STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave 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. 10326 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 2 residents reviewed for dignity. (Resident 72) Finding includes: On 2/3/25 at 11:49 a.m. and 2:12 p.m., Resident 72 was observed in her room in bed. The resident was wearing a hospital gown at both times. On 2/4/25 at 10:23 a.m., the resident was again observed in her room in bed wearing a hospital gown. On 2/5/25 at 9:27 a.m., 10:54 a.m., and 1:49 p.m., the resident was observed in her room in bed wearing a hospital gown. On 2/6/25 at 9:25 a.m., 10:25 a.m., 11:40 a.m., and 3:27 p.m., the resident was again observed in her room in bed wearing a hospital gown. On 2/7/25 at 5:45 a.m., AM care was provided to the resident. The resident was dressed in a clean hospital gown. The record for Resident 72 was reviewed on 2/6/25 at 10:54 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, dysphagia (difficulty swallowing) and gastrostomy status (a tube surgically inserted into the stomach that allows for the delivery of food and medication). A Significant Change Minimum Data Set (MDS) assessment, dated 1/18/25, indicated the resident was cognitively impaired for daily decision making and was dependent on staff for upper and lower body dressing. A Care Plan, which was last reviewed on 1/14/25, indicated there was no current care plan related to the resident wanting to wear a gown in bed during the day. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated a care plan would be initiated related to the resident wearing a gown in bed during the day. 3.1-3(t)

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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. 10770 Based on observation, record review, and interview, the facility failed to ensure residents were assessed to self-administer medications and oxygen therapy and had physician's orders to self-administer for 3 of 3 residents reviewed for self-administration of medication. (Residents 91, 105 and 30) Findings include: 1. During a random observation on 2/3/25 at 2:15 p.m., there was an Albuterol hand held inhaler observed on Resident 91's over bed table. The resident was not in her room at that time. During random observations on 2/4/25 at 9:39 a.m. and 11:25 a.m., the resident was observed in bed. At those times, the Albuterol inhaler was observed on the over bed table. During an interview on 2/4/25 at 9:40 a.m., the resident indicated she brought the inhaler from home and used it almost every day. The record for Resident 91 was reviewed on 2/4/25 at 10:00 a.m. Diagnoses included, but were not limited to, heart failure, type 2 diabetes, and dyspnea (difficulty breathing) The 12/21/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no care plan indicating the resident could self-administer her own medications. There was no physician's order for the Albuterol inhaler. There was no self-administration of medication completed for the resident. During an interview on 2/5/25 at 9:42 a.m., Assistant Director of Nursing (ADON) 2 indicated she was made aware the resident had an inhaler on her over bed table on 2/4/25 in the afternoon. The resident informed staff that she brought the inhaler from home. She had discontinued the inhaler months ago because it was an as needed medication and the resident was not asking for it. The current 2/15/21 Self-Administration of Medications-Clinically Appropriate policy, provided by Nurse Consultant 1 on 2/10/25 at 11:55 a.m., indicated a resident may only self-administer medications after the interdisciplinary team (IDT) had determined which medications may be self-administered. The IDT will determine at a minimum if the resident had the capacity to follow directions, the resident's cognitive status was evaluated, and the resident's ability to understand and store medication securely. 2. During a random observation on 2/3/25 at 2:20 p.m., Resident 105 was observed in bed and indicated she was not feeling well. At that time, there was a plastic cup filled with an orange substance on the over bed table. The resident was asked what was in the cup, and she indicated it was her potassium medication. She had vomited and had diarrhea earlier, so the nurse waited and brought her medication to her later after lunch. (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 observation on 2/3/25 at 2:45 p.m., the resident's call light was on and Assistant Director of Nursing (ADON) 2 got up to answer it. At that time, she observed the orange liquid on the over bed table. She was not aware it was the potassium medication and thought it was an orange drink. During an interview at 2:45 p.m., LPN 1 indicated she had administered the potassium medication after lunch and then heard a code blue, so she ran out of the room to go and help, and left the medication on the resident's over bed table. She did not go back to see if the resident had consumed the medication. The record for Resident 105 was reviewed on 2/5/25 at 10:12 a.m. Diagnoses included, but were not limited to stroke, heart disease, and heart failure. There was no care plan the resident could consume medication without supervision. There was no self-administration of medication assessment completed to indicate the resident could consume medication without staff supervision. A Physician's Order, dated 11/20/24, indicated Effer-K Oral Tablet Effervescent 25 milliequivalents (meq), give 1 tablet by mouth two times a day for supplement. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing had no additional information. The current 10/25/14 Oral Medication Administration Policy provided by Nurse Consultant 1 on 2/7/25 at 11:25 a.m., indicated staff were to administer medication and remain with the resident while the medication was swallowed. 43293 3. During observations on 2/3/25 at 3:13 p.m., 2/5/25 at 1:53 p.m., and 2/7/25 at 9:15 a.m., an oxygen concentrator with nasal cannula (a pronged tube for dispensing oxygen through the nose) connected was observed in Resident 30's room. During an interview on 2/3/25 at 3:13 p.m., the resident indicated he used the oxygen whenever he felt like he needed it, and usually at night. He demonstrated how to turn the concentrator on, which he learned from watching staff do it. The record for Resident 30 was reviewed on 2/5/25 at 10:09 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), dementia, schizophrenia, and sleep apnea. The 12/1/24 Annual Minimum Data Set (MDS) Assessment indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 1/27/25, indicated oxygen at two lpm (liters per minute) every eight hours as needed for shortness of breath. There was no order or an assessment for self-administration. (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 2/7/25 at 9:20 a.m., Respiratory Therapist (RT) 1 indicated the resident put his oxygen on and off independently, and she did not know she needed to assess his ability to use the oxygen correctly. During an interview on 2/7/25 at 9:23 a.m. the Director of Nursing (DON) indicated they should determine if a resident could use oxygen correctly before allowing them to self-administer. 3.1-11(a)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 43293 Based on record review and interview, the facility failed to ensure a PASARR (preadmission screening and resident review) was completed when a new mental health diagnoses was added for 1 of 1 resident reviewed for PASARR. (Resident 124) Finding includes: The record for Resident 124 was reviewed on 2/7/25 at 10:32 a.m. Diagnoses included but were not limited to, metabolic encephalopathy, dementia, and unspecified psychosis not due to a substance or known physiological condition. A PASARR level I, dated 1/10/25, indicated further screening was not needed unless the resident had a serious mental illness or intellectual development disability. The diagnosis of unspecified psychosis not due to a substance or known physiological condition was added to the resident's record on 1/13/25. There was no PASARR level 2 performed. During an interview on 2/4/25 at 1:44 p.m., the Social Services Director indicated they did not do a level 2 PASARR, but she would re-do the level 1. She thought the resident had the diagnosis of psychosis since a prior hospitalization , but she was not sure. The PASARR level I, completed on 2/5/25, indicated a face-to-face level 2 was needed. During an interview on 2/6/25 at 4:45 p.m., the Social Services Director indicated she was making arrangements for the level 2 to be done. 3.1-16(d)(1)(A)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43293 Based on observation, record review, and interview, the facility failed to develop a plan of care that was individualized to the needs of a bilateral amputee for 1 of 27 residents reviewed for care plans. (Resident P) Finding includes: During a random observation on 2/3/25 at 3:37 p.m., Resident P was observed to have bilateral below-the-knee amputations. The record for Resident P was reviewed on 2/7/25 at 8:44 a.m. Diagnoses included, but were not limited to, ESRD (end-stage renal disease), congestive heart failure, diabetes, and stroke. The 11/27/24 Quarterly Minimum Data Set (MDS), indicated the resident was cognitively intact for daily decision making and required maximum assistance with ADLs. A Care Plan, revised on 2/4/25, indicated the resident was at risk for complications related to diabetes. Approaches included inspecting the resident's feet for open areas, sores, pressure areas, blisters, edema, or redness and referring to a podiatrist to monitor and document foot care needs and cut long nails as needed. During an interview on 2/7/25 at 4:00 p.m., the Director of Nursing (DON) indicated foot inspection / care / podiatry should be removed from the resident's care plan because he was a bilateral amputee. 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to ensure residents received a care conference and were involved in decisions about their care related to not informing them of new medications and lab results for 2 of 3 residents reviewed for participation in care planning. (Residents 4 and 30) Findings include: 1. During an interview on 2/4/25 at 9:34 a.m., Resident 4 indicated she did not recall having a recent care conference and staff did not always inform her of new medications that were ordered by the doctor. The record for Resident 4 was reviewed on 2/5/25 at 7:50 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, type 2 diabetes, heart failure, cardiac pacemaker, anemia, and peptic ulcer. The 11/6/25 Quarterly Minimum Data Set assessment indicated the resident was cognitively intact for daily decision making. The resident had documented care plan conferences on 7/12/24 and 12/18/24. There were no other conferences for the resident. A Nurse's Note, dated 9/20/24 at 1:57 p.m., indicated the resident's cardiologist called and ordered to discontinue the Xarelto (a blood thinner), then start Aspirin 81 milligrams (mg) daily and Plavix 75 mg daily. Physician's Orders, dated 9/20/24, indicated Plavix 75 mg, give 1 tablet by mouth one time a day for heart disease and Aspirin 81 mg daily. There was no documentation the resident was made aware of the new medications. Nurse's Notes, dated 9/23/24 at 3:44 p.m., indicated the resident has been started on Bactrim (an antibiotic) for an urinary tract infection. At 4:04 p.m., the resident's daughter was made aware of the residents antibiotic therapy. A Physician's Order, dated 9/23/24, indicated Bactrim 400-80 mg, give one tablet by mouth two times a day for 10 days. There was no documentation the resident was made aware of the new medications. Physician's Orders, dated 1/2/25, indicated Hiprex (an urinary antiseptic) 1 gram, give one tablet two times a day for urine acidification and Macrobid (an antibiotic) 100 mg, give one capsule by mouth two times a day for 10 days for an urinary tract infection. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note, dated 1/2/25 at 10:51 a.m., indicated the resident's daughter was called and informed of the new orders. There was no documentation the resident was notified of the new medications. During an interview on 2/6/25 at 2:10 p.m., the Social Service Director indicated there was one care plan conference missing. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing had no additional information to provide. 43293 2. During an interview on 2/3/25 at 3:05 p.m., Resident 30 indicated he was trying to contact his sister to get his lab results because when the facility got the results, they gave them to his sister and not to him. The record for Resident 30 was reviewed on 2/5/25 at 10:09 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), dementia, schizophrenia, and sleep apnea. The 12/1/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident had lab testing completed on 1/28/25, 1/31/25, and 2/3/25. There was no documentation the resident was informed of his lab results. During an interview on 2/7/25 at 1:40 p.m., Assistant Director of Nursing (ADON) 2 indicated she documented that she updated the family member because they were the POA (power of attorney), but that she would inform the resident of his results. 3.1-35(c)(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** 10326 Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to assistance with meals, shaving, oral care, and providing showers and nail care for 12 of 14 residents reviewed for ADLs. (Residents E, K, O, B, M, G, F, H, L, N, P, and J) Findings include: 1. On 2/5/25 at 8:05 a.m., Resident E received her breakfast tray. The resident was seated at a table with two other residents. At 8:11 a.m., the resident was asked by a staff member if she was going to eat. The resident picked up her milk and put it back down. At 8:18 a.m., no staff had offered to sit down and feed the resident or assist her with her meal. Staff were observed to be passing coffee and the trays. At 8:25 a.m., a CNA walked over to the resident and handed her a spoon and told her where her fork was. The resident then proceeded to start eating her oatmeal. On 2/6/25 at 11:59 a.m., Resident E was seated at a table in the unit dining room. She had been served her lunch tray and she was making no attempts to feed herself. The resident's eyes were open and she was looking around the room. At 12:15 p.m., a CNA told the resident to wake up and that it was time to eat. The CNA approached the resident and gave her something to drink and she also gave her a few bites of food. The resident started feeding herself after that. This was the first time the resident was provided assistance since 11:59 a.m. The record for Resident E was reviewed on 2/5/25 at 2:02 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavior disturbance, nonpsychotic mental disorder, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 12/7/24, indicated the resident was cognitively impaired for daily decision making and she needed set up assistance with eating. A current Care Plan indicated the resident required assistance with ADLs including bed mobility, eating, transfers, toileting and bathing related to dementia. Interventions included, but were not limited to, assist with meal consumption, eating and drinking as needed. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the resident should have been assisted with her meals in a more timely manner. 10770 2. During random observations on 2/4/25 at 9:10 a.m. and 11:10 a.m., Resident K was observed with dry cracked lips with flakes of skin hanging from the top lip. During random observations on 2/5/25 at 7:21 a.m., on 2/6/25 at 9:27 a.m., 9:54 a.m., and 3:20 p.m., and on 2/7/25 at 11:16 a.m., the resident's lips were dry, and cracked. There was a scabbed area noted on his bottom lip. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record for Resident K was reviewed on 2/5/25 at 10:35 a.m. Diagnoses included, but were not limited to, cerebral palsy, quadriplegia, epilepsy, autistic disorder, severe protein malnutrition, peg tube, and dysphagia (difficulty swallowing). The 1/22/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and was dependent on staff for oral hygiene and bathing. A Care Plan, revised on 8/29/24, indicated the resident needed assistance with ADLs including bathing. The approaches were to assist with oral care as needed and provide a shower or a complete bed bath at least two times a week. A Care Plan, revised on 9/25/24, indicated the resident was at risk for oral/dental health problems. The approaches were to provide mouth care as per ADL personal hygiene. There was no documentation of oral care in the CNA task section. The CNA task section of the electronic record indicated the resident was scheduled to receive showers every Monday and Thursday evenings. For December 2024 and January 2025, the resident was missing showers on 12/9/24, 12/19/24, 1/2/25, 1/13/25, 1/20/2, and 1/23/25. During an interview on 2/7/25 at 11:51 a.m., the resident's mother indicated there were many times she had come in and his lips were very dry, cracked or flakes of skin hanging off of them. During an interview on 2/8/25 at 3:15 p.m., the Director of Nursing indicated oral care was to be completed daily and showers were to be done two times a week. 3. During an observation on 2/3/25 at 2:52 p.m., Resident O was observed sitting in his wheelchair in his room. At that time, his left hand was flaccid and closed and he could not open his hand without assistance. His fingernails on the left hand were very long and digging into his skin. During random observations on 2/4/25 at 11:02 a.m. and 2/5/25 at 7:25 a.m., the resident's fingernails on the left hand were long and digging into his skin. During an interview on 2/5/25 at 1:56 p.m., the resident indicated the nurse had cut his fingernails for him so they would not dig into his skin. The record for Resident O was reviewed on 2/5/25 at 3:06 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia affecting the left side. The 11/27/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed substantial to maximum assist for bathing and personal hygiene. A Care Plan, revised on 6/14/23, indicated the resident required assistance with ADLs including bathing. The approaches were to provide a shower or complete bed bath at least two times a week. The documentation in the CNA task section indicated nail care had not been provided from 1/7/25 through 2/2/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CNA task section of the electronic record indicated the resident was to receive a shower on Monday and Thursday evenings. There were no showers documented on 12/19/24, 1/6/25, 1/13/25, 1/20/25, 1/23/25, and 1/30/25. There were no showers documented for the resident for 2/2025. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing had no further information to provide. 4. During an interview on 2/3/25 at 11:55 a.m., Resident B indicated he liked to be clean shaven. At that time, the resident had a large amount of facial hair on his face and his fingernails were very long and dirty, and had a black like substance underneath them. The resident indicated he did not always get a shower two times a week. On 2/5/25 at 7:20 a.m. and 9:22 a.m., the resident's fingernails were still long and dirty. The record for Resident B was reviewed on 2/7/25 at 11:57 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, periprosthetic fracture of the internal prosthetic left hip joint and right hip joint, end stage renal disease, dependence on renal dialysis, and a skin infection. The 12/10/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and needed partial to moderate assist with bathing and substantial to max assist with personal hygiene. A Care Plan, dated 1/30/25, indicated the resident required assistance with ADLs including bathing. The approaches were to assist with person hygiene including dressing/grooming as needed. There was no documentation the resident was assisted with shaving. The CNA task section of the electronic record indicated the resident was to receive a shower every Monday and Thursday evening. The resident refused a shower on 1/2/25 and there were no other complete bed baths or showers documented. There was no documentation of any other refusals. Nail care had been completed last on 1/20/25. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing indicated she had no additional information to provide. 5. During an observation on 2/6/25 at 11:44 a.m., the lunch trays arrived to the memory care unit. The first trays passed to the residents who were seated in the dining room was at 11:52 a.m. Resident M was seated at a table with 3 other residents. Two of the four residents seated at the table were served immediately. At 12:09 p.m., Resident M still had not received her lunch tray. Finally at 12:16 p.m., the resident received her meal tray. It was left front of her and not set up, so she could not eat it. At 12:23 p.m., the resident still had not been assisted with eating. At 12:30 p.m., the resident picked up her juice and removed the lid and drank from it by herself. All other residents were eating and one other resident was being assisted by CNA 1. At 12:34 p.m., QMA 1 was asked why no one was assisting Resident M, and she stated Oh she is a feed. Finally at 12:35 p.m., Assistant Director of Nursing (ADON) 1 moved Resident M to a different table and started to feed her. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record for Resident M was reviewed on 2/10/25 at 2:00 p.m. The resident was admitted on [DATE]. Diagnoses included, but were not limited to, dementia, anxiety, heart disease, and protein calorie malnutrition. The 12/16/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and she needed substantial to maximal assistance with eating. A Care Plan, dated 12/20/24, indicated the resident required assistance with ADLs including eating. The approaches were to assist with meal consumption and eating/drinking as needed. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing indicated the resident should have been assisted to eat in a timely manner. 6. During an interview on 2/3/25 at 3:00 p.m., Resident G indicated she had not received a shower since been being admitted . The record for Resident G was reviewed on 2/5/25 at 8:25 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, cellulitis of the limb, chronic obstructive pulmonary disease (COPD), heart failure, bipolar disorder, anxiety, and depression. The Admission Minimum Data Set (MDS) assessment, dated 1/29/25, indicated the resident was cognitively intact for daily decision making, and was dependent on staff for bathing. A Care Plan, dated 1/25/25, indicated the resident required assistance with ADLs including bathing. The approaches were to provide a shower or complete bed bath at least two times a week. The CNA task section of the electronic record indicated the resident was to receive a shower on Tuesday and Friday evenings. The resident received 1 complete bed bath on 1/28/25 and there was no other documentation the resident refused or had another shower or completed bed bath since admission. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing had no additional information to provide. 43293 7. During random observations on 2/3/25 at 1:06 p.m., 3:15 p.m., 3:30 p.m. and 3:55 p.m., Resident F was observed lying in bed, curled up on his left side. On 2/5/25 at 10:38 a.m., the resident was observed lying on his right side. At 1:49 p.m. he was observed lying on his right side, and a melted, unopened sherbet was on the bedside table. He was observed again at 3:08 p.m., lying on his right side. On 2/6/25 at 11:11 a.m., the resident was observed lying on his right side. Two full styrofoam cups were on the bedside table. At 11:13 a.m., the CNA repositioned the resident on his left side, but did not offer him any fluids. At 1:22 p.m., he was observed lying on his left side. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/25 at 9:04 a.m., the resident was observed lying on his right side. An unopened dietary supplement carton and full juice cup were on the bedside table. At 10:54 a.m., he was observed lying on his right side. At 1:30 p.m., he was lying on his right side. A full juice and unopened applesauce were both warm and on the nightstand. The record for Resident F was reviewed on 2/5/25 at 8:33 a.m. Diagnoses included, but were not limited to, congestive heart failure, dementia, depression, and emphysema. The 11/3/24 Annual Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs), and was receiving hospice services. A Care Plan, revised on 2/12/24, indicated the resident was dependent with ADLs including bed mobility and eating. The approaches included assisting with bed mobility and eating and drinking as needed. During an interview on 2/7/24 at 4:08 p.m., ADON (Assistant Director of Nursing) 2 indicated the resident should be turned and repositioned every two hours and the CNAs should assist/feed the resident for between meal drinks and snacks. 8. During a Resident Council meeting on 2/6/25 at 2:17 p.m., Resident H indicated he was supposed to be getting showers on Tuesdays and Fridays, but had not been receiving them. The record for Resident H was reviewed on 2/6/25 at 2:53 p.m. Diagnoses included but were not limited to, Alzheimer's disease, unspecified intellectual disabilities, and depression. The 11/16/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and required one-person physical assistance with activities of daily living (ADLs) and transfers. A Care Plan, revised on 11/22/23, indicated the resident required assistance with ADLs. Approaches included assist with bathing as needed. The CNA task section of the electronic record indicated there was no shower or bath documented for 12/3/24, 12/10/24, 1/7/25, 1/14/25, and 2/5/25. There were no documented resident refusals. During an interview on 2/7/25 at 9:34 a.m., ADON (Assistant Director of Nursing) 2 indicated the resident should have been getting showers every Tuesday and Friday. 9. During random observations on 2/4/25 at 9:16 a.m. and 2/5/25 at 8:06 a.m., Resident L's fingernails were long, jagged, and dirty. During an interview on 2/6/25 at 11:04 a.m., the resident indicated he wanted his fingernails cut and wanted a shower. At that time, his fingernails remained long, jagged, and dirty. The record for Resident L was reviewed on 2/5/25 at 1:23 p.m. Diagnoses included, but were not limited to pneumonia, type 2 diabetes, and dementia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 12/31/24 Medicare-5 day Minimum Data Set (MDS) assessment indicated, the resident had severe cognitive impairment, and required moderate assistance with ADLs. A Care Plan, updated 3/24/25, indicated the resident had the potential for impaired skin integrity. Approaches included keeping the resident's fingernails short. The CNA task section of the electronic record indicated only one shower, on 1/29/25, was documented since the resident was admitted on [DATE]. Resident refusal of showers were documented on 1/11/25, 1/15/25, and 1/18/25. The record lacked documentation of attempting to re-schedule missed showers. During an interview on 2/7/25 at 3:56 p.m., ADON (Assistant Director of Nursing) 1 indicated all showers should be documented in the electronic record, refused showers should be re-attempted, and that she would have a nurse cut the resident's fingernails. 10. During a dining room observation on 2/3/25 at 12:03 p.m., Resident N was observed in a broda chair (a positioning chair for individuals with complex needs) without a meal tray. The three other residents in the room had meal trays. There was no staff in the room. At 12:17 p.m., there still was no staff in the room and Resident N had no lunch tray. At 12:24 p.m., a CNA started to feed the resident. During a dining room observation on 2/6/25, the meal trays arrived at 11:44 a.m. At 12:22 p.m., CNA 1 started feeding Resident N. At 12:23 p.m., CNA 1 left the dining room. No other staff were present. At 12:29 p.m., CNA 1 returned and resumed feeding the resident. The record for Resident N was reviewed on 2/6/25 at 10:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and hypertension. The 1/5/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, was dependent with ADLs and required maximum assist with eating. The Task List, updated 2/3/25, indicated the resident was totally dependent for feeding, and the staff must complete the task for the resident. During an interview on 2/7/25 at 4:00 p.m., the Director of Nursing (DON) indicated the resident should not have had to wait to be fed. 11. During an interview on 2/3/25 at 3:37 p.m., Resident P indicated he was supposed to be getting showers on Tuesdays and Fridays but was not receiving them. The record for Resident P was reviewed on 2/7/25 at 8:44 a.m. Diagnoses included, but were not limited to, ESRD (end-stage renal disease), congestive heart failure, diabetes, and stroke. The 11/27/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and required maximum assistance with ADLs. A Care Plan, revised on 7/3/24, indicated the resident required assistance with ADLs related to the amputation of both lower legs. Approaches included assisting with hygiene as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CNA task section of the electronic record indicated there was no shower or bath documented for 12/3/24, 12/6/24, 12/10/24, 12/17/24, 12/24/24, 12/27/24, 12/31/24, 1/10/25, 1/17/25, 1/21/25, and 1/31/25. There were no documented resident refusals. During an interview on 2/7/25 at 9:34 a.m., Assistant Director of Nursing (ADON) 1 indicated the resident should be getting showers on Tuesdays and Fridays. During an interview on 2/7/25 at 9:34 a.m. the Director of Nursing (DON) indicated she had talked to the resident about showers before, and with the schedule they made, he should be getting them. 48055 12. During an interview on 2/4/25 at 9:20 a.m., Resident J indicated he did not get a shower at least two times a week, he only remembered receiving a shower on Saturday. The record for Resident J was reviewed on 2/5/25 at 1:54 p.m. Diagnoses included, but were not limited to, acquired absence of right below knee, type 2 diabetes mellitus with neuropathy, other complications of amputation stump, and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 12/9/24, indicated the resident was cognitively intact and needed substantial to maximal assist for showers. The CNA task section of the electronic record indicated the resident was supposed to receive a shower every Tuesday and Friday. Documentation for the month of January 2025 indicated the resident did not receive a shower or bed bath from 1/3/25 - 1/20/25. During an interview on 2/6/25 at 3:15 p.m., Nurse Consultant 1 indicated the resident should have received at least two showers per week. This citation relates to Complaints IN00450533 and IN00451791. 3.1-38(a)(2)(A) 3.1-38(a)2)(D) 3.1-38(a)(3)(C) 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 insulin was signed out as ordered for 2 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure treatments for skin excoriation, skin tears, and bruises were ordered and the areas were assessed and monitored for 2 of 6 residents reviewed for non-pressure related skin conditions, signs and symptoms of edema were addressed for 1 of 1 resident reviewed for edema, and no assessment of lung sounds were documented and new orders put into place for 1 of 1 resident reviewed for a change in condition. (Residents S, T, R, Q, and F) Findings include: 1. The record for Resident S was reviewed on 2/6/25 at 9:44 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and type 2 diabetes. The Annual Minimum Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively impaired for daily decision making and she was receiving insulin injections. A Care Plan, reviewed on 12/30/24, indicated the resident was at risk for complications related to a diagnosis of diabetes mellitus. Interventions included, but were not limited to, administer diabetes medications as ordered. A Physician's Order, dated 5/25/24 and listed as current on the February 2025 Physician's Order Summary (POS), indicated the resident was to receive Humalog insulin based on a sliding scale twice a day. The sliding scale insulin dose was to be administered based on the resident's blood sugar: If 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units. If blood sugar was over 400, call the Physician. The December 2024 Medication Administration Record (MAR), indicated there was no documentation of the resident's blood sugar and/or insulin administration at 5:00 p.m. on 12/9/24 and 12/23/24. The January 2025 MAR, indicated there was no documentation of the resident's blood sugar and/or insulin administration on 1/5/25 at 9:00 a.m. and at 5:00 p.m. on 1/4/25, 1/10/25, and 1/29/25. The February 2025 MAR, indicated there was no documentation of the resident's blood sugar and/or insulin administration on 2/2/25 at 5:00 p.m. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the insulin and/or blood sugar results should have been signed out as given. 2. On 2/3/25 at 11:59 a.m., Resident T was observed in his room in bed. The resident had multiple reddish/purple discolored areas to his bilateral arms and blood stains were observed on the sheet underneath the resident's left arm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 10:31 a.m., the discoloration remained to the resident's bilateral arms and again there were fresh blood stains on the sheet beneath the resident's left arm and on the protective sleeve to the resident's left elbow. On 2/5/25 at 1:53 p.m., the resident was observed in his room in bed. There was dried blood on the sheet beneath the resident's left arm. The discoloration remained to both of his arms. The record for Resident T was reviewed on 2/7/25 at 7:58 a.m. Diagnoses included, but were not limited to, chronic respiratory failure and atherosclerotic heart disease. The Admission Minimum Data Set (MDS) assessment, dated 2/5/25, was in progress. A Care Plan, dated 1/30/25, indicated the resident was at risk for complications related to antiplatelet (a medication that prevents blood clots from forming) therapy use. Interventions included, but were not limited to, daily skin inspection and report abnormalities to the nurse. An Admission Nurse's Note, dated 1/29/25 at 1:20 p.m., indicated the resident was admitted with many purple areas to the bilateral upper and lower extremities. He indicated his skin was very fragile and he had a skin tear to the left wrist area with a Hydrocolloid (a self adhesive water proof dressing for wounds) dressing in place. The Admission Assessment, dated 1/29/25, indicated the resident was admitted with purple discolored areas to the bilateral upper and lower extremities, a wound to the left chin area, and a skin tear to the left wrist. The Weekly Skin Observation sheet, dated 2/6/25, indicated the resident's skin was intact and no new areas were observed. The February 2025 Physician's Order Summary (POS) had no orders related to assessing and monitoring the discolorations and there were no treatment orders for the resident's left arm. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated areas of bruising were to be monitored every shift and orders should have been obtained to do so. 10770 3. The record for Resident R was reviewed on 2/6/25 at 10:13 a.m. Diagnoses included, but were not type 2 diabetes, major depressive disorder, anxiety disorder, dementia, altered mental status, adult failure to thrive, high blood pressure, and heart failure. The 12/7/24 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and received insulin in the last 7 days. A Care Plan, revised on 2/4/25, indicated the resident had the diagnosis of diabetes and received insulin. The approaches were to provide diabetic medication as ordered by the doctor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated 10/25/24, indicated Humalog KwikPen Subcutaneous Solution Pen-injector 100 units/ml, inject as per sliding scale: if 151 - 200 = 6 units; 201 - 250 = 8 units; 251 - 350 = 10 units; 351 - 400 = 12 units. If the glucose was greater than 400, give 12 units and call the doctor four times a day. A Physician's Order, dated 10/28/24, indicated Insulin Detemir Solution 100 units/milliliter (ml), inject 50 units subcutaneously at bedtime. A Physician's Order, dated 1/31/25, indicated Humalog KwikPen Subcutaneous Solution Pen-injector 100 units/ml, inject as per sliding scale: if 151 - 200 = 6 units; 201 - 250 = 8 units; 251 - 350 = 10 units; 351 - 400 = 12 units. If the glucose was greater than 400, give 12 units and call the doctor four times a day and inject 10 unit subcutaneously three times a day. The 11/2024, 12/2024, and 1/2025 Medication Administration Records (MAR) indicated the Humalog KwikPen was not signed out as being administered at 8:00 a.m. on 11/6/24, 11/20/24, 1/4/25, 1/13/25, and 1/16/25, at 11:30 a.m., on 11/20/24, 12/4/24, 1/4/25, 1/5/25, 1/8/25, 1/16/25, 1/17/25, 1/18/25, and 1/19/25, at 4:30 p.m. on 11/7/24, 11/26/24, 12/22/24, and 1/5/25, and at 9:00 p.m., on 11/7/24, 11/9/24, 11/26/24, 12/22/24, and 12/23/24. The 11/2024 and 12/204 MAR indicated the Insulin Detemir 50 units at 9:00 p.m. was not signed out as being administered on 11/7/24, 11/9/24, 11/26/24, 12/3/24, 12/22/24, and 12/23/24. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing had no additional information to provide. 4. During a random observation on 2/5/25 at 1:30 p.m., Resident Q was observed sitting in a broda chair in the dining room on the memory care unit. At that time, an audible loose, congested, weak cough could be heard and observed from the resident. The resident's eyes were closed and she did not respond when spoken to. At 2:05 p.m., the resident remained in the same position as above and was still observed with an audible gurgle and a loose and congested cough. No staff were observed in the room at that time. On 2/5/25 at 2:19 p.m., CNA 7 came into the dining room and heard the resident's loose cough with the audible gurgle and indicated she needed to tell the nurse about the resident. At that time, she removed the resident from the dining room and took her back to her room. At 2:25 p.m LPN 1 entered the memory care and assessed the resident in her room and indicated she needed to notify the Nurse Practitioner. The words chest x-ray could be heard from the nurse while she was in the hallway. During an observation on 2/6/25 at 9:33 a.m., the resident was dressed in street clothes lying in a broda chair. Her eyes were closed and an audible wheeze could be heard while she was breathing. There was a clear liquid running down her face, shirt and right arm. Her shirt was visibly wet on the right side. At 10:54 a. m., the Social Service Employee brought in the traveling dentist to assess the resident's mouth. At that time, the dentist donned clean gloves to both hands and performed an assessment of her mouth and teeth right there in the dining room in front of all the other residents. The dentist indicated to CNA 1 the resident was severely dehydrated and possibly needed intravenous fluids as her tissue in her mouth was sticking to her teeth. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/25 at 11:00 a.m., CNA 1 entered the dining room, removed the resident and took her back to her room where she was placed in bed. The record for Resident Q was reviewed on 2/6/25 at 2:33 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited fracture right pubis, osteoarthritis, heart failure, heart disease, vascular dementia, chronic kidney disease, anxiety, dysphagia (difficulty swallowing), protein calorie malnutrition, and mood disorder. The Admission Minimum Data Set (MDS) assessment, completed on 1/30/25, indicated the resident was not cognitively intact for daily decision making and needed set up or clean up assistance for eating. A Care Plan, dated 1/15/25, indicated the resident required assistance with ADLs (activities of daily living) including eating. The approaches were to assist with meal consumption, eating and drinking as needed. A Care Plan, dated 1/15/25, indicated the resident was at risk for complications secondary to renal insufficiency related to chronic kidney disease and will have no complications of fluid overload. A Nurse's Note, dated 2/5/25 at 2:39 p.m., indicated Resident coughing/congestion noted, Vitals 64, b/p [blood pressure] 128/66. Np [Nurse Practitioner] notified orders received and noted. POA [Power of Attorney] made aware. A Nurse's Note, dated 2/5/25 at 5:04 p.m. and documented on 2/6/25 at 4:10 p.m., indicated the resident was fed and consumed 25% of dinner. The resident had 120 cubic centimeters (cc) of juice and two ounces of the mighty shake supplement. There was no cough or temperature noted and no other issues or concerns. A Nurse's Note, dated 2/5/25 at 8:15 p.m. and documented on 2/6/25 at 4:13 p.m., indicated the resident received her evening medications and took few sips of water. Her vital signs were stable. A Nurse's Note, dated 2/6/25 at 11:15 a.m., indicated the resident was sitting in the dining room up in the broda chair and was seen by the dentist. The CNA informed the nurse of the concerns about resident sounding like she was gurgling. The resident was assessed and her blood pressure was 95/58, pulse was 58, respirations were 16 and the oxygen saturation was 65% on room air. The resident was started on oxygen at two liters and the Nurse Practitioner (NP) was notified and gave orders to send the resident to hospital for an evaluation. An NP Progress Note, dated 2/6/25 at 11:21 a.m., indicated the resident was seen for dehydration, abnormal vital signs and hypoxia (a condition where the body's tissues do not receive enough oxygen) and lethargy. The resident was currently lying in bed, was lethargic and had reports of dry mucous membranes and notable for dehydration with profound hypoxia of 65% on room air. Her respiratory exam indicated diminished lung sounds throughout with equal excursions (when both sides of the chest expand equally when a person inhales deeply). The plan was to send the resident out to the hospital for an evaluation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's temperature, oxygen saturation, and blood pressure were checked on 2/5/25 at 1:04 p.m. (prior to the nurse's assessment when the resident was observed with the loose cough). The next documented temperature, oxygen saturation and blood pressure was documented on 2/5/25 at 4:10 p.m., all of which were within normal limits. There were no vital signs, including an oxygen saturation, checked for the midnight shift on 2/5/24. There was no documented assessment of the resident's lung sounds on 2/5/25 after her change of condition. There was no documentation of any orders obtained from the NP on 2/5/25. During an interview on 2/6/25 at 11:30 a.m., Assistant Director of Nursing (ADON) 1 indicated she had a resident who she needed to send out to the hospital. When queried if the resident was Resident Q, she indicated yes it was. The ADON was unaware the resident was observed with congestion, a loose cough and gurgling the day before. She was not made aware of those details, and was told the resident just needed to see the nurse. ADON 1 indicated she was going to send the resident out immediately. During an interview on 2/6/25 at 3:15 p.m., ADON 1 indicated the resident was assessed by the NP and had an oxygen saturation of 65% and the NP indicated to send the resident to the hospital. During an interview on 2/6/25 at 3:47 p.m., Nurse Consultant 1 indicated she called LPN 1, who did order the chest x-ray, however, it was ordered through the mobile x-ray portal and not in the point click care system. She indicated the Director of Nursing was looking into why the mobile x-ray company had not been out to do the x-ray. There was no physician order documented in the point click care system, therefore ADON 1 would not have known the x-ray had been ordered and there was no assessment for the resident on the midnight shift. During an interview on 2/6/25 at 4:25 p.m., Nurse Consultant 1 indicated the mobile x-ray company indicated a routine order meant they had 24 hours to come out to the facility and get it done. During an interview on 2/7/25 at 11:10 a.m., LPN 1 indicated she notified the NP of the resident's condition and orders were obtained to get a chest x-ray as soon as possible. LPN 1 indicated the x-ray was put in as routine because she did not know when the mobile x-ray company would get there as sometimes they come from all different parts of the state. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing had no additional information to provide. The resident was admitted to the hospital on 2/6/25 with influenza A, healthcare associated bacterial pneumonia and acute kidney injury. A chest x-ray report, dated 2/6/25 and obtained in the hospital, indicated consider a cat scan to further evaluate the findings to exclude any possibility of pulmonary nodules versus possibility of nodular infiltrates in the right lung base accounting for these opacities. Additionally, the possibility of right lower lobe and right middle lobe pneumonia including possible aspiration pneumonia was considered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current 10/1/20 Change in Condition/Assessment policy, provided by Nurse Consultant 1 on 2/10/25 at 11:55 a.m., indicated when a change in resident condition was identified, the RN/LPN must complete an assessment including vital signs and any complaints of pain. Any recommendations or new orders related to the change in condition were to be transcribed and carried out per the providers instructions. 43293 5. During an observation on 2/4/25 at 10:00 a.m., Resident F's left hand was very swollen and he had red, excoriated skin patches on the back of his right shoulder area. The hospice aide indicated there was no treatment she knew of for either area. On 2/5/25 at 8:30 a.m., the hospice aide finished bathing the resident and pointed out where the excoriated area remained on the back of the resident's shoulder. The swelling to the resident's hand was unchanged. The record for Resident F was reviewed on 2/5/25 at 8:33 a.m. Diagnoses included, but were not limited to, CHF, dementia, depression, and emphysema. The 11/3/24 Annual Minimum Data Set (MDS) assessment, indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs), and was receiving hospice services. A Care Plan, updated on 11/4/24, indicated the resident had the potential for impaired skin integrity related to fragile skin. Approaches included identifying and documenting potential causative factors, monitoring and documenting location, size and treatment of skin injury, and reporting abnormalities to the physician. A Nurse's Note dated 2/3/25 at 6:44 a.m., indicated the resident's left hand was very puffy, and they would report it to the a.m. nurse. A Nurse's Note dated 2/3/25 at 8:57 a.m., indicated the hospice aide informed LPN 1 the resident had skin excoriation under the right arm, groin, and buttocks. The record lacked follow up assessments and treatments for the swollen hand and skin excoriation. During an interview on 2/7/25 at 10:13 a.m., LPN 1 indicated she would normally inform the hospice nurse and they would get orders for treatment, but she did not call them on 2/3/25, then she was off for a few days. She indicated she would call them immediately. On 2/7/25 at 10:54 a.m., the Director of Nursing and Assistant Director of Nursing (ADON) 2 were informed of the findings and offered no further information. This citation relates to Complaint IN00451791. 3.1-37(a)

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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. 10770 Based on observation, record review, and interview, the facility failed to ensure a resident with a limited range of motion had a physician-ordered splint in place for 1 of 1 resident reviewed for range of motion. (Resident O) Finding includes: During an observation on 2/3/25 at 2:52 p.m., Resident O was observed sitting in his wheelchair in his room. At that time, his left hand was flaccid and closed and he could not open his hand without assistance. There was no anti-contracture device in his left hand. During random observations on 2/4/25 at 11:02 a.m., 2/5/25 at 7:25 a.m. and 1:56 p.m., on 2/6/25 at 9:28 a.m. and 3:20 p.m., and on 2/7/25 at 11:05 a.m., the resident's left hand was observed flaccid and closed. There was no anti-contracture device in his left hand. The record for Resident O was reviewed on 2/5/25 at 3:06 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia affecting the left side. The 11/27/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a functional range of motion impairment to one side of his upper and lower extremity. A Care Plan, revised on 7/29/24, indicated the resident was at risk for complications secondary to experiencing alteration in musculoskeletal status due to a contracture to the left hand that required a splint. There was no care plan the resident refused care or the splint. A Physician's Order, dated 7/29/24, indicated apply a resting hand splint to the left hand daily, on for a minimum of four hours and maximum of eight hours. The Treatment and Medication Administration Records for the months of 11/2024, 12/2024 and 1/2025 indicated the splint was not signed out as being donned or doffed. During an interview on 2/7/25 at 11:20 a.m. CNA 2 indicated she had not donned a splint to his left hand because when restorative was working, they took care of it. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing indicated she had no additional information to provide. 3.1-42(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 10770 Based on observation and interview, the facility failed to ensure residents in the memory care unit were supervised during meals and while eating for 4 of 4 residents reviewed for supervision. (Residents 81, R, L, and 6) Findings include: 1. During a random observation on 2/3/25 at 12:03 p.m., there were 4 residents observed in the memory care unit lounge at the end of the hall. All of them were observed with their lunch meal in front of them and eating by themselves with no staff in the room. Resident 81 and Resident R were observed seated at a table by themselves. Resident R was served pork, broccoli, and a baked potato. The baked potato was cut up, however the pork was still whole and not cut into smaller pieces. Resident 81 was observed sitting in a wheelchair next to Resident R. She was served pureed meat, pureed vegetable, pureed potatoes, and a pureed dessert in a separate bowl. She was also served a red beverage and a carton of lactose free milk. At 12:15 p.m., Resident R picked up the carton of lactose free milk, which was Resident 81's milk, and drank it. Again there was no staff in the room to assist the residents. Resident 6 and Resident L were seated at a table by themselves and eating their food. Resident 6 had a mechanically altered diet and her meat was ground. She also had a cup of thickened liquid in front of her. There was no staff in the room to supervise the residents. At 12:23 p.m., CNA 6 entered the lounge and sat down to feed another resident who was in the room as well. Residents 81, R, L, and 6 were still eating their food without staff supervision. 2. During a random observation on 2/6/25 at 9:33 a.m., Resident 81 was observed sitting in the dining room on the memory care unit. At that time, she was eating a jelly packet. There was no staff in the room. At 11:44 a.m., the lunch trays arrived to the unit and were parked by the dining room. At 11:52 a.m., Assistant Director of Nursing (ADON) 1 started to pass the trays to the residents who were seated in the dining room. Resident 81 received her lunch tray at 11:54 a.m., which consisted of a carton of lactose free milk, double portions of pureed meat, pureed rice, pureed vegetables and applesauce. Resident R received her lunch at 11:59 a.m., which consisted of some type meat, mashed potatoes, vegetables, and green jello. She received one cup of pink lemonade, of which she drank the entire cup in one breath. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:01 p.m., CNA 1 left the dining room and proceeded to pass the rest of the lunch trays to those residents who were in their rooms. QMA 1 was observed passing medications by the medication cart in the hallway, therefore there was no staff in the dining room supervising the residents while they ate. At 12:09 p. m., there still was no staff in the dining room to supervise the residents while they ate. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing indicated the residents were to be supervised while eating. 3.1-45(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. 10770 Based on observation, record review and interview, the facility failed to ensure residents were assisted with meals and nutritional supplement consumption was recorded for residents with a history of weight loss for 2 of 4 residents reviewed for nutrition. (Residents R and 81) Findings include: 1. During a random observation on 2/3/25 at 12:03 p.m., Resident R was observed sitting in a wheelchair in the memory care lounge area at a table. The resident's lunch was in front of her. She was served pork, broccoli, and a baked potato. The baked potato was cut up, however the piece of pork was still whole and not cut into smaller pieces. There was no staff in the room to assist the resident and she just stared out of the window. At 12:15 p.m., the resident picked up a carton of lactose free milk, belonging to the resident who was sitting next to her, and drank it. Again, no staff were in the room to assist the resident. At 12:23 p.m., CNA 6 entered the lounge and offered to help the resident eat. The resident had not touched or ate any of her food before the CNA arrived. During a random observation on 2/6/25 at 11:59 a.m., Resident R was observed seated in the dining room on the memory care unit. At that time, she received her lunch tray, which consisted of some type meat, mashed potatoes, vegetables, and green jello. She received one cup of pink lemonade, for which she drank the entire cup in one breath. She was observed to pick up her fork and started to eat her mashed potatoes. No staff were observed to help the resident at that time. At 12:06 p.m., the resident stopped eating and no staff were in the room to assist her or encourage her to eat. At 12:09 p.m., QMA 1 entered the room and gave the resident her health shake supplement. The carton was already opened with a straw and the resident was observed to drink the shake. The QMA did not offer to help or encourage the resident to eat. At 12:12 p.m., the resident reached over to the resident sitting to her left and grabbed a cup of pink lemonade and drank the entire contents in one breath. Again, no staff were in the room helping the resident eat or redirecting the resident. At 12:15 p.m., the resident pushed herself away from the table and sat and stared out the window. No staff were observed to redirect or offer to help the resident finish her lunch, as she only ate the mashed potatoes. The record for Resident R was reviewed on 2/6/25 at 10:13 a.m. Diagnoses included, but were not type 2 diabetes, major depressive disorder, anxiety disorder, dementia, altered mental status, adult failure to thrive, high blood pressure, and heart failure. The 12/7/24 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed supervision or touching assistance with eating. She weighed 181 pounds with no weight loss and received a therapeutic diet. The Care Plan, revised on 7/29/24, indicated the resident was at risk for impaired nutritional status due to depression, dementia, and functional decline. The approaches were to provide assistance with meal intake as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident weighed 207 pounds on 6/5/24 and 181 pounds on 12/3/24, which was a significant weight loss of 10% or greater in 6 months. The resident weighed 184 pounds on 1/9/25. A Physician's Order, dated 12/10/23, indicated consistent carbohydrate and a no added salt general diet with regular texture and thin liquids. A Physician's Order, dated 11/13/24, indicated sugar free mighty shakes house supplement three times a day. A Registered Dietitian (RD) Note, dated 12/18/24, indicated the resident had a 10.8% weight loss in the last six months which mostly occurred in June and July 2024. The staff reported the resident's dementia may be progressing and she slept a lot. The resident received sugar free health shakes three times a day, fed herself with set up and staff assist as needed. The 1/2025 and 2/2025 Medication Administration Record (MAR) indicated there was no documentation of how much of the health shake was consumed by the resident. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing indicated the consumption of health shakes were to be documented and the resident also needed more assistance with eating. 2. During a random observation on 2/3/25 at 12:03 p.m., Resident 81 was observed sitting in a wheelchair at a table in the memory care lounge with her lunch meal in front of her. She was served pureed meat, pureed vegetable, pureed potatoes, and a pureed dessert in a separate bowl. She was also served a red beverage and a carton of lactose free milk. At 12:17 p.m., no staff were observed in the room and resident was observed pouring her red beverage over the mashed potatoes. She then picked up her plate and was going to set it on the floor as she thought there was a dog there to eat it. At 12:19 p.m. she put the plate back on the table and started playing with all of her food. She mixed the dessert with the meat and green vegetable. She was not eating and there was no staff in the room to assist the resident. She was not using any utensils while playing with her food and she used her fingers. The resident sitting next to her picked up the resident's carton of lactose free milk and drank it. Again no staff were observed in the room. At 12:23 p.m., CNA 6 entered the lounge and sat down to feed another resident. The CNA picked up the carton of lactose free milk from the other resident and placed it back in front of Resident 81, despite the other resident having drank from the carton. She did not offer to assist Resident 81 with eating or encourage the resident to use the spoon to eat rather than her fingers. At 12:26 p.m., the resident was eating the dessert with her hands and still mixing all of it together. Again no staff were observed to assist the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a random observation on 2/5/25 at 7:34 a.m., Resident 81 was observed in bed and awake. At 8:00 a.m., the resident was observed still in bed and feeding herself with her fingers. At that time, she had placed the cup of water in the middle of her plate. At 8:13 a.m., the resident put the cup of juice on her plate and was observed licking the food from the bottom of the cup and spilling the juice on herself. No staff were observed in the room helping the resident eat or redirecting her, so at that time, she was asked by the surveyor if she could try to use the spoon to eat. The resident picked up the spoon and started to eat her food and ate all of the pureed food that was left on the plate. No staff were observed to assist the resident to eat. At 8:28 a.m., the resident was observed pouring juice into the inverted dome lid, again no staff were around to help the resident. During a random observation on 2/6/25 at 11:54 a.m., the resident received her lunch tray in the memory care dining room. She received a carton of lactose free milk, double portions of pureed meat, pureed rice, pureed vegetables and applesauce. The resident was handed a plastic spoon and started to eat her food. At 12:26 p.m., the resident was not eating and was just sitting in her wheelchair at the table with her eyes closed. No staff were observed to help the resident. At 12:32 p.m., Assistant Director of Nursing (ADON) 1 woke the resident up and encouraged her to finish eating, as she had not eaten much food. The record for Resident 81 was reviewed on 2/6/25 at 8:45 a.m. Diagnoses included, but were not limited to, heart disease, major depressive disorder, anxiety disorder, psychosis, dementia with behaviors, high blood pressure, and osteoarthritis. The 10/29/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making and needed supervision or touching assistance with eating. The resident weighed 199 pounds and had no weight loss and received a mechanically altered diet. A Care Plan, revised on 11/1/24, indicated the resident was at risk for impaired nutritional status related to a history of weight fluctuations. The approaches were to provide assistance with meal intake as needed. A Physician's Order, dated 10/3/24, indicated a general pureed diet. A Physician's Order, dated 11/13/24, indicated weekly weights times four weeks. The weight log indicated the resident was weighed on the following dates: 11/19/24 194 pounds 11/27/24 190 pounds 12/6/24 191 pounds 1/9/25 192 pounds The resident weighed 216 pounds on 9/2/24 and 192 pounds on 1/9/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Registered Dietitian (RD) Note, dated 1/26/25, indicated the January weight of 192 pounds showed significant weight loss of 11.2% in three months and a significant weight loss of 10% in six months. The resident required set up and as needed staff assistance with meals. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing indicated the resident needed more assistance with eating. 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. 10326 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) placement was checked prior to medication administration, water flushes and medications were instilled via gravity, and documentation of gastrostomy tube care was completed for 2 of 3 residents reviewed for tube feeding. (Residents 72 and K) Findings include: 1. On 2/7/25 at 6:40 a.m., RN 3 was observed preparing a medication for Resident 72. The resident received her medications by the way of a gastrostomy tube. Upon entering the room, the RN donned gloves and placed the cup containing the medication on the over bed table. The RN proceeded to place his stethoscope on the resident's abdomen and listen to her bowel sounds. After listening to the resident's bowel sounds, the RN proceed to flush the resident's gastrostomy tube, he pushed 30 milliliters (mls) of water in via the syringe plunger rather than instilling the water via gravity. He then proceeded to administer the resident's medication. Again, he pushed the medication in rather than instilling the medication via gravity. After he was done administering the medication, he listened to the resident's bowel sounds and proceeded to check the gastrostomy tube for residual (the amount of fluid left in the stomach after receiving enteral nutrition). The RN proceeded to remove his gloves and left the resident's room. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the RN should have checked for residual prior to administering the medication and should have the let the flush and the medications instill by gravity. The facility policy titled, Enteral Feeding Tube Medication Administration was provided by Nurse Consultant 1 and identified as current on 2/7/25 at 11:05 a.m. The policy indicated, prior to flushing a feeding tube, the administration of medication via a feeding tube , or the providing of tube feedings, the nurse performing the procedure ensures the proper placement of the feeding tube. Once residual is checked and prior to medication administration, the nurse will flush the tube with 30 (mls) of water. 10770 2. During a random observation on 2/4/25 from 10:00 a.m. to 11:00 a.m., Resident K was observed sitting in the wheelchair in the hallway by the nurses' station. At that time, the resident was not connected to any enteral feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:01 a.m. the resident was taken to his room by Assistant Director of Nursing (ADON) 2 and was seated in the wheelchair by his bed. RN 1 entered the room at 11:05 a.m. and obtained 30 cubic centimeters (cc) of tap water from the sink. She unclamped his peg tube (a tube inserted directly into the stomach for nutrition) and pushed (plunged) the water through the tube rather than via gravity. RN 1 indicated she wanted to make sure the tube was patent before connecting him to the enteral feeding. The record for Resident K was reviewed on 2/5/25 at 10:35 a.m. Diagnoses included, but were not limited to, cerebral palsy, quadriplegia, epilepsy, autistic disorder, severe protein malnutrition, peg tube, and dysphagia (difficulty swallowing) The 1/22/25 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact for daily decision making, weighed 70 pounds, had a feeding tube, and received 51% or more and 501 cc of fluids through the peg tube. The Care Plan, revised on 9/25/24, indicated the resident required a tube feeding. The approaches were to monitor and report infections at tube site. A Physician's Order, dated 11/16/22, indicated enteral feeding of Jevity 1.5 at 50 cc per hour for 20 hours, on at 10:00 a.m., and off at 6:00 a.m. A Physician's Order, dated 8/31/24, indicated NPO (nothing by mouth) There were no orders to clean around the peg tube site at least daily. A Nurse's Note, dated 2/4/25 at 9:55 a.m. and created on 2/4/25 at 12:11 p.m., indicated staff attempted to flush the resident's peg tube and was only able to flush 90 cc of water, was unable to flush remaining 30 cc and hang the enteral feeding due to the resident refusing care, swinging his right arm towards abdomen, and yelling out. The Nurse Practitioner was made aware. The Medication and Treatment Administration Records for 12/2024, 1/2025 and 2/2025 indicated there were no orders to clean around the peg tube site on daily basis. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing indicated the water should not be plunged into the peg tube. There was no documentation of the peg tube site care in the clinical record. The current 2/15/21 Gastrostomy Site Care policy, provided by the Administrator on 2/7/25 at 4:10 p.m., indicated it was the facility policy to provide gastrostomy site care to decrease the risk of infection. The procedure was to obtain a physician order to include the type of solution for cleansing and the frequency of the treatment. For an established site, the procedure was to use soap and water and gently clean the area around the tube and under the bolster, use gauze pads and dry after cleaning. Leave the site open to air unless otherwise ordered. 3.1-44(a)(2)

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Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 3 of 3 residents reviewed for oxygen. (Residents T, G, and 30) Findings include: 1. On 2/3/25 at 11:59 a.m., Resident T was observed in his room in bed. The resident had oxygen in use by the way of a nasal cannula. The oxygen concentrator, which was located in the resident's bathroom, was set at four liters. At 3:18 p.m., the oxygen remained in use at four liters. On 2/4/25 at 10:34 a.m., the resident's oxygen remained in use at four liters per nasal cannula. On 2/5/25 at 9:31 a.m., 11:10 a.m., and 1:53 p.m., the resident remained in his room in bed with oxygen per nasal cannula in use. The resident's oxygen concentrator was set at three liters. On 2/6/25 at 9:30 a.m., 11:58 a.m., and 3:03 p.m., the resident remained in his room in bed with oxygen per nasal cannula in use. The resident's oxygen concentrator was set at three liters. On 2/7/25 at 5:43 a.m., the resident was observed in his bed with oxygen per nasal cannula in use. The resident's oxygen concentrator was set at three liters. The record for Resident T was reviewed on 2/7/25 at 7:58 a.m. Diagnoses included, but were not limited to, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), hypertensive heart disease with heart failure, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 2/5/25, was in progress. A Care Plan, dated 1/30/25, indicated the resident required oxygen therapy related to the diagnosis of COPD with chronic hypoxic respiratory failure. Interventions included, but were not limited to, oxygen via nasal cannula per physician's order. A Physician's Order, dated 1/30/25, indicated the resident was to receive oxygen at two liters per minute via nasal cannula continuously. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the resident's oxygen concentrator should have been at the correct flow rate of two liters. 10770 2. During a random observation on 2/3/25 at 3:00 p.m., Resident G was observed in bed with her eyes closed. At that time, she was wearing oxygen per nasal cannula and flow rate was set at 1.5 liters. During random observations on 2/4/25 at 11:03 a.m. and 11:45 a.m., the resident was in bed and wearing oxygen at 1 liter per nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident G was reviewed on 2/5/25 at 8:25 a.m. the resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, cellulitis of the limb, chronic obstructive pulmonary disease (COPD), heart failure, bipolar disorder, anxiety, and depression. The Admission Minimum Data Set (MDS) assessment, dated 1/29/25, indicated she was cognitively intact for daily decision making and received oxygen while a resident. The Care Plan, dated 1/27/25, indicated the resident has oxygen therapy related to the diagnosis of COPD. The approaches were to administer oxygen as ordered. A Physician's Order, dated 1/24/25, indicated continuous oxygen per nasal cannula at two liters per minute. During an interview on 2/7/25 at 3:15 p.m., the Director of Nursing had no additional information to provide. 43293 3. On 2/3/25 at 3:13 p.m., an oxygen concentrator with nasal cannula (a pronged tube for dispensing oxygen through the nose) connected was observed in Resident 30's room. The resident indicated he used the oxygen whenever he felt like he needed it, and usually at night. He demonstrated how to turn the concentrator on, and the flow rate was observed at 3 lpm (liters per minute). On 2/5/25 at 1:53 p.m., the set oxygen flow rate was again observed at 3 lpm. The record for Resident 30 was reviewed on 2/5/25 at 10:09 a.m. Diagnoses included, but were not limited to, COPD, dementia, schizophrenia, and sleep apnea. The 12/1/24 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 1/27/25, indicated oxygen at 2 lpm (liters per minute) every eight hours as needed for shortness of breath. During an interview on 2/5/25 at 3:11 p.m., LPN 1 indicated the oxygen should be at 2 lpm, and she would change it. During an interview on 2/7/25 at 9:23 a.m., the Director of Nursing (DON) observed the oxygen flow rate remained at 3 lpm and indicated the flow rate should match what was ordered. 3.1-47(a)(6)

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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. 10326 Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 8 residents observed during medication pass. Four errors were observed during 34 opportunities for errors during medication administration. This resulted in a medication error rate of 11.7% (Residents 72, 9, and 114) Findings include: 1. On 2/7/25 at 6:58 a.m., RN 3 was observed preparing Resident 72's Lispro insulin. The RN administered 8 units of insulin by the way of an insulin pen for a blood sugar of 362. At 8:34 a.m., RN 2 was observed preparing the resident's Entrapenem (an antibiotic) for an intramuscular (IM) injection (a medical procedure where the medication was injected directly into the muscle). The RN diluted the medication with 3.2 milliliters (mls) of Lidocaine (a medication to numb the skin) and then proceeded to dilute the medication with 10 cc's (cubic centimeters) of normal saline. The RN administered the injection into the right upper arm. The record for Resident 72 was reviewed on 2/7/25 at 10:00 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes and urinary tract infection. Current Physician's Orders indicated the resident was to receive 10 units of Lispro insulin for a blood sugar between 351 and 400. The resident was also to receive Entrapenem 1 gram IM. The medication was to be diluted with 3.2 mls of Lidocaine and administered immediately. There was no order for the medication to be diluted with 10 cc's of normal saline. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the resident should have received 10 units of insulin rather than eight and the IM antibiotic should have only been diluted with the Lidocaine based on the information received from the pharmacy. 2. On 2/7/25 at 8:02 a.m., QMA 1 was observed preparing medications for Resident 9. The QMA dispensed a Buspirone (an anti-anxiety medication) 5 milligram tablet into the medication cup. The resident was observed to take the medication at 8:05 a.m. The record for Resident 9 was reviewed on 2/7/25 at 10:10 a.m. The resident's Buspirone had been discontinued on 2/5/25. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the resident should not have received the Buspirone and the medication should have been removed from the medication cart. 3. On 2/7/25 at 9:20 a.m., LPN 2 was observed preparing Resident 114's medications. A 5 milligram (mg) Lexapro tablet was dispensed into the medication cup. The resident was given her medications at that time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident 114 was reviewed on 2/7/25 at 10:15 a.m. A current Physician's Order, indicated the resident was to receive Lexapro 5 mg, three tablets daily. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the resident should have received three tablets of Lexapro instead of one. 3.1-48(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48055 Based on observation, record review and interview, the facility failed to ensure a controlled substance was double locked at all times for 1 of 2 medication rooms observed. (West Unit) Finding includes: On 2/10/25 at 10:11 a.m., the [NAME] Unit Medication Room was observed with Assistant Director of Nursing (ADON) 2. Inside the unlocked refrigerator, there was an unlocked white hospice box which contained Morphine Sulfate Roxanol 20 milligrams (mg), a Schedule II controlled substance. During an interview on 2/10/25 at 10:11 a.m., ADON 2 indicated the hospice box should be locked due to the narcotic contents inside. A facility policy, titled Receiving Controlled Substances, indicated, .G Medications listed in Schedules II, III, IV, and V were stored double lock . 3.1-25(m)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 48055 Based on observation, record review, and interview, the facility failed to ensure a resident received routine dental services for 1 of 1 resident reviewed for dental services. (Resident J) Finding includes: During an interview on 2/4/25 at 9:18 a.m., Resident J indicated he wanted to see a dentist for routine dental treatment. The record for Resident J was reviewed on 2/5/25 at 1:54 p.m. Diagnoses included, but were not limited to, dysphasia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 12/9/24, indicated the resident was cognitively intact. A signed dental consent, dated 3/28/24, indicated the resident wanted to receive dental services offered by the facility. There was no documentation any dental appointments had been completed for the resident. Documentation provided by the Social Service Director on 2/6/25 at 12:40 p.m., indicated the facility switched to a different dental company in July of 2024. During an interview on 2/6/25 at 12:47 p.m., the Social Service Director indicated the resident did not sign a consent form for the new dental company and was accidentally skipped for dental services. 3.1-24(a)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to staff failing to disinfect multi-use equipment, perform hand hygiene after glove removal, medications touched with bare hands, hand hygiene not completed after direct resident contact, glucometers not disinfected after use for 1 of 1 glucometer observed, not donning personal protective equipment (PPE) for a resident in enhanced barrier precautions (EBP), not containing soiled linen, and the improper storage of personal care equipment during random infection control observations. (Residents 63, 25, 83, 72, and 10) Findings include: 1. On 2/4/25 at 9:13 a.m., CNA 4 and CNA 5 were observed in Resident 63's room preparing to transfer her via a Hoyer lift (a mechanical lift). At 9:25 a.m., the CNAs donned gloves without hand sanitizing and transferred the resident via the Hoyer lift. After transferring the resident, the CNAs removed their gloves and CNA 5 placed the Hoyer lift in the hallway outside of the resident's room. The CNA did not disinfect the Hoyer after use and both CNAs did not hand sanitize after removing their gloves. At 9:39 a.m., a different CNA removed the Hoyer from the hallway and took it into another resident's room. At 9:45 a.m., the Hoyer was again taken into another resident's room. The Hoyer was not disinfected until 9:50 a.m. by CNA 4. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing and Assistant Director of Nursing 1 indicated the multi-use equipment was to be wiped down with a germicidal wipe after use. The Hand Hygiene policy was provided by Nurse Consultant 1 on 2/7/25 at 11:05 a.m. and identified as current. The policy indicated an alcohol based hand sanitizer was to be used immediately before touching a patient, after touching a patient or the patient's immediate environment, and immediately after glove removal. 2. On 2/7/25 at 5:30 a.m., RN 4 was observed preparing Resident 25's medication. The RN dispensed the medication into her bare hand and then she placed the medication into the medication cup prior to administer to the resident. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the RN should not have touched the resident's medication with her bare hand. 3. On 2/7/25 at 5:35 a.m., RN 4 was observed preparing Resident 83's medication. The RN dispensed the medication into her bare hand and then she placed the medication into the medication cup prior to administering to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated the RN should not have touched the resident's medication with her bare hand. The Oral Medication Administration policy was provided by Nurse Consultant 1 on 2/7/25 at 11:05 a.m. The policy indicated to pour or push the correct number of tablets or capsules into the souffle cup, taking care to avoid touching the tablet or capsule, unless wearing gloves. 4. On 2/7/25 at 5:45 a.m., CNA 3 was observed in Resident 72's room providing morning care. The CNA was wearing gloves but no gown. The resident was in Enhanced Barrier Precautions (EBP) due to having a gastrostomy tube (a tube surgically inserted into the stomach that allows for the delivery of food and medication) and a pressure ulcer. At that time, soiled bed linens and a gown were observed on the floor. An incontinence brief soiled with bowel movement and disposable wash cloths were also observed on the floor next to the resident's bed. There was also two areas of bowel movement observed on the floor next to the resident's bed. None of the linen and personal care items were contained. During an interview at that time, the CNA indicated the resident needed to be changed and she didn't have a bag. The CNA proceeded to pick the items up from the floor and dispose of them in the trash can. The linens were placed in a bag and removed from the room. The CNA left the resident's room wearing her gloves in the hallway and carrying the bag of soiled linen and went to another resident's room in another hallway. The CNA donned a clean pair of gloves over her dirty gloves and placed the soiled bag of linen on the floor outside of another resident's room. After leaving the resident's room, the CNA proceeded down the hallway wearing her gloves and dragging the bag of soiled linen on the floor while she made multiple stops in other resident rooms in the hallway. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing and Assistant Director of Nursing 1 indicated the linen should have been contained in Resident 72's room and gloves were not to be worn in the hallway. They also indicated the bag of soiled linen should not have been dragged down the hallway. The facility Infection Prevention and Control Program was provided by Nurse Consultant 1 on 2/7/25 at 11:05 a.m., and identified as current. The policy indicated soiled linens were to be bagged or otherwise contained at the point of collection in leak-proof containers or bags. 5. On 2/7/25 at 6:40 a.m., RN 3 was observed checking Resident 72's blood pressure. He was not wearing gloves and he did not wash or sanitize his hands prior to entering the resident's room. After obtaining the resident's blood pressure result, the RN left the room. He did not wash or sanitize his hands and the blood pressure cuff was not disinfected. At 6:53 a.m., RN 3 was observed checking the resident's blood sugar with a glucometer. The RN donned gloves but did not sanitize or wash his hands prior. After obtaining the resident's blood sugar result, the RN removed his gloves and did not sanitize or wash his hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 6:58 a.m., the RN administered the resident's insulin. Prior to administering the insulin, the RN donned gloves without sanitizing or washing his hands. After administering the insulin, the RN walked back to the medication cart in the hallway. The RN was still wearing his gloves and proceeded to document on the computer while wearing his gloves. The glucometer was placed back inside the medication cart. During an interview on 2/7/25 at 7:05 a.m., RN 3 indicated the glucometer was for the unit and not individual residents. He also indicated he should have disinfected the glucometer prior to putting it back into the medication cart. The RN then proceeded to wipe the glucometer with a germicidal wipe and then placed it back into the cart. RN 3 indicated he should have sanitized his hands in between contact with each resident. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing and Assistant Director of Nursing 1 indicated the multi-use equipment was to be wiped down with a germicidal wipe after use. They also indicated the glucometer was to wiped down and wrapped with a germicidal wipe and then left open to air to dry. Hand sanitizing should be completed after resident contact and after glove removal. The facility Glucometer Cleaning policy was provided by Nurse Consultant 1 on 2/7/25 at 11:05 a.m. and identified as current. The policy indicated the glucometer was to be cleaned and disinfected with a pre-moistened germicidal or antimicrobial wipe. The meter was to be wiped with the wipe/towel until all surfaces of the glucometer were visibly wet, wrap with wipe, leave wet according to manufacturer's instructions and place the glucometer on a clean surface such as a paper towel and allow to air dry. 6. On 2/7/25 at 6:30 a.m., RN 3 was observed administering medications to Resident 10. The RN was not wearing gloves at the time. The RN did not sanitize his hands prior to administering the medications and he did not sanitize his hands after making direct contact with the resident. During an interview on 2/7/25 at 1:45 p.m., the Director of Nursing indicated hands were to be sanitized and/or washed after each direct resident contact. The Hand Hygiene policy was provided by Nurse Consultant 1 on 2/7/25 at 11:05 a.m. and identified as current. The policy indicated an alcohol based hand sanitizer was to be used immediately before touching a patient, after touching a patient or the patient's immediate environment, and immediately after glove removal. 48055 7. During the environmental tour with the Maintenance Director on 2/11/25 at 1:16 p.m., the following was observed: a. room [ROOM NUMBER] - A pink wash basin was positioned on the back of the toilet and uncontained. b. room [ROOM NUMBER] - A bed pan was on the floor in the bathroom next to the garbage can. c. room [ROOM NUMBER] - There was a pink bed pan on the night stand that was uncontained. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. room [ROOM NUMBER] - A urinal with yellow fluid was in the sink and open. e. room [ROOM NUMBER] - An uncontained wash basin was on the floor in the resident's room. During an interview on 2/11/25 at 1:45 p.m. the Maintenance Director, indicated the bed pans should not be on the floor. 3.1-18(b)