

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Clinton House Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 809 W Freeman St Frankfort, IN 46041	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48525</p> <p>Based on observation, interview and record review, the facility failed to ensure baseline care plans were completed within 48 hours after admission for 2 of 2 residents reviewed for baseline care plans. (Resident B and 34)</p> <p>Findings include:</p> <p>1. During an observation, on 9/3/24 at 10:51 a.m., Resident B was wearing oxygen at 3 liters.</p> <p>The clinical record for Resident B was reviewed on 9/5/24 at 1:25 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, type 2 diabetes, stage 3 chronic kidney disease, obstructive sleep apnea, and retention of urine.</p> <p>The resident was admitted on [DATE]. While reviewing the resident's care plan, the resident did not have a baseline care plan for the use of oxygen.</p> <p>During an interview, on 9/6/24 at 2:31 p.m., the Chief Nursing Officer (CNO) indicated there was not a respiratory baseline care plan for the resident. The policy was for the baseline care plan to be started within 48 hours of admission.</p> <p>49891</p> <p>2. The clinical record for Resident 34 was reviewed on 9/4/24 at 2:39 p.m. The diagnoses included, but not limited to, pneumonia, acute on chronic systolic congestive heart failure, major depressive disorder, chronic kidney disease stage 3, and anxiety disorder.</p> <p>The resident's initial admitted was 7/18/24. The baseline care plan meeting date was recorded as occurring on 7/22/24 at 10:30 a.m.</p> <p>The resident was discharged to the hospital on 7/23/24. The resident was readmitted to the facility again on 7/27/24. The clinical record did not include a new baseline care plan meeting.</p> <p>During an interview, on 9/6/24 at 2:05 p.m., the Social Services Director indicated the baseline care plan meetings were recorded in the clinical record.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, titled Baseline Care Plan, dated 10/20/23 and received from the Interim Executive Director on 9/6/24 at 2:40 p.m., indicated .Upon admission, the admission nurse will initiate the development of the baseline care plan as part of the admission assessment. The baseline care plan will continue to be developed by the interdisciplinary team and be completed within 48 hours of admission.</p> <p>3.1-35(a)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>49891</p> <p>Based on interview and record review, the facility failed to administer an as needed medication for weight gain, to notify the physician of a weight gain and to hold insulin doses per the physician's orders for 2 of 2 residents reviewed for quality of care. (Resident 34 and 68)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The clinical record for Resident 34 was reviewed on 9/4/24 at 2:39 p.m. The diagnoses included, but were not limited to, pneumonia, acute respiratory failure with hypoxia (absence of enough oxygen to sustain bodily functions), acute on chronic systolic congestive heart failure (heart is unable to pump blood as well as it should), and chronic kidney disease stage 3. <p>A physician's order, dated 7/28/24, indicated to weigh the resident daily and to notify the physician if the resident had a weight gain of 3 pounds in a day or 5 pounds in a week for congestive heart failure.</p> <p>A physician's order, dated 7/28/24, indicated to give furosemide (a diuretic medication) 40 milligrams (mg) by mouth every 24 hours as needed (PRN) for a greater than 3-pound weight gain.</p> <p>The vitals record in the electronic medical record indicated the resident's weights included, but were not limited to,</p> <ol style="list-style-type: none"> a. On 8/4/24, the weight was 152 pounds and on 8/5/24 the weight was 155.5 pounds. This was a documented increase of 3.5 pounds in a day. b. On 8/10/24, the weight was 149.9 pounds and on 8/16/24 the weight was 161 pounds. This was a gain of 11.1 pounds in a week. c. On 8/11/24, the weight was 150 pounds and on 8/12/24 the weight was 156.5 pounds. This was an increase of 6.5 pounds in a day d. On 8/13/24, the weight was 156.5 pounds and on 8/14/24 the weight was 162 pounds. This was a gain of 5.5 pounds in a day. e. On 8/28/24, the weight was 158.5 pounds and on 8/30/24 the weight was 162 pounds. There was no weight found for 8/29/24. This was a gain of 3.5 pounds. <p>The vitals record had multiple dates of missing weights.</p> <p>The Medication Administration Record (MAR), dated 8/1/24 through 8/31/24, indicated there had been no administrations of the furosemide PRN dose for a weight gain greater than 3 pounds.</p> <p>The electronic medical record did not indicate the physician had been notified of any weight gain greater than 3 pounds in a day or greater than 5 pounds in a week.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/3/24 at 12:15 p.m., the resident indicated her main issue was with her breathing and feeling short of breath. She indicated the oxygen, and breathing treatments did not take away her discomfort of feeling short of breath on some days. The resident indicated her legs hurt more when they were more swollen.</p> <p>During an interview, on 9/6/24 at 2:25 p.m., the Director of Nursing (DON) indicated there had been no PRN furosemide doses documented as being given with the weight gain of greater than 3 pounds. She also indicated the provider had not been notified of weight gains as it occurred.</p> <p>2. The clinical record for Resident 68 was reviewed on 9/6/24 at 1:32 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, type 2 diabetes mellitus with hyperglycemia and diabetic neuropathy, Parkinson's disease, gastroparesis, vascular dementia with mood disturbance, mild cognitive impairment, long term current use of insulin, depression, anxiety disorder, visual hallucinations, and tremor.</p> <p>A physician's order, dated 3/11/24 and discontinued 6/9/24, indicated to inject 28 units of insulin glargine-yfgn subcutaneously two times a day for diabetes and to hold if the blood glucose was less than 200.</p> <p>A physician's order, dated 6/9/24, indicated to inject 34 units of insulin glargine-yfgn subcutaneously two times a day for diabetes and to hold if the blood glucose was less than 200.</p> <p>A MAR, dated 6/1/24 through 6/30/24, indicated insulin glargine-yfgn 34 units was given with a documented blood glucose level less than 200 on 6/2/24 for the a.m. and p.m. doses, 6/4/24 for the a.m. dose, 6/7/24 for the p.m. dose, 6/11/24 for the a.m. dose, 6/13/24 for the a.m. and p.m. doses, 6/13/24 for the a.m. and p.m. doses, 6/14/24 for the a.m. dose, 6/16/24 for the a.m. dose, 6/18/24 for the a.m. dose, 6/21/24 for the p.m. dose, 6/22/24 for the a.m. dose, 6/28/24 for a.m. dose, and 6/30/24 for the a.m. dose. The documented blood glucose range was 115 to 197 for the doses given against the order to hold for a blood glucose less than 200.</p> <p>A MAR, dated 7/1/24 through 7/31/24, indicated insulin glargine-yfgn 34 units was given with a documented blood glucose level less than 200 on 7/4/24 for the a.m. and p.m. doses, 7/5/24 for the a.m. dose, 7/6/24 for the a.m. dose, 7/8/24 for the a.m. dose, 7/9/24 for the a.m. dose, 7/13/24 for the a.m. and p.m. doses, 7/14/24 for the a.m. dose, 7/16/24 for the a.m. dose, 7/17/24 for the a.m. dose, 7/20/24 for the a.m. and p.m. doses, 7/22/24 for the a.m. dose, 7/23/24 for the a.m. dose, 7/28/24 for the a.m. dose, and on 7/30/24 for the a.m. dose. The documented blood glucose range was 107 to 197 for the doses given against the order to hold for a blood glucose less than 200.</p> <p>A MAR, dated 8/1/24 through 8/31/24, indicated insulin glargine-yfgn 34 units was given with a documented blood glucose level less than 200 on 8/2/24 for the a.m. dose, 8/4/24 for the a.m. dose, 8/5/24 for the a.m. dose, 8/8/24 for the p.m. dose, 8/10/24 for the a.m. dose, 8/11/24 for the a.m. dose, 8/13/24 for the a.m. dose, 8/14/24 for the a.m. dose, 8/15/24 for the a.m. dose, 8/16/24 for the a.m. and p.m. doses, 8/22/24 for the a.m. dose, and 8/23/24 for the a.m. and p.m. doses. The documented blood glucose range was 149 to 198 for the doses given against the order to hold for a blood glucose less than 200.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A MAR, dated 9/1/24 through 9/30/24, indicated insulin glargine-yfgn 34 units was given on 9/1/24 for the a. m. dose with a blood glucose of 134, on 9/2/24 for the a.m. dose with a blood glucose of 199, on 9/3/24 for the a.m. dose with a blood glucose of 187, and on 9/6/24 for the a.m. dose with a blood glucose of 195.</p> <p>During an interview, on 9/6/24 at 2:06 p.m., Licensed Practical Nurse (LPN) 7 indicated a medication was given if there was a check mark and initials on the MAR. There would be a code with initials when the medication was not given. LPN 7 indicated the insulin doses had been given on 9/1/24, 9/2/24, 9/3/24, and 9/6/24 with blood glucose levels less than 200.</p> <p>During an interview, on 9/6/24 at 2:21 p.m., the DON indicated the insulin doses were given against the hold order on multiple occasions.</p> <p>A current facility policy, titled Change in Condition/Physician Notification Guidelines, dated 11/23 and received from the DON on 9/10/24 at 12:00 p.m., indicated .physician notification is based on assessment findings and is to be documented in the medical record</p> <p>A current facility policy, titled Medication Administration Policy, dated 6/1/22 and received from the DON on 9/10/24 at 11:58 a.m., indicated .Check for vital signs or other tests to be done during or prior to medication administration</p> <p>A current facility policy, titled Subcutaneous Insulin, undated and received from the Clinical Support Nurse on 9/10/24 at 1:00 p.m., indicated .Administer to resident .as ordered .</p> <p>3.1-37(a)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38872</p> <p>Based on observation, interview and record review, the facility failed to ensure staff stored a nebulizer mask and a CPAP/BiPap mask in a sanitary manner, failed to sanitize a CPAP/BiPap mask after it was found on the floor, and failed to ensure a resident receiving oxygen supplement therapy had an order for the oxygen for 3 of 3 residents reviewed for respiratory care. (Resident 58, 27 and B)</p> <p>Findings include:</p> <p>1. During an observation, on 9/3/24 at 10:20 a.m., Resident 58 was resting in bed. A nebulizer mask was found lying on top of the nebulizer machine. It was not stored in a bag.</p> <p>The clinical record for Resident 58 was reviewed on 9/3/24 at 12:26 p.m. The diagnoses included, but were not limited to, history of traumatic brain injury, acute respiratory failure with hypoxia, and other diseases of the bronchus.</p> <p>A physician's order, initiated on 10/21/23, indicated to administer albuterol sulfate (a respiratory medication) 2.5 milligrams in 3 milliliters via nebulizer every six (6) hours as needed for shortness of breath and/or wheezing.</p> <p>During an interview, on 9/3/24 at 10:38 a.m., CNA 5 indicated the mask should not be stored on top of the nebulizer machine.</p> <p>During an interview, on 9/3/24 at 11:25 a.m., the Director of Nursing indicated the nebulizer mask was not stored appropriately.</p> <p>2. During an observation, on 9/3/24 at 10:35 a.m., Resident 27 was sitting up in bed. A mask for a CPAP/BiPap (machine used to assist with breathing while sleeping) was noted to be on the floor.</p> <p>During an observation, on 9/3/24 at 10:36 a.m., CNA 5 entered the room, picked up the CPAP/BiPap mask from the floor and placed it on top of the machine. CNA 5 indicated the mask was not stored in a sanitary manner. She was not observed to have cleaned the mask prior to exiting the room.</p> <p>The clinical record for Resident 27 was reviewed on 9/10/24 at 10:56 a.m. The diagnoses included, but were not limited to, unspecified asthma, chronic respiratory failure with hypoxia, and obstructive sleep apnea.</p> <p>The resident did not have an order for a CPAP/BiPap machine.</p> <p>The resident did not have a care plan addressing the use of a CPAP/BiPap machine.</p> <p>During an interview, on 9/10/24 at 12:33 p.m., Resident 27 indicated he used the machine every night and nursing staff put the mask on him.</p> <p>During an interview, on 9/3/24 at 11:26 a.m., the Director of Nursing indicated the mask should have been sanitized and placed in a bag with a new date.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/10/24 at 12:05 p.m., the Director of Nursing (DON) indicated Resident 27 needed to have an order for the CPAP.</p> <p>During an interview, on 9/10/24 at 12:32 p.m., RN 6 indicated when the resident admitted to the facility he had an order for the CPAP. The order was discontinued in October of 2023 when he went out to the hospital.</p> <p>48525</p> <p>3. During an observation, on 9/3/24 at 10:51 a.m., Resident B was wearing oxygen at 3 liters.</p> <p>The clinical record for Resident B was reviewed on 9/3/24 at 1:25 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, type 2 diabetes, stage 3 chronic kidney disease, obstructive sleep apnea, and retention of urine.</p> <p>The resident was admitted on [DATE]. While reviewing the resident's physician's orders, the resident did not have an order for the use of oxygen.</p> <p>During an interview, on 9/3/24 at 3:01 p.m., the DON indicated she was not aware the resident did not have an order for oxygen.</p> <p>During an interview, on 9/10/24 at 12:00 p.m., the DON indicated they did not have a policy for physician's orders.</p> <p>A current facility policy, titled CPAP/BiPap CLEANING POLICY, dated as last revised and received from the Director of Nursing on 9/10/24 at 11:58 a.m., indicated, .Nebulizer/BiPap/CPAP mask and oxygen tubing is to be stored in plastic bag when not in use</p> <p>3.1-47(a)(6)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>50956</p> <p>Based on observation, interview and record review, the facility failed to ensure assessments were completed and a consent was obtained prior to the use of side rails for 2 of 3 residents reviewed for accident hazards. (Resident O and 63)</p> <p>Findings include:</p> <p>1. During an observation, on 9/3/24 at 9:34 a.m., 9/3/24 at 10:49 a.m., 9/4/24 at 9:19 a.m., 9/5/24 at 2:42 p.m., 9/6/24 at 1:40 p.m., 9/9/24 at 2:54 p.m., and 9/10/24 at 10:47 a.m., a side rail was in the raised position and in use on Resident O's bed.</p> <p>The clinical record for Resident O was reviewed on 9/4/24 at 2:02 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic neuropathy and hyperglycemia, unsteadiness on feet, weakness, lack of coordination, difficulty in walking, peripheral vascular disease, anxiety disorder, chronic pain syndrome, hypertension, and major depressive disorder.</p> <p>A side rail assessment, completed on 7/24/23, indicated Resident O did not need a side rail to assist in bed mobility.</p> <p>The electronic record did not have documentation showing the risks and benefits were explained to Resident O or a consent was obtained prior to the use of side rails.</p> <p>A physical therapy treatment note, dated 6/25/24, indicated Resident O completed transfers using the bedside rail during his therapy session.</p> <p>2. During an observation, on 9/3/24 at 9:37 a.m., 9/4/24 at 9:29 a.m., 9/5/24 at 1:23 p.m., and 9/9/24 at 2:54 p.m., a side rail was in place on Resident 63's bed.</p> <p>The clinical record for Resident 63 was reviewed on 9/4/24 at 2:03 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, lack of coordination, difficulty in walking, bipolar disorder, generalized anxiety disorder, seizures, gastroesophageal reflux, hypertension, pain in right knee, pain in left knee, and age-related physical debility.</p> <p>A side rail assessment was completed on 2/20/24 at 1:09 p.m. The assessment had the following question, Risks & Benefits have been explained & agreed to bed rail utilization, and indicated one of the following should be selected: 1. Resident representative notified and agreed or 2. Resident notified and agreed. Neither option was selected.</p> <p>The electronic record did not have documentation showing the risks and benefits were explained to Resident 63 or a consent was obtained prior to the use of side rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility document, titled Admission Packet, was found in the electronic record for Resident O and 63. The document indicated .Prior to installing a side or bed rail, the Facility will attempt to use appropriate alternatives. If the Facility determines it is necessary to use a bed or side rail, the Facility will (1) assess the Resident for risk of entrapment from bed rails prior to installation; (2) review the risks and benefits of bed rails with the Resident, Resident Representative and/or Resident Representative and obtain informed consent prior to installation .</p> <p>A current policy, titled Policy and Procedure Subject: Bedrails, dated 11-22 and received from the Clinical Support nurse on 9/5/24 at 9:00 a.m., indicated .when bed/side rails are requested .the admitting nurse will complete the Side Rail Evaluation .When bed/side rails are deemed to be appropriate for the resident, upon completion of the Side Rail Evaluation, the admitting nurse will review risks and benefits and obtain informed consent.</p> <p>3.1-45(a)(1)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>49891</p> <p>Based on interview and record review, the facility failed to ensure a PRN (as needed) psychotropic medication was not ordered beyond 14 days or the attending physician documented their rationale in the resident's medical record to indicate the duration for the PRN order for 2 of 5 residents reviewed for unnecessary medications. (Resident K and 183)</p> <p>Findings include:</p> <p>1. The clinical record for Resident K was reviewed on 9/5/24 at 10:54 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, fibromyalgia, type 2 diabetes mellitus with hyperglycemia, recurrent major depressive disorder with psychotic symptoms, insomnia, unspecified affective mood disorder, anxiety disorder, post-traumatic stress disorder, and unspecified psychosis not due to a substance or known physiological condition.</p> <p>A physician's order, dated 2/9/24, indicated to give 1 tablet of alprazolam (an anti-anxiety medication) 0.25 mg (milligrams) by mouth every 12 hours as needed for anxiety with a 90 day stop date of 5/9/24.</p> <p>A physician's order, dated 5/16/24, indicated to give 1 tablet of alprazolam 0.25 mg by mouth every 12 hours as needed for anxiety with a 90 day stop date of 8/14/24.</p> <p>A physician's order, dated 8/15/24, indicated to give 1 tablet of alprazolam 0.25 mg by mouth every 12 hours as needed for anxiety with no end date given.</p> <p>During an interview, on 9/9/24 at 9:22 a.m., the Director of Nursing (DON) indicated she had not noticed the current PRN alprazolam order did not have a stop date. She could not find any documentation of a clinical reasoning from the physician for the extended duration of the PRN orders.</p> <p>48525</p> <p>2. The clinical record for Resident 183 was reviewed on 9/4/23 at 2:36 p.m. The diagnoses included, but were not limited to, severe bipolar disorder with psychotic features, type 2 diabetes, and irritable bowel syndrome.</p> <p>A physician's order, with a start date of 8/23/24, indicated to give clonazepam (an anti-anxiety medication) 0.5 mg every 12 hours as needed.</p> <p>The order for the clonazepam did not have an end/stop date.</p> <p>During an interview, on 9/9/24 at 2:03 p.m., the DON indicated she did not see a stop date for the PRN order.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Clinton House Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 809 W Freeman St Frankfort, IN 46041	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/9/24 at 2:34 p.m., the Clinical Support nurse indicated as needed psychotropics should have stop dates within 14 days.</p> <p>A current policy, titled Psychotropic Drug Policy. Gradual Dose Reduction, PRN Psychotropics, not dated and received from the Clinical Support nurse on 9/10/24 at 9:35 a.m., indicated .PRN Psychotropics hypnotics, antianxiety or antidepressant medications shall not be used beyond 14 days unless the prescribing practitioner indicates the clinical rationale for extended use and the expected duration for PRN use of the medication</p> <p>3.1-48(a)(2)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>50901</p> <p>Based on observation, interview and record review, the facility failed to ensure food was being served at proper (safe and appetizing) temperature for 1 of 1 kitchen reviewed for safe food temperatures.</p> <p>Findings include:</p> <p>During an interview, on 9/3/24 at 11:22 a.m., Resident E indicated room trays were often delivered late, and the food was cold.</p> <p>The posted mealtimes were as followed:</p> <p>Breakfast: 7:00 a.m. to 8:00 a.m.</p> <p>Lunch: 12:00 p.m. to 1:00 p.m.</p> <p>Dinner: 5:00 p.m. to 6:00 p.m.</p> <p>During a continuous dining observation, on 9/3/24 from 12:17 p.m. to 12:57 p.m., 30 residents in the dining room were served lunch.</p> <p>During a continuous dining observation, on 9/3/24 from 12:57 p.m. to 1:08 p.m., room trays were delivered to residents on the 200 hall and 400 hall.</p> <p>During a continuous dining observation, on 9/3/24 from 1:08 p.m. to 1:20 p.m., room trays were delivered to residents on the 500 hall and 600 hall.</p> <p>During the delivery of the room trays on the 500 hall, at 1:17 p.m., a food temperature check was requested on the last room tray.</p> <p>During an observation and interview, on 9/3/24 at 1:17 p.m., the Dietary Manager checked the temperature of the meal and indicated the hot foods should be served at 120 degrees Fahrenheit and the cold foods should be served at 45 degrees Fahrenheit. The Dietary Manager indicated if the food did not meet the recommended temperatures, the food would be reheated.</p> <p>The temperatures of the last room tray were as followed:</p> <ol style="list-style-type: none"> The cheeseburger was 106 degrees Fahrenheit. The potato salad was 51 degrees Fahrenheit. The watermelon was 65 degrees Fahrenheit. <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation, on 9/3/24 at 1:20 p.m., the last room tray was delivered with the hot food below the recommended temperature (greater than 135 degrees Fahrenheit) and the cold food was above the recommended temperature (less than 41 degrees Fahrenheit).</p> <p>During an interview, on 9/4/24 at 10:39 a.m., Resident C indicated the food being served was bland, cold, and the meal trays brought to the resident's room were delivered late.</p> <p>During an interview, on 9/6/24 at 1:31 p.m., Resident F indicated if they ate in the main dining room, the food temperatures were not a concern. If they ate the meals in their rooms, the food was cold when it was delivered. Resident F indicated complaints about the food had been discussed in the monthly resident council meetings.</p> <p>During an interview, on 9/6/24 at 1:33 p.m., Resident G indicated meal portions were not consistent, the food was bland, and if they chose to eat in their room, the food was cold when it was delivered.</p> <p>During an interview, on 9/9/24 at 2:35 p.m., the Interim Executive Director (ED) indicated he was aware of the ongoing complaints about the food. The concern had been discussed at resident council meetings almost every month.</p> <p>A current facility policy, titled Food and Nutrition Services, dated as revised 11/22 and received from the Clinical Support nurse indicated .The facility will provide each resident with a nourishing, palatable, well-balanced diet .</p> <p>A facility document, titled .Quick Resource Tool: Safe Food Handling . dated 9/1/2021 and received from the Director of Nursing (DON) on 9/10/24 at 10:40 a.m., indicated .The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that the food items are exposed to temperatures greater than 41 degrees Fahrenheit and/or less than 135 degrees Fahrenheit, or per state regulation .All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (or as state regulation requires) for hot holding, and less than 41 degrees Fahrenheit for cold food holding . Temperature for Time/Temperature Control for Safety (TCS) foods will be recorded at time of service and monitored periodically during meal service periods .</p> <p>This citation relates to Complaint IN00441593.</p> <p>3.1-21(a)(1)</p> <p>3.1-21(a)(2)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48525</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was placed in contact isolation immediately after being tested and while waiting for the results for Clostridium Difficile (C-Diff) for 1 of 1 resident reviewed for antibiotic use. (Resident B)</p> <p>Finding includes:</p> <p>During an observation, on 9/3/24 at 10:51 p.m., Resident B was on enhanced barrier precautions.</p> <p>The clinical record for Resident B was reviewed on 9/5/24 at 1:25 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, type 2 diabetes, stage 3 chronic kidney disease, obstructive sleep apnea, and retention of urine.</p> <p>A nursing progress note, dated 9/2/24, indicated the resident had an episode of bowel movement which was foul smelling and mucus in appearance. The physician was notified.</p> <p>A physician's order, dated 9/2/24 at 11:30 a.m., indicated to obtain a stool sample.</p> <p>A physician's order, dated 9/2/24, indicated the Medical Doctor (MD) started Resident B on Flagyl (an antibiotic) 500 mg (milligram) by mouth three times per day for diarrhea to rule out C-Diff (a highly contagious bacteria which causes diarrhea and inflammation of the colon).</p> <p>A physician's order, dated 9/3/24 at 6:00 p.m., indicated the resident was to be in contact isolation every shift until C-Diff was ruled out.</p> <p>The resident was not placed into contact isolation immediately while being tested for C-Diff. Resident B was not in contact isolation for over 24 hours after being tested .</p> <p>During enhanced barrier precautions, personal protective equipment (PPE) was not required to be put on every time when entering the room. Contact isolation required PPE every time when entering a room.</p> <p>During an interview, on 9/3/24 at 3:01 p.m., the Director of Nursing (DON) indicated when you get an order for a stool sample to rule out C-Diff, a resident should be put in contact isolation until they get the results back.</p> <p>A current policy, titled Clostridium Difficile, dated as effective 6/14/24 and received from the DON indicated . Resident with diarrhea and suspected CDI are placed on contact precautions while awaiting laboratory results</p> <p>3.1-18(j)</p>