STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155361	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amber Manor Care Center	801 E Illinois St Petersburg, IN 47567

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 38770 Based on interview and record review, the facility failed to ensure physician notification prior to or after administration of an excessive dose of a medication as ordered for 1 of 2 residents reviewed for pain. (Resident 21) Finding includes: On 7/9/24 at 10:04 A.M., Resident 21's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy and arthritis. The most recent Annual MDS (Minimum Data Set) Assessment, dated 5/3/24, indicated a moderate cognitive impairment. Resident 21 had received scheduled pain medication. Current physician orders included, but were not limited to: acetaminophen capsule 650 mg (milligram) twice a day for mild pain (6:00 A.M. - 10:00 A.M., 6:00 P.M. - 10:00 P.M.), dated 7/27/23. acetaminophen capsule 650 mg oral every 4 hours as needed for fever, DO NOT exceed 3000mg acetaminophen in 24 hr period, dated 7/27/23. acetaminophen tablet 650 mg every 4 hours as needed for pain, DO NOT exceed 3000mg acetaminophen in 24 hr period, dated 7/27/23. Resident 21's Medication Administration Record (MAR) for July 2024 indicated acetaminophen 650mg was administered on the following dates: 7/5/24 at 1:27 P.M. (as needed dose) 7/5/24 6-10 P.M. scheduled dose 7/6/24 at 12:21 A.M. (as needed dose) 7/6/24 at 5:13 A.M. (as needed dose) 7/6/24 6-10 A.M. scheduled dose (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/6/24 at 1:03 P.M. (as needed dose) Total amount of acetaminophen administered for the 24 hour period was 3900mg. On 7/10/24 at 9:55 A.M., Licensed Practical Nurse (LPN) 5 indicated staff was expected to add up all acetaminophen milligrams that had been given prior to giving an as needed dose to ensure they did not go over 3000mg in a 24 hour period. LPN 5 indicated if Resident 21 required a dose over the 3000mg limit, staff could either ask the resident if she would want to wait until it could be given, or staff could call the physician to request a different pain medication to give. LPN 5 indicated any communication with the physician would be placed in the progress notes. On 7/10/24 at 2:13 P.M., the Director of Nursing (DON) indicated staff was expected to monitor Resident 21's acetaminophen intake to make sure it did not go over 3000 mg in a 24 hour period. On 7/12/24 at 10:14 A.M., the DON provided a current Physician Notification policy, dated 9/17/17 that indicated To ensure the resident's physician or practitioner . is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care . Attempts to notify the physician/provider and their response should be documented in the resident electronic health record 3.1-5(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50827 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided consistent with the resident's orders and care plans for 1 of 2 residents observed and reviewed for respiratory care (Resident 5). Findings include: On 7/8/24 at 1:48 PM Resident 5 was observed resting in bed, oxygen concentrator was observed to be set to 1LPM(liter per minute). On 7/10/24 at 1:54 PM Resident 5's clinical record was reviewed. Diagnoses included but were not limited to pulmonary fibrosis and COPD (chronic obstructive pulmonary disease). The most recent Quarterly MDS (Minimum Data Set) assessment dated [DATE] indicated Resident 5 is cognitively intact, had no behaviors, required substantial or maximum assistance from staff with bathing, transfers, and toileting, and used oxygen while a resident. Current physician orders included, but were not limited to: Continuous administration of oxygen at 2LPM per nasal cannula, dated 4/27/24. Assess/observe for signs and symptoms of shortness of breath while laying flat related to chronic lung disease, dated 4/27/24. Head of bed to be elevated to alleviate or reduce shortness of breath while laying flat related to chronic lung disease, dated 4/27/24. A current oxygen care plan related to COPD, dated 7/19/2018. Care plan had interventions as following but not limited to administer oxygen per orders, dated 7/19/2018. Observe and report signs of respiratory distress such as restlessness, wheezing, dyspnea (shortness of breath), difficulty with expectoration (coughing up phlem), diaphoresis (appearing pale and sweating), crackles, bubbling, tachycardia (elevated heart rated above 100 beats per minute), cyanosis (skin appearing blue) decreased breath sounds dated 7/19/2018. Resident requires elevation of head due to shortness of breath while lying flat as needed, dated 7/19/2018. Care plan dated 8/17/2018 related to COPD included intervention elevate head of bed or place in upright position. That intervention was dated 8/17/2018. On 7/10/24 at 9:55 AM Resident 5 was observed resting in bed, oxygen concentrator was observed to be set at 1LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 observed CNA 2 and CNA 4 perform incontinence care on Resident 5 prior to getting her out of bed. CNA 2 lowered the Resident's head of bed prior to performing incontinence care at 11:17 AM. Resident 5 then removed her nasal cannula, of which was administering her oxygen, and handed it to CNA 4. CNA 4 placed it in storage bag connected to the stationary oxygen concentrator in the resident's room. CNA 4 left room to get supplies for incontinence care at that time. Resident remained flat in bed without supplemental oxygen and nasal cannula in place. When CNA 4 returned, care was provided. CNA 2 and CNA 4 assisted resident to the side of the bed, preparing to transfer to wheelchair. Resident 5 was observed to be audibly wheezing. Resident 5 was observed for 20 minutes without supplemental oxygen or nasal cannula in place during care and was not offered oxygen during the process. On 7/10/24 at 2:18 PM DON (Director of Nursing) indicated that if a resident had a care plan for the head of the bed to be elevated due to chronic lung disease and staff observed signs of respiratory distress during care, staff would be expected to stop what they are doing and allow the resident to recover before finishing care. On 7/12/24 at 9:57 AM it was observed that Resident 5 was resting in bed without head of bed elevated. At that time resident indicated that it is common to have oxygen off and the head of her bed flattened when CNAs are caring for her. Indicated that if she were to tell staff she is short of breath, they would put her nasal cannula and oxygen back on her. Resident verbalized she feels like she is getting enough oxygen through her tank and nasal cannula. On 7/12 at 10:01 AM RN (Registered Nurse) 6 indicated Resident 5 has an order for 2L continuous oxygen via nasal cannula. Also indicated it is expected staff or CNAs caring for the residents to notify the nurse if oxygen was not administered correctly so that it may be corrected. Asked that RN 6 look at Resident 5's oxygen concentrator to ensure it is set correctly. RN 6 observed it to be set at 1L, increased it to 2L per what resident is ordered for. RN 6 also raised Resident 5's head of bed at that time, as it was not elevated. On 7/12/24 at 10:15 AM the ADON (Assistant Director of Nursing) indicated it is facility policy to follow a resident's orders and care plan. On 7/12/24 at 10:40 AM an Administration of Oxygen policy dated 5/2018 was reviewed. It indicated that oxygen setting must be set and adjusted by a licensed nurse and adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is administered. 3.1-47(a)(6)

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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. 45933 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 2 of 5 residents during observation of perineal care. Staff touched items with gloved hands, gloves were not changed between dirty and clean tasks during perineal care, and staff failed to wash hands or sanitize between dirty and clean tasks. During a random observation, staff failed to don gloves to empty a urinal (Resident 33, Resident 150, Resident 301) Findings include: 1. During an observation on 7/10/24 at 9:47 A.M., Certified Nurse Aide (CNA) 7 and CNA 9 performed incontinence care on Resident 33. CNA 9 used 1 wipe to clean Resident 33's vaginal area, then Resident 33 rolled to her right side and CNA 9 used 1 wipe to clean Resident 33's rectal area/buttocks. At that time, CNA 9 failed to removed gloves and perform hand hygiene before she obtained a clean brief. 2. During an observation on 7/10/24 at 11:10 A.M., CNA 7 and CNA 9 performed incontinence care on Resident 150. CNA 7 used her gloved hand to pull the curtain in the room and then used both gloved hands to use the remote to lower Resident 150's head of the bed. CNA 9 failed to change gloves before she cleaned Resident 150's perineal area and stool off of his rectal area/buttocks. 50827 3. On 7/8/24 at 10:45 AM a random staff member in blue uniform was observed emptying a urinal in a resident's room without wearing gloves. During an interview on 7/10/24 at 1:32 P.M., the Infection Preventionist (IP) indicated gloves should be changed and hand hygiene should be performed between dirty and clean tasks, and staff should obtain new gloves prior to providing direct care to a resident if they touched items in the room. On 7/12/24 at 10:20 AM a Standard Precautions Guidelines policy provided by the facility was reviewed. The policy indicated In addition to proper hand hygiene, it is important for staff to use appropriate protective equipment such as a barrier to exposure to any body fluids gloves and other equipment such as gowns and masks are to be used as necessary to control the spread of infections. On 7/10/24 at 2:17 P.M., the IP provided a Guideline for Handwashing/ Hand Hygiene policy, revised 2/9/17, that indicated, .Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub .1. All health care workers shall utilize hand hygiene frequently and appropriately .d. After removing gloves, worn per Standard Precautions for direct contact with excretions . 3.1-18(b) 3.1-18(l)