STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155251	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Hobart Skilled Nursing Facility, The	2901 W 37th Ave Hobart, IN 46342

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 10326 Based on observation, record review, and interview, the facility failed to ensure residents had physician's orders for medications and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 100 and 2) Findings include: 1. During a random observation on 7/8/24 at 3:19 p.m., Resident 100 was observed in his room in bed. At that time, a tube of over the counter hydrocortisone cream was observed on his over bed table with the cap off as well as an Albuterol Sulfate inhaler. During an interview at that time, the resident indicated he left the medications on his over bed table in case he needed them. During random observations on 7/9/24 at 9:00 a.m. and 3:00 p.m. and 7/10/24 at 8:55 a.m. and 11:42 a.m., the inhaler remained on the resident's over bed table. The record for Resident 100 was reviewed on 7/8/24 at 3:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, emphysema, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 6/28/24, indicated the resident was cognitively intact. The July 2024 Physician's Order Summary (POS), indicated the resident did not have an order for the Albuterol Sulfate inhaler nor the hydrocortisone cream. The resident also did not have an order to self-administer his medications. There was no Self-Administration of Medication assessment available for review. During an interview on 7/10/24 at 1:35 p.m., Nurse Consultant 1 was informed about the medications at the bedside. At 3:39 p.m., the Consultant indicated the resident's family brought the medications in for him. She indicated the family was spoken to and a care plan was initiated. 10770 2. During random observations on 7/8/24 at 7:55 a.m., 10:22 a.m., 11:10 a.m., and 1:45 p.m., Resident 2 was observed in bed. At those times, there was an opened tube of Iodosorb (a gel used to treat wet ulcers or wounds) gel with the cap off on top of the dresser by the television set. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident 2 was reviewed on 7/9/24 at 1:52 p.m. Diagnoses included, but were not limited to, left side hemiplegia, stroke, type 2 diabetes, heart disease, dementia, dysphagia (swallowing difficulties), and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/24, indicated the resident was moderately impaired for daily decision making. The resident received an enteral feeding of 51% or more through a peg tube. There was no care plan to keep the Iodosorb gel at the bedside. A Physician's Order, dated 6/1/24, indicated to apply Iodosorb gel to the left heel every 72 hours. There was no physician's order to keep the Iodosorb gel at the bedside. During an interview on 7/9/24 at 3 p.m., Nurse Consultant 1 indicated the cream was not to be left in the resident's room nor was there an order to keep the medication at bedside. The current and updated Self Administration of Medication by Residents policy, provided by Nurse Consultant 1 on 7/11/24 at 3:00 p.m., indicated if the resident desired to self-administer medications, an assessment was conducted by an Interdisciplinary team. 3.1-11(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependent residents related to nail care and the removal of facial hair for 2 of 7 residents reviewed for ADL care. (Residents 44 and 22) Findings include: 1. On 7/8/24 at 11:25 a.m., Resident 44 was in her room seated in a wheelchair. The resident's fingernails were long with a dark substance underneath and she had an accumulation of facial hair. At 3:18 p.m., the resident was observed in bed sleeping. The facial hair remained to her chin and her hands were covered with a blanket. On 7/9/24 at 9:03 a.m. and 3:00 p.m., the resident's fingernails remained long and dirty and the gray facial hair remained to her chin. On 7/10/24 at 8:58 a.m. and 11:42 a.m., the resident's fingernails remained long and dirty and the gray facial hair remained to her chin. The record for Resident 44 was reviewed on 7/10/24 at 11:12 a.m. Diagnoses included, but were not limited to, stroke, sepsis, dysphagia (difficulty swallowing), type 2 diabetes, and chronic kidney disease. A 5 day Medicare Minimum Data Set (MDS) assessment was in progress. The resident was identified as being moderately impaired for daily decision making. The Admission MDS assessment, dated 6/4/24, indicated the resident was dependent on staff for personal hygiene. A Care Plan, dated 6/7/24, indicated the resident required assistance with ADL's. There was no care plan indicating the resident preferred long fingernails. The shower schedule indicated the resident was to receive a shower on Wednesday and Saturday evenings. The Task section in the Point of Care charting indicated the resident received a shower on 7/3/24 and a bed bath on 7/4 and 7/5/24. There was no documentation on the Weekly Skin Check/Shower Sheet since the resident was readmitted to the facility on [DATE]. During an interview on 7/11/24 at 10:40 a.m., Nurse Consultant 2 was informed the resident had long nails and facial hair and the resident had not had a documented bed bath or shower since 7/5/24. No further information was provided. 10770 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During random observations on 7/8/24 at 8:03 a.m., 10:33 a.m., and 2:14 p.m., on 7/9/24 at 9:10 a.m., 12:40 p.m., and 3:00 p.m., and on 7/10/24 at 9:00 a.m., 9:30 a.m., and 11:15 a.m., Resident 22 was observed sitting in a wheelchair. At those times, his fingernails were long and he was unshaven. During an interview on 7/8/24 at 8:03 a.m., the resident indicated he would like his nails trimmed because they were starting to break off. The record for Resident 22 was reviewed on 79/24 at 9:50 a.m. Diagnoses included, but were not limited to, type 2 diabetes, Urinary Tract Infection (UTI), dementia without behaviors, high blood pressure, obstructive and reflux uropathy (a condition where urine cannot drain into the urinary tract), and anxiety disorder. The 5/30/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and was dependent on staff for personal hygiene. The Care Plan, dated 2/13/24, indicated the resident had an ADL self care deficit. There was no documentation to indicate if the resident had his nails trimmed recently. A shower sheet, dated 7/1/24, indicated the resident received a shower and a shave. During an interview on 7/10/24 at 9:30 a.m., CNA 3 indicated staff shave and trim nails on shower days. When asked if a resident wanted their nails or a shave done more often, the CNA indicated they would try to do it, but they focus on shower days. During an interview on 7/11/24 at 8:41 a.m., the Administrator indicated all documentation regarding showers and personal hygiene was completed in the point of care (POC) on the computer. 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 - Few

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

10326

Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 1 resident reviewed for skin conditions non-pressure related(Resident 100), failed to administer medications according to physician's orders related to not following parameters for 1 of 6 residents reviewed for unnecessary medications (Resident 44), and failed to identify and assess a resident's edema (swelling) for 1 of 1 resident reviewed for edema. (Resident 250)

Findings include:

1. On 7/8/24 at 10:31 a.m., Resident 100 was observed in his room in bed. Areas of reddish/purple discolorations were observed on his left and right forearms. During an interview at that time, the resident indicated the bruises may have been from lab draws, but he wasn't sure.

The record for Resident 100 was reviewed on 7/8/24 at 3:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, emphysema, anemia, and anxiety.

The Admission Minimum Data Set (MDS) assessment, dated 6/28/24, indicated the resident was cognitively intact and he required partial to moderate assistance with bed mobility and transfers.

The Weekly Wound Evaluation, dated 7/5/24, indicated the resident had skin tears to the left and right upper arm. There was no documentation related to the bruising on the left and right forearms.

The Weekly Skin Check form, dated 7/9/24, indicated the resident had no new skin issues.

There was no documentation in the nursing progress notes related to the resident's bruising and when they were observed.

During an interview on 7/10/24 at 1:35 p.m., Nurse Consultant 1 was informed of the arm discoloration.

A Change in Condition Evaluation, dated 7/10/24 at 3:30 p.m., indicated the resident had discolorations/bruising to his bilateral upper and lower extremities at various stages of healing.

The facility policy titled, SWAT Program (Skin-Weight-Assessment-Team Program) Guidance, provided by Nurse Consultant 1 on 7/11/24 at 3:00 p.m., indicated skin alterations such as bruising would appear on the Weekly Skin Assessments and would be followed by the Clinical Management staff for progress. Those conditions/alterations would be care planned and managed and treated as per physician order.

2. The record for Resident 44 was reviewed on 7/10/24 at 11:12 a.m. Diagnoses included, but were not limited to, stroke, sepsis, dysphagia (difficulty swallowing), type 2 diabetes, hypertension, and chronic kidney disease.

(continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5 day Medicare Minimum Data Set (MDS) assessment was in progress. The resident was identified as being moderately impaired for daily decision making. A Physician's Order, dated 6/10/24, indicated the resident was to receive Midodrine HCl (a medication to treat low blood pressure) 2.5 milligrams (mg) with meals for hypotension (low blood pressure), hold the medication if the systolic (top number) blood pressure was over 130. The June 2024 Medication Administration Record (MAR) indicated the resident's blood pressure for the morning dose of medication on 6/18 was 132/74 and her blood pressure for the HS (bedtime) dose on 6/24/24 was 133/76. The resident received the Midodrine on both dates. A Physician's Order, dated 7/6/24, indicated the resident was to receive Midodrine HCl 2.5 mg, give 1 tablet with meals for hypotension, hold the medication if the systolic (top number) blood pressure was greater than 110. The July 2024 MAR, indicated the Midodrine was given at the following dates and times when the resident's systolic blood pressure was greater than 110: - 7/6 at 12:00 p.m., blood pressure 128/68 - 7/6 at 5:00 p.m., blood pressure 126/72 - 7/7 at 5:00 p.m., blood pressure 134/78 - 7/8 at 12:00 p.m., blood pressure 146/73 - 7/9 at 5:00 p.m., blood pressure 134/67 During an interview on 7/10/24 at 1:35 p.m., Nurse Consultant 1 indicated the resident's medication should have been held as ordered. 48383 3. On 7/8/24 at 9:30 a.m., Resident 250 was observed sitting in her wheelchair. The resident indicated she had swelling in her right hand and right arm. The resident's hand was observed to be visibly swollen. On 7/9/24 at 10:49 a.m., the resident was observed in the dining hall. The resident indicated the swelling in her arm was better, but her hand was worse. The resident's hand was remarkably swollen. On 7/9/24 at 1:36 p.m., the resident was observed sitting in her room with family. The resident's right arm was not elevated, and her right hand was swollen. On 7/9/24 at 2:59 p.m., the resident was observed asleep in her wheelchair. The right hand remained swollen and was not elevated. On 7/10/24 at 9:23 a.m., the resident was in her room using her left hand to brush her teeth. Her right hand was observed to still be swollen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident 250 was reviewed on 7/9/24 at 2:16 p.m. The diagnoses included, but were not limited to, anemia, heart failure, hypertension (high blood pressure), chronic kidney disease, and a right artificial shoulder joint. The Admission Minimum Data Set (MDS) assessment, dated 7/1/24, indicated the resident was cognitively intact for daily decision making. The resident required substantial/maximum assistance for personal hygiene, toileting, shower/bathing, oral hygiene and rolling left to right. The resident was dependent with dressing upper and lower body dressing. During an interview on 7/10/24 at 9:31 a.m., Nurse Consultant 2 indicated the resident's hand should have been assessed by nursing staff. During an interview on 7/10/24 at 1:39 p.m., Nurse Consultant 2 indicated she had no additional information to provide. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 10770 Based on observation, record review, and interview, the facility failed to ensure a Podiatrist's recommendations were followed related to thick, painful, and fungal toenails for 1 of 7 residents reviewed for ADLs (activities of daily living). (Resident 40) Finding includes: On 7/8/24 at 11:00 a.m., Resident 40 was observed with long, thick and yellow discolored toenails. During an interview at that time, the resident indicated he had seen the Podiatrist and was told he had a fungus on his toenails. The record for Resident 40 was reviewed on 7/9/24 at 1:00 p.m. Diagnoses included, but were not limited to, stroke, left side hemiplegia, major depressive disorder, heart disease, and atrial flutter. The Annual 5/15/24 Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident had an impairment of functional range of motion to one side for his upper and lower extremity. A Podiatry Exam Note, dated 1/26/24, indicated the resident had pain on the on left great toe, left 2nd toe, left 3rd toe, left 4th toe, left 5th toe, right great toe, right 2nd toe, right 3rd toe, right 4th toe, and right 5th toe. All toenails were yellow, brown and crumbly and were thickened to 3 millimeters (mm). The assessment and plan was all the mycotic (an infection with a fungus or a disease caused by a fungus) nails were debrided in both length and thickness. The plan for the painful mycotic nails was for a prescription for Cyclopirex (used to treat fungal infections) cream to be applied to nails daily for 6 months or until healed. There was no physician's order for the Cyclopirex cream. A Podiatry Exam Note, dated 4/18/24, indicated the resident had pain on the on left great toe, left 2nd toe, left 3rd toe, left 4th toe, left 5th toe, right great toe, right 2nd toe, right 3rd toe, right 4th toe, and right 5th toe. All toenails were yellow, brown and crumbly and were thickened to 4 mm. All the mycotic nails described were debrided in both length and thickness. During an interview on 7/11/24 at 8:41 a.m., Nurse Consultant 2 indicated she could not find any additional information regarding the medication that was ordered for the resident's mycotic toenails in January 2024. 3.1-47(a)(7)

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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 splint was ordered and in place as recommended by therapy for 1 of 1 resident reviewed for limited range of motion (ROM). (Resident 40) Finding includes: During an observation on 7/8/24 at 11:02 a.m., Resident 40 was observed with a left hand contracture (fixed tightening of muscle, tendons, ligaments, or skin which prevents normal movement of the associated body part.) The resident was not able to voluntarily open his left hand, he had to use his right hand to lift it and open it. During an interview at that time, the resident indicated he had a splint and it was supposed to be on at night, however, he had to ask staff to put on the splint, because they did not put it on every night. He indicated the splint was not placed on his left hand the previous night. At that time, the splint was observed on top of the night stand. During an interview on 7/9/24 at 9:13 a.m., the resident indicated the splint was not placed on his left hand the previous night. The record for Resident 40 was reviewed on 7/9/24 at 1:00 p.m. Diagnoses included, but were not limited to, stroke, left side hemiplegia (paralysis on one side of the body), major depressive disorder, heart disease, and atrial flutter (abnormal heart rhythm). The Annual 5/15/24 Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. The resident had an impairment of functional range of motion to one side for his upper and lower extremity. There was no care plan for the contracted left hand or for splint use. There was no Physician's Order for the splint to be donned at night time. An Occupational Therapy (OT) Note, dated 5/14/24, indicated a splint was applied to the left upper extremity and the resident tolerated it for 11.5 hours. An OT Note, dated 5/27/24, indicated reviewed the splint wear/care schedule with the patient and he tolerated it for 6 hours. During an interview on 7/10/24 at 9:30 a.m., CNA 2 and CNA 3 indicated they thought the resident was supposed to have his splint on every morning when he got up. CNA 3 indicated the resident did his own thing and put his splint on himself, but would also take it off himself. CNA 2 indicated she believed he had taken it to therapy and they would put it on for him. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24 at 9:45 a.m., COTA 1 indicated the resident was to wear his splint every night while sleeping. He had come down to therapy and asked her to put on his splint and she had helped him put it on. He would come down to therapy from time to time to ask questions or want to exercise. During an interview on 7/10/24 at 2:00 p.m., the Director of Rehab indicated there was no order for the hand splint and there was no care plan developed. The resident was to wear the left hand splint every night while sleeping. 3.1-42(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 10770 Based on random observations, record review, and interview, the facility failed to ensure a suprapubic foley catheter (urinary catheter that is inserted into the bladder from a small cut in the lower abdomen) bag and tubing was kept off the floor for 1 of 1 resident reviewed for urinary catheters. (Resident 22) Finding includes: During random observations on 7/8/24 at 8:03 a.m., 10:33 a.m., and 2:14 p.m., Resident 22 was observed sitting in a wheelchair. At those times, a foley catheter bag was observed under the wheelchair and the bottom of the bag was touching the floor. During random observations on 7/10/24 at 9:00 a.m., 9:30 a.m., and 11:15 a.m., the resident was observed sitting in a wheelchair. At those times, a foley catheter bag and tubing were observed under the wheelchair and both were on the floor. The record for Resident 22 was reviewed on 79/24 at 9:50 a.m. Diagnoses included, but were not limited to, type 2 diabetes, urinary tract infection (UTI), dementia without behaviors, high blood pressure, obstructive and reflux uropathy (a condition where urine cannot drain into the urinary tract), and anxiety disorder. The 5/30/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and was dependent on staff for personal hygiene. The resident had an indwelling catheter. A Care Plan, revised on 7/8/24, indicated the resident has a suprapubic catheter. Physician's Orders, dated 2/14/24 and discontinued on 2/24/24, indicated Amoxicillin (an antibiotic)oral tablet 500 milligrams (mg), give 1 tablet by mouth every 12 hours for a complicated UTI. Physician's Orders, dated 7/8/24, indicated suprapubic catheter 14 French with 5 milliliter (ml) balloon. During an interview on 7/10/24 at 1:30 p.m., Nurse Consultant 1 indicated the foley catheter and tubing should not have been on the floor. The undated Catheters policy, provided as current by Nurse Consultant 1 on 7/11/24 at 3:00 p.m., indicated insertion, ongoing care, and catheter removal protocols should adhere to professional standards of practice and facility policy and procedure, with adherence to infection prevention and control techniques. 3.1-41(a)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 10770 Based on observation, record review, and interview, the facility failed to ensure enteral tube feedings were infusing at the correct time and flow rate through a peg tube (a tube inserted directly into the stomach for nutrition) for 2 of 3 residents reviewed for tube feeding. (Residents 2 and 251) Findings include: 1. On 7/8/24 at 7:55 a.m., Resident 2 was observed lying in bed. At that time, an enteral tube feeding was infusing at 55 cubic centimeters (cc) an hour through the peg tube. At 10:22 a.m., the resident's enteral feeding was observed to be turned off. On 7/8/24 at 10:48 a.m., 11:10 a.m., 11:30 a.m., and 1:45 p.m., the resident was in bed and the enteral tube feeding remained off. The record for Resident 2 was reviewed on 7/9/24 at 1:52 p.m. Diagnoses included, but were not limited to, left side hemiplegia, stroke, type 2 diabetes, heart disease, dementia, dysphagia (swallowing difficulties), and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/24, indicated the resident was moderately impaired for daily decision making. The resident received an enteral feeding of 51% or more through a peg tube. A Care Plan, dated 4/11/24, indicated the resident required a feeding tube related to dysphagia (difficulty swallowing). The approaches were to administer feedings and flushes as ordered. Physician's Orders, dated 7/6/24, indicated Glucerna 1.5 at 65 cc per hour for 20 hours, turn off at midnight and turn on at 4:00 a.m. The resident was NPO (nothing by mouth). During an interview on 7/10/24 at 1:30 p.m., Nurse Consultant 1 indicated the tube feeding should have been on and infusing as ordered by the physician. 48383 2. On 7/8/24 at 9:20 a.m., the resident was observed awake lying in bed. He indicated he received tube feeding every day. The tube feed was not infusing at the time. The tube feeding bottle was dated 7/7/24, and the tube feeding water bag was dated 7/3/24. On 7/8/24 at 1:35 p.m., the tube feeding was observed off. The tube feeding water bag was dated 7/3/24. On 7/9/24 at 3:00 p.m. and 4:03 p.m., the resident was observed asleep in bed and the tube feeding was not infusing. (continued on next page)

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	155251	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Hobart Skilled Nursing Facility, The	2901 W 37th Ave Hobart, IN 46342

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 8:58 a.m., the resident was observed asleep in bed. The tube feeding was infusing, and the start time was listed on the tube feeding bottle as 12:00 a.m. On 7/10/24 at 9:26 a.m., the tube feeding was no longer infusing and all contents were thrown away. The record for Resident 251 was reviewed on 7/8/24 at 3:08 p.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body), COPD, gastrostomy status, and hypertension (high blood pressure). The Admission Minimum Data Set (MDS) assessment, dated 6/14/24, indicated the resident was cognitively intact for daily decision making. The resident had impairment on one side of the upper and lower extremities. Oral hygiene required partial/moderate assistance. The resident had a feeding tube and had a mechanically altered diet. A Care Plan, dated 6/13/24, indicated the resident required tube feeding related to inadequate oral intake and need for nutritional support. The interventions were to administer tube feeding as ordered and to check for tube placement. A Care Plan, dated 6/10/24, indicated the resident had swallowing difficulties and required enteral feedings related to dysphagia. Interventions were to provide oral care every shift and to provide feedings as ordered. A Physician's Order, dated 6/14/24, indicated to administer daily tube feeding at 70 milliliters (ml)/ hour for 16 hours. The feeding was to be started at 3:00 p.m. and turned off at 7:00 a.m. A Physician's Order, dated 6/7/24 indicated to change the tube feeding tubing every 24 hours. The July 2024 Medication Administration Record (MAR) indicated tube feeding tubing was signed out as being changed every 24 hours on the following dates: 7/3/24, 7/4/24, 7/5/24, 7/6/24, 7/7/24, and 7/8/24. During an interview on 7/10/24 at 9:00 a.m., QMA 1 indicated the nurses turn the tube feeding off at 7:00 a. m. During an interview on 7/10/24 at 9:31 a.m., the Nurse Consultant 2 indicated she understood the tube feeding concerns for Resident 251 and had no additional information to provide. 3.1-44(a)(2)

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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 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. 10770 Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate and ordered by the physician for 3 of 4 residents reviewed for respiratory care. (Residents 13, 251, and 254) Findings include: 1. During random observations on 7/8/24 at 8:07 a.m., 10:20 a.m., 11:10 a.m., and 11:30 a.m., on 7/9/24 at 9:12 a.m., 9:52 a.m., 12:50 p.m., and 3:00 p.m., and on 7/10/24 at 9:00 a.m. and 11:30 a.m., Resident 13 was observed lying in bed and wearing oxygen per nasal cannula. The center of the oxygen bubble was below the 3 liter mark and above the 2.5 liter mark. The record for Resident 13 was reviewed on 7/9/24 at 9:30 a.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, dysphagia (difficulty swallowing), and anemia. The 4/30/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident did not receive oxygen and was currently on hospice. There was no care plan for oxygen therapy. Physician's Orders, dated 7/8/24, indicated oxygen at 2 liters continuous as needed to maintain an oxygen saturation of 90%. During an interview on 7/11/24 at 8:45 a.m., Nurse Consultant 2 indicated the oxygen should have been on as ordered by the physician. 48383 2. On 7/8/24 at 9:21 a.m., Resident 251 was observed lying in bed wearing oxygen via nasal cannula. The oxygen flow rate was set at 2.5 liters. On 7/8/24 at 1:34 p.m., the resident was observed asleep in bed. Oxygen was in place via nasal cannula. The oxygen was set at 2.5 liters. On 7/9/24 at 9:22 a.m., the resident's oxygen was on and in place. The oxygen flow rate was set at 2.5 liters. On 7/9/24 at 1:38 p.m., the resident was observed asleep in bed with oxygen in place. The oxygen was set at 2.5 liters. On 7/10/24 at 8:58 p.m., the resident was observed in bed wearing oxygen via nasal cannula. The oxygen rate was set above 2.5 liters. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident 251 was reviewed on 7/8/24 at 3:08 p.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body), COPD, gastrostomy status, and hypertension (high blood pressure). The Admission Minimum Data Set (MDS) assessment, dated 6/14/24, indicated the resident was cognitively intact for daily decision making. The resident had impairment on one side of the upper and lower extremities. The resident was dependent with eating, toileting, shower/bathing, lower body dressing and upper body dressing. Oral hygiene required partial/moderate assistance. The resident had a feeding tube and had a mechanically altered diet. A Baseline Care Plan, dated 6/7/24, indicated the resident required oxygen therapy. A Physician's Order, dated 7/8/24 at 3 p.m., indicated to continuously administer oxygen at 2 liters/minute via nasal cannula. A Physician's Order, dated 7/8/24 at 3 p.m., indicated to check oxygen flow rate every shift. A Daily Skilled Nurse's Note, dated 7/7/24 at 1:13 a.m., indicated the resident was wearing oxygen at 3 liters via nasal cannula. A Daily Skilled Nurse's Note, dated 7/6/24 at 1:12 a.m., indicated the resident was wearing oxygen at 3 liters via nasal cannula. A Daily Skilled Nurse's Note, dated 7/5/24 at 1:10 a.m., indicated the resident was wearing oxygen at 3 liters via nasal cannula. A Daily Skilled Nurse's Note, dated 7/3/24 at 9:23 p.m., indicated the resident was wearing oxygen at 3 liters via nasal cannula. A Physician's Progress Note, dated 6/18/24 at 1:38 p.m., indicated the resident was dependant on supplemental oxygen and was on 3 liters via nasal cannula at the time. The July 2024 Treatment Administration Record (TAR), indicated oxygen was signed out as being given at 2 liters every shift on the following dates: 7/8/24, 7/9/24, and 7/10/24. During an interview on 7/10/24 at 9:31 a.m., Nurse Consultant 2 indicated Resident 251's oxygen was on at the incorrect flow rate. 3. On 7/8/24 at 9:27 a.m. Resident 254 was observed awake in her wheelchair. The resident was wearing oxygen via nasal cannula. The oxygen flow rate was set above 3 liters. On 7/08/24 at 1:36 p.m., the resident was observed awake in her wheelchair. Oxygen was in place via nasal cannula. Oxygen was administered from a portable oxygen tank and was set at 3 liters. On 7/9/24 at 9:59 a.m., the resident was observed in her wheelchair. The resident was using oxygen via a portable oxygen tank. The oxygen flow rate was set at 3 liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/09/24 at 10:51 a.m., the resident was observed asleep in bed. Oxygen was in place via nasal cannula and the flow rate was set at 3 liters. The record for Resident 254 was reviewed on 5/29/24 at 3:47 p.m. Diagnoses included, but were not limited to, COPD, hypertension (high blood pressure), heart failure, depression, and dysphagia (difficulty swallowing). The Admission Minimum Data Set (MDS) assessment, dated 6/20/24, indicated the resident was severely impaired for daily decision making. The resident had no impairment of her upper and lower extremities and used a wheelchair. The resident required supervision or touching assistance for eating and oral hygiene. The resident was dependent with toileting, personal hygiene, shower/bathing, lower body dressing, and upper body dressing. A Baseline Care Plan, dated 6/14/24, indicated the resident received oxygen therapy. There was no further care plan related to oxygen use. A Daily Skilled Nursing Note, dated 6/16/24, indicated the resident was on 2 liters of continuous oxygen. A Physician's Progress Note, dated 6/18/24 at 1:34 p.m., indicated the resident was oxygen dependent and to continue supplemental oxygen per orders. A Physician's Progress Note, dated 7/5/24 at 8:06 a.m., indicated the resident was dependent on supplemental oxygen at 3 liters via nasal cannula. A Daily Skilled Nursing Note, dated 7/9/24, indicated the resident was on 2 liters of continuous oxygen. There were no physician's orders to administer oxygen listed on the Physician's Order Summary. During an interview on 7/10/24 at 9:31 a.m., the Nurse Consultant 2 indicated there should have been an oxygen order and a oxygen care plan for Resident 254. 3.1-47(a)(6)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 10326 Based on observation and interview, the facility failed to post the daily staffing sheet which indicated how many staff were working in the facility and the facility census in a timely manner. This had the potential to affect the 50 residents who resided in the facility. Finding includes: On 7/8/24 at 7:33 a.m., the daily staffing sheet located by the front desk in the main lobby was dated 7/5/24. During an interview on 7/11/24 at 2:58 p.m., the Administrator indicated the staffing sheets should have been changed daily over the weekend.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48383 Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair, related to personal items not contained in a shared environment, discolored floor tile, missing caulk around toilet bases, leaking toilets, dried tube feeding on the base of poles, and urine odors in 1 of 2 units. (West Unit) Findings include: During the Environmental tour on the [NAME] Unit with the Maintenance Director on 7/10/24 at 2:36 p.m., the following was observed: a. room [ROOM NUMBER]: the floor tile was discolored, the caulk around the base of the toilet was missing and discolored and the toilet was leaking around the base. There were tooth brushes and hair brushes sitting out on the bathroom counter not contained. Two residents shared the bathroom b. room [ROOM NUMBER]: there was a strong urine odor. c. room [ROOM NUMBER]: there was dried tube feeding on the base of the tube feeding pole. d. room [ROOM NUMBER]: the bathroom tile floor was discolored and there was a pink wash basin under the sink that was not contained. Two residents resided in this room and used the bathroom. e. room [ROOM NUMBER]: there was dried tube feeding on the base of the tube feeding pole. During an interview on 7/10/24 at 2:56 p.m., the Maintenance Director indicated he would start correcting the environmental concerns today. The facility had plans to remodel all the rooms and had currently been completing 1 room a month. 3.1-19(f)