen continuously every shift via nasal cannula. During an interview on 2/21/25 at 3:30 p.m., the Director of Nursing indicated the resident's portable oxygen tank and concentrator should have been set at two liters. 3.1-47(a)(6)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 10770 Based on observation, record review, and interview, the facility failed to ensure a resident's pain was controlled with over the counter medications for 1 of 5 residents reviewed for pain. (Resident E) Finding includes: During an observation on 2/17/25 at 10:46 a.m., Resident E was observed in her room lying in bed and crying out that she was in pain. During an interview on 2/18/25 at 11:30 a.m the resident indicated an area on her bottom hurt constantly, and all they had given her was over the counter medications, however, she would like something stronger. On 2/19/25 at 9:10 a.m. and 2:50 p.m., the resident was observed lying in bed. At those times, the resident indicated her current pain level was a six out of 10 and all she had received was over the counter Tylenol. She had stopped using the Lidoderm patches because they made her back raw and tender, however, no one had offered any other topical cream for pain. On 2/20/25 at 9:45 a.m., the resident was observed in bed and indicated her pain level was around a five. At 11:45 a.m., her pain was at a six out of 10. The record for Resident E was reviewed on 2/19/25 at 10:50 a.m. Diagnoses included, but were not limited to, multiple sclerosis, quadriplegia, chronic pain, anxiety disorder, and low back pain. The 1/24/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was not receiving scheduled pain medication, but received PRN (as needed) medications. She occasionally had pain that affected her sleep and day to day activities. The resident's pain level was a 5 out of 10. A Care Plan, revised on 12/14/23, indicated the resident had chronic pain related to a decline in functional status, weakness, and multiple sclerosis. The approaches were to observe for pain every shift, provide medication as ordered, and have a pain management consult. A Physician's Order, dated 11/12/22 and listed as current on the 2/2025 Physician's Order Summary, indicated Acetaminophen 325 milligrams (mg), give 2 tablets by mouth every 6 hours as needed for pain. A Physician's Order, dated 11/14/22 and listed on the current 2/2025 Physician's Order Summary, indicated to monitor for pain every shift. A Physician's Order, dated 6/13/24 and discontinued on 12/4/24, indicated Lidocaine Pain Relief 4% patch, apply to low back topically one time a day for chronic back pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR) for 11/2024 indicated the Lidoderm patch had been refused many times during the month. The MAR for the months of 12/2024, 1/2025, and 2/2025, indicated the pain assessment was only signed out as competed by nursing staff, there was no pain level (numbered) assessment completed. The 1/2025 and 2/2025 MARs indicated the pain level each time the resident had asked for the Tylenol ranged from one to four out of 10. A Behavioral Health Note, dated 2/16/25 at 11:00 p.m., indicated the resident was awake and in bed during the session. The resident indicated she was having pain in her legs and back. She stated that nursing was aware. The last Pain Observation Assessment was dated 5/24/24, and indicated the resident had no pain. A Physician's Progress Note, dated 1/27/25 at 12:26 p.m., indicated the resident had leg and muscle cramps. During an interview on 2/20/25 at 11:45 a.m., LPN 3 indicated the resident had nothing ordered for pain except over the counter Tylenol. The resident had not ever expressed a desire to have something more than that and she would let the Nurse Practitioner (NP) know about her complaints. The LPN indicated the resident had a fungal rash going on around the time she had refused the Lidoderm patches, so she did not think the patch caused her to have a rash. There was never any topical pain cream ordered for her. During an interview on 2/21/25 at 8:17 a.m., the resident indicated she received her first dose of Tramadol (a pain medication) and was happy and hoped the medication would relieve some of her pain. During an interview on 2/21/25 at 2:15 p.m., the Director of Nursing was unaware the resident was crying out in pain and if she had been aware, she would have requested something else for her pain. During an interview on 2/21/25 at 4:00 p.m., the NP indicated he was just made aware the resident was having pain to the open area on her buttocks and in her lower back . He ordered Tramadol for her two times a day. The current 2022 Pain Management and Assessment policy, provided by the DON, indicated the 1-10 pain scale for assessing pain was to be used for residents with intact cognition abilities who could or were willing to determine their worst pain ever and no pain using numbers. This citation relates to Complaints IN00443889 and IN00451991. 3.1-37(a)

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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. 10770 Based on observation, record review, and interview, the facility failed to monitor for signs and symptoms of an infection of a resident's perma cath (a long, flexible tube that's inserted into a vein in the neck or chest) used for dialysis for 1 of 2 residents reviewed for dialysis. (Resident M) Finding includes: During a random observation on 2/19/25 at 2:50 p.m., Resident M was observed in bed and dressed in a hospital gown. At that time, there was a clear bandage over his perma cath located on his right upper chest. The resident indicated the perma cath was used for dialysis. The record for Resident M was reviewed on 2/20/25 at 3:08 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes, stroke, and high blood pressure. The 1/17/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and received dialysis while a resident. A Care Plan, revised on 7/1/24, indicated the resident had direct access to the circulatory system related to a right subclavian perma cath. The approaches were to evaluate for signs and symptoms of infection such as redness, tenderness, swelling, pain, drainage and to visually inspect the site each shift. A Physician's Order, dated 3/12/24, indicated check dialysis site (Chest) for signs and symptoms of infection every shift . There was no documentation on the 12/2024, 1/2025 and 2/2025 Medication or Treatment Administration Records of the dialysis site being checked for signs and symptoms of infection. During an interview on 2/21/25 at 2:01 p.m., the Director of Nursing had no additional information to provide. This citation relates to Complaint IN00452308. 3.1-37(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 10770 Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents observed during medication pass. Two errors were observed during 28 opportunities for errors during medication administration. This resulted in a medication error rate of 7.14% (Residents 12 and 147) Findings include: 1. During medication pass on 2/18/25 at 11:27 a.m., LPN 2 was preparing to check Resident 12's blood sugar. The resident's blood sugar was 335 and the LPN indicated she was to receive 33 units of Lispro Insulin. She removed the insulin pen from the medication cart and dialed it to 2 units and primed the pen. She then dialed the pen to 30 units, as it would not dial any further. She administered 30 units to the resident and then removed the needle, placed a new one on the pen and dialed the pen to 3 units and administered the remaining 3 units. She did not prime the second needle before administering the remaining 3 units of insulin. The record for Resident 12 was reviewed on 2/18/25 at 1:10 p.m. Diagnoses included, but were not limited to, type 2 diabetes. A Physician's Order, dated 9/27/24, indicated Humalog injection solution, inject 33 units subcutaneously before meals for diabetes management at 8:00 a.m., 11:00 a.m., and 4:00 p.m. During an interview on 2/18/25 at 11:30 a.m., LPN 2 indicated she was aware she had forgotten to prime the second needle to administer the 3 units of insulin. During an interview on 2/18/25 at 1:50 p.m., the Director of Nursing indicated the insulin pen needed to be primed before administration. 2. On 2/19/25 at 4:21 p.m., LPN 5 was observed preparing a medication for Resident 147. The resident received his medications by the way of a gastrostomy tube. The LPN poured Atorvastatin (a medication used to lower cholesterol) 80 milligrams (mg), Metoprolol (a medication used to lower the blood pressure and heart rate) 100 mg and Lansoprazole (a medication used to help with food digestion) 10 ml/30 mg. She crushed all the medications and placed them separately into the medication cups. Upon entering the room, the LPN donned gloves and an isolation gown and placed the cups containing the medication on the over bed table. The LPN checked for placement by pulling back any residual in the peg tube. She then proceeded to flush the resident's gastrostomy tube, by plunging 30 milliliters (mls) of water rather than instilling the water via gravity. She diluted all of the medications with 10 ml of water and added them one at time, and rather than administering them completely via gravity, she pushed most of the medication with the plunger. After the last medication she plunged another 30 ml of water through the peg tube. The record for Resident 147 was reviewed on 2/24/25 at 9:00 a.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), and peg tube. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 2/10/25, indicated Lansoprazole Oral Suspension 3 mg/ml, give 10 ml via peg tube every morning and at bedtime. During an interview on 2/19/25 at 4:36 p.m., LPN 5 indicated the Lansoprazole was to be administered at bedtime. During an interview on 2/21/25 at 2:15 p.m., the Director of Nursing indicated bedtime administration was not at 4:30 p.m. 3.1-48(c)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure a resident was free from a significant medication error related to the administration of a sliding scale insulin for 1 of 6 residents and 1 of 5 nurses observed during medication pass. (Resident 12 and LPN 2) Finding includes: During medication pass on 2/18/25 at 11:27 a.m., LPN 2 was preparing to check Resident 12's blood sugar level. The resident's blood sugar was 335 and the LPN indicated she was to receive 33 units of Lispro Insulin. She removed the insulin pen from the medication cart and dialed it to 30 units, as it would not dial any further. She administered 30 units to the resident and then dialed the pen to 3 units and administered the remaining 3 units. There was no other insulin administered to the resident. The record for Resident 12 was reviewed on 2/18/25 at 1:10 p.m. Diagnoses included, but were not limited to, type 2 diabetes. A Physician's Order, dated 1/16/24, indicated Humalog [NAME] Kwik Pen, inject as per sliding scale: if 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units; 501 - 550 = 14 units; 551 - 600 = 16 units subcutaneously every 8 hours as needed for diabetes management with meals. If the blood sugar was greater than 600 or less than 60, the doctor was to be called. A Physician's Order, dated 9/27/24, indicated Humalog injection solution, inject 33 units subcutaneously before meals for diabetes management at 8:00 a.m., 11:00 a.m., and 4:00 p.m. The Medication Administration Record (MAR) for the months of 1/2025 and 2/2025 indicated the medication had been assigned as PRN (as needed) and not as a routine sliding scale. There was no documentation the resident received any Humalog Insulin per sliding scale from 1/1/25-1/31/25 and 2/1/25-2/18/25 for the noon meal. The 1/2025 MAR, indicated the resident's blood sugar was greater than 200 and should have received extra insulin at the following times: - 8:00 a.m., 28 times - 11:00 a.m., 22 times - 4:00 p.m., 20 times The 2/2025 MAR (2/1/25-2/17/25) indicated the resident's blood sugar was greater than 200 and should have received extra insulin at the following times: - 8:00 a.m., 14 times (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11:00 a.m., 13 times - 4:00 p.m., 13 times During an interview on 2/18/25 at 1:15 p.m., LPN 2 indicated the sliding scale insulin did not pop up on her MAR, therefore, she was unaware there was an order for the sliding scale insulin. During an interview on 2/18/25 at 1:50 p.m., the Director of Nursing indicated the sliding scale insulin was put into the computer incorrectly as a PRN order so it did not come up for the nursing staff to administer. 3.1-48(c)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 10770 Based on observation, record review, and interview, the facility failed to ensure proper medication storage related to insulin pens and multi-dose vials not labeled when opened or expired, and loose pills observed in the medication carts and medication rooms for 2 of 2 units (The [NAME] and East Units) Findings include: 1. The medication cart on the [NAME] unit was observed with the Assistant Director of Nursing (ADON) on [DATE] at 9:02 a.m. At that time, there were eight loose pills observed inside the medication drawers. The [NAME] medication room was also observed at that time and inside the refrigerator was an opened multi-dose vial of Aplisol (a medication used for tuberculin vaccines). The vial was not dated when opened. During an interview at that time, the ADON indicated pharmacy came out every Thursday and cleaned the carts and checked the medication rooms. 2. A medication cart was observed on [DATE] at 9:15 a.m. with LPN 2 on the East unit. At that time, there were 22 loose pills noted inside the medication drawers. There was 1 Lantus Insulin multi-dose vial with a discard date of [DATE] and Humalog Insulin multi-dose vial with a discard date of [DATE]. A Lispro Insulin pen was opened with no date. During an interview at that time, LPN 2 indicated the carts were cleaned out by pharmacy but she did not know how often. 3. A medication cart on the East unit was observed on [DATE] at 9:25 a.m. with RN 1. At that time, there were four loose pills observed in the medication drawers and a Lispro Insulin multi-dose vial with a discard date of [DATE]. There was an Aspart Insulin pen with a discard date of [DATE] and a Lantus Insulin pen with a discard date of [DATE]. During an interview at that time, RN 1 indicated she just checked each insulin pen and the multi-dose vials for dates and did not see when or if they had expired. During an interview on [DATE] at 1:50 p.m., the Director of Nursing (DON) indicated there were protocols for the medication carts to be cleaned and to date opened insulin pens and multi-dose vials of Aplisol as well as to discard expired vials and pens of Insulin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current and undated Storage of Medications policy, provided by the DON on [DATE] at 8:30 a.m., indicated all medications dispensed by the pharmacy were stored in the container with the pharmacy label. Medication storage areas were kept clean and free of clutter. When the original seal of a manufacture's container or vial was initially broken, the container or vial would be dated. The nurse shall place a date opened sticker on the medication and enter the date opened. The nurse would check the expiration date of each medication before administering it. Drugs dispensed in the manufacture's original container would carry the manufacture's expiration date, unless a multi-dose injectable vial or an item for which the manufacture has specified a usable life after opening. 3XXX,d+[DATE](j)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43293 Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to dirty oven doors, dry storage bin, light fixtures, vents, and floors for 1 of 1 kitchen. Finding includes: During the Initial Kitchen Sanitation Tour on 2/17/25 at 9:09 a.m. with the Kitchen Manager, the following was observed: a. There was a dark, dripping substance along the bottom of the oven door. b. There was an accumulation of dirt on the edges of the ceiling light fixtures above the food preparation area. c. There was an accumulation of dirt on the vents in the ceiling above the food preparation area. d. There was a tan, sticky substance on the handle of the sugar storage bin. e. There was an accumulation of dust and debris under the shelves in the dry storage room. During an interview on 2/17/25 at 9:12 a.m., the Kitchen Manager indicated they needed to do some deep cleaning and maintenance may need to come in with a ladder to clean the light fixtures and vents. A policy titled Environment, received as current from the Administrator on 2/24/25 at 9:50 a.m., indicated, . It is the center policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition . 3.1-21(i)(3)

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43293 Based on observation, record review, and interview, the facility failed to ensure that every resident received specialized rehabilitative services as determined by their comprehensive plan of care to restore their highest practicable level of physical well-being for 1 of 1 resident reviewed for rehabilitative services. (Resident G) Finding includes: During an observation of a physical therapy session on 2/18/25 at 10:55 a.m., Resident G was observed in bed. He had a dressing intact to his left upper arm AV fistula (an access port for dialysis), and a large gauze wrap around his left forearm with a baseball-sized area bleeding through. There were large areas of bruising to both sides of his neck and his chest. His right arm was swollen. Physical Therapist (PT) 1 had the resident hold his hands and pull his upper body toward him multiple times. The resident then fell back on the bed and complained that his chest hurt. PT 1 left the room to look for an aide to help him reposition the resident in bed. The record for Resident G was reviewed on 2/19/25 at 9:29 a.m. Diagnoses included, but were not limited to, endocarditis (inflammation of the heart valve), diabetes type 2, heart failure, and dependence on renal dialysis. He was admitted to the facility on [DATE] after hospitalization following open heart surgery. On 1/16/25 he had an aortic valve replacement, pulmonic valve replacement, and tricuspid valve annuloplasty (repair of a leaky heart valve). The Nursing Admission Evaluation, dated 2/13/25, indicated the resident was cognitively intact for daily decision making, required set-up assistance with ADLs (activities of daily living), and maximum assistance with transfers. The hospital Physical Therapy Notes, dated 2/13/25, indicated sternal precautions (a set of guidelines for protecting the sternum after surgery which included no pushing or pulling with the arms for 6 to 8 weeks) were in place. The notes indicated the resident was trying to use his arms for pushing and pulling, but the physical therapist reinforced the importance of following sternal precautions. The Therapy Care Plan indicated, . Precautions (OT) Fall precautions, sternotomy + cardiac precautions, ESRD [end stage renal disease] on HD [hemodialysis] M-W-F, DM [diabetes], HTN [hypertension] (PT) Fall risk, Diabetic precautions, HTN, a-fib [arrhythmia], low back pain. Dialysis MWF . During an interview on 2/18/25 at 11:00 a.m., when asked if having a resident grab your hands and pull his body weight toward you was an appropriate exercise for a resident who had open heart one month ago, a dialysis graft to his left upper arm, and a wound dressing with large bleed-through on his left lower arm, PT 1 indicated it was to strengthen his arms. During an interview on 2/20/25 at 3:32 p.m., the Therapy Manager was informed of the findings and offered no further information. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25 at 10:45 a.m., the Administrator indicated that sternal precautions were under OT (occupational therapy) on the care plan and maybe the PT did not think they needed them. There was no documentation or physician's orders that indicated standard sternal precautions were not to be followed for physical therapy. There was no documentation of communication with the physician regarding what safety precautions were necessary for the resident or if the same movement of pulling oneself up that the hospital physical therapist instructed the resident against doing 5 days prior was now a safe exercise. 3.1-23(a)(1)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 32664 Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to documentation of medications given for 1 of 5 residents reviewed for unnecessary medications (Resident F) and percentage of tube feeding given for 1 of 2 residents reviewed for tube feeding. (Resident 75) Findings include: 1. Record review for Resident F was completed on 2/19/25 at 9:11 a.m., Diagnoses included, but were not limited to, diabetes mellitus, atrial fibrillation (irregular heart beat), heart failure, hypertension, Parkinson's disease, anxiety, depression, and chronic obstructive pulmonary disease (COPD). The Admission Minimum Data Set (MDS) assessment, dated 11/15/24, indicated the resident was cognitively intact. The February 2025 Physician's Order Summary (POS) indicated orders for Metoprolol Succinate ER (heart medication) 50 mg (milligrams) in the morning and Glimepiride (anti-diabetic medication) 4 mg in the morning. The February 2025 Medication Administration Record (MAR) indicated the following: - Metoprolol Succinate ER had an X and a code of 5 which indicated to see the nurse's note on 2/8/25 and 2/16/25 - Glimepiride had a blank on 2/10/25 There was no documentation to indicate why the Metoprolol had an X and the Glimepiride was blank on the above dates. During an interview on 2/19/25 at 2:30 p.m., the Director of Nursing (DON) indicated she could not provide any documentation if the medications had been administered or not on the above dates. The nurse had probably held the Metoprolol due to blood pressure but she could not find any documentation to indicate that. 43293 2. The record was reviewed for Resident 75 on 2/19/25 at 11:14 a.m. Diagnoses included, but were not limited to, encephalopathy, alcohol dependence, epilepsy, and vascular dementia. The 11/16/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, dependent in ADLs and transfers, and received tube feedings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, revised on 11/6/24, indicated the resident had a PEG tube (a feeding tube inserted through the abdomen into the stomach) due to failure to thrive and malnutrition. Interventions included to monitor intake of enteral tube feeding. The eMAR (electronic medication administration record) indicated the following, Enteral Feed Order one time a day Glucerna 1.2 [a type of liquid nutrition] @ 65 ml/hr for 12 hrs 7pm 7am for 720 ml/12 hrs total - Start Date 12/20/2024. The percentage of the feeding intake was to be documented on the eMAR. The following numbers were documented: 2/1/25 180, 2/2/25 180, 2/3/25 60, 2/4/25 180, 2/5/25 180, 2/6/25 180, 2/7/25 180, 2/8/25 300, 2/9/25 65 ml, 2/10/25 100, 2/11/25 100, 2/12/25 100, 2/13/25 195, 2/14/25 X, 2/15/25 180, 2/16/25 195, 2/17/25 100, and 2/18/25 180. During an interview on 2/24/25 at 2:28 p.m., the Director of Nursing indicated the numbers documented did not make sense, and they did not reflect the percentage of the tube feeding intake. She indicated the staff needed to be educated on documenting. 3.1-50(a)(1) 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 10770 Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place and implemented related to medications touched with bare hands, disposal of a used lancet into the garbage can, glucometers not disinfected after use for 1 of 2 glucometers observed, and not donning personal protective equipment (PPE) for residents in enhanced barrier precautions (EBP). (Residents C, 20, 12, 146, and G) Findings include: 1. During medication pass on 2/18/25 at 8:03 a.m., LPN 1 was observed removing Resident C's medications from the punch cards into her bare hands and then placing all of the pills into the medication cup. After finishing pouring all of the medications, she picked up the glucometer from a basket on top of the medication cart, a lancet, a test strip and an alcohol pad, and walked into the room to administer the resident her medications as well as check her blood sugar. After checking the resident's blood sugar, she put the glucometer into her shirt pocket and picked up the used lancet, walked into the bathroom and wrapped it in a paper towel and put that into her shirt pocket as well. She performed hand hygiene and walked out of the room and back to the medication cart. She removed the glucometer from her pocket and placed it in the basket on top of the medication cart. She did not clean it immediately after use. On 2/18/25 at 8:18 a.m., LPN 1 was observed preparing Resident 20's medications. At that time, she punched all 11 pills into her bare hands and then placed them into the medication cup. She walked into the resident's room and administered all 11 medications to her. During an interview on 2/18/25 at 8:25 a.m., LPN 1 indicated she was aware she was not supposed to punch the resident's medications into her bare hands. She was not aware that placing the dirty glucometer into her shirt pocket was an infection control issue. When queried as to when she cleaned the glucometer, the LPN indicated she was supposed to clean it with a bleach wipe. At that time, she removed the tub of wipes, wiped down the glucometer with her bare hands and then placed it back into the basket where she had it before. During an interview on 2/24/25 at 8:30 a.m., the Director of Nursing (DON) indicted LPN 1 should not have punched the pills into her bare hands before administration and the glucometer was to be cleaned immediately after use The current and undated Cleaning and Disinfection of Glucose Meter policy, provided by the DON on 2/24/25 at 8:30 a.m., indicated place all used sharps immediately in the sharps safety disposal box. Return glucometer after use for disinfection process placing on a clean barrier until disinfection was completed. Do not place a contaminated glucometer on top of the medication cart or other surface without a clean protective barrier. Disinfect the glucometer immediately before re-use and clean and disinfect the meter after use. The current 2013 Medication Administration policy provided by the DON on 2/24/25 at 9:08 a.m., indicated do not touch the medication when opening a liquid or dose pack. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During medication pass on 2/18/25 at 11:27 a.m., LPN 2 was preparing to check Resident 12's blood sugar with the glucometer. She entered the resident's room and checked the blood sugar, which was 335. She rolled her gloves off of her hands and inside the ball of gloves was the used lancet, the strip, and the alcohol wipe. After removing the gloves, she walked out of the room back to the medication cart and placed the used gloves on top of the medication cart. She performed hand hygiene and then prepared the insulin for the resident. She walked back into the resident's room and administered the insulin, walked back out the room and threw the gloves with the used lancet inside into the trash can on the side of the medication cart. During an interview at that time, LPN 2 indicated she just set the used gloves into the garbage can to get them out of the way, she was going to put them into the sharps container. During an interview on 2/18/25 at 1:50 p.m., the Director of Nursing indicated used lancets were to be disposed of in the sharps container. The current and undated Cleaning and Disinfection of Glucose Meter policy, provided by the DON on 2/24/25 at 8:30 a.m., indicated place all used sharps immediately in the sharps safety disposal box. 3. During medication pass on 2/19/25 at 8:57 a.m., LPN 4 was observed preparing an IV (intravenous) antibiotic medication through a PICC (peripherally inserted central catheter) line for Resident 146. There was a sign on the resident's door, which indicated she was in Enhanced Barrier Precautions (EBP) due to the PICC line, so an isolation gown and gloves were to be used for resident contact. The LPN performed hand hygiene, donned an isolation gown, and clean gloves to both hands, she then removed the IV tubing from the package and mixed the saline with the antibiotic. She primed the tubing and placed it inside the IV pump for infusion. She walked to the other side of the bed, where the resident's PICC line was in her left arm. The LPN removed the green cap from the port and put it on top of the over bed table, she wiped the port with an alcohol swab and pushed 10 cubic centimeters (cc) of saline through the port. She did not have another alcohol wipe, so she removed her gloves and walked over to the medication cart, which was located in the doorway, and picked up some more wipes, walked back to the bed, reached into her shirt pocket under the isolation gown and pulled out a pair of clean gloves which she donned at that time. She opened the wipe, cleaned the port and connected the IV antibiotic for infusion. During medication pass on 2/19/25 at 9:37 a.m., LPN 4 was observed to take down the IV antibiotic medication because it was completed. She performed hand hygiene, donned a clean isolation gown and gloves to both hands, and removed the IV from the port. With her gloved hands, she reached into her shirt pocket and pulled out an alcohol wipe to wipe off the port after she disconnected the tubing. She wiped the port off and pushed the normal saline through the line. She was then looking for another alcohol wipe, so she reached into the same shirt pocket with gloved hands, however, she could not find one, so she reached into her other shirt pocket wearing the same gloves to both hands and found more alcohol wipes. The LPN cleaned the port and put the green cap back on it, she removed all of her personal protective equipment and performed hand hygiene. During an interview on 2/19/25 at 9:45 a.m., LPN 4 indicated she was not aware she could not store the gloves or alcohol wipes in her shirt pockets and reach into them for a resident who was on EBP. During an interview on 2/19/25 at 10:00 a.m., the Director of Nursing indicated she should not have put the gloves or alcohol wipes in her shirt pockets. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43293 4. On 2/19/25 at 1:51 p.m., CNA 3 and CNA 4 were observed transferring Resident G from a chair to a bed using a Hoyer lift (a mechanical transport device). There was an intravenous access device in the resident's right chest, a dressing with visible bleed-through on his left lower arm, and another dressing to his left upper arm. Once in bed, the CNAs changed the resident's brief and repositioned him. There was a sign on the door indicating the resident was on Enhanced Barrier Precautions (EBP). There were disposable gowns in a bin on the wall. Neither CNA was wearing a gown while providing direct care. The record for Resident G was reviewed on 2/19/25 at 9:29 a.m. Diagnoses included, but were not limited to, endocarditis (inflammation of a heart valve), diabetes type 2, and dependence on renal dialysis. The Nursing Admission Evaluation, dated 2/13/25, indicated the resident was cognitively intact for daily decision making, required set-up assistance with ADLs (activities of daily living), and maximum assistance with transfers. A Care Plan, dated 2/15/25, indicated the resident required Enhanced Barrier Precautions (EBP) and that those providing direct care, including transferring and changing briefs, should wear appropriate PPE (personal protective equipment). During an interview on 2/19/25 at 2:02 p.m., CNA 4 indicated she should have put on a gown. During an interview on 2/19/25 at 2:05 p.m., CNA 3 indicated he did not know when he had to wear a gown, and the gowns were not always available nearby. During an interview on 2/21/25 at 2:43 p.m. the Director of Nursing (DON) indicated the CNAs should have worn gowns and gloves when transferring and changing the resident's brief. A policy titled, Enhanced Barrier Precautions, received as current from the DON on 2/25/25 at 11:20 a.m., indicated, . EBP are indicated for residents with any of the following . Indwelling medical device examples include central lines including PICC [peripherally inserted central catheter] , urinary catheters, feeding tubes, and tracheostomies. A peripheral IV line is not considered an indwelling medical device for the purpose of EBP . 3.1-18(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32664 Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dirty resident equipment, floors, curtains, personal and hygiene items not contained, and a clock not working for 2 of 2 units. (East Unit and [NAME] Unit) Findings include: During the Environmental Tour on 2/24/25 at 1:34 p.m., with the Maintenance Director, Account Manger, and the Administrator, the following was observed: 1. East Unit a. room [ROOM NUMBER] A: The resident's bed handrails had a build up of a dark brown substance. One resident resided in the room. 2. [NAME] Unit a. room [ROOM NUMBER] B: A tube feeding pole was observed next to the bed. There was spillage of tube feeding on the floor and the bottom of the tube feeding pole. Two residents resided in the room. b. room [ROOM NUMBER] A: The resident had a Broda chair that had a dried up brown substance on the side and on the front of the Broda chair. Two residents resided in the room. c. room [ROOM NUMBER] A: There was clothing piled up on boxes on the floor and in a wheelchair. Two residents resided in the room. d. room [ROOM NUMBER] B: The window curtains were stained on the bottom by the heat register. There were two emesis basins on the sink that contained a toothbrush and denture cup. They were not contained. Two residents resided in the room. e. room [ROOM NUMBER]: The garbage bins were overflowing in the room and the bathroom. The floor had crumbs and food spilled on it. The bathroom had briefs on the floor that were uncontained. There were washcloths and resident hygiene items on the back seat of the toilet. Two residents resided in the room. f. room [ROOM NUMBER] B: The clock on the wall did not work. There was another clock on a shelf that did not work. There were items on the floor in a bag by the bed. The resident indicated that the bag was not his and was unsure of what the items were. Two residents resided in the room. During an interview on 2/24/25 at 1:59 p.m., the Administrator indicated all of the above areas were in need of cleaning or repair. This citation relates to Complaint IN00443889. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-19(f)