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	06/17/2025

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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(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. 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 3 residents reviewed for self-administration of medication. (Residents 18 and 52) Findings include: 1. During a random observation on 6/10/25 at 1:55 p.m., two Preparation H suppositories were observed on Resident 18's bed side table. There was also a bottle of lubricating eye drops on the resident's over bed table. The record for Resident 18 was reviewed on 6/11/25 at 11:54 a.m. Diagnoses included, but were not limited to, constipation and chronic pain. The Quarterly Minimum Data Set (MDS) assessment, dated 5/20/25, indicated the resident had moderate cognitive impairment. The June 2025 Physician's Order Summary (POS) indicated the resident had orders for Artificial Tears Solution 1.4%, instill 1 drop in both eyes every 8 hours as needed (PRN) for dryness and redness. The resident also had an order for Anusol-HC External Cream 2.5% (a hemorrhoid cream) apply to rectum topically every 8 hours PRN for pain or irritation. There was no physician's order for the Preparation H suppositories and there was no order for the medications to be left at the bedside. A Self-Administration of Medication Assessment, dated 7/12/24, indicated the resident did not want to self-administer his medications. During an interview on 6/11/25 at 3:30 p.m., the Director of Nursing indicated the medications should not have been left at the resident's bed side. 2. On 6/10/25 at 9:47 a.m., a cup with a separated yellow liquid with sediment was observed on Resident 52's bedside table. The resident indicated it was medicine QMA 2 had left for her to take later. On 6/10/25 at 9:50 a.m., the QMA came into the resident's room. The QMA indicated the cup contained Cholestyramine (a cholesterol lowering medication) and that she did not have to stay with the resident until she took the medication, and left the room. (continued on next page)

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 52 was reviewed on 6/12/25 at 1:53 p.m. Diagnoses included, but were not limited to, Parkinson's Disease, peripheral vascular disease, and anxiety. The 3/31/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment, and was dependent in activities of daily living (ADLs) and transfers. There were no assessments or orders for the resident to self-administer medications. During an interview on 6/11/25 at 3:38 p.m., when informed of the findings, the Corporate Nurse indicated they would have to do staff education on medication administration. The current facility policy titled, Self-Administration of Medications by Residents was provided by the Director of Nursing on 6/17/25 at 3:35 p.m. The policy indicated if the resident desired to self-administer medications, an assessment was conducted by the interdisciplinary team. The assessment included the resident's cognitive, physical, and visual ability to carry out the responsibility. The policy also indicated a physician order was to be obtained to self-administer medications if the above storage and skill assessment had been approved for the resident by the interdisciplinary team. 3.1-11(a)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure the resident's physician was notified of medication refusals for 1 of 6 residents reviewed for unnecessary medications. (Resident 47) Finding includes: During an interview on 6/10/25 at 2:15 p.m., Resident 47 indicated he did not like taking his Eliquis (a blood thinner). The record for Resident 47 was reviewed on 6/17/25 at 9:00 a.m. Diagnoses included, but were not limited to, hypertension, orthopedic aftercare, and peripheral vascular disease. The Quarterly Minimum Data Set (MDS) assessment, dated 5/2/25, indicated the resident was cognitively intact and received an anticoagulant (blood thinner). A Physician's Order, dated 2/25/25, indicated the resident was to receive Eliquis 2.5 milligrams (mg) twice a day. The June 2025 Medication Administration Record (MAR) indicated the resident refused his Eliquis on the following dates and times: - AM dose: 6/3/25, 6/8/25, 6/10/25, 6/11/25, and 6/17/25 - PM dose: 6/1/25 and 6/2/25 - AM and PM dose: 6/7/25, 6/9/25, 6/14/25, 6/15/25, and 6/16/25 There was no documentation indicating the physician was made aware of the resident's refusals of the Eliquis. During an interview on 6/17/25 at 12:10 p.m., the Director of Nursing (DON) indicated the physician should have been notified of the medication refusals. The current facility policy titled Drug Administration-General Guidelines was provided by the DON on 6/17/25 at 3:35 p.m. The policy indicated if a dose of regularly scheduled medication was withheld, refused, or given at another time than the scheduled time (e.g. resident not in facility at scheduled dose time, initial dose of antibiotic), the MAR should reflect documentation as to the reason the medication could not be administered. If two consecutive doses of a medication were withheld or refused, the physician was to be notified. 3.1-5(a)(3)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to mobility, hearing, and insulin use for 2 of 19 MDS assessments reviewed. (Residents 3 and 38) Findings include: 1. On 6/10/25 at 10:47 a.m., Resident 3 was observed resting in his bed. He could not move his left arm, and his left hand was contracted (a structural change in the body's soft tissues that cause them to stiffen and shorten). He indicated he could not hear. On 6/12/25 at 9:35 a.m., the resident was observed propelling himself in his wheelchair using his right leg. His left leg remained on the footrest. He put in his hearing aid with his right hand. At that time, he indicated his left arm was dead and he could not move it, and he had minimal movement of his left leg. With the hearing aid on, the resident could only hear when spoken to loudly and in close proximity. The record for the resident was reviewed on 6/11/25 at 1:29 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis of one side of the body), and hearing loss. The 4/21/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, used a hearing aid, was able to hear with minimal difficulty, and was dependent in activities of daily living (ADLs). The assessment indicated the resident had no impairment in range of motion or functional limitation to his upper and lower extremities. During an interview on 6/11/25 at 9:02 a.m., LPN 3 indicated the resident couldn't hear much, they had been working on his hearing aides, but they weren't working anymore. During an interview on 6/16/25 at 1:22 p.m., the MDS coordinator indicated the MDS assessment should have indicated the resident had a mobility impairment and probably should not have indicated the resident could hear with minimal difficulty, but she did not assess the resident. 2. The record for Resident 38 was reviewed on 6/16/25 at 10:50 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, dementia, and bipolar disorder. The 3/17/25 Quarterly MDS assessment indicated the resident had moderate cognitive impairment, required partial assistance with ADLs and supervision or touching assistance with transfers. It indicated the resident received insulin injections. The record lacked physician's orders or any documentation that the resident received any insulin in March 2025. During an interview on 6/16/25 at 1:22 p.m., the MDS Coordinator indicated the assessment had been coded in error and the resident had not received insulin. 3.1-31(i)

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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. Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to skin and nail care for 1 of 3 residents reviewed for ADLs. (Resident 166) Finding includes: During random observations on 6/9/25 at 10:31 a.m., 6/10/25 at 9:24 a.m., 6/11/25 at 8:35 a.m., and 6/12/25 at 9:41 a.m., Resident 166's fingernails were dirty and long. Her feet were dry and scaly with flakes of skin accumulating on the bed sheet. During an interview at the time, the resident indicated she did not want her fingernails to be that long, and she would like it if someone put lotion on her feet. The record for the resident was reviewed on 6/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes and heart failure. The 5/2/25 Medicare-5 Day Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, and was dependent in Activities of Daily Living (ADLs) and transfers. A 3/14/25 Podiatry Note indicated the resident had extremely dry, scaly skin on greater than 60% of her feet, and she required at-risk foot care. The shower sheets from the prior 30 days lacked documentation of skin and nail care completed or refused. During an interview on 6/16/25 at 2:18 p.m., the Director of Nursing (DON) was informed of the findings and offered nothing further. 3.1-38(a)(3)(A) 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. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to a delay in scheduling a post-operative doctor's appointment for 1 of 2 residents reviewed for skin conditions non-pressure related, assessment and treatment of edema for 1 of 2 residents reviewed for edema, and holding an insulin dose without an order for 1 of 6 residents reviewed for unnecessary medications. (Residents 166, 52, and 36) Findings include: 1. During random observations on 6/9/25 at 10:31 a.m., 6/10/25 at 9:24 a.m., 6/11/25 at 8:35 a.m., and 6/12/25 at 9:41 a.m., Resident 166 had a dressing to her left upper chest. The dressing was no longer fully adhering to the skin, and at times, an incision underneath was visible. The resident indicated she had pacemaker surgery and had to keep the dressing on until she saw the doctor, but it was taking too long to get an appointment. The record for the resident was reviewed on 6/11/25 at 9:45 a.m. Diagnoses included, but were not limited to, diabetes and heart failure. The 5/2/25 Medicare-5 Day Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, and was dependent in Activities of Daily Living (ADLs) and transfers. The physician's post-operative instructions from the 5/28/25 pacemaker surgery indicated to schedule an appointment with the doctor as soon as possible for an appointment in one week for wound re-check. During an interview on 6/12/25 at 2:45 p.m., the Medical Records Coordinator indicated she had been calling the doctor's office for two weeks, but had not been able to speak to someone there to make the follow-up appointment. She indicated she informed the resident she had not been able to contact the office, but no one else. During an interview on 6/16/25 at 2:18 p.m., the Director of Nursing (DON) indicated she was not aware that the follow up had not been scheduled, and the Medical Records Coordinator should have informed her or someone else who could follow up on the problem. 2. During random observations on 6/10/25 at 9:51 a.m., 6/11/25 at 9:18 a.m., 6/12/25 at 10:08 a.m., and 6/16/25 at 9:05 a.m., Resident 52's legs and feet were visibly swollen and she was not wearing compression socks or Tubigrips (compression sleeves) to her legs. The record for the resident was reviewed on 6/12/25 at 1:53 p.m. Diagnoses included, but were not limited to, Parkinson's Disease, peripheral vascular disease, and weakness. The 3/31/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment, and was dependent in activities of daily living (ADLs) and transfers. A Care Plan, last reviewed 4/23/25, indicated the resident had potential for cardiac distress. Interventions included to observe and report any increased edema (swelling) to the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 4/30/25 Physician's Order indicated Tubigrips to both legs, on during the day, off in evening for bed. A 5/16/25 Nurse Practitioner Progress Note indicated the resident reported swelling to both legs, and that her legs felt heavy like a ton of bricks. A 5/22/25 Physician's Progress Note indicated the resident had 1+ pitting edema (swelling where a slight indentation appears on the skin after pressure is applied) to both legs. The record lacked regular assessment of the resident's edema. During an interview on 6/17/25 at 12:14 p.m., the Director of Nursing was informed of the findings and offered no further information. 3. The record for Resident 36 was reviewed on 6/16/25 at 2:28 p.m. Diagnoses included, but were not limited to, diabetes and acquired absence of left foot. The 3/14/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment, and required substantial assistance with ADLs and transfers. The June 2025 Medication Administration Record (MAR) indicated Insulin Glargine Solution (a long-acting insulin), 22 units at bedtime. The 6/13/25 dose was held with the reason of No Sliding Scale Insulin Required Per Order. The June 2025 MAR indicated Humalog (a fast-acting insulin) 8 units, three times a day. The 6/1/25 and 6/6/25 4:30 p.m. doses were held with the reason of No Sliding Scale Insulin Required Per Order. There were no blood sugar parameters, sliding scale, or physician's orders to hold the insulin. A Care Plan, last reviewed 6/11/25, indicated the resident had the potential for having high or low blood sugars due to diabetes. Interventions included giving medications as ordered. During an interview on 6/17/25 at 12:14 p.m., the Director of Nursing was informed of the findings and offered no further information. 3.1-37(a)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, record review, and interview, the facility failed to ensure timely podiatry visits were provided related to painful ingrown toenails for 1 of 1 resident reviewed for foot care. (Resident 55) Finding includes: During a random observation on 6/9/25 at 10:30 a.m., Resident 55 was in his room in bed. A band aid was observed on his left great toe. During an interview at that time, the resident indicated he wanted to see the podiatrist for his painful toenails. He indicated he had told staff several times and no one ever followed up with him. The record for Resident 55 was reviewed on 6/11/25 at 9:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes and acute infarction of the spinal cord. The Quarterly Minimum Data Set (MDS) assessment, dated 5/27/25, indicated the resident was cognitively intact. A Physician's Order, dated 3/19/25, indicated the resident may receive services of eye care, audiologist, podiatrist, dental, psychiatrist, cardiologist, physiatrist, Nurse Practitioner, Wound Physician and any other specialist as deemed necessary An SBAR (Situation, Background, Assessment, and Recommendation) Summary, dated 3/27/25 at 3:29 p.m. , indicated the resident had complaints of ingrown toenails with slight drainage. Recommendations were received to refer to the in-house podiatrist. A Nurse Practitioner (NP) note, dated 4/1/25, indicated the resident's great toes were described as infected and painful. The resident reported that both of his thumb toes were ingrown. Will monitor the resident's toes for signs of worsening. If necessary, a referral to podiatry would be made for further evaluation and treatment. An NP note, dated 4/22/25 at 12:04 p.m., indicated the resident was being seen for his bilateral ingrown toenails. He had ingrown toenails on the bilateral hallux (big toes) and the left second toe. The left second toe recently expressed purulent (a thick pus-like fluid) and sanguineous (a type of fluid that is composed primarily of blood) drainage. He had redness to his bilateral big toes and left middle toe. A topical steriod cream was ordered along with warm soapy water soaks. The resident was also to be seen by in-house podiatry. A Care Plan, dated 4/24/25, indicated the resident was at risk for complications related to acute skin impairment (ingrown toenails). Interventions included, but were not limited to, refer to podiatrist as needed (PRN). An NP note, dated 4/28/25 at 10:02 a.m., indicated the resident had persistent swelling in his toes and toe pain. He was to see the in-house podiatrist when available. There was no documentation the resident had been seen by the in-house podiatrist. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/25 at 9:55 a.m., the Social Service Designee (SSD) indicated the last time the podiatrist was at the facility was on 5/16/25. She also indicated the resident was not on the list to be seen. The SSD indicated she would put the resident on the list to be seen by the podiatrist the next time he visited. 3.1-47(a)(7)

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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. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 2 of 3 residents reviewed for respiratory care. (Residents 5 and 13) Findings include: 1. During a random observation on 6/9/25 at 10:50 a.m., Resident 5 was in her room in bed. The resident had oxygen in use by the way of a nasal cannula. The oxygen concentrator was set at 1 1/2 liters. On 6/10/25 at 10:25 a.m., the resident was again observed in her room in bed. The resident had oxygen in use via a nasal cannula and her oxygen concentrator was set at 1 1/2 liters. On 6/12/25 at 9:30 a.m. and 2:05 p.m., the resident was in her room in bed. The resident had oxygen in use via a nasal cannula and her oxygen concentrator was set at 1 1/2 liters. The record for Resident 5 was reviewed on 6/11/25 at 2:52 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The Quarterly Minimum Data Set (MDS) assessment, dated 5/23/25, indicated the resident had moderate cognitive impairment and was using oxygen while a resident of the facility. A Physician's Order, dated 5/7/25, indicated the resident was to have oxygen at 2 liters per nasal cannula as needed (PRN) for shortness of breath. Maintain oxygen saturations greater than 90 percent. During an interview on 6/17/25 at 12:10 p.m., the Director of Nursing indicated the flow rate on the resident's oxygen concentrator should have been set at 2 liters. 2. During a random observation on 6/9/25 at 2:53 p.m., Resident 13 was in her room in bed. The resident had oxygen in use by the way of a nasal cannula. The resident's oxygen concentrator was set at 4 liters. On 6/11/25 at 9:01 a.m. and 2:25 p.m., the resident was observed in her room in bed. She had oxygen in use via a nasal cannula and the oxygen concentrator was set at 4 liters. On 6/12/25 at 9:30 a.m. and 2:15 p.m., the resident was observed in her room in bed. She had oxygen in use via a nasal cannula and the oxygen concentrator was set at 4 liters. The record for Resident 13 was reviewed on 6/17/25 at 9:23 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and chest pain. The Quarterly Minimum Data Set (MDS) assessment, dated 3/17/25, indicated the resident had moderate cognitive impairment and received oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, dated 12/13/24 and reviewed 3/2025, indicated the resident was at respiratory risk related to COPD. Interventions included, but were not limited to, administer oxygen per physician's order. A Physician's Order, dated 1/2/25 and listed as current on the June 2025 Physician's Order Summary (POS), indicated the resident was to receive 3 liters of oxygen continuously per a nasal cannula. During an interview on 6/17/25 at 12:10 p.m., the Director of Nursing indicated the flow rate on the resident's oxygen concentrator should have been set at 3 liters. 3.1-47(a)(6)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure blood pressure and heart rate parameters were monitored for 1 of 6 residents reviewed for unnecessary medications. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 6/11/25 at 2:52 p.m. Diagnoses included, but were not limited to, ischemic heart disease, hypertensive heart disease with heart failure, and congestive heart failure (CHF). The Quarterly Minimum Data Set (MDS) assessment, dated 5/23/25, indicated the resident had moderate cognitive impairment. A Physician's Order, dated 3/25/25 and listed as current on the June 2025 Physician's Order Summary (POS), indicated the resident was to receive Metoprolol Tartrate (a medication used to treat high blood pressure and chest pain) 25 milligrams (mg), give 0.5 tablet twice a day. Hold for a heart rate less than 60 and systolic blood pressure (top number) greater than 110. The May and June 2025 Medication Administration Records (MARs), indicated the medication had been signed out as being given twice a day as ordered, however, there was no documentation of the resident's heart rate or blood pressure. During an interview on 6/17/25 at 12:15 p.m., the Director of Nursing indicated the resident's heart rate and blood pressure should have been documented. The Assistant Director of Nursing indicated a clarification order needed to be obtained regarding the resident's blood pressure parameter. 3.1-48(a)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 3. During random observations on 6/9/25 at 9:10 a.m., 6/10/25 at 10:10 a.m., and 6/11/25 at 9:10 a.m., tubes of clotrimazole and betamethasone diphenhydramine (a topical antifungal) and hydrogel (an advanced topical wound treatment) were observed on Resident 32's nightstand. At that time, the resident indicated staff left the topical medications in the room for when they provided wound care to her and Resident 36, who shared the room. The record for Resident 32 was reviewed on 6/17/25 at 10:30 a.m. Diagnoses included, but were not limited to, morbid obesity, chronic kidney disease, and difficulty walking. The 5/28/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment and required maximal assistance with activities of daily living (ADLs) and transfers. A Physician's Order, dated 4/15/25, indicated to cleanse the left plantar foot with wound cleanser, mix collagen particles and hyrogel to form a paste, fill wound bed with paste, cover with an ABD dressing, and wrap with rolled gauze every evening shift and PRN (as needed). During an interview on 6/11/25 at 4:21 p.m., the Director of Nursing was informed of the treatment medications left at the bedside and offered no further information. Based on observation and interview, the facility failed to ensure medications were properly labeled and stored for 2 of 3 medication carts observed and random room observations. (East medication cart and Northwest medication cart, Residents 48, 10, 21 & 32) Findings include: 1. On 6/9/25 at 9:39 a.m., the East Medication Cart was observed with LPN 1. The following medications were not labeled or stored appropriately: a. There were 2 loose pills inside a medication cup in the top drawer. b. There was 1 loose pill inside a medication cup in the sixth drawer. During an interview at the time, LPN 1 indicated the resident had refused the pills in the top drawer and she needed a second nurse to waste the medication. She denied either pill was a narcotic. The single loose pill in a medication cup found in drawer six was not given by the night nurse. LPN 1 and RN 1 indicated they were told in shift report the medication, which was an antibiotic, needed to be wasted. 2. On 6/9/25 at 11:22 a.m., the Northwest Medication Cart was observed with QMA 1. The following medications were not labeled or stored appropriately: a. There was an insulin pen in the top drawer that was labeled with Resident 48's first name only. There were no administration instructions. (continued on next page)

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	155251	A. Building B. Wing	06/17/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. There was a second insulin pen labeled with Resident 10's first name and last initial. There were no administration instructions. During an interview at the time, QMA 1 indicated she would have new labels put on the insulin pens. c. There was a probiotic bottle in the third drawer that was labeled with Resident 21's first and last initial. There were no administration instructions. During an interview at the time, QMA 1 indicated the medication was brought in by Resident 21, and she thought it was okay because the bottle had administration instructions. During an interview on 6/10/25 at 4:10 p.m., the Director of Nursing indicated the medication had already been corrected with new labels. There was no additional information provided. 3.1-25(j)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food was stored and prepared under safe conditions related to storage of housekeeping chemical test kits in the walk-in cooler near food items, unlabeled and undated opened stored food, and lack of accurate temperature and sanitation logs for 1 of 1 kitchen. This had the potential to affect 57 of 59 residents who resided in the facility and received food from the kitchen. (The Main Kitchen) Findings include: During the Initial Kitchen Sanitation Tour on 6/9/25 at 8:49 a.m. with the Kitchen Supervisor, the following was observed: a. In the walk-in cooler, three large boxes of UltraSnap Surface ATP tests (a chemical swab kit for testing the cleanliness of a surface) were observed on the top shelves, above food items. The Safety Data Sheet for UltraSnap, revised 12/4/24, indicated for safe handling, the product should be kept away from food and drink. b. In the walk-in cooler, the following items were open and undated: a bottle of tea, a bottle of ranch dressing, and a package of sliced cheese. The following items were unlabeled and undated: a container of jelly, individual cups of mustard, a bag of sliced tomatoes, a plastic bin of onions, and a clear plastic bag of cheese. c. In the walk-in freezer, there were open, unlabeled bags of brussel sprouts and hamburger buns. d. In the reach-in cooler, there was an unlabeled and undated clear plastic bag of cheese. e. In the food prep area, there was a large unlabeled, undated bin filled with oats. f. In the dry storage room, there was an open can of shortening, dated 8/14/23. g. The temperature and sanitation logs were reviewed on 6/9/25 at 9:00 a.m. At that time, the refrigerator temperature, freezer temperature, and sanitizer solution logs were already filled out for 6/9/25 at 3:30 p.m. The dishwasher temperature log was filled out through 6/10/25. During an interview on 6/9/25 at 9:05 a.m., the Kitchen Supervisor indicated the boxes of UltraSnap tests were being kept in the walk-in cooler for Housekeeping, but she did not know what they were or why they were there. All food items should have been labeled and dated when opened. The shortening should have been disposed one year after opening. The temperature and sanitation checks should be recorded in the log when the task was completed, after each meal service. During an interview on 6/11/25 at 3:50 p.m., the Regional Dietary Director indicated the UltraSnap should be removed from the walk-in cooler and the staff needed to be re-educated on performing and documenting temperature and sanitation checks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A policy titled Date Marking, received as current from the Corporate Dietary Manager on 6/12/25 at 3:00 p.m. , indicated, Any ready-to-eat, potentially hazardous food prepared and held in refrigeration shall be date marked utilizing an established procedure to ensure food safety. 3.1-21(i)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure the medical record was complete and accurately documented related to infection monitoring for 2 of 3 records reviewed for infections. (Residents 3 and 36) Findings include: 1. The record for Resident 3 was reviewed on 6/11/25 at 1:29 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia (paralysis of one side of the body), and hearing loss. The 4/21/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment and was dependent in activities of daily living (ADLs). The June 2025 Medication Administration Record (MAR) indicated, Monitor for s/s [signs/symptoms] of infection to include: fever, new/worsening skin impairments, sore throat, nausea/vomiting/diarrhea every day shift for change in condition screening-Start Date 05/17/2025. The documentation for 6/7/25 and 6/8/25 was y. The record lacked any other documentation of the resident having signs or symptoms of an infection on 6/7/25 and 6/8/25. During an interview on 6/17/25 at 12:14 p.m., the Director of Nursing indicated that was a documentation error and the nurse probably did not understand how to document correctly for that task. 2. The record for Resident 36 was reviewed on 6/16/25 at 2:28 p.m. Diagnoses included, but were not limited to, diabetes and acquired absence of left foot. The 3/14/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment and required substantial assistance with ADLs and transfers. The June 2025 Medication Administration Record (MAR) indicated, Monitor for s/s [signs/symptoms] of infection to include: fever, new/worsening skin impairments, sore throat, nausea/vomiting/diarrhea every day shift for change in condition screening-Start Date 05/17/2025. The documentation for 6/7/25 and 6/8/25 was y. The record lacked any other documentation of the resident having signs or symptoms of an infection on 6/7/25 and 6/8/25. During an interview on 6/17/25 at 12:14 p.m., the Director of Nursing indicated that was a documentation error and the nurse probably did not understand how to document correctly for that task. 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place and implemented related to the cleaning of a shared glucometer before and after use for 1 of 1 glucometer (machine used to test blood sugar levels) test observed. (Resident 34) Finding includes: On 6/9/25 at 11:43 p.m., LPN 2 indicated she was going to check Resident 34's blood sugar level. The LPN walked in with the glucometer and indicated she had already cleaned the monitor, but she would clean it again. She grabbed a bottle of germicidal wipes and donned a new pair of gloves, she grabbed a couple of pieces of dry tissue and placed it on the bedside table. She then used the germicidal wipe to clean the glucometer. After cleaning the monitor she immediately wiped it dry with the dry tissue. Once the glucometer was dry, LPN 2 proceeded to obtain the resident's blood sugar. When the blood sugar test was completed, she walked the glucometer back to the medication cart and proceeded to clean the glucometer with a germicidal wipe. She again, immediately dried off the glucometer with a dry tissue. The glucometer was then placed back in the medication cart. During an interview on 6/9/25 at 12:01 p.m., LPN 2 indicated she cleaned the glucometer with the purple wipes (germicidal wipes) and then dried it off and wrapped it in a tissue. She indicated she did not know of any other way to clean the glucometer. During an interview on 6/10/25 at 11:46 a.m. with the Infection Preventionist (IP) and the Director of Nursing, the IP indicated she would expect staff to wipe down a glucometer with an appropriate germicidal wipe and wrap the germicidal wipe around the glucometer for 2-3 minutes. That was how she had educated the staff to clean the glucometer. The Director of Nursing (DON) indicated she would expect staff to follow manufacturer guidelines. A facility policy titled, Disinfecting Glucose Meters and received as current from the facility, indicated, . Contact time, also known as dwell/contact time is the amount of time an EPA registered disinfecting product needs to be present on a surface to be effective against microorganisms listed on it's label. Contact times usually fall between 30 seconds and 10 minutes . .5. Use disinfected wipe per manufactures guidelines. Ensure all surfaces are wet and contact/dwell time is followed . The manufacturer guidelines for Sani Wipes indicated to disinfect and deodorize nonporous surfaces, .Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for 2 minutes. Let air dry . 3.1-18(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred walls, floors, and doors, missing toilet paper holders, dirty base boards, dirty over bed table, and uncontained personal care items in a shared environment in 2 of 2 units. (The East and [NAME] Units) Findings include: During the Environmental Tour on 6/16/25 at 1:40 p.m., with the Maintenance Director, the following was observed: 1. East Unit a. The chair rail in room [ROOM NUMBER] was scratched. There was one resident residing in the room. 2. [NAME] Unit a. In room [ROOM NUMBER], the floor was marred in front of the television. There were two residents residing in the room. b. In room [ROOM NUMBER], the toilet paper holder was taped up and there were 2 uncontained toothbrushes laying on the vanity. There was one person who used the bathroom. c. In room [ROOM NUMBER], the bathroom door was marred and there was dirt along the base board in the room. There was no toilet paper holder in the bathroom. There was one resident residing in the room and used the bathroom. d. In room [ROOM NUMBER], the walls were marred in the room and there was dirt along the base board. There was one resident residing in the room. e. In room [ROOM NUMBER], there was no toilet paper holder in the room and the seat of the resident's wheelchair was peeling and cracked. There were two residents residing in the room. f. In room [ROOM NUMBER], the bottom of the over table was stained and dirty. There were two residents residing in the room. During an interview on 6/16/25 at 1:50 p.m., the Maintenance Director indicated all of the above was in need of cleaning and/or repair. 3.1-19(f)