STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Princeton, The	1020 W Vine St Princeton, IN 47670

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on observation, interview, and record review, the facility failed to ensure physician consultation was provided before treatment alterations occurred to modify medications prior to administration for 1 of 1 residents reviewed for crushed medications received. (Resident 47) Finding includes: On 10/18/24 at 10:23 A.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on [DATE]. Diagnoses included, but were not limited to, dementia, major depressive disorder, and anxiety. The most recent Significant change MDS (Minimum Data Set) assessment, dated 9/13/24, indicated Resident 47 was severely cognitively impaired, required partial assistance from staff for eating, toileting, and bathing, and was completely dependent on staff for transfers. A progress note, dated 10/17/24 at 12:32 P.M., indicated Resident 47 had been given her medications in a crushed form. The clinical record, including physician orders, progress notes, care plan, and assessments, lacked an order for medications to be crushed prior to administration or physician notification indicating resident need for medications to be crushed for administration. During a random observation on 10/22/24 at 9:01 A.M., LPN (Licensed Practical Nurse) 16 placed four tablets and opened one capsule of medication into a medication cup, crushed the medications together, and mixed the crushed medications in chocolate pudding. LPN 16 took the medication and pudding mixture to Resident 47 and spooned the medications into Resident 47's mouth. During an interview on 10/22/24 at 11:46 A.M., the Director of Nursing indicated she was unable to find a physician order or evaluation related to crushing Resident 47's medications. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 11:01 A.M., the Director of Nursing provided a policy titled Medication Administration, dated 2/2017, that indicated Review the resident's Medication Administration Record (MAR). Read each order entirely. Remove the medication from the drawer. If there is any discrepancy between the MAR and the label, check physician orders before administering medication. Crush medications only after checking with the 'Crush List' reference. Refer to medication reference text for administration when when added to any substance i.e., applesauce, juice, milk, etc. 3.1-5(a)(3)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50827 Based on record review and interview, the facility failed to ensure residents' MDS (Minimum Data Set) Assessment's were completed within 14 days of admission for 1 resident reviewed for accidents and 1 resident reviewed for advanced directives. (Resident 259 and Resident 261) Findings included: 1. On 10/17/24 at 1:43 P.M., Resident 261's clinical record was reviewed. The resident's Admission MDS dated [DATE] indicated it was in progress and was not complete. Resident 261 was admitted on [DATE]. 2. On 10/21/24 at 10:00 A.M., Resident 259's clinical record was reviewed. The resident's Admission MDS dated [DATE], indicated it was in progress and was not complete. On 10/22/24 at 9:45 A.M., the DON (Director of Nursing) indicated it was expected that an Admission MDS be completed within 14 days after admission to facility, and the facility followed the RAI (Resident Assessment Instrument) manual guidelines for comprehensive assessments. 3.1-31(d)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on observation, record review, and interview, the facility failed to ensure the MDS (Minimum Data Set) Assessments were completed accurately for 1 of 2 residents reviewed for falls, 1 of 2 residents for nutrition, 1 of 5 residents reviewed for unnecessary medications. (Resident 50, Resident 30) Findings include 1. On 10/16/24 at 11:44 A.M., Resident 50 was observed sitting in a chair in the activities room with a chair alarm attached to the resident's clothing. On 10/18/24 at 1:25 P.M., Resident 50 was observed sitting in a chair in the activities room with a chair alarm. On 10/21/24 at 9:55 P.M., Resident 50 was observed sitting in a chair in the activities without a chair alarm. On 10/18/24 at 9:53 A.M., Resident 50's clinical record was reviewed. Diagnoses included, but were not limited to, weakness, osteoarthritis, and dementia. The current Quarterly MDS assessment dated [DATE], indicated Resident 50 was moderately cognitively impaired. The resident needed supervision for toileting, dressing, and mobility. The resident was not coded for the quarterly assessment for a chair alarm or significant weight loss. Current physicians order included, but were not limited to: General diet, Regular texture, Thin Liquids consistency, fortified foods with meals as available dated 2/27/24. There were no orders for chair alarms or Dycem devices. The current fall risk care plan lacked interventions for a chair alarm and a Dycem device. The current care plan lacked a intervention for fortified foods with each meal. An IDT (Interdisciplinary Team) note dated 9/9/2024 at 12:02 P.M., indicated a recommendation to access chair for need of adding Dycem or other devices. During an interview on 10/21/24 at 10:35 A.M., the MDS (Minimum Data Assessment) Coordinator indicated the chair alarm should have been in the MDS Assessment. During an interview on 10/21/24 at 3:15 P.M., the DON (Director of Nursing) indicated it was the policy of the facility to use the RAI (Resident Assessment Instrument) as a guide for the MDS Assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48057 2. On 10/17/24 at 12:54 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and hypertension. The most recent Annual MDS (Minimum Data Set) assessment, dated 10/2/24, indicated Resident 30 was cognitively intact, required partial assistance from staff for toileting, bathing, and transfers, and was receiving antipsychotic, antianxiety, anticoagulant, antiplatelet, and hypoglycemic medications during the 7-day lookback period. Physician orders for September 2024 and October 2024 lacked an antiplatelet medication. During an interview on 10/22/24 at 8:52 A.M., the MDS Coordinator indicated the antiplatelet medication marked as received by Resident 30 on the Annual MDS assessment, dated 10/2/24, was marked in error and Resident 30 had not received an antiplatelet medication.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on interview and record review, the facility failed to develop care plans for 1 of 1 residents reviewed for communication. A care plan was not developed for residents with English as a second language. (Resident 50) Findings include: 1. On 10/17/24 at 9:01 A.M., during a random observation in Resident 50's room there was no Spanish communication board available in room to meet the resident's needs if asked. On 10/18/24 at 9:53 A.M., Resident 50's clinical record was reviewed. Diagnoses included, but were not limited to, weakness, osteoarthritis, and dementia. The current Quarterly MDS assessment dated [DATE], indicated Resident 50 was moderately cognitively impaired. The resident needed supervision for toileting, dressing, and mobility. The resident was not coded this assessment for a chair alarm or significant weight loss. The clinical record lacked an order for the use of communication devices. The clinical record lacked a care plan to concerning the resident's communication needs. On 10/21/24 at 10:04 A.M., the communication board was observed under a stack of papers on the resident's dresser and readily available. On 10/21/24 at 2:22 P.M., the resident was observed using her wheelchair in the activities room trying to talk with a CNA (Certified Nurse Aide) in Spanish. The CNA indicated that she could not understand the resident and made no effort to communicate with the resident because she was preoccupied passing ice water. During an interview on 10/21/24 at 10:15 A.M., the ADON (Assistant Director of Nursing) indicated there should be a care plan for communication since the resident spoke Spanish as a first language. On 10/22/24 at 12:56 P.M., the DON (Director of Nursing) provided a current, non-date policy Communication in the Predominant Language. The policy indicated the resident has the right to a dignified existence .and communication with and access to persons and with services with the facility. The resident has the right to be full informed in a language that he or she understand of his/her health status . On 10/21/24 at 3:15 P.M., the DON provided a current policy Baseline Care Plan Assessment/ Comprehensive Care Plan revised 3/23/21. The policy indicated .the comprehensive care plan will further expand on the resident's medical, nursing, physical functioning . needs. These needs will be based on observation, record review, interviews, and thorough assessments .the comprehensive care plan shall include any specialized services . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-35(b)(1) 3.1-35(d)(2)(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** 46758 Based on record review and interview the facility, failed to ensure that documentation of interventions were not revised for 1 of 2 residents reviewed for falls and revise a residents care plan after they returned to facility from a hospital admission with a urinary tract infection and sepsis for 1 of 1 resident reviewed for urinary tract infections. (Resident 36, Resident 50). Findings include: 1. On 10/18/24 at 9:53 A.M., Resident 50's clinical record was reviewed. Diagnoses included, but were not limited to, weakness, osteoarthritis, and dementia. The current Quarterly MDS (Minimum Data Set) assessment dated [DATE], indicated Resident 50 was moderately cognitively impaired. The resident needed supervision for toileting, dressing, and mobility. The resident was not coded in assessment for a chair alarm or significant weight loss. There were no orders for chair alarms or Dycem devices. The current fall risk care plan lacked interventions for a chair alarm and a Dycem device. During an interview on 10/21/24 at 10:12 A.M., the ADON (Assistant Director of Nursing) indicated care plans need to be updated with each fall and there should be an intervention for the Dycem and chair alarms. 50827 2. On 10/21/24 at 11:54 A.M., Resident 36's clinical record was reviewed. The diagnoses included Sepsis and End Stage Renal Disease (ESRD). The most recent Quarterly MDS Assessment, on 10/4/24, indicated Resident 36 was cognitively intact, had complex medical conditions included, but not limited to, sepsis and end stage renal disease. Resident 36's clinical record lacked an updated care plan to reflect their recent hospitalization for sepsis with a Urinary Tract Infection. On 10/22/24 at 9:45 A.M., the DON (Director of Nursing) indicated that a resident's care plan should have been updated after a hospitalization . On 10/21/24 at 3:15 P.M., the DON provided a current policy Baseline Care Plan Assessment/ Comprehensive Care Plan revised 3/23/21. The policy indicated .the comprehensive care plan will be reviewed and updated every quarter at a minimum. The facility may need to be review the care plans more often based on changes in the resident's conditions and/or newly developed health/psychological-social issues . 3.1-35(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on interview and record review, the facility failed to ensure practitioner's diagnostic practices met professional standard of care for 1 of 1 resident diagnosed with scizoaffective disorder and bipolar disorder after admission. (Resident 47) Finding includes: On 10/18/24 at 10:23 A.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on [DATE]. Diagnoses included, but were not limited to, dementia, major depressive disorder, and anxiety. The most recent Significant change MDS (Minimum Data Set) assessment, dated 9/13/24, indicated Resident 47 was severely cognitively impaired, required partial assistance from staff for eating, toileting, and bathing, was completely dependent on staff for transfers, and received antipsychotic, antianxiety, and antidepressant medications during the 7-day lookback period. Current physician orders included, but were not limited to: Depakote sprinkles (antiepileptic medication) oral capsule delayed release 125 MG, Give one capsule by mouth three times a day, Start date 6/8/24 risperidone (atypical antipsychotic medication) oral tablet 1 MG, Give one tablet by mouth two times a day for, Start date 6/8/2024 Alprazolam (antianxiety medication) tablet 0.5 MG, Give one tablet by mouth two times a day, Start date 6/13/2024 Escitalopram oxalate (antidepressant medication) oral tablet 10 MG, Give one tablet by mouth one time a day, Start date 6/8/2024 Hydroxyzine HCl (antihistamine medication) 25 MG, Give one tablet every eight hours as needed, Start date 6/12/24 The clinical record lacked a care plan related to behavioral disturbances requiring antipsychotic medication use or monitoring for side effects of antipsychotic medications. A pharmacy medication review, dated 7/13/24, indicated Resident 47 was receiving risperdone 1 mg twice a day for dementia with behaviors. The physician selected to change the diagnosis associated with the medication from dementia with behaviors to schizoaffective disorder. A pharmacy medication review, dated 7/13/24, indicated Resident 47 was receiving Depakote 125 mg three times a day for dementia. The physician selected to change the diagnosis associated with the medication from dementia with behaviors to bipolar disorder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 11:46 A.M., the Director of Nursing indicated she was unable to find a physician evaluation related to Resident 47's diagnosis of schizoaffective disorder or bipolar disorder. On 10/21/24 at 1:30 P.M., a policy related to services provided meeting professional standards was requested and unable to be provided. 3.1-35(g)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48057 Based on clinical record review and interview, the facility failed to ensure care consistent with professional standards of practice were received to prevent pressure ulcers from progressing by administering treatments as physician ordered and treatments were administered by qualified personnel for 1 of 2 residents reviewed for wounds. (Resident 16) Finding includes: On 10/17/24 at 12:08 P.M., Resident 16's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 8/19/24, indicated Resident 16 was cognitively intact, required partial assistance from staff for toileting and bathing, and was completely dependent on staff for transfers. Current physician orders included, but were not limited to: Sacral wound: Cleanse and pat dry, apply skin prep, and cover with bordered gauze every day shift, Start date 10/12/24. Left heel: cleanse with wound cleanser, apply skin prep to peri wound, apply collagen to wound bed, and cover with silver alginate. Secure with abdominal pad and rolled gauze every day shift, Start date 9/14/24. Use wedge or pillow to alleviate pressure off of wound to sacrum- document any non-compliance every shift, Start date 9/6/24 Off loading device to left foot every shift when in bed, Start date 9/11/23 Apply skin prep to left heel every shift for prevent skin break down, Start date 8/16/24 Care plan: Wound is present on sacral region- Pressure ulcer stage 3, Start date 4/25/24. Interventions: air mattress on bed, 9/17/24; treatment as ordered, 4/25/24. Wound is present on left heel- Pressure ulcer stage 3, Start date 9/15/23. Interventions: air mattress on bed, 9/17/24; treatment as ordered, 2/7/24. (Stage three pressure ulcer is defined as a full-thickness tissue loss that extends through the skin into deeper tissue and fat.) Wound evaluations dated 8/29/24 through 10/17/24 indicated the following weekly measurements: Stage three left heel wound: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/17: 2.6 cm x 3 cm x 0.1 cm 10/10: 2.5 cm x 3.1 cm x 0.1 cm 10/3: 2.6 cm x 3.2 cm x 0.1 cm 9/26: 2.6 cm x 3.2 cm x .1 cm 9/19: 3.1 cm x 4.1 cm x .1 cm 9/12: 1.6 cm x 1.2 cm x .1 cm 9/5: 1.4 cm x 1 cm x .1 cm 8/29: 1 cm x 0.5 x 0.1 cm Stage three sacral wound: 10/17: 4.4 cm x 7.1 cm 10/10: 4.5 cm x 8.2 cm 10/3: 0.2 cm x 0.2 cm 9/26: 0.8 cm x 1.4 cm x 0.2 cm 9/19: 2 cm x 1.5 cm x 0.2 cm 9/12: 1.9 cm x 1.2 cm x 0.2 cm 9/6: 2.5 cm x 2 cm x .1 cm 8/29: 2 cm x 2 cm x 0.1 cm On the following dates treatment administration was documented by a QMA on the electronic medication administration record during the last 60 day period: Stage three left heel wound: 9/12/24 9/20/24 9/23/24 9/27/24 10/2/24 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/3/24 10/17/24 10/21/24 Stage three sacral wound: 9/12/24 9/13/24 9/20/24 9/27/24 10/2/24 10/3/24 10/17/24 10/21/24 On the following dates treatment administration was not documented as completed during the last 60 days: Stage three left heel wound: 9/1/24 9/13/24 10/13/24 10/16/24 10/18/24 Stage three sacral wound: 10/11/24 10/16/24 The clinical record, including electronic administration record and progress notes, did not indicate any refusal of wound treatment during the last 60 days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A laboratory wound culture, resulted on 9/16/24, indicated Resident 16's stage three pressure ulcer left heel wound was positive for the organism methicillin resistant staphylococcus aureus. A nurse practitioner skin and wound note, dated 10/10/24, indicated staff had obtained a pressure reduction air flow mattress since last seen, on 10/3/24, due to long standing wound. Unfortunately, the air pressure mattress developed issues, so (resident) was placed back on a regular mattress. At today's visit the wound size worsened in size and shape. During an interview on 10/22/24 at 11:11 A.M., the Assistant Director of Nursing indicated a QMA (Qualified Medication Aide) should never administer treatments. On 10/22/24 at 9:58 A.M., the Director of Nursing provided a document titled Qualified Medication Aide Scope of Practice that indicated The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all. The following tasks shall not be included in the QMA scope of practice: Administer a treatment that involves advanced skin conditions, including stage two, three, and four decubitus ulcers. On 10/22/24 at 9:58 A.M., a policy related to treatment and staging of wounds was requested and was not provided. 3.1-40(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on record review and interview, the facility failed to ensure diet recommendations were followed in 1 of 3 residents reviewed for nutrition. (Resident 34) Findings include: On 10/17/24 at 1:11 P.M., Resident 34's clinical record was reviewed. Diagnoses included, but were not limited to, gastro-esophageal reflux disease, schizoaffective disorder, and dementia. The current Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated Resident 50 was moderated cognitively impaired. The resident needed partial assistance to for toileting and dressing. The resident was noted for significant weight loss during the assessment period. Physician orders included, but were not limited, General diet, regular texture, and thin liquid consistency dated 4/12/24. Weekly weight records as follows: 10/2/2024 1:06 P.M. 124.5 Lbs. (Pounds) 9/25/2024 10:35 A.M. 126.5 Lbs. 9/16/2024 9:25 A.M. 121.5 Lbs. 9/9/2024 10:49 A.M. 122.0 Lbs. 9/2/2024 9:34 A.M. 128.0 Lbs. 8/23/2024 7:22 A.M. 124.5 Lbs. 8/1/2024 10:12 A.M. 128.5 Lbs. 7/29/2024 3:08 P.M. 130.0 Lbs. 7/22/2024 12:20 P.M. 128.5 Lbs. 7/15/2024 10:20 A.M. 129.5 Lbs. 7/8/2024 9:37 A.M. 130.0 Lbs. 7/3/2024 11:07 A.M. 131.0 Lbs. 7/1/2024 11:19 A.M. 130.0 Lbs. 6/26/2024 1:14 P.M. 131.5 Lbs. (continued on next page)

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Waters of Princeton, The	1020 W Vine St Princeton, IN 47670

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/10/2024 9:08 A.M. 129.0 Lbs. 6/5/2024 10:25 A.M. 135.0 Lbs. 5/27/2024 10:31 A.M. 134.0 Lbs. 5/20/2024 1:18 P.M. 133.0 Lbs. 5/13/2024 10:02 A.M. 134.0 Lbs. 5/6/2024 10:00 A.M. 134.5 Lbs. 5/1/2024 2:09 P.M. 137.0 Lbs. 4/29/2024 1:20 P.M. 149.0 Lbs. 4/22/2024 12:31 P.M. 145.8 Lbs. 4/17/2024 10:53 A.M. 146.5 Lbs. The weight loss calculator indicated the resident had a 15.1% weight loss in 6 months A Nutrition at Risk Review (NAR) dated 5/8/24, at 2:40 P.M., recommended fortified food with breakfast to help prevent further weight loss. A NAR dated 5/22/24, at 3:24 P.M., recommended fortified food with meals to help prevent further weight loss. A NAR dated 5/29/24, at 3:15 P.M., recommended fortified food with meals to help discourage further weight loss. A NAR dated 6/12/24, at 2:41 P.M., recommended fortified food with meals to help discourage any further weight loss. A NAR dated 6/21/24, at 4:15 P.M., recommended fortified food with meals to help discourage any further weight loss the diet indicated it was general, regular, thin fluids, fortified foods with meals. The record lacked an order for change of of diet. A NAR dated 10/17/24, at 9:43 A.M., indicated the resident had a weight warning when the resident was at 126.5 pounds, had a weight change in 6 months of 15.01 pounds over 6 months, and the diet was general, regular, with thin liquids. The record lacked an order for fortified foods with meals. The current care plan for nutritional risk indicates the resident is at risk related to BMI (Body Mass Index) > (greater than) 25, with a diagnosis of depression and dementia. Interventions included, but were not limited to, serve diet as ordered and offer substitutions if resident consumes < (less than) 50 % (Percent) of meal dated 9/15/23. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/24 at 9:13 A.M., the DON (Director of Nursing) indicated the resident should be on supplements if there is significant weight loss. During an interview on 10/18/24 at 9:17 A.M., the Diet Manager indicated he had talked with the dietitian about the resident's weight loss and were suggesting using fortified shakes, boost, etc. and change had not been done yet. On 10/21/24 at 3:12 P.M., the DON provided a current, non-dated policy SWAT Program/ Skin and Weight Assessment Team. The policy indicated . it is the policy of the facility to assess the nutritional status of each resident .the program is designed to aggressively review and address those residents exhibiting significant weight changes. these residents will be monitored .involving all disciplines to best cater to the improvement of the resident nutritional status . 3.1-46(2)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48057 Based on record review and interview, the facility failed to ensure a pharmacy recommendation was followed for 1 of 5 residents reviewed for unnecessary medications (Resident 47). Finding includes: On 10/18/24 at 10:23 A.M., Resident 47's clinical record was reviewed. Resident 47 was admitted on [DATE]. Diagnoses included, but were not limited to, dementia and cognitive communication deficit. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 9/13/24, indicated Resident 47 was severely cognitively impaired, required partial assistance from staff for eating, toileting, and bathing, and was completely dependent on staff for transfers. Physician orders included, but were not limited to: Omeprazole (proton pump inhibitor (PPI) medication) 40 MG capsule delayed release, give one capsule by mouth one time a day. Start date 6/8/24 The clinical record lacked a care plan related to the use of a proton pump inhibitor (PPI) medication. A pharmacy recommendation, dated 9/14/24, indicated a pharmacy recommendation to reduce or hold Resident 47's omeprazole medication for two weeks and if no GI symptoms occur, discontinue the medication. The eMAR (electronic medication administration record) indicated omeprazole 40 MG was held for 14 days and started again. The clinical record, including orders, care plans, assessments, and progress notes, lacked documentation if any GI symptoms occurred during the 14 day hold period and rationale for Resident 47 continuing the medication. On 10/22/24 at 9:58 A.M., the Director of Nursing provided an undated policy titled Pharmacy Recommendations the stated It is the policy of the facility to monitor medication by pharmacy regimen review conducted monthly or more often if indicated. The objective being to ensure that the residents are receiving medications that are effective and safe. The pharmacy consultant will contact the DON and or the physician and the concern will be addressed and resolved per physician orders/direction. This will be documented. 3.1-25(b)(2)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48057 Based on observation, interview, and record review, the facility failed to ensure medications were administered according to physician's orders and professional standard for 4 of 4 residents observed during medication pass. (Resident 10, Resident 39, Resident 42, Resident 30) Five medication errors were observed during 31 opportunities for error in medication administration. This resulted in a 16.13 error rate. Findings include: 1. During a medication administration on 10/18/24 at 8:02 A.M., RN 6 prepared the following medications for Resident 10: one tablet of certirizine 10 mg, one tablet of desvenlafaxine 100 mg, one tablet of famotidine 10 mg, one tablet of furosemide 40 mg, one tablet of meloxicam 7.5 mg, one tablet of Nuedexta 20-10mg, one tablet of vitamin D3 5000 units, one tablet of asenapine 5mg, and mixed a packet of polyethylene glycol in 8oz of water. RN 6 took the medications to Resident 10; Resident 10 took all of the medications orally and drank the polyethylene gylcol mixed in water. RN 6 then went to the EDK and removed a tablet of metoprolol 25mg, placed the pill in a medication cup, and gave the medication to Resident 10. On 10/18/24 at 9:45 A.M., Resident 10's clinical record was reviewed. Physician orders included, but were not limited to: asenapine 5mg take medication sublingually. During the medication administration, asenapine 5mg was not given to Resident 10 sublingually. 2. During the medication administration on 10/18/24 at 8:22 A.M., RN 6 prepared the following medications for Resident 39: one tablet of metformin 500mg, one soft gel of docusate sodium 100mg, one tablet of escitalopram 10 mg, one tablet of Farxiga 5 mg, one tablet of levetiracetam 1000mg, one tablet of metoprolol 25 mg, two tablets of quetiapine 25mg, attached a needle to the Admelog insulin pen and turned the dial to 10 units. RN 6 entered Resident 39's room and handed Resident 39 the cup of medications, then administered 10 units of Admelog insulin in Resident 39's right lower abdomen. During the medication administration, RN 6 did not prime the insulin pen needle prior to administration. Resident 39's clinical record was reviewed on 10/18/24 at 10:00 A.M. 3. During the medication administration on 10/18/24 at 8:40 A.M., RN 7 prepared the following insulin for Resident 42: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lantus insulin pen 70 units and lispro insulin pen 50 units. RN 7 primed each insulin pen with two units with the cap on, then set the dial to 70 units for Lantus insulin pen and 50 units to insulin lispro pen. RN 7 then administered 70 units of Lantus insulin in the resident's left lower abdomen and 50 units insulin lispro in the resident's left upper abdomen. During the medication administration, RN 7 did not prime the insulin pen needle properly prior to administration. Resident 42's clinical record was reviewed on 10/18/24 at 2:27 P.M. 4. During the medication administration on 10/18/24 at 8:52 A.M., RN 7 prepared the following medications for Resident 30: one tablet of Eliquis 5 mg, two tablets of Tylenol 235 mg, one tablet of folic acid 1mg, one tablet of lansoprazole 15mg, one tablet of vitamin D3 5000 units, one tablet of levothyroxine 50mcg, one tablet of lisinopril 20 mg, one tablet of loratadine 10 mg, a multivitamin tablet, and one tablet of olanzapine 5 mg. RN 7 took the cup of medications to Resident 30 and Resident 30 took the medications orally. On 10/18/24 at 9:55 A.M., Resident 30's clinical record was reviewed. Current physician orders included, but were not limited to: olanzapine 2.5mg give 2.5mg by mouth one time a day, Start date 10/1/24. During an interview on 10/18/24 at 10:07 A.M., RN 7 opened the medication cart and pulled the medication card for olanzapine and confirmed the instructions on the card indicated give 5mg twice a day. RN 7 indicated there were not 2.5 mg tablets available and Resident 30 had been given the incorrect dose during the medication pass. On 10/22/24 at 11:01 A.M., the Director of Nursing provided a policy titled Medication Administration, dated 2/2017, that indicated Review the resident's Medication Administration Record (MAR). Read each order entirely. Remove the medication from the drawer. If there is any discrepancy between the MAR and the label, check physician orders before administering medication. On 10/22/24 at 11:01 A.M., the Director of Nursing provided an insulin injection instruction leaflet that stated Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly, removing air bubbles. A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle. You may have to perform the safety test several times before insulin is seen. 3.1-48(c)(1)

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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. 48057 Based on observation, interview and record review, the facility failed to ensure medications were properly dated and labeled, failed to keep medications refrigerated until opening, and failed to destroy expired medications for 2 of 2 medication carts observed. (100 hall west medication cart and 200 hall east medication cart) Findings include: 1. During an observation on 10/16/24 at 9:03 A.M., the 200 hall east medication cart contained the following items: Humalog insulin pen - opened; lacked opened on or expiration date Lantus insulin pen- opened; lacked opened on or expiration date, pen needle attached and not capped Latanoprost eye drops- expiration date 10/13/24 Lantus insulin pen - expiration date 9/23/24 Humalog insulin pen- lacked identification tag or resident name - expiration date 10/14/24 insulin aspart pen- name rubbed off of identification tag two insulin lispro pens - seal is unopened, tag on insulin states refrigerate until opening opened bottle of Pro-Stat (liquid protein)- lacked label or opened date 2. During an observation on 10/16/24 at 9:25 A.M., the 100 hall west medication cart contained the following items: Humalog insulin pen- expiration date 9/11/24 insulin lispro pen- expiration 9/11/24 Basaglar insulin pen- opened; lacked opened on or expiration date two novolog insulin pens - opened; lacked opened on or expiration date Lantus insulin pen- opened; lacked opened on or expiration date Two novolog insulin pens - seal is unopened, tag on insulin states refrigerate until opening (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ozempic (antidiabetic medication) injection- unopened, tag on injection box states refrigerate until opening two Basaglar insulin pens - opened; lacked opened on or expiration date Bottle of opened Pro-Stat (liquid protein)- lacked label or opened date During an interview on 10/22/24 at 11:46 A.M., the Director of Nursing stated the facility was aware of the injections in the medication carts not being refrigerated properly due to pharmacy delivering the injections without ice packs. On 10/21/24 at 3:31 P.M., the Director of Nursing provided a policy titled Medication Storage in the Facility, dated 6/2012, that stated Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations. Medications requiring refrigeration or temperature between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled, or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists. 3.1-25(j) 3.1-25(m) 3.1-25(o)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48147 Based on observation, interview, and record review, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 trays tested for temperature. (200-hall) Finding includes: On 10/16/24 at 10:13 A.M., Resident 52 indicated the food was cold. On 10/16/24 at 10:38 A.M., Resident 31 indicated the food was cold. On 10/16/24 at 12:14 P.M., Resident 15 indicated the food tasted bad and was cold. On 10/17/24 at 10:45 A.M., Resident 42 indicated the food tasted bad and was cold. On 10/21/24 at 12:22 P.M., a test tray was obtained. Food temperatures for that meal were: BBQ chicken 102.9 F (Fahrenheit) Roasted potatoes 109.7 F Yellow squash 107.9 F At that time, the food tasted cold. On 10/21/24 at 12:31 P.M., the Dietary Manager expected food to be about 148 F when served. He indicated he was aware cold food was an issue and hoped to get new insulated holders and carts to help. On 10/22/24 at 10:05 A.M., the Dietary Manager provided an undated current Food Temperatures policy that indicated Best efforts will be made to present hot foods hot and cold foods cold at point of service . 3.1-21(a)(2)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on observation, interview, and record review, the facility failed to ensure food was correctly prepared for 4 of 4 residents who received puree altered diets. Finding includes: On [DATE] at 10:01 A.M., [NAME] 5 was observed preparing 4 servings of pureed beef and cheddar sandwiches. [NAME] 5 added the following ingredients to the blender and blended in between each item: 8 slices of pre-cooked roast beef 1-ounce (oz) scoop of mayonnaise 1-oz scoop of mayonnaise 1-oz scoop of mayonnaise 4 hamburger buns torn up 2 1-oz scoops of mayonnaise 2 1-oz scoops of mayonnaise 4 slices of cheese torn up 2 1-oz scoops of mayonnaise At that time, [NAME] 5 indicated the food did not look right and it would probably taste like straight mayonnaise. She indicated she usually would add broth to help with the consistency, but the recipe did not call for it. That was a new recipe and she had never made it before. Cook 5 added 4 more 1-oz scoops of mayonnaise. (Total mayonnaise added was 13-oz.) Cook 5 went to the reach-in refrigerator and obtained milk. The best by date on the milk was [DATE]. She added a quarter cup of milk to the blender and blended to pudding consistency. On [DATE] at 9:37 A.M., the Dietary Manager provided the recipe for the Beef and Cheddar Sandwich that was prepared by [NAME] 5 on [DATE]. The ingredients for one serving included: 2-oz shaved roast beef 1 slice cheese (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 bun The puree preparation instructions indicated to place in food processor and process to a smooth pudding like consistency. Add mayo, a little at a time, as needed to achieve smooth consistency. No serving size was identified per serving. On [DATE] at 2:32 P.M., the Dietary Manager indicated the menu and recipes were new to the facility. He indicated 13 oz of mayonnaise was a lot of mayonnaise and he would have advised [NAME] 5 to use milk to help achieve the appropriate consistency. At that time, he indicated expired food was thrown out daily and he didn't realize the milk in the refrigerator was expired. On [DATE] at 11:00 A.M., the Dietary Manager provided an undated current Characteristics and Procedures for Consistency Modified Foods policy that indicated Properly prepared pureed food has the following characteristics .it is soft (pudding like consistency) . Successfully pureeing food depends on using the right process as well as the right equipment. If you cannot puree an item to meet the above characteristics with the processing equipment that you have, contact your manager or dietician to determine an appropriate substitute. On [DATE] at 11:00 A.M., the Dietary Manager provided a current Pureed Food Preparation policy, dated [DATE], that indicated Milk, broth, soup, gravy, juice, and margarine will be used to thin the pureed food . The flavor of pureed foods will be checked as these items must have the same flavor as original regular menu item. On [DATE] at 11:21 A.M., the Director of Nursing (DON) provided a current First In First Out (FIFO) policy, dated ,d+[DATE], that indicated Stock must be used before the expiration date. Items not used by the expiration date will be discarded. 3XXX,d+[DATE](a)(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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48147 Based on observation, interview, and record review, the facility failed to ensure food was prepared under sanitary conditions during 3 of 3 kitchen observations and 1 of 1 dining observations. Staff did not wear hairnets, and gloves were not changed before touching food items. (Dietary Manager, [NAME] 5, [NAME] 14, Activities Department Staff) Findings include: 1. During a lunchtime dining observation on 10/16/24 at 12:00 P.M., Activities Department staff were observed assembling and serving hot dogs for lunch in the dining room. Residents placed orders and staff assembled buns, hot dogs, condiments, and chili in the dining room. Staff did not change gloves in between touching the hot dog buns and touching condiment bottles. Staff were not wearing hairnets while assembling food. 2. On 10/16/24 at 9:12 A.M., the Dietary Manager was observed in the kitchen without a beard net. [NAME] 5 and [NAME] 14 were observed in the kitchen wearing a hairnet that did not cover all of their hair. 3. On 10/17/24 at 10:01 A.M., the Dietary Manager was observed in the kitchen without a beard net. [NAME] 5 was observed in the kitchen wearing a hairnet that did not cover all of her hair. 4. On 10/21/24 at 11:30 A.M., [NAME] 5 was observed taking temperatures of lunch foods on the steam table. [NAME] 5 was wearing gloves. She touched her face, the refrigerator, a cart, the hot plate heater, the oven, a cooking tray, and a hot pad. Without changing gloves, [NAME] 5 reached in a bread bag and retrieved a bun, opened the bun, and prepared a chicken sandwich. [NAME] 5 was observed wearing a hairnet that did not cover all of her hair. At that time, the Dietary Manager was observed in the kitchen without a beard net. On 10/21/24 at 2:32 P.M., the Dietary Manager indicated hairnets were worn when handling food. All hair should be covered while wearing a hairnet including facial hair. At that time, he indicated gloves should be changed after touching nonfood items and before touching food, and [NAME] 5 should have changed gloves before touching the bun. On 10/22/24 at 10:05 A.M., the Dietary Manager provided an undated Glove Use policy that indicated Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled or when interruptions occur in the operation . Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed: . During food preparation, as often as necessary .to prevent cross contamination when changing tasks. On 10/22/24 at 10:05 A.M., the Dietary Manager provided an undated current Hair Restraints/Jewelry/Nail Polish policy that indicated Hairnet, hat or hair restraint will be worn at all times in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 12:56 P.M., the Administrator provided a current Employee Health and Personal Hygiene policy, dated 9/17/23, that indicated Hair restraints will be worn at all times. Beards should be well-trimmed and covered with an appropriate hair restraint. 3.1-21(i)(2) 3.1-21(i)(3)

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	155275	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Princeton, The	1020 W Vine St Princeton, IN 47670

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 4 of 5 residents reviewed for insulin, 5 of 5 reviewed for late medications and 1 of 2 residents reviewed for wound care. Insulin documentation and wound treatments were not documented by the staff that provided the service, medications were documented correctly when administered one hour and 45 minutes late. (Resident 53, Resident 15, Resident 42, Resident 16, Resident 259, Resident 17, Resident 22) Findings include: 1. On 10/17/24 at 12:37 P.M., Resident 53's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The most current Admission Minimum Data Set (MDS) Assessment, dated 8/20/24, indicated Resident 53 was cognitively intact and received insulin. Physician orders included, but were not limited to: Insulin lispro (a fast-acting insulin) 100 units/milliliter (mL) - Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units; 401+ = 7units subcutaneously before meals for diabetes mellitus, dated 8/14/24 The Medication Administration Record (MAR) from 8/7/24 to 10/17/24 indicated Qualified Medication Aide (QMA) 10 administered insulin lispro to Resident 53 on the following dates: 8/24/24 at 7:02 A.M. 8/24/24 at 5:24 P.M. 9/7/24 at 12:48 P.M. 9/9/24 at 5:28 P.M. 9/24/24 at 10:20 A.M. 9/30/24 at 10:04 A.M. Medication Administration progress notes from QMA 10 indicated the insulin was given by the nurse on duty on those days. The progress notes did not specify which nurse on duty gave the insulin. The clinical record lacked documentation from the nurse that administered the insulin on those days. 48057 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 10/17/24 at 12:08 P.M., Resident 16's clinical record was reviewed. Resident 16 was admitted on [DATE]. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 8/19/24, indicated Resident 16 was cognitively intact, required partial assistance from staff for toileting and bathing, and was completely dependent on staff for transfers. Current physician orders included, but were not limited to: Basaglar (insulin medication) Inject 10 unit subcutaneously every morning and at bedtime for diabetes, Start date 4/9/24 On the following dates subcutaneous insulin administration was documented by QMA 10 on the electronic medication administration record during the last 30 day period: 9/20/24 8:00 A.M. 9/27/24 8:00 A.M. 10/2/24 8:00 A.M. 10/3/24 8:00 A.M. 10/16/24 8:00 A.M. 10/17/24 8:00 A.M. 10/21/24 8:00 A.M. On 10/22/24 at 9:58 A.M., the Director of Nursing provided a document titled Qualified Medication Aide Scope of Practice that indicated The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all. The following tasks shall not be included in the QMA scope of practice: Administering medication by the injection route, including the following: Subcutaneous route. 50827 3. On 10/17/24 at 2:03 P.M., Resident 15's clinical record was reviewed. The most recent Quarterly MDS (Minimum Data Set) Assessment, on 10/27/24, indicated that the resident was cognitively intact, had diagnoses that included but was not limited to diabetes mellitus, and received insulin. Current orders included: Humalog KwikPen (short-acting insulin) dated 11/2/23. Resident 15's MAR (Medication Administration Record) for October 2024 indicated that the following doses of Humalog (insulin) for the resident were administered by QMA (Qualified Medication Aide) 10: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/2/24 8 A.M. and 12 P.M. 10/3/24 8 A.M. and 12 P.M. 10/16/24 8 A.M. and 12 P.M. 10/17/24 8 A.M. and 12 P.M. QMA 10 was not qualified to administer insulin. On 10/18/24 at 11:30 A.M., Resident 15's MAR (Medication Administration Record) was reviewed. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24 4. On 10/18/24 at 2:27 P.M., Resident 42's clinical record was reviewed. The most recent State Optional MDS , dated 8/9/24, indicated the resident was cognitively intact and had diagnoses that included but was not limited to diabetes mellitus and received insulin. Current orders included: Insulin Lispro Injection Solution 50 units before meals, dated 6/28/24. Insulin Lispro Injection Solution, inject as per sliding scale before meals and bedtime, dated 6/28/24. Resident 42's MAR (Medication Administration Record) for October 2024 indicated that the following doses of Insulin Lispro injections for the resident were administered by QMA (Qualified Medication Aide) 10: 10/3/24 11 A.M. insulin Lispro 50 units 10/3/24 11 A.M. insulin Lispro sliding scale QMA 10 was not qualified to administer insulin. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24. 5. On 10/16/24 at 3:50 P.M., Resident 259's clinical record was reviewed. The resident was recently admitted and did not have a completed MDS. Resident 259 had diagnoses that included but was not limited to zoster (shingles). Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24. 6. On 10/18/24 at 2:30 P.M , Resident 17's clinical record was reviewed. The most recent Quarterly MDS dated [DATE], indicated the resident was cognitively intact, had diagnoses that included but was not limited to cerebrovascular accident, and was receiving opioid medications. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 10/18/24 at 2:20 P.M., Resident 22's clinical record was reviewed. The most recent Quarterly MDS dated [DATE], indicated the resident was cognitively intact, had diagnoses that included but was not limited to coronary artery disease, and was receiving an opioid medication. Resident's electronic MAR indicated that they had not received their medications due at 8 P.M. on 10/15/24. On 10/18/24 at 2:40 P.M., RN (Registered Nurse) 7 indicated that she did not stay over her scheduled shift to give Resident 15, Resident 17, Resident 42, Resident 259, and Resident 22's medications and the nurse scheduled to relieve her had called in, the nurse working night shift gave Residents' 8 P.M. medications late but had not charted they were given. On 10/21/24 at 9:40 A.M., the Administrator indicated that RN 7 gave some of the scheduled medications and RN 22 gave the rest, also that RN 22 fixed their documentation to reflect that they had given these medications. On 10/21/24 at 10:00 A.M., controlled drug receipt/record/disposition forms were reviewed for Residents 15, 17, 42, 259, and 22. These indicated that the residents received their medications scheduled for 10/15/24 at 8:00 P.M., at 8:00 P.M. on 10/15/24 with the signature of RN 22. DON (Director of Nursing) indicated on 10/21/24, at 10:20 A.M., RN 22 clocked in for their shift on 10/15/24 at about 9 or 9:30 P.M. An official time stamp from RN 22's time card on 10/15/24, indicated they clocked in for their shift at 9:45 P. M. On 10/21/24 at 2:20 P.M., the Director of Nursing (DON) indicated that QMAs did not give insulin. A nurse would give the insulin for the QMA and the QMA could mark it done for the nurse who gave the insulin. At that time, the DON indicated that insulin is the only medication in the facility that one staff could give and another staff could sign off on giving. On 10/21/24 at 3:12 P.M., the DON provided a current Guidelines for Nursing Documentation, dated 5/17/23, that indicated be definite in what you record . If you did not write it down, you did not do it. If you did not do it, you were negligent.should you need to document something out of time do it properly and in an orderly manner by first documenting when you are making the last note, then detailing the actual time the event occurred. Never be deceptive and 'back-date' or fake that you are writing at an earlier time. 3.1-50(a)(1) 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48057 Based on observation, record review, and interview, the facility failed to implement infection prevention measures by following physician orders for enhanced barrier precautions for 1 of 1 residents observed for wound care. (Resident 6) Finding includes: On 10/17/24 at 10:40 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, seizures and bipolar disorder. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 8/16/24, indicated Resident 6 was severely cognitively impaired and required partial assistance from staff for eating, bathing, toileting, and transfers. Current physician orders included, but were not limited to: Enhanced Barrier Precautions, start date 9/16/24 Left calf abrasion: Cleanse with wound cleanser, apply collagen and secure with rolled gauze due to fragile skin. No tape on skin every day shift, Start date 9/28/24. During an observation of wound care on 10/21/24 at 9:11 A.M., LPN (Licensed Practical Nurse)12 entered Resident 6's room. Resident 6's door had a sign that indicated enhanced barrier precautions. LPN 12 washed her hands, put gloves on, and began opening wound care supplies on a bedside table. LPN 12 sprayed wound cleanser on gauze and cleaned Resident 6's wound bed on her left calf. LPN 12 applied collagen to the wound, applied rolled gauze around the left lower extremity, secured the gauze with tape, removed her gloves, and used a marker to write the date on the tape. LPN 12 gathered the wound supplies, threw the trash away, and washed her hands. LPN 12 did not wear a gown while providing wound care. During an interview on 10/22/24 at 8:52 A.M., the MDS coordinator indicated Resident 6 had wounds that required enhanced barrier precautions. On 10/21/24 at 3:31 P.M., the Director of Nursing provided a policy titled Enhanced Barrier Precautions, dated 12/19/22, that indicated Enhanced Barrier Precautions (EBP) are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDROs (multi-drug resistant organisms) in the form of blood or body fluids, onto the hands and/or clothing of the rendering caregiver. EBP is to be used when Contact Precautions do not otherwise apply and where there is a diagnosis of MRDO or a colonized MRDO. 3.1-18(b)