

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Merrillville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 Virginia Place Merrillville, IN 46410	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>45666</p> <p>Based on observation, interview, and record review, the facility failed to ensure dependent residents received help with Activities of Daily Living (ADLs) related to build up on teeth for 1 of 7 residents reviewed for ADLs. (Resident 54)</p> <p>Finding includes:</p> <p>On 6/10/24 at 10:38 a.m., Resident 54 was observed sitting in bed. The resident's mouth was dry and crusty. His teeth were noted to be discolored and had build up on them.</p> <p>On 6/11/24 at 2:39 p.m., Resident 54 was observed sitting in bed. His mouth was dry and crusty when he opened it. His teeth were discolored and had build up on them.</p> <p>On 6/13/24 at 3:59 p.m., Resident 54 was observed in bed. His mouth was dry and crusty. His teeth were discolored and had build up on them.</p> <p>Resident 54's record was reviewed on 6/11/24 at 3:50 p.m. Diagnoses included, but were not limited to, cerebral infarction and chronic respiratory failure.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/24, indicated the resident was severely cognitively impaired. He was dependent on staff for oral hygiene, toileting hygiene, and personal hygiene.</p> <p>A Care Plan, dated 7/27/23, indicated the resident had an ADL self-care deficit related to weakness, history of a cerebral infarction, chronic respiratory failure, status post tracheostomy removal. Interventions included, but were not limited to, oral care assistance as needed.</p> <p>A Care Plan, dated 5/10/24, indicated the resident was at risk for dental problems related to discolored teeth and the resident was dependent on staff for oral care. Interventions included, but were not limited to, assist with oral care as ordered and as needed.</p> <p>A Physician's Order, dated 5/13/24, indicated oral care every shift.</p> <p>The June 2024 Medication Administration Record (MAR) indicated oral care was signed off as completed every shift.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/24 at 3:48 p.m., CNA 1 indicated the resident received oral care by wiping his mouth with a foam swab dipped in mouth wash. She had never brushed his teeth with a toothbrush.</p> <p>During an interview on 6/14/24 at 10:18 a.m., the Nurse Consultant indicated the resident was unable to follow commands to swish water or spit. She had no further information to provide.</p> <p>3.1-38(a)(3)(C)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>32788</p> <p>Based on record review and interview, the facility failed to ensure residents with impaired vision received the necessary services for 1 of 1 resident reviewed for vision. (Resident 70)</p> <p>Finding includes:</p> <p>During an interview on 6/10/24 at 2:49 p.m., Resident 70 indicated he needed to get his cataracts checked. He had an appointment set up over a year ago, but it was canceled.</p> <p>Resident 70's record was reviewed on 6/12/24 at 8:56 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and hyperlipidemia.</p> <p>The Quarterly Minimum Data Set assessment, dated 3/13/24, indicated the resident was cognitively intact. His vision was listed as adequate with no corrective lenses.</p> <p>A Progress Note, dated 1/27/23, indicated the resident had received a referral for a cataract evaluation from the optometrist. The appointment was scheduled for 2/7/23.</p> <p>A Progress Note, dated 2/3/23, indicated the resident wanted to cancel his scheduled eye appointment due to the cold weather and would like to reschedule when the weather was warmer.</p> <p>A Progress Note, dated 2/6/23, indicated the resident's family had been informed of his choice to cancel his eye appointment and it would be rescheduled for a later date.</p> <p>An optometry note, dated 1/4/24, indicated the resident was referred for removal of right eye cataract but was unable to make the appointment last year. His right eye distance vision was still blurry. The recommendation was to get a consult for a cataract evaluation of the right eye and possible treatment. A written order was given to the charge nurse, who indicated the resident had been scheduled in the past and refused to go.</p> <p>Care plan meeting reviews, dated 2/22/24 and 4/30/24, indicated the resident had last been seen by optometry on 1/4/24. No further information was documented.</p> <p>There was a lack of documentation the facility had attempted to reschedule the appointment or make any further arrangements for the resident to receive the recommended specialty eye care services.</p> <p>During an interview on 6/13/24 at 2:12 p.m., Social Services 1 indicated she was still looking for a traveling eye doctor/specialist who could come see the resident and possibly perform any procedures in the facility because the resident required a stretcher for transportation. If she were to make an outside appointment for him, they would refuse to see him since he could not transfer himself off the stretcher, and the ambulance staff would not assist the resident with transferring once at the appointment. She was unable to provide any documentation she had followed up with the 1/4/24 optometry recommendation and indicated she needed to be better about her documentation.</p> <p>3.1-39(a)(1)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>32582</p> <p>Based on observation, record review, and interview, the facility failed to ensure a dependent resident was transferred with a Hoyer lift (a full body mechanical lift) as indicated on the Resident Care Sheet for 1 of 1 resident reviewed for accidents. (Resident 113)</p> <p>Finding includes:</p> <p>On 6/11/24 at 8:55 a.m., CNA 2 was observed attempting to transfer Resident 113 from her bed into her wheelchair. The resident was on her bed in a semi-seated position, her left arm was contracted and she had a splint on her right hand. Resident 113 was unable to sit upright on the side of bed by herself and was falling backward. The CNA was leaning forward in front of her, instructing Resident 113 to hold on to her neck as CNA 2 was attempting to hold the resident around her waist. The resident was unable to hold onto the CNA with her right arm only. Her legs were stretched forward and her feet were not securely on the floor. After several minutes, CNA 3 entered the room and indicated to CNA 2 that the resident could not be transferred like that, she needed a sit to stand lift (a device that assists residents from a seated to standing position for transferring).</p> <p>The resident's record was reviewed on 6/11/24 at 1:33 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) of the non dominant side, cerebral ischemia and degenerative disease of the nervous system.</p> <p>The Quarterly Minimum Data Set assessment, dated 4/8/24, indicated the resident was cognitively intact and was dependent for transfers, bed mobility and toileting.</p> <p>The Resident Care Sheet indicated the resident was a two person assist with a Hoyer mechanical lift for transfers.</p> <p>During an interview with CNA 2 on 6/11/24 at 9:10 a.m., she indicated she was not familiar with the resident and should have checked the Care Sheet prior to attempting to transfer her.</p> <p>During an interview with the D Unit Manager on 6/11/24 at 11:10 a.m., she indicated the resident needed a Hoyer mechanical lift for transfers and she would begin education with the staff.</p> <p>On 6/12/24 at 11:29 a.m., the resident was observed seated in her wheelchair in the hallway. Her left arm was contracted, she had a splint on her left hand and her left leg was in a foot rest.</p> <p>During an interview on 6/12/24 at 1:26 p.m., CNA 4 indicated he had transferred the resident by himself from the bed that morning by standing and pivoting her to the wheelchair. He was not aware she was supposed to be transferred with a mechanical lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The policy, Safe Resident Handling/Transfers, indicated, .All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lift are a safer alternative and should be used . and, .Staff members are expected to maintain compliance with safe handling/ transfer practices</p> <p>3.1-45(a)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>45666</p> <p>Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube (peg tube) care was completed as ordered related to incorrect enteral feeding administration for 1 of 3 residents reviewed for peg tubes. (Resident 54)</p> <p>Finding includes:</p> <p>On 6/10/24 at 10:38 a.m., Resident 54 was observed in bed. He had a tube feeding pump connected to Jevity 1.5 cal (type of feeding) infusing at 70 milliliters per hour (ml/hour)</p> <p>On 6/11/24 at 2:39 p.m., Resident 54 was observed in bed. He had a tube feeding pump connected to Jevity 1.5 cal infusing at 70 ml/hour.</p> <p>Resident 54's record was reviewed on 6/11/24 at 3:50 p.m. Diagnoses included, but were not limited to, cerebral infarction and chronic respiratory failure.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 3/19/24, indicated the resident was severely cognitively impaired. He was dependent on staff for oral hygiene, toileting hygiene, and personal hygiene.</p> <p>A Care Plan, dated 7/27/23, indicated the resident was dependent on tube feedings. Interventions included, but were not limited to, elevate head of bed at least 30-45 degrees during and for 30 to 60 minutes after feeding and enteral formula and feedings as ordered.</p> <p>The June 2024 Physician's Order Summary indicated enteral tube feeding of Jevity 1.5 cal at 75 ml/hour for 22 hours a day.</p> <p>During an interview on 6/13/24 at 9:27 a.m., the Director of Nursing had no further information to provide.</p> <p>3.1-44(a)(2)</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>45666</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received proper care and treatment related to oxygen administration flow rate for 1 of 1 resident reviewed for oxygen. (Resident 13)</p> <p>Finding includes:</p> <p>On 6/11/24 at 2:33 p.m., Resident 13 was observed in bed. He had a nasal cannula in his nares and the oxygen concentrator was set to a flow rate 4.5 liters per minute (lpm).</p> <p>On 6/13/24 at 8:57 a.m., Resident 13 was observed in bed. He had a nasal cannula in his nares and the oxygen concentrator was set to a flow rate 4.5 lpm.</p> <p>Resident 13's record was reviewed on 6/11/24 at 2:21 p.m. Diagnoses included, but were not limited to, acute respiratory failure, chronic bronchitis, and adult failure to thrive.</p> <p>The Significant Change Minimum Data Set (MDS) assessment, dated 4/8/24, indicated the resident was cognitively intact for daily decision making and was dependent on staff for all activities of daily living including, eating, hygiene, and bathing.</p> <p>The June 2024 Physician's Order Summary indicated oxygen at 3 liters per minute per nasal cannula if oxygen saturations were 90% or below, as needed for shortness of breath.</p> <p>A Care Plan, dated 6/13/24, indicated the resident required oxygen therapy. Interventions included, but were not limited to, administer oxygen as needed per Physician's Orders.</p> <p>During an interview on 6/13/24 at 10:33 a.m., the Nurse Consultant indicated she had no further information to provide.</p> <p>A policy titled, Oxygen Administration, indicated .1. Oxygen is administered under orders of a physician, except in the case of an emergency .</p> <p>3.1-47(a)(6)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>32788</p> <p>Based on record review and interview, the facility failed to ensure a follow up for a pain specialist's medication order was completed for 1 of 1 resident reviewed for pain. (Resident 128)</p> <p>Finding includes:</p> <p>During an interview on 6/10/24 at 11:43 a.m., Resident 128's daughter indicated she had taken the resident to see a pain specialist in April. The resident had a history of spinal fusion surgery and would sometimes have pain when doing activities of daily living (ADLs) and therapy. She was aware the resident would not get back to her prior level of function and was worried about her being in pain. The specialist had ordered Tramadol (an opioid pain medication) as needed (PRN). The daughter had taken the prescription to a pharmacy, had the medication filled, brought the medication to the facility, and had given it to the resident's nurse. She had recently found out the resident had never received the Tramadol medication and she was not told why. She had asked the D Wing Unit Manager about it and was told there was no order for the medication and the pain assessment showed the resident was not having any pain. She had spoken with the Director of Nursing (DON) about her concerns a couple days ago.</p> <p>The resident's record was reviewed on 6/11/24 at 2:51 p.m. Diagnoses included, but were not limited to, wedge compression fracture of T (thoracic vertebrae) 11-12, dementia with psychotic disturbance, and arthrodesis (joint fusion).</p> <p>The Quarterly Minimum Data Set assessment, dated 5/21/24, indicated the resident was cognitively impaired and received a scheduled pain medication.</p> <p>A current care plan indicated the resident was at risk for pain related to a wedge compression fracture. The interventions included, to administer pain medication as ordered.</p> <p>The Physician's Order Summary, dated 6/2024, indicated the resident received Tylenol (acetaminophen) 500 mg (milligrams) every eight hours. There were no orders for Tramadol.</p> <p>The Medication Administration Records (MAR), dated 6/2024, 5/2024, and 4/2024, indicated the resident had not received any Tramadol medication.</p> <p>A Pain Evaluation in Advanced Dementia assessment, dated 4/8/24, had a score of zero which indicated no signs and symptoms of pain.</p> <p>A Progress Note, dated 4/22/24 at 10:04 a.m., indicated the resident had returned from her appointment and there were no new orders.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note Late Entry, dated 6/5/24 at 2:35 p.m., written for 4/22/24, indicated the resident's daughter was requesting the resident start Tramadol 50 mg daily and that the pain specialist had ordered it. There were no orders received from the specialist and no script had been received. The resident had no pain upon assessment. The facility's Nurse Practitioner (NP) was notified of the daughter's request and denied it. The NP felt the resident's pain was managed with Tylenol. There was lack of any documentation that the pain specialist's office had been contacted for clarification or follow up or that the resident's daughter had been updated.</p> <p>A Progress Note Late Entry, dated 6/9/24 at 9:33 a.m., written for 4/22/24, indicated the Tramadol order per the family's request was on hold due to waiting for the pain specialist to clarify. There was lack of any documentation of any further follow-up with the pain specialist's office or that the resident's daughter had been updated.</p> <p>A Progress Note, dated 6/7/24 at 10:28 a.m., indicated the pain specialist's office had been contacted to obtain clarification orders from the resident's appointment in April.</p> <p>A Nurse Practitioner Note, dated 4/3/24, indicated, .Plan .wedge compression fracture of T 11-T 12 vertebra . PRN Tramadol. Continue lidocaine, PRN Tylenol .</p> <p>A Nurse Practitioner Note, dated 5/17/24, indicated, .Her daughter tells staff that her mother is in a lot of pain. She wants her mother to have pain medication. She did not appear to be in pain during her visit today . No diaphoresis, screaming, wincing, grimacing, or guarding present .Plan .wedge compression fracture of T 11-T 12 vertebra .PRN Tramadol. Continue lidocaine, PRN Tylenol .</p> <p>During an interview on 6/13/24 at 9:33 a.m., the DON indicated she had spoken with the resident's daughter last week and the daughter indicated she had taken the resident to the pain specialist on 4/15/24 and received an order for Tramadol. The daughter had the order filled at a pharmacy, brought it in, and gave it to staff. The DON indicated staff had not given the medication since they had no script or orders from the Doctor's office. The DON had called the Doctor's office last week to clarify and had not received a call back. She had then contacted the facility Physician and obtained the order for the Tramadol per the resident's daughter's request. She was unsure why no one had followed up with the pain specialist sooner.</p> <p>During an interview on 6/13/24 at 11:42 a.m., the D Wing Unit Manager indicated the resident's daughter had brought in a bottle of PRN Tramadol and given it to the nurse. She had not brought in any order or script. The Unit Manager had contacted the pain specialist office and had not heard back. She then contacted the facility NP, who had completed a pain assessment and had not agreed with the daughter and indicated Tylenol would cover any pain. There was a pain assessment documented every shift on the MAR and the resident had no documented pain. She had not completed any further follow-up with the pain specialist's office, as she felt the situation had been handled by the facility NP.</p> <p>A facility policy, received as current, titled, Consulting Physician/Practitioner Orders, indicated, .A consulting physician/practitioner may include, but is not limited to, a resident's: .d. Specialist .Regarding orders for controlled substance the nurse will: a. verify that the order and original, valid prescription, match. b. Forward the original, valid prescription, with the verification order to the pharmacy per protocol. c. If the orders do not match, or in the absence of an original, valid prescription, obtain an original, valid prescription, and forward it along with the written order to pharmacy per protocol .</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>45666</p> <p>Based on record review and interview, the facility failed to update physician's orders after a medication regimen review was conducted for 1 of 5 residents reviewed for unnecessary medications. (Resident 68)</p> <p>Finding includes:</p> <p>Resident 68's record was reviewed on 6/12/24 at 11:38 a.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis.</p> <p>The Quarterly Minimum Data Set assessment, dated 4/22/24, indicated the resident was cognitively intact for daily decision making and received dialysis treatments.</p> <p>A Pharmacy Medication Regimen Review, dated 4/23/24, indicated a recommendation was made to reduce polypharmacy. Current orders included pantoprazole (decreases stomach acid) 40 milligrams (mg) every morning, melatonin (a sleep aid) 8 mg every night, hydroxyzine (antihistamine used to reduce itching) 25 mg every night and Zyrtec (treats allergy symptoms) 10 mg daily. The Physician/Prescriber response indicated to change hydroxyzine 25 milligrams by mouth to nightly as needed.</p> <p>The June 2024 Physician's Order Summary indicated hydroxyzine 25 milligram tablet by mouth at bedtime.</p> <p>During an interview on 6/13/24 at 2:45 p.m., the Nurse Consultant indicated the orders should have been updated.</p> <p>3.1-(i)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>32582</p> <p>Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to a medication scheduled during the resident's routine dialysis time and blood sugars levels and insulin administration not documented, for 2 of 5 residents reviewed for unnecessary medications. (Residents 28 and 74)</p> <p>Findings include:</p> <p>1. During an interview with Resident 28 on 6/11/24 at 8:54 a.m., he indicated he attended dialysis three times a week on Tuesdays, Thursdays and Saturdays. Tuesdays and Thursdays he was picked up around 9:30 a.m. and returned around 3:00 p.m. On Saturdays, he was picked up earlier, around 6 a.m.</p> <p>Resident 28's record was reviewed on 6/12/24 at 2:23 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus, dependence on renal dialysis and cerebral infarction.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 4/24/24, indicated the resident was cognitively intact and was dependent for bed mobility, transfers and toileting.</p> <p>A Physician's Order, dated 1/25/24, indicated to give Pepcid (a medication used to treat stomach acid) 20 milligrams, in the afternoon on Tuesdays, Thursdays and Saturdays for GERD (gastroesophageal reflux disease).</p> <p>The May and June 2024 Medication Administration Record (MAR) indicated the Pepcid was scheduled to be given on Tuesdays, Thursdays and Saturdays at 2:00 p.m. The medication was not given on the following days due to the resident not being in the facility:</p> <p>5/2/24</p> <p>5/4/24</p> <p>5/7/24</p> <p>5/14/24</p> <p>5/21/24</p> <p>5/23/24</p> <p>6/4/24</p> <p>6/6/24</p> <p>6/11/24</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Merrillville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 Virginia Place Merrillville, IN 46410	
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on 6/13/24 at 2:05 p.m., she indicated the medical director indicated if a resident was at dialysis when a medication was due, it was just not given. When asked why the medication was scheduled only during dialysis times, she indicated that should be looked into. She later indicated the medication had been discontinued.</p> <p>The policy, Medication Administration was reviewed and did not pertain to medication scheduling.</p> <p>32788</p> <p>2. The record for Resident 74 was reviewed on 6/12/24 at 2:34 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and congestive heart failure.</p> <p>The Significant Change Minimum Data Set assessment, dated 5/16/24, indicated the resident was cognitively impaired and received insulin injections.</p> <p>A care plan, updated 3/25/24, indicated the resident had diabetes. The interventions included, .diabetes medications as ordered by physician .glucose monitoring as per order .</p> <p>The Physician's Order Summary, dated 6/2024, indicated an order for Humalog (insulin) per sliding scale (insulin given based on blood sugar results) with meals:</p> <p>151-200=2u (units)</p> <p>201-250=10u</p> <p>251-300=15u</p> <p>301-350=20u</p> <p>351-400=25u</p> <p>The Medication Administration Record (MAR), dated 6/2024, indicated the blood sugar result and the amount of insulin administered were left blank on the following dates and times:</p> <p>- 8:00 a.m. on 6/8/24, and 6/9/24</p> <p>- 12:00 p.m. on 6/6/24, 6/8/24, and 6/9/24</p> <p>- 5:00 p.m. on 6/1/24, 6/2/24, 6/3/24, 6/7/24, 6/8/24, and 6/9/24.</p> <p>There were no eMAR (electronic medication administration record) notes documented for the above dates and times.</p> <p>A Daily Blood Sugar Log, dated 6/2024, was provided by the Director of Nursing (DON). There were documented blood sugars for the above dates and times but no documented insulin administration.</p> <p>The resident's blood sugar at 8:00 a.m. on 6/8/24 was 176, he should have received 2 units of insulin.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's blood sugar at 8:00 a.m. on 6/9/24 was 203, he should have received 10 units of insulin.</p> <p>The resident's blood sugar at 12:00 p.m. on 6/6/24 was 329, he should have received 20 units of insulin.</p> <p>The resident's blood sugar at 12:00 p.m. on 6/9/24 was 244, he should have received 10 units of insulin.</p> <p>The resident's blood sugar at 5:00 p.m. on 6/1/24 was 183, he should have received 2 units of insulin.</p> <p>The resident's blood sugar at 5:00 p.m. on 6/2/24 was 161, he should have received 2 units of insulin.</p> <p>The resident's blood sugar at 5:00 p.m. on 6/9/24 was 344, he should have received 20 units of insulin.</p> <p>During an interview on 6/13/24 at 3:22 p.m the DON indicated when there was a QMA working the unit, the blood sugars were documented on a paper log since they could not administer insulin. The nurses would administer the insulin but would not document it in the MAR. They would then cosign the blood sugar log. When staff completed their monthly audits, if any blanks were noted, they would have the nurse who worked document a late entry.</p> <p>3.1-48(a)(1)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>10326</p> <p>Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to dirty and greasy food equipment, an accumulation of dust on fan blades, food spillage, lack of hair restraints, touching food with gloved hands after touching other items, and the dishwasher gauge not functioning for 1 of 1 kitchen observed. (The Main Kitchen). This had the potential to affect 137 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation Tour on 6/10/24 at 9:10 a.m. with the Dietary Food Manager (DFM), the following was observed:</p> <p>a. A bag of noodles, located in the dry storage room, was not fastened. Loose noodles were observed on the shelves and on top of food boxes.</p> <p>b. The upper shelf located on the oven had an accumulation of crumbs and dust.</p> <p>c. There was an accumulation of dust and dried food spillage on the front of the convection oven.</p> <p>d. A large orange fan, located on a shelf in the dish room, had an accumulation of dust on the fan blades and fan cover. The fan was in use at that time and blowing directly towards clean dishes.</p> <p>e. The dishwasher was identified as being high temperature by the DFM. The final rinse temperature gauge did not move during the rinse cycle and registered at 140 degrees Fahrenheit. There was also no plastic cover over the gauge.</p> <p>The June 2024 Dish Machine Temperature Log indicated the final rinse cycle registered 140 degrees Fahrenheit for the noon and evening meal on 6/9 and the breakfast meal on 6/10/24.</p> <p>During an interview at that time, the DFM indicated he would call someone out to look at the dishwasher.</p> <p>2. On 6/10/24 at 11:06 a.m., Dietary Employee 1 was observed to don a pair of clean gloves and proceeded to the walk in refrigerator. He exited the refrigerator with a bag of lettuce. He opened the bag of lettuce and put some on a plate, he then obtained a knife and a boiled egg. He held the boiled egg with his gloved hand while slicing it. He did not change gloves prior to doing this.</p> <p>The Dietary Employee was not wearing a beard guard while preparing the salad.</p> <p>During an interview at that time, the DFM indicated the above was in need of cleaning and the Dietary Employee should have been wearing a beard guard and changed his gloves prior to touching the boiled egg.</p> <p>3.1-21(i)(3)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>10326</p> <p>Based on observation, record review, and interview, the facility failed to ensure a sanitary environment was maintained related to an accumulation of dust and debris on floors, piping, and fan blades, as well as loose and detached base boards for 1 of 1 kitchen areas. (The Main Kitchen)</p> <p>Findings include:</p> <p>During the Kitchen Sanitation Tour on 6/10/24 at 9:10 a.m. with the Dietary Food Manager (DFM), the following was observed:</p> <p>a. The wall located behind the convection oven and the oven had an accumulation of dust and debris along the base of the wall. The white pipes located behind the convection oven and oven had an accumulation of dried food spillage.</p> <p>b. The ceiling vent located in between the steam table and the exit door to the kitchen had an accumulation of dust.</p> <p>c. A fan, anchored to the wall in the dish room, had an accumulation of dust on the fan blades and fan cover. The fan was not in use at the time.</p> <p>d. The base board located underneath the eye wash sink in the dish room was loose in some sections and pulled away from the wall.</p> <p>During an interview at that time, the DFM indicated all of the above was in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>