STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hammond-Whiting Care Center	1000 114th St Whiting, IN 46394

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 10326 Based on observation, record review, and interview, the facility failed to ensure call lights were placed within reach of the resident for 1 of 1 resident reviewed for accommodation of needs. (Resident B) Finding includes: On 10/2/24 at 9:08 a.m., 11:15 a.m., and 12:05 p.m., Resident B was observed in her room in bed. Her eyes were closed and she was positioned on her right side. At 12:29 p.m. and 1:57 p.m., the resident's eyes were open and she remained in bed. The resident's call light was clipped to the call light cord above the head of the resident's bed and was out of reach at all of the above times. During an interview on 10/2/24 at 12:29 p.m., CNA 3 indicated the resident could tell staff if she needed assistance. On 10/3/24 at 8:58 a.m. and 10:35 a.m., the resident was observed in her room in bed. The call light remained out of the resident's reach and clipped to the call light cord. On 10/4/24 at 9:10 a.m., the resident was observed in her room in bed. Again, the call light remained out of reach. The record for Resident B was reviewed on 10/2/24 at 2:46 p.m. Diagnoses included, but were not limited to, hemiplegia/hemiparesis (muscle weakness/muscle paralysis) following a stroke, dementia without behavior disturbance, and history of falling. The 9/27/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively impaired for daily decision making and she was substantial to maximum assist with rolling left to right and bed to chair transfers. A Care Plan, reviewed on 7/10/24, indicated the resident was at risk for falls. Interventions included, but were not limited to, call light within reach. During an interview on 10/4/24 at 9:28 a.m., the Interim Administrator indicated the resident's call light should have been within reach.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48055 Based on record review and interview, the facility failed to ensure residents' care plans were held and families were invited to attend care plan meetings for 2 of 19 residents whose care plans were reviewed. (Residents 35 and 37) Finding includes: 1. On 10/1/24 at 3:48 p.m., Resident 35 was observed lying in bed. The resident indicated he did not know about his care plan meetings. The staff told him they would call and talk with his daughter regarding his care plan. Resident 35 indicated the staff never called his daughter or held his care plan meeting. Resident 35's record was reviewed on 10/2/24 at 10:07 a.m. Diagnoses included, but were not limited to, retention of urine, insomnia, chronic obstructive pulmonary disease, heart failure, gout, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 7/9/24, indicated the resident was cognitively intact for daily decision making. During an interview on 10/03/24 at 10:19 a.m the Social Service Director indicated she did not have any documentation showing that she attempted to reach out to the resident or the resident's family regarding missed care plan meetings. 2. On 9/30/24 at 3:03 p.m., Resident 37 indicated he had not been invited to his care plan meetings. Resident 37's record was reviewed on 10/02/24 at 11:32 a.m. Diagnosis included, but not limited to, psychotic disturbance, mood disturbance, anxiety, and atherosclerotic heart disease. The Significant Change Minimum Data Set (MDS) assessment, dated 9/20/24, indicated the resident was cognitively impaired. During an interview on 10/03/24 at 10:19 a.m the Social Service Director indicated she did not have any documentation showing that she attempted to reach out to the resident or the resident's family regarding missed care plan meetings. 3.1-35(d)(2)(B)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 10326 Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with activities of daily living (ADL's) related to meal assistance and the removal of facial hair for 2 of 7 residents reviewed for ADL's and for 1 of 2 meal observations. (Residents 28, 29, and 27) Findings include: 1. On 9/30/24 at 12:02 p.m., Resident 28 was seated in her broda chair (a type of wheelchair) in the restorative dining room. She and her tablemate were served their lunch trays at 12:02 p.m. Resident 28's tray was placed in front of her and remained covered. The resident was not assisted with her meal until 12:15 p.m. The record for Resident 28 was reviewed on 10/1/24 at 3:44 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, diabetes, and long term use of insulin. The Quarterly Minimum Data Set (MDS) assessment, dated 8/21/24, indicated the resident was cognitively impaired for daily decision making and required supervision or touching assistance with eating. A Care Plan, reviewed on 8/8/24, indicated the resident had an ADL self-care performance deficit related to dementia and arthritis. Interventions included, but were not limited to, the resident required set up supervision to eat. During an interview on 10/4/24 at 9:28 a.m., the Interim Administrator indicated the resident should have been assisted with her meal in a more timely manner. 2. On 9/30/24 at 12:02 p.m., Resident 29 was seated in her wheelchair in the restorative dining room. Her lunch tray was placed in front of her at the time and left covered. Staff did not assist the resident until 12:13 p. m. The record for Resident 29 was reviewed on 10/4/24 at 9:50 a.m. Diagnoses included, but were not limited to, Alzheimer's, dementia, dysphagia (difficulty swallowing), and severe protein calorie malnutrition. The Significant Change Minimum Data Set (MDS) assessment, dated 7/8/24, indicated the resident was cognitively impaired for daily decision making and was dependent on staff for eating. A Care Plan, reviewed on 7/4/24, indicated the resident had an ADL self care performance deficit and required extensive to dependent assistance as needed with ADL's including bed mobility, transfers, toileting, and eating related to dementia with behavioral disorder. Interventions included, but were not limited to, the resident required extensive assistance of 1 staff to eat. During an interview on 10/4/24 at 9:28 a.m., the Interim Administrator indicated the resident should have been assisted with her meal in a more timely manner. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48383 3. On 9/30/24 at 11:33 a.m., and 3:29 p.m., Resident 27 was observed with facial hair on her chin and above her lip. She indicated at that time the staff had not shaved her recently and she did not want any facial hair. On 10/2/24 at 10:05 a.m., the resident was observed in the dining hall participating in activities. The resident still had facial hair above her lip and a on her chin. The record for Resident 27 was reviewed on 10/3/24 01:46 p.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), asthma, diabetes, anemia (low iron), hypertension (high blood pressure), and kidney disease. The 5 day Minimum Data Set (MDS) assessment, dated 7/25/24 . indicated the resident was moderately impaired for daily decision making. The resident required set up or clean up assistance for eating, personal hygiene and oral hygiene. The resident required partial/moderate assistance with shower and bathing and upper body dressing. The resident required substantial/maximum assistance with toileting and lower body dressing. A Care Plan, dated 7/25/24 , indicated the resident had hemiplegia/hemiparesis. Interventions were to give medications as ordered and for physical therapy to evaluate and treat. A Care Plan, dated 7/25/24, indicated the resident had impaired visual function related to blindness in the left eye. The resident had scheduled bath days on Mondays and Thursdays. The CNA bath sheet and skin check documents for 9/2024 and 10/2024 indicated the following: On 9/19/24, facial hair was trimmed. On 9/26/24, facial hair was not trimmed or shaved. On 9/30/24, facial hair was not trimmed or shaved. On 10/3/24, there was no shower sheet available. During an interview on 10/3/23 at 3:11 p.m., the Interim Administrator indicated the resident should have been shaved at minimum on a weekly basis. 3.1-38(a)(2)(D) 3.1-38(a)(3)(D)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 10326 Based on observation, record review, and interview, the facility failed to provide a personalized activity program for a cognitively impaired and dependent resident related to ongoing stimulation and one to one visits for 1 of 1 resident reviewed for activities. (Resident C) Finding includes: On 9/30/24 at 4:18 p.m., Resident C was observed in her room in bed. The resident was awake and attempting to lift her head off of the pillow and her feet off of the mattress. The resident's television was turned off and the privacy curtain was pulled half way between her and her roommate. The resident was confined to her room due to being in isolation. On 10/1/24 at 11:30 a.m. and 4:40 p.m., the resident's television remained off. On 10/2/24 at 2:05 p.m., the resident was again lifting her head and feet off of the mattress and her television was turned off. On 10/3/24 at 9:30 a.m., the resident was fidgeting in bed and her television was turned off. The record for Resident C was reviewed on 10/2/24 at 3:09 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with agitation, cognitive communication deficit, and delusional disorder. The 2/13/24 Significant Change Minimum Data Set (MDS) assessment, indicated it was somewhat important for the resident to listen to music and participate in her favorite activities. The Quarterly Minimum Data Set (MDS) assessment, dated 9/18/24, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. A Care Plan, dated 8/14/24, indicated the resident was able to accept and/or decline invitations to participate in various activities. The resident benefited from small group activities with support and encouragement depending how she felt. Interventions included, but were not limited to, provide and offer visits with customer care, small talk, small group activities, if possible video chats, redirection, room service, snacks, short stories, suggestions, requests, encouragement, love, and support. A Care Plan, reviewed on 9/20/24, indicated the resident had little or no activity involvement related to disinterest, the resident wished not to participate. Interventions included, but were not limited to, the resident's preferred activity was watching sports, baseball and football. The September 2024 One to One Visit Log, indicated the resident's last one to one visit was on 9/20/24 which consisted of a hand massage. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/24 at 4:10 p.m., the Activity Director indicated the resident was currently in isolation. The resident had received sensory stimulation in the past and she liked to watch television. The resident's television should have been turned on and the activity department was down a staff member, so one to one visits weren't being completed as often as she would like. 3.1-33(a)

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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 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. 10326 Based on observation, record review, and interview, the facility failed to ensure insulin was administered as ordered and held per insulin parameters for 2 of 5 residents reviewed for unnecessary medications. (Residents 28 and 219) The facility also failed to ensure areas of bruising were assessed and monitored for 1 of 6 residents reviewed for skin conditions non-pressure related. (Resident 35) Findings include: 1. The record for Resident 28 was reviewed on 10/1/24 at 3:44 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, diabetes, and long term use of insulin. The Quarterly Minimum Data Set (MDS) assessment, dated 8/21/24, indicated the resident was cognitively impaired for daily decision making and she had received insulin injections during the assessment reference period. A Care Plan, reviewed on 8/8/24, indicated the resident had Diabetes Mellitus. The goal was for the resident to have no complications related to diabetes through the next review date. A Physician's Order, dated 8/13/24, indicated the resident was to receive Lispro insulin, 8 units subcutaneous (injection in the fatty tissue just under the skin) with meals. Hold if the resident's blood sugar was less than 100. The September 2024 Medication Administration Record (MAR), indicated the resident's insulin was not signed out as being administered on the following dates and times: - 8:00 a.m. on 9/12, 9/23, and 9/28/24 -12:00 p.m. on 9/12, 9/16, 9/23, 9/28, and 9/29/24 - 5:00 p.m. on 9/12, 9/13, and 9/20/24 The September 2024 MAR also indicated the resident received the Lispro insulin when her blood sugar was below 100 on 9/6, 9/16, and 9/25/24 at 8:00 a.m. A Physician's Order, dated 5/15/24 and listed as current on the October 2024 Physician's Order Summary (POS), indicated the resident was to receive Glargine insulin, 26 units in the morning. The insulin was to be held if the resident's blood sugar was less than 150. The September 2024 MAR, indicated the Glargine insulin was not signed out as being administered on 9/12, 9/23, and 9/28/24 at 8:00 a.m. During an interview on 10/4/24 at 4:10 p.m., the Interim Administrator indicated the insulin should have been administered as ordered. 48055 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 9/30/24 at 3:39 p.m., Resident 35 was observed with a discoloration on the right wrist. The record for Resident 35 was reviewed on 10/2/24 at 10:07 a.m. Diagnoses included, but were not limited to, retention of urine, insomnia, chronic obstructive pulmonary disease, heart disease and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 7/9/24, indicated the resident was cognitively intact. A Physician's order, dated 6/18/24, indicated to give Eliquis (a blood thinner) 5 mg oral tablet and to give Plavix (an antiplatlet drug that prevents blood clots), 5 mg oral tablet. A Care Plan, dated 5/20/24, indicated the resident was on anticoagulant therapy of Eliquis and Plavix. Interventions included the following: administer anticoagulant medications as ordered by the physician, monitor for side effects and effectiveness every shift, labs as ordered. and to observe for and report adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs). There was no skin assessment indicating a discoloration to the right wrist of Resident 35. During an interview on 10/03/24 at 2:57 p.m., the MDS Coordinator indicated the resident did not have a monitoring order in place for the discoloration to the right wrist. 48383 3. On 9/30/24 at 11:16 a.m., Resident 219 was observed in her room. She indicated she had to ask for her insulin on 9/29/24 and it was late when it was administered. The record for Resident 219 was reviewed on 10/02/24 at 9:07 a.m. The diagnoses included, but were not limited to, hypertension (high blood pressure), depression, back pain, insomnia, diabetes, long term insulin use, and muscle weakness. The 5 day Minimum Data Set (MDS) Assessment, dated 9/12/24. Indicated the resident was moderately impaired for daily decision making. The resident had no impairment of the upper and lower extremities and used a walker. The resident was administered a hypoglycemic medication. A Baseline Care Plan, dated 9/13/24, did not include a diabetes/ insulin care plan. A Physician's order, dated 9/20/24 indicated to administer Insulin Aspart (insulin pen) per sliding scale before meals for diabetes management. A Nurse's Note, dated 9/26/2024, indicated the resident was resting in bed and had no adverse reactions related to insulin administration on 9/22/24. A Nurse's Note, dated 9/25/2024, indicated the resident had no adverse side effects related to previous late medication administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note, dated 9/23/2024 at 4:30 p.m., indicated the family and physician were notified of late medication administration. Continue to follow up with all staff on duty to complete education and compliance to insulin dosing. A Nurse's Note, dated 9/23/24 at 4:00 p.m., indicated a follow up with the resident and Social Services Director (SSD). The resident had indicated her insulin was delayed 3 hours on 9/22/24. A Nurse's Note, dated 9/23/24 at 2:53 p.m., indicated a verbal report was received by the physician that Resident 219 did not receive her insulin on time and prior to her dinner meal on 9/22/24. The Medication Administration Record indicated insulin was administered late on 9/29/24 and was given at the following times: On 9/29/24, insulin was scheduled to be given at 7:00 a.m. Insulin was administered at 9:09 a.m. On 9/29/24 insulin was scheduled to be given at 11:00 a.m. Insulin was administered at 1:02 p.m. During an interview on 10/04/24 at 11:38 a.m., the Interim Administrator indicated insulin was not given within the correct medication parameters. 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. 10326 Based on observation, record review, and interview, the facility failed to ensure the necessary treatment and services were provided to promote healing of pressure ulcers related to the use of pressure reducing devices for 1 of 3 residents reviewed for pressure ulcers. (Resident B) Finding includes: On 10/2/24 at 9:08 a.m., 11:15 a.m., 12:05 p.m., 12:29 p.m., and 1:57 p.m., Resident B was observed in her room in bed. Her pressure reducing heel boots were observed in her wheelchair and her feet were not off loaded (positioning the body so that pressure does not rest on top of the wounded area) while she was in bed. On 10/3/24 at 8:58 a.m., the resident was in her room in bed sleeping. The resident was dressed and she was not covered with any blankets. The resident was observed with gauze dressings to both of her feet that were dated 10/2/24. The resident's feet were resting directly on the mattress and her heel boots were in the chair next to the bed. The record for Resident B was reviewed on 10/2/24 at 2:46 p.m. Diagnoses included, but were not limited to, hemiplegia/hemiparesis (muscle weakness/muscle paralysis) following a stroke, dementia without behavior disturbance, and pressure ulcers to the left and right heel. The 9/27/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively impaired for daily decision making and she was substantial to maximum assist with rolling left to right and bed to chair transfers. The resident was also identified as having 3, Stage 4 pressure areas (an area of full thickness skin loss that extends into the bone, muscle, joint, or tendon). A Care Plan, dated 7/15/24, indicated the resident was admitted with pressure areas to the left lateral heel, left medial heel, and right heel. Interventions included, but were not limited to, treatment per order. A Physician's Order, dated 7/10/24, indicated the resident's heels were to be off loaded while in bed as tolerated by the resident. A Physician's Order, dated 9/4/24, indicated the resident was to have Prevalon boots (pressure reducing boots) to the left and right heel every shift as tolerated. The October 2024 Treatment Administration Record (TAR), indicated the heel boots and the off loading had been signed out as being completed on 10/2/24. During an interview on 10/4/24 at 11:00 a.m., the Wound Nurse indicated the resident's heel boots should have been in place when she was in bed or at least her heels off loaded. She indicated the heel boot application and offloading should not have been signed out as being completed if it wasn't done. 3.1-40(a)(2)

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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. 48383 Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 1 of 1 resident reviewed for oxygen. (Resident 21) Finding included: On 9/30/24 at 4:16 p.m., Resident 21's oxygen was on via nasal cannula and the flow rate was set under 3 liters. On 10/01/24 at 11:32 a.m., the resident's oxygen flow rate was observed under 3 liters. 10/02/24 9:06 a.m., and 11:03 a.m., the resident was observed asleep in bed. She was wearing oxygen via nasal cannula. The flow rate was at 2.5 liters. The record for Resident 21 was reviewed on 10/02/24 at 9:44 p.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body, candidiasis, hyperlipidemia (high cholesterol), anxiety, depression, heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). The Quarterly Minimum Data Set (MDS) assessment, dated 7/2/24, indicated the resident was moderately impaired for daily decision making. The resident had impairment on one side of the lower extremities and used a wheelchair. The resident required oxygen therapy. A Care Plan, dated 4/17/24, indicated the resident used continuous supplemental oxygen at 3 liters via nasal cannula. Interventions were to administer oxygen at 3 liters via nasal cannula and observe for any side effects and effectiveness. A Physician's Order, dated 4/25/24 indicated to administer oxygen via nasal cannula continuously at 3 liters/minute. The Medication Administration Record (MAR), indicated oxygen was signed out as being given at 3 liters every shift on the following dates: 9/30/24, 10/1/24, and 10/2/24. During an interview on 10/03/24 at 10:07 a.m., the Interim Director of Nursing indicated she understood the oxygen concern and had no additional information to provide. 3.1-47(6)

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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. 48383 Based on record review and interview, the facility failed to complete a post dialysis assessment for 1 of 1 resident reviewed for dialysis. (Resident 217) Finding includes: The record for Resident 217 was reviewed on 10/03/24 at 3:31 p.m. The diagnoses included, but were not limited to, kidney disease, hemiplegia (paralysis of one side of the body, dependence on renal dialysis, hypertension (high blood pressure), and anemia (low iron). The 5 day Minimum Data Set (MDS) assessment, dated 9/26/24, indicated the resident was severely impaired for daily decision making. The resident had impairment on one side of the lower extremities and used a wheelchair. The resident required dialysis. A Care Plan, dated 9/20/24, indicated the resident received hemodialysis and had an arteriovenous (AV) fistula (a connection made between an artery and a vein for dialysis access). Interventions included, but were not limited to, observe for bleeding at dialysis access site, obtain dry weights from dialysis center, and assess shunt site for bruit and thrill. A Physician's Order, dated 9/20/24, indicated the resident was a dialysis patient and received dialysis on Monday, Wednesday, and Friday at a dialysis center. A Nurse's Note, dated 9/23/2024 at 9:00 a.m., indicated the resident went out to dialysis. A Nurse's Note, dated 9/30/24 at 2:44 p.m., indicated the resident had returned from the dialysis center. The Dialysis Communication binder included communication forms that had information for the facility to fill out prior to the resident going to the dialysis center and upon return from the dialysis center. The information included vital signs, bruit and thrill assessment, medication sent to the dialysis center, medication received prior to dialysis, and other pertinent information (lunch or snack sent with resident, comments, or concerns). The post dialysis form was not filled out on 10/4/24, 9/30/24, and 9/25/24. The 9/23/24 form was not in the binder. A policy titled, Hemodialysis Offsite Policy with reviewed date 9/6/24, indicated .1. Obtain vital signs of resident upon return from dialysis and complete Pre/Post Dialysis Communication Form . During an interview on 10/7/24 at 8:49 a.m., LPN 1 indicated she would check the resident's vital signs and check the bruit/thrill prior to the resident leaving for dialysis. She would then document on the pre/post dialysis communication sheet. During an interview on 10/7/24 at 8:55 a.m., LPN 1 indicated vitals should be checked when the resident returned from the dialysis center and documented in the dialysis binder. (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 10/7/24 at 11:47 p.m., the Nurse Consultant indicated the post dialysis communication sheet was not filled out consistently. 3.1-37(a)

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F 0727 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48055 Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours in the facility for 1 of 14 days reviewed. This had the potential to affect 67 of 67 residents who resided in the facility. Finding includes: The staffing schedules for 9/16-9/29/24 were reviewed on 10/4/24 at 10:25 a.m. Nursing schedules indicated there was no RN coverage for 9/29/24. During an interview on 10/4/24 at 12:10 p.m., the Interim Administrator indicated they did not have an RN working on 9/29/24. She was aware they should have RN coverage daily. 3.1-17(b)(3)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 48383 Based on observation, record review, and interview, the facility failed to provide ongoing psychosocial visits for a resident in indefinite isolation for 1 of 3 residents reviewed for isolation. (Resident 21) Finding included: On 9/30/24 at 4:14 p.m., Resident 21 was observed sitting up in bed. She was tearful and indicated she was going crazy in isolation. She was told she had another month in isolation and she could not take it anymore, she wanted out. The record for Resident 21 was reviewed on 10/02/24 at 9:44 p.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body, candidiasis, hyperlipidemia (high cholesterol), anxiety, depression, heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). The Quarterly Minimum Data Set (MDS) assessment, dated 7/2/24, indicated the resident was moderately impaired for daily decision making. The resident had impairment on one side of the lower extremities and used a wheelchair. A Care Plan, dated 7/4/24, indicated the resident was at risk for a change in mood behavior due to anxiety. Interventions were to have a psychiatric consult as needed and administer medications as ordered. A Care Plan, dated 7/4/24, indicated he resident was able to verbalize her preferred leisure activities. She liked to attend bingo and some arts and crafts. It was very important for her to listen to music, keep up with the news, and go outside in nice weather. A Care Plan, dated 9/5/24, indicated the resident had Candida auris. Interventions were to administer medications as ordered and the resident would have designated caregivers when applicable. A Physician's order, dated 8/22/24, indicated to place the resident in contact isolation and enhanced barrier precautions every shift related to a wound and Candida auris. A Psychosocial Note, dated 8/28/2024, indicated the resident had been seen by psych services. A Psychosocial Note, dated 9/12/2024 at 11:30 a.m., indicated the interdisciplinary team had met with the resident to discuss overall health and psychosocial well being. A Psychosocial Note, dated 9/19/2024 at 11:30 a.m., indicated social services (SS) notified the resident's family of a room change. SS would continue to provide therapeutic services. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/03/24 at 3:01 p.m., the Interim Administrator indicated the residents were allowed to leave their room but staff would need to clean behind them. The facility was waiting for a visit from the epidemiology team to give them more guidance and educate them on what specific cleaning agents to use. There should have been more psychosocial visits occurring for a resident in prolonged isolation. During an interview on 10/7/24 at 9:47 a.m., the Social Service Director (SSD) indicated she had not been doing psychosocial checks on the residents in prolonged isolation, but she would start to have daily checks. 3.1-34(a)(1)

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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. 10326 Based on record review and interview, the facility failed to ensure gradual dose reductions (GDR's) of psychotropic medications were implemented for 2 of 5 residents reviewed for unnecessary medications. (Residents B and C) Findings include: 1. The record for Resident B was reviewed on 10/2/24 at 2:46 p.m. Diagnoses included, but were not limited to, hemiplegia/hemiparesis (muscle weakness/muscle paralysis) following a stroke, dementia without behavior disturbance, Alzheimer's disease, and major depressive disorder. The 9/27/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making and she had received antipsychotic medications during the assessment reference period. A GDR was attempted on 9/13/24. A Physician's Order, dated 7/10/24 and listed as current on the October 2024 Physician's Order Summary (POS), indicated the resident was to receive Seroquel (an antipsychotic medication) 25 milligrams (mg) at bedtime for restlessness. A GDR Psychiatric Progress Note, dated 9/13/24, indicated the resident's Seroquel was to be decreased to 12.5 mg at bedtime. The September 2024 Medication Administration Record (MAR) indicated the resident received 25 mg of Seroquel 9/14-9/30/24. The October 2024 MAR indicated the resident received 25 mg of Seroquel 10/1-10/4/24. There was no documentation indicating the GDR had been declined by the resident's physician. During an interview on 10/7/24 at 10:00 a.m., the Nurse Consultant indicated the medication had not been GDR'd as ordered. 2. The record for Resident C was reviewed on 10/2/24 at 3:09 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with agitation, cognitive communication deficit, and delusional disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/18/24, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident had received antipsychotic and anti-anxiety medications during the assessment reference period. A gradual dose reduction (GDR) was attempted on 9/13/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 3/1/24 and listed as current on the October 2024 Physician's Order Summary (POS), indicated the resident was to receive Ativan (an anti-anxiety medication) 0.5 milligrams (mg) daily for anxiety. A Plan of Care Note, dated 9/17/24 at 11:46 a.m., indicated a GDR was completed for the resident. It was recommended to decrease the resident's Ativan from 0.5 mg daily to 0.25 mg. The resident's behaviors were discussed and the Interdisciplinary Team (IDT) was in agreement. The September 2024 Medication Administration Record (MAR) indicated the resident continued to receive 0. 5 mg of Ativan 9/18-9/30/24. The October 2024 MAR indicated the resident received 0.5 mg of Ativan 10/1-10/4/24. There was no documentation indicating the GDR had been declined by the resident's physician. During an interview on 10/7/24 at 10:00 a.m., the Nurse Consultant indicated the medication had not been GDR'd as ordered. The facility policy, titled Psychotropic Medication Management was provided by the Nurse Consultant on 10/7/24 at 2:35 p.m. The policy was identified as being current. The policy indicated, with regard to psychotropic medications, the regulations additionally require implementing GDR and other non-pharmacologic interventions for residents who receive psychotropic medications unless contraindicated. This citation relates to Complaint IN00440581. 3.1-48(a)(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. 48383 Based on observation, record review, and interview, the facility failed to label and store medication appropriately related to storing unlabeled bulk medication for 1 of 2 medication rooms and 1 of 2 medication carts observed during medication storage observations. (South medication room and North medication cart) Findings include: 1. On 10/1/24 at 4:58 p.m., the north medication cart was observed with QMA 1. The top drawer had 2 bottles of acetaminophen that were not labeled. During an interview at the time, QMA 1 indicated the acetaminophen bottles were house medications. 2. On 10/1/24 at 3:30 p.m., the south medication room was observed with LPN 2. In the top left cabinets there was a box of benadryl and 2 bottles of acetaminophen with no labels. During an interview on 10/1/24 at 3:29 p.m., LPN 2 indicated the benadryl and acetaminophen were in the cabinet because those were in house medications. During an interview on 10/2/24 at 9:35 a.m., the nurse consultant indicated they should not have house medications and those medications have been removed. 3.1-25(j)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 10326 Based on observation, record review, and interview, the facility failed to ensure the menu was followed as written related to pureed diets. This had the potential to affect the 7 residents in the facility who received a pureed diet. Finding includes: On 10/3/24 at 11:05 a.m., [NAME] 1 was observed preparing the pureed lunch meal. The residents who received a pureed diet were receiving pureed ham, peas, mashed potatoes and gravy, and bread. At that time, the [NAME] indicated the residents who received a regular diet were being served beef tips with mushrooms over parsley noodles. On 10/3/24 at 1:45 p.m., the menu for the pureed diets was reviewed. The residents who received a pureed diet were also to be served beef tips with mushrooms over parsley noodles. During an interview on 10/3/24 at 3:30 p.m., the Dietary Food Manager indicated the residents should have been served pureed beef tips rather than ham based on the spreadsheet. She indicated the cook usually made the pureed residents their own special meal. 3.1-20(i)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 10326 Based on observation and interview, the facility failed to ensure food was served and prepared under sanitary conditions related to dried food spillage, scoops in bins, and food that was not labeled for 1 of 1 kitchens observed. (The Main Kitchen) This had the potential to affect all residents receiving food from the kitchen. Finding includes: During the brief kitchen sanitation tour on 9/30/24 at 9:34 a.m. with the Dietary Food Manager (DFM), the following was observed: a. An accumulation of dried food spillage was on the outside and on the lids of the flour, sugar, and rice bins. b. A plastic scoop was observed inside the flour and rice bins positioned directly on the food. c. A bag of thawed chicken was observed in a plastic bin in the walk in refrigerator. The bag was twisted closed and not dated. During an interview at that time, the DFM indicated the bins would be cleaned and the scoops removed and the chicken would be discarded. 3.1-21(i)(3)

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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. 48383 Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to improper use of personal protective equipment (PPE) prior to entering and leaving an isolation room, staff not knowing why a resident was in isolation, and not completing an antiseptic bath as ordered for 1 of 9 residents reviewed for infection control. (Resident 21) Finding includes: On 10/1/24 at 3:34 p.m., the signage on the outside of the resident's door indicated the resident was in contact, enhanced barrier, and droplet precautions. During an interview on 10/1/24 at 3:40 p.m., LPN 3 indicated she was unsure why the resident was in droplet precautions and would have to look it up. On 10/2/24 at 12:43 p.m., family members entered the resident's room and were wearing gloves, gown, mask, face shield, and shoe covers. They indicated they were instructed by staff what PPE to wear before entering the room. On 10/2/24 at 12:47 p.m., QMA 1 was observed donning PPE which included, a mask, gown, gloves, and shoes covers. During an interview on 10/2/24 at 12:49 p.m., QMA 1 indicated she was told to wear a mask and shoe covers on her feet and also preferred to wear them. QMA 1 indicated she was unsure why there was a droplet sign on the door and did not know if the resident was in droplet isolation. During an interview on 10/2/24 at 12:54 p.m., CNA 1 indicated she was unaware why the resident was in droplet isolation. During an interview on 10/2/24 at 12:55 p.m., CNA 2 indicated a droplet sign was on the resident's door due to having shingles. During an interview on 10/2/24 at 1:00 p.m., the MDS Coordinator indicated the droplet sign was wrong and the resident only had contact/EBP precautions for Candida auris. The record for Resident 21 was reviewed on 10/02/24 at 9:44 p.m. The diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body, candidiasis, hyperlipidemia (high cholesterol), anxiety, depression, heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). The Quarterly Minimum Data Set (MDS) assessment, dated 7/2/24, indicated the resident was moderately impaired for daily decision making. The resident had impairment on one side of the lower extremities and used a wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, dated 9/5/24, indicated the resident had Candida auris. Interventions were to administer medications as ordered and resident would have designated caregivers when applicable. A Physician's Order, dated 8/22/24, indicated to place the resident in contact and enhanced barrier precautions every shift related to a wound and Candida auris. A Physician's Order, dated 9/6/24, indicated to administer Chlorhexidine Gluconate (antiseptic soap) body wash topically every evening shift for 7 days related to Candida auris. A Physician's note, dated 9/9/2024 at 11:41 a.m., indicated to continue with isolation per protocol, and continue with a short course of hibiclens (antiseptic soap) body wash daily. The Medication Administration Record (MAR) for 9/2024 indicated the Chlorhexidine Gluconate (antiseptic soap) body wash was not signed out on 9/12/24. During an interview on 10/04/24 at 11:38 a.m., the Interim Administrator indicated the Chlorhexidine Gluconate (antiseptic soap) was not administered or signed out as given on 9/12/24. There was no additional information provided. 3.1-18(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 10326 Based on observation and interview, the facility failed to ensure kitchen areas were maintained in a functional and sanitary manner, related to dirty floor tile, dried food spillage, and an accumulation of dust on pipes for 1 of 1 kitchen areas. (The Main Kitchen) This had the potential to affect all residents who received food from the kitchen. Findings include: 1. During the brief kitchen sanitation tour on 9/30/24 at 9:34 a.m. with the Dietary Food Manger (DFM), the following was observed: a. The floor tile throughout the kitchen had an accumulation of dirt and debris along the base boards. The tile grout was also discolored and dirty. b. There was an accumulation of dried spillage on top of the dishwasher and on the front of the dishwasher. c. The metal pipes located above the dishwasher had an accumulation of dust. During an interview at that time, the DFM indicated the above was in need of cleaning. 2. During the kitchen sanitation tour on 10/3/24 at 11:15 a.m. with the DFM, the following was observed: a. The white wall located beneath the coffee and juice machines had an accumulation of dried liquid spillage. b. The white PVC pipes located underneath the 3 compartment sink had an accumulation of dried food spillage. During an interview at that time, the DFM indicated the above was in need of cleaning. 3.1-19(f)