STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155402	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Healthcare	3401 Soldiers Home Rd West Lafayette, IN 47906

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 46961 Based on interview and record review, the facility failed to submit a discharge MDS (Minimum Data Set) assessment upon discharge, making the assessment greater than 120 days since the last submitted assessment for 1 of 2 residents reviewed for resident assessments. (Resident 67) Finding includes: The clinical record for Resident 67 was reviewed on 7/12/24 at 3:10 p.m. The diagnoses included, but were not limited to, hypo-osmolality (nutrient levels in the blood are lower than normal), hyponatremia (low sodium level in the blood), alcohol abuse, pneumonia, cystitis (infection in the bladder), dysphagia (difficulty swallowing), and protein calorie nutrition. An admission MDS assessment, dated 2/9/24, indicated it was submitted 2/9/24 and was approved. A discharge MDS assessment, dated 5/1/24, indicated the assessment was pending and was not submitted. During an interview, on 7/12/24, the MDS Coordinator indicated the discharge assessment should have been completed and submitted. During an interview, on 7/12/24 at 3:28 pm, the Administrator indicated the facility used the RAI manual, there was no facility policy. 3.1-31(b)

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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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 48525 Based on interview and record review, the facility failed to resubmit a PASARR (Preadmission Screening and Record Review) for a resident after a new mental health diagnosis and medication were added for 1 of 3 residents reviewed for PASARR. (Resident 70) Finding includes: The clinical record for Resident 70 was reviewed on 7/10/24 at 9:52 a.m. The diagnoses included, but were not limited to, major depressive disorder, moderate vascular dementia, psychotic disorder with delusions, and sleep disorder. A medical diagnosis list indicated the resident was added a diagnosis of mild major depressive disorder on 2/2/24 A physician's order, with a start date of 2/3/24, indicated the resident was prescribed sertraline (an antidepressant medication) 25 mg (milligram). A PASARR, with a notice date of 4/24/23, indicated Resident 70 was evaluated and had no mental health diagnosis or mental health medications There was no record of another PASARR being completed after the major depressive disorder diagnosis or antidepressant medication were added. During an interview, on 7/12/24 at 10:37 a.m., the Social Services Director (SSD) indicated the resident did not do another PASARR after the added diagnosis and medication. The resident should have had another PASARR completed, and it was just missed. A current policy, titled Pre-admission Screening and Resident Review (PASARR), dated as reviewed on 9/25/23 and received from the Administrator on 7/12/24 at 3:30 p.m., indicated .A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later .Any resident with newly evident or possible serious mental disorder, ID or a related condition must be referred, by the facility to the appropriate state-designated mental health or disability authority for review. Examples of individuals who may not have previously been identified by PASARR to have MD, ID or a related condition include, but is not limited to: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 48525 Based on observation, interview and record review, the facility failed to notify the physician of blood glucose levels out of the physician's parameters and to follow-up on a hospice order for a Broda chair (chair which helps accommodate residents with impaired mobility) for 3 of 3 residents reviewed for quality of care. (Resident L, C and 136) Findings include: 1. During an interview, on 7/10/24 at 10:00 a.m., Resident L indicated he had high blood sugar readings while being at the facility. The clinical record for Resident L was reviewed on 7/10/24 at 3:16 p.m. The diagnoses included, but were not limited to, mild chronic stage 2 kidney disease, hypertensive heart disease with heart failure, and type 2 diabetes with diabetic neuropathy. A current physician's order, with a start date of 7/26/23, indicated to notify the physician for blood sugars greater than 400. A facility vital log indicated Resident L had the following blood sugars: On 3/26/24, his blood sugar was 433. On 3/27/24, his blood sugar was 452. On 3/27/24, his blood sugar was 432. On 3/28/24, his blood sugar was 426. On 4/1/24, his blood sugar was 493. On 4/2/24, his blood sugar was 531. On 4/5/24, his blood sugar was 444. On 4/11/24, his blood sugar was 423. On 4/26/24, his blood sugar was 434. During an interview, on 7/11/24 at 10:53 a.m., the Administrator indicated he did not see any call outs to the physician for the high blood sugars. 36454 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview, on 7/10/24 at 12:02 p.m., Resident C's family member indicated the resident's blood sugar readings were in the 400 and 500 range and the facility did not try to give her a different insulin. The clinical record for Resident C was reviewed on 7/10/24 at 10:37 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, generalized anxiety disorder, and generalized muscle weakness. A physician's order, dated 3/24/24, indicated to check the fasting blood sugar one time a day. A physician's order, dated 3/24/24, indicated to notify the physician for blood sugars less than 60 or greater than 400. The resident had the following blood sugar readings: a. On 5/22/24 at 6:16 a.m., the blood sugar was 429. b. On 6/4/24 at 6:13 a.m., the blood sugar was 453. c. On 6/7/24 at 6:16 a.m., the blood sugar was 448. d. On 6/9/24 at 6:12 a.m., the blood sugar was 538. e. On 6/12/24 at 6:05 a.m., the blood sugar was 436. c. On 6/13/24 at 5:34 a.m., the blood sugar was 437. A physician's order, dated 6/9/24, indicated to recheck the blood sugar at 7:30 a.m., and notify the physician if the reading was greater than 400. The progress notes showed the physician was only notified on the elevated blood sugar on 6/9/24. 3. During an observation, on 7/10/24 at 11:45 a.m., Resident 136 was lying in bed in her room with her eyes closed. During an observation, on 7/11/24 at 3:37 p.m., the resident was lying in bed in her room and her eyes were closed. During an observation, on 7/12/24 at 1:50 p.m., the resident was lying in bed in her room, her eyes were closed, and the room was darkened. The clinical record for Resident 136 was reviewed on 7/12/24 at 1:56 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis affecting the right dominant side, chronic obstructive pulmonary disease, and pressure ulcers. During an interview, on 7/11/24 at 3:37 p.m., CNA 10 indicated the resident was on hospice, was totally dependent for care, and did not get out of bed on the evening shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/11/24 at 3:47 p.m., LPN 11 indicated the resident was fairly new and was on hospice. The family preferred for the resident not to get out of bed. A physician's order indicated to be admitted to Hospice with a diagnosis of hemiplegia and hemiparesis following a cerebral infarction. A hospice social worker note, dated 7/3/24, indicated the resident's daughter stated the resident was very social prior to her strokes and she still enjoyed having companionship although she was unable to talk as much as she would like to. During an interview, on 7/10/24 at 11:55 a.m., the Activity Director indicated the resident would get up in her Broda (chair for positioning) although she did not know what time of day she got up. The resident did not have a Broda chair in her room. During an interview, on 7/12/24 at 2:19 p.m., the Hospice Registered Nurse (RN) indicated the Broda chair was ordered upon admission to hospice on 7/3/24. The hospice had some changes in leadership, and it was just missed for approval. Since the Broda chair was ordered, it was an expectation the resident would be getting up in the Broda chair. The resident had a decline in condition although was not in the active phase of dying. The facility staff and the hospice staff would determine in collaboration how long the resident would be up daily. The Broda chair would be approved today as soon as the RN got the request to the correct person in hospice. A Hospice Services Agreement, approved on 7/19/21, indicated .Hospice will ensure that all Hospice Services are provided to Hospice Patients in a manner which meets or exceeds professional standards and principles that apply to individuals providing services in Facility. Hospice will provide all reasonable and necessary Hospice Services to Hospice Patients in a timely manner and accordance with each Hospice Patient's Hospice Plan of Care .Hospice Services will include .medical direction and management of the Hospice Patient .medical supplies, durable medical equipment .Coordination of Services .Hospice will participate, upon request, in interdisciplinary and other care planning conferences required to coordinate the Hospice Services, Facility Services, and other services provided to an individual Hospice Patient .Hospice shall retain professional management responsibility for Hospice Services provided in accordance with the Hospice Plan of Care A current policy, titled Changes in Resident's Condition or Status, dated as last reviewed on 8/9/23 and received from the Administrator on 7/12/24 at 10:55 a.m., indicated .This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status . This citation relates to Complaint IN00436564. 3.1-37(a)

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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. 49891 Based on observation, interview and record review, the facility failed to turn and reposition a resident every 2 hours as ordered to promote healing and to prevent future pressure injuries for 1 of 4 residents reviewed for pressure ulcers. (Resident 50) Finding includes: During an observation, on 7/8/24 at 1:26 p.m., Resident 50 was sitting up in bed waiting for her lunch tray. She was paralyzed from the waist down with her right arm severely limited in range of motion and function with severe muscle wasting. The clinical record for Resident 50 was reviewed on 7/11/24 at 3:36 p.m. The diagnoses included, but were not limited to, paraplegia, type 2 diabetes mellitus, neuromuscular dysfunction of bladder, abnormal posture, depression, colostomy, indwelling urethral catheter, seizures, stage 3 and 4 pressure ulcers of sacral region, right and left buttock stage 3 pressure ulcers, recurrent moderate major depressive disorder, generalized anxiety disorder, and chronic obstructive pulmonary disease. A physician's order, dated 11/15/22, indicated to turn the resident every two hours for comfort and wound healing. If the resident is asleep, turn her anyway, per resident. A care plan, initiated on 11/30/22, indicated to turn the resident every 2 hours due to limited mobility, pressure ulcer, and to prevent new pressure injuries. It indicated she was dependent for bed mobility. A Skin/Wound note, dated 6/8/24 at 12:28 p.m., indicated the resident was compliant with every 2-hour turning. A care management note from the facility interdisciplinary team, dated 6/20/24 at 11:02 a.m., indicated the resident had a pressure wound to her coccyx which had been there for several years, did not get out of bed except for showers, and she was to be turned and repositioned every 2 hours to promote wound healing. The certified nursing assistant (CNA) task record, dated 6/13/24 through 7/12/24, indicated the resident required extensive assistance of 1 person for bed mobility. It indicated the task of bed mobility did not occur on some night shifts (6/16/24, 6/17/24, 6/20/24). The CNA task record, dated 6/28/24 through 7/11/24, indicated the charting of every 2-hour turns was missing on: 6/28/24 for 10:00 a.m., 12:00 p.m., 4:00 p.m., 6:00 p.m., and 8:00 p.m. 6/30/24 for 12:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., 6:00 p.m., and 8:00 p.m. 7/1/24 for 5:00 p.m., 7:00 p.m., and 11:00 p.m. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/2/24 for 2:00 a.m., 4:00 a.m., 6:00 a.m., 4:00 p.m., and 6:00 p.m., 7/3/24 for 4:00 p.m., 6:00 p.m., and 11:00 p.m. 7/4/24 for 12:00 a.m., 2:00 a.m., 10:00 a.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. 7/5/24 for 12:00 a.m., 2:00 a.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., and 11:00 p.m. 7/6/24 for 3:00 a.m., 5:00 a.m., 9:00 a.m., 4:00 p.m., 6:00 p.m., and 11:00 p.m. 7/7/24 for 10:00 a.m., 3:00 p.m., and 11:00 p.m. 7/8/24 for 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. 7/9/24 for 12:00 a.m., 3:00 a.m., and 5:00 a.m. 7/10/24 for 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., and 11:00 p.m. 7/11/24 for 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., and 8:00 a.m. A Skin/Wound note, dated 7/01/24 at 1:33 p.m., indicated the resident continued to have a slow healing sacrococcygeal wound. The resident was to be turned and repositioned every 2 hours and to utilize a wedge cushion for positioning. The physician was updated regarding continued skin issue. During an interview, on 7/8/24 at 1:26 p.m., the resident indicated she was supposed to be turned every 2 hours, but evenings and nights often did not turn her. They waited for her to turn her call light on and ask, despite her telling them she wanted to be woken up every 2 hours during the night. She did not want to have to call and/or wake herself up with an alarm because it was far more disruptive to her sleep and made it more difficult for her. She indicated it was very important to her because she had chronic pressure wounds which she really wanted to heal and because she did not want to get any new wounds. During an interview, on 7/10/24 at 11:14 a.m., the resident indicated, on 7/9/24, she had been turned around 4:00 p.m., and then took a nap. She turned her call light on after she woke up around 8:00 p.m., and believed she was turned about 20 minutes later. She was then not turned again until roughly 1:00 a.m. and 5:00 a.m. She indicated this was a regular occurrence, especially on evening and night shift except for when certain CNAs were on duty. She had complained about this multiple times, and she had personally told CNAs she wanted to be woken up every 2 hours no matter what. It had been an on-going issue, and this was why she even had an order to turn every 2 hours even when she was sleeping. During an interview, on 7/12/24 at 9:59 a.m., the Social Services Director indicated during the resident's care plan meeting, on 6/25/24, there was a nursing concern of evening/night CNAs not always turning every 2 hours. The Director of Nursing (DON) was present at the meeting and was addressing the issue. This was not the first time the resident had brought this issue up. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/12/24 at 10:23 a.m., the Director of Nursing (DON) indicated every 2-hour checks and turning had been an ongoing concern. She had re-educated the CNAs to turn even when Resident 50 was asleep and to set alarms on their phones to help them remember. The facility had several brand-new CNAs who had just completed their certifications. During an interview, on 7/12/24 at 10:32 a.m., CNA 1 indicated they would try to turn her on even hours because it usually worked out better and to make it easier to remember. The resident had often complained that the night staff only turned her during their last round before the day shift came on. She tried to remind other staff members during their report/hand-off. A current job description, titled Certified Nursing Aide (CNA) Job Description: Primary, dated 11/10/16 and received from the Administrator on 7/11/24 at 1:30 p.m., indicated .The Certified Nursing Aide is responsible for providing routine daily nursing care to assigned patients to assure patient safety and attain or maintain the highest practicable physical .well-being .Must be able to lift, turn, move, position, and transport patients . Must be able to accurately document and chart patient care A policy for preventing pressure ulcers and/or routine turning of residents was requested on 7/12/24. The facility indicated they did not have a policy, and they did not provide one. 3.1-40(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 36454 Based on interview and record review, the facility failed to follow the physician's orders for indwelling urinary catheters for 2 of 3 residents reviewed for indwelling catheters. (Resident C and H) Findings include: During an interview, on 7/10/24 at 12:02 p.m., Resident C's family member indicated the resident's catheter needed to be changed the day she was being discharged and the staff would not listen. The family decided to take the resident to the emergency room after her discharge from the facility so they could put in a new catheter. The clinical record for Resident C was reviewed on 7/10/24 at 10:37 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, obstructive reflux uropathy (urine backing up in the kidneys), generalized anxiety disorder, and generalized muscle weakness. A care plan, dated 12/2/23 and revised on 6/21/24, indicated the resident had obstructive uropathy and had an indwelling urinary catheter. The interventions included, but were not limited to, catheter care every shift and educating the resident and family on catheter care. A physician's order, dated 6/3/24, indicated an indwelling catheter to straight drainage, size 22 French (Fr indicates diameter of catheter) with 30 cc bulb. Change the indwelling catheter for infection, obstruction, or when the closed system was compromised. A progress note, dated 6/14/24 at 2:11 p.m., indicated Resident C was crying and stated something was wrong with her catheter. The catheter bag was on the floor with the resident sitting on the bed and the catheter tubing was taut and hematuria (blood in the urine) was noted. The nurse offered to deflate the balloon and reposition the Foley catheter. The resident initially refused and then the daughter stated she would take the resident to the emergency room and have a new catheter put in. The resident consented and the catheter balloon was deflated, then the indwelling catheter was advanced, and the balloon was re-inflated. The catheter was draining tea colored urine. The progress note did not include a notification to the physician of the blood in the catheter tubing. A progress note, dated 6/14/24 at 3:55 p.m., indicated the resident was discharged with her daughter and the daughter indicated she was taking the resident to the emergency room . During an interview, on 7/10/24 at 2:50 p.m., RN 9 indicated Resident C did her all her own catheter care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/10/24 at 3:31 p.m., the Director of Nursing (DON) indicated it was a nursing measure to deflate a catheter bulb, advance the catheter and to re-inflate the catheter bulb. The resident had a huge risk of infection. The facility did not need to get the deflating of the catheter bulb, advancing the catheter and re-inflation of the bulb cleared by the urologist. The facility would not notify the urologist or physician of the blood in the catheter unless it was a huge amount of blood. Usually, blood in a catheter would resolve on its own in 24 hours. 49891 2. During an observation, on 7/08/24, Resident H was in the hallway in her wheelchair with her foley catheter in a dignity bag. The clinical record for Resident H was reviewed on 7/10/24 at 9:50 a.m. The diagnoses included, but were not limited to, peripheral vascular disease, retention of urine, polyneuropathy, acquired absence of left leg above the knee, restless legs syndrome, cerebral infarction without residual deficits, and obstructive and reflux uropathy. A physician's order, dated 2/2/24, indicated indwelling catheter to straight drainage. Size: 18 Fr Bulb: 30 cc. Change for infection, obstruction, or when the closed system was compromised as needed. A progress note, dated 4/3/24 at 4:47 p.m., indicated the resident complained the Foley catheter was leaking. The nurse deflated the balloon, advanced the catheter and re-inflated the balloon. The electronic medical record did not include a physician's order for the procedure of deflating the balloon, advancing the catheter, and re-inflating the balloon of the catheter. A progress note, dated 4/4/24 at 11:24 a.m., indicated the Foley catheter was lying on the resident's bed with the balloon still inflated. A new 18 Fr 30 cc Foley catheter was placed utilizing aseptic technique. A progress note, dated 4/9/24 at 6:00 p.m., indicated the Foley catheter was found lying in the resident's incontinence brief with the balloon intact. A new 18 Fr 10 cc Foley catheter was placed utilizing aseptic technique. During an interview, on 7/10/24 at 11:35 a.m., the resident indicated her catheter was not secured in any way to her leg to prevent pulling or dislodgement. The electronic medical record did not include documentation of the use of a device to secure the catheter for the resident. A current policy, titled Indwelling Urinary Catheter (Foley) Management, dated as reviewed on 8/24/23 and received from the Administrator on 7/10/24 at 3:10 p.m., indicated .The facility will ensure .Insertion, ongoing care, and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures .If .leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment .Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaint IN00436564. 3.1-41(a)(2)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 36454 Based on interview and record review, the facility failed to ensure transportation was available for dialysis for 1 of 1 resident reviewed for dialysis. (Resident 18) Finding includes: During an interview, on 7/9/24 at 10:06 a.m., Resident 18 indicated she had to be hospitalized about a month ago when the facility did not have transportation to dialysis on a Saturday. The facility did not tell the resident until the last minute there was no transportation. The clinical record for Resident 18 was reviewed on 7/11/24 at 11:44 a.m. The diagnoses included, but were not limited to, dependence on renal dialysis, type 2 diabetes mellitus, end stage renal disease, congestive heart failure, right lower leg amputation at level between knee and ankle and acquired absence of the left leg below the knee. A care plan, dated as last revised on 4/9/24, indicated the resident had chronic congestive heart failure. The interventions included, but were not limited to, observing and reporting signs of congestive heart failure including shortness of breath on exertion. A care plan, dated as last revised on 5/14/24, indicated the resident received hemodialysis outside of the facility. The interventions included, but were not limited to, dialysis treatments as ordered. A care plan, dated as last revised on 7/2/24, indicated the resident was at risk for fluctuations in weight related to hemodialysis and fluid imbalances. The interventions included, but were not limited to, reporting any shortness of breath, abnormal breath sounds, and to notify the physician of increasing shortness of breath, increased anxiety or inability to lie flat. A physician's order indicated the resident was to receive dialysis on Tuesdays, Thursdays and Saturdays. A progress note, dated 6/1/24 at 9:24 a.m., indicated the transportation to dialysis was canceled and the facility was unable to take the resident to dialysis. A progress note, dated 6/2/24 at 8:07 a.m., indicated the resident had called 911 and told 911 she could not breathe. The resident indicated she had missed dialysis the day before. A hospital note, dated 6/2/24, indicated the diagnoses were fluid overload, pulmonary edema, congestive heart failure, and acute respiratory failure with hypoxia. The resident was not able to go to dialysis on 6/1/24 due to a transportation issue. The resident had felt short of breath the entire night and was not able to breathe normally this morning. Nephrology was consulted for dialysis needs. The resident received hemodialysis on 6/2/24 with significant improvement in shortness of breath. A progress note, dated 6/4/24 at 6:34 p.m., indicated the resident had returned to the facility from the hospital stay. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/12/24 at 10: 25 a.m., the Activities Director indicated the transport company used on Tuesdays and Thursday for dialysis would not provide transportation on Saturdays. The transport company who usually transported Resident 18 on Saturdays had staff on vacation and were not available for the transport on 6/1/24. There was a miscommunication and the facility only found out on 6/1/24 about 20 minutes prior to the usual pick-up time for dialysis. The facility was going to call a cab for the transport although the dialysis center was not able to assist the resident to get out of a cab and into the facility. The resident had to miss dialysis on 6/1/24 since the facility could not find transportation to dialysis. An Agreement for Dialysis Services with U.S. Renal Care, approved on 7/19/21, indicated, .Provider is in the business of providing dialysis services. Facility is a licensed health care facility in the business of providing skilled nursing services .Provider shall furnish the equipment, supplies, instruments and other items necessary to provide the Services .Transportation of Residents .Facility shall have the responsibility for arranging suitable transportation of the residents to and from Provider, including the selection of the mode of transportation, qualified personnel to accompany the resident and transportation equipment usually associated with this type of transfer .Facility shall .be responsible for all costs of transportation associated with the transfer of resident to and from Provider and Facility. Facility shall be responsible for, and shall provide the necessary personnel for, assisting the resident in entering into and exiting from Provider 3.1-37(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50901 Based on observation, interview and record review, the facility failed to ensure an order for side rails was obtained and an assessment for side rails was completed prior to the use of side rails for 1 of 3 residents reviewed for accident hazards. (Resident D) Finding includes: During an interview, on 7/9/24 at 9:02 a.m., Resident D indicated she used the side rails for mobility assistance while in bed. During an observation, on 7/9/24 at 10:25 a.m., Resident D was in bed with the side rails in the raised position. During an observation, on 7/11/24 at 9:37 a.m., Resident D was asleep in bed with both side rails in the raised position. The clinical record for Resident D was reviewed on 7/10/24 at 9:22 a.m. The diagnoses included, but were not limited to, generalized muscle weakness, unspecified protein-calorie malnutrition, attention and concentration deficit, and insomnia. The physician's orders did not include an order for the use of the side rails. The electronic health record did not include a side rail assessment. The electronic health record did not include a signed consent for the use of the side rails. The electronic health record did not include appropriate alternatives attempted prior to installation of the side rails. The care plan did not include the use of the side rails. During an interview, on 7/11/24 at 9:46 a.m., the Administrator indicated Resident D was given a new bed and it already had the side rails. He indicated they had missed obtaining an order or an assessment for the use of the side rails. During an interview, on 7/11/24 at 9:29 a.m., the Administrator indicated they obtained blanket consent from everyone in the facility even if they did not need the side rails at the time. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy, titled Bed Rails- Safe and Effective Use of Bed Rails, dated as last revised on 12/30/22 and received from the Administrator on 7/11/24 at 10:00 a.m., indicated .To prevent entrapment and other safety hazards associated with bed rail use .The facility must attempt to use appropriate alternative prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements .Assess the resident for risk of entrapment from bed rails prior to installation .Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation .If bed rails are determined to be appropriate for use with a resident, a reassessment of bed rail(s) use will be assessed at a minimum quarterly and potentially with a change of condition utilizing the Evaluation of Use of Bed Rails Form (Quarterly) .If a bed rail will be utilized, the risks and benefits of bed rail(s) usage will be reviewed with the resident and/or resident representative and consent will be obtained prior to installation of the bed rails or as soon a practically possible. The facility should use the Med-Pass Consent for Use of Bed Rails (LCCA-574) . The facility will document alternative to the use of a bed rail(s) and how these alternatives did not meet the resident's assessed needs prior to the utilization of a bed rail(s). 3.1-45(2)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49891 Based on observation, interview, and record review, the facility failed to address an annual gradual dose reduction (GDR) for an anti-depressant and an antipsychotic for 1 of 5 residents reviewed for unnecessary medications. (Resident J) Finding includes: During an observation, on 7/8/24 at 12:30 p.m., Resident J was smiling and engaged in conversation with the surveyor. The resident was sitting up in her wheelchair, waiting for her lunch tray. During an observation, on 7/9/24 at 10:15 a.m., the resident was up in her wheelchair. The resident was smiling and eager to engage in conversation. The resident was very talkative. During all other observations, between 7/10/24 and 7/12/24, Resident J was smiling, talkative, and readily engaged in conversation. The clinical record for Resident J was reviewed on 7/10/24 at 2:29 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with hyperglycemia and polyneuropathy, schizoaffective disorder bipolar type, affective mood disorder, major depressive disorder, malignant neoplasm of brain, mild cognitive impairment, history of falling, generalized anxiety disorder, and pain. A physician's order, dated 3/26/20, indicated bupropion (an anti-depressant) 150 milligram (mg) tablet, give 1 tablet by mouth one time a day related to major depressive disorder. A physician's order, dated 5/3/23, indicated olanzapine (an antipsychotic) oral tablet 10 mg, give 1 tablet by mouth two times a day related to schizoaffective disorder, bipolar type. The last GDR for bupropion was contraindicated on 3/26/20. A psychosocial note, dated 3/26/2020 at 12:41p.m., indicated resident's bupropion was up for GDR. Resident is doing well and making positive adjustments in light of recent increased precautions associated to COVID-19. GDR will be contra-indicated today due to present circumstances. There was no annual GDR recommendation for bupropion between 6/1/23 and 7/12/24. The last GDR for the olanzapine was accepted on 4/24/23. There was no annual GDR recommendation for olanzapine between 4/24/23 and 7/12/24. No other GDRs for bupropion or olanzapine were recorded in the electronic medical record. All GDRs for Resident J were requested on 7/10/24 at 2:30 p.m. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/11/24 at 3:45 p.m., the Administrator indicated he had provided all available GDRs. He did not find any GDR requests from pharmacy during the monthly reviews for bupropion. The last GDR for olanzapine was 4/24/23. The Administrator indicated he believed no one had looked at bupropion again since the order said the GDR was contraindicated on 3/26/20. He did not realize it was denied due to the Covid situation at that time. A current policy, titled Unnecessary Medication, dated as last reviewed on 8/09/23 and received from the Administrator on 7/12/24 at 10:15 a.m., indicated .ensure only mediations required to treat the resident's assessed condition are being used, reducing the need for and maximizing the effectiveness of medications . Gradual Dose Reduction (GDR)- This is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued .The facility's medication management process will support and promote .Selection and use of medications in doses and for the duration appropriate to each resident's clinical conditions, age, and underlying causes of symptoms 3.1-48(b)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50901 Based on observation, interview and record review, the facility failed to ensure medications administered orally were separated from topical medications and eye drops, to store cleaning supplies separately from medications, correctly label OTC (over the counter) medications, date opened medications, and routinely dispose of medications after the date of expiration for 4 of 4 medication carts reviewed. (medication cart 1, medication cart 2, medication cart 3, and medication cart 4) Findings include: During a medication cart observation with Qualified Medical Assistant (QMA) 6, on [DATE] at 11:06 a.m., medication cart 1 was observed to have the following: a. The top right drawer had two medication cups containing one pill in each cup not labeled with the resident's names or with the medication name. b. The bottom right drawer had an unlabeled nebulizer machine (a device which turned liquid medication into a mist to be inhaled into the lungs through a mask or mouthpiece) c. The top left drawer had Smooth Nighttime eye ointment, dated opened [DATE]. d. A Saline Nose Spray without a date opened. During a medication cart observation with QMA 6, on [DATE] at 11:19 a.m., medication cart 2 was observed to have the following: a. The top left drawer had ear wax removal drops improperly stored next to Ferrocite oral tablets. b. The second left drawer had OTC vitamin C tablets not labeled with the dose of the medication, the administration directions, or the physician's name. c. The bottom left drawer had mupirocin ointment (an ointment put onto the skin to treat a skin infection) stored in the medication cart instead of being stored in a treatment cart. d. The bottom left drawer had sanitizer wipes stored next to oral medications. During an interview, QMA 6 indicated the sanitizer wipes should not be stored next the oral medications and the ointment should have been stored in the treatment cart. During a medication cart observation with QMA 7, on [DATE] at 11:34 a.m., medication cart 3 was observed to have the following: a. The top drawer had oral medications stored next to eye drop medications without a divider between the two medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The second drawer had Refresh Eye Tears (eye drops which help with dry eye) opened, dated [DATE], and more than 30 days past the discard after opening date. c. The second drawer had Polyvinyl alcohol eye drops (eye drops which help with dry eye) opened, dated [DATE], and more than 30 days past the discard after opening date. During an interview, on [DATE] at 11:45 a.m., QMA7 indicated the eye drops were good for 90 days once opened. During a medication cart observation with RN 8, on [DATE] at 11:49 a.m., medication cart 4 was observed to have the following: a. Glucose gel (to treat low blood sugar) unopened and past expiration date of ,d+[DATE]. A current policy, titled .Storage and Expiration Dating of Medications, Biologics, dated as last revised on [DATE] and received from the Administrator on [DATE] at 1:47 p.m., indicated .Topical (external) use medications or other medications should be stored separately from oral medications when infection control issues may be a consideration .Facility should ensure that test reagents, germicides, disinfectants, and other household substances are stored separately from medications .Facility should ensure that medication and biologicals that: (1) have an expired date on the label; (2) have been retained longer tan recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier .Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened .Medications with a manufacturer's expiration date expressed in month and year (e.g. [DATE]) will expire on the last day of the month .When an ophthalmic solution or suspension has a manufacturers shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container .Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions .Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis. Facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assists Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals . 3XXX,d+[DATE](j) 3XXX,d+[DATE](o)