STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwood Healthcare Center	2222 Margaret Ave Terre Haute, IN 47802

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 34525 Based on observation, interview, and record review, the facility failed to ensure the code status (a medical term that indicates a patient's wishes regarding what life-saving measures should be taken if their heart stops beating or breathing stops) was documented and readily available to staff for 1 of 24 residents reviewed for advanced directives (a written document that tells the health care providers who should speak for a resident and what medical decisions they should make if the resident becomes unable to speak for themselves) (Resident 152). Findings include: Resident 152's record was reviewed on 12/3/24 at 9:51 a.m. The profile indicated the resident's diagnoses included, but were not limited to, atherosclerotic heart disease of the native coronary artery (a condition where plaque [a buildup of cholesterol, fat, blood cells, and other substances in the walls of the heart arteries] builds up in the coronary arteries, cardiomegaly (enlarged heart), and history of myocardial infarction (heart attack). An admission Minimum Data Set (MDS) assessment, dated 11/18/24, indicated the resident had severe cognitive deficit. Review of the resident physician orders lacked an order of an established code status for the resident. The resident's electronic medical record (EMR) lacked documentation of an established code status for the resident. During an interview, on 12/3/24 at 10:33 a.m., Licensed Practical Nurse (LPN) 3 indicated the resident's code status should be documented in the EMR and in the physician's orders. At the same time, the LPN was unable to locate the resident's code status in the EMR. On the third attempt to locate the resident's code status, the LPN looked in the hard chart (the medical record with paper documents) and found the resident's POST (Physician Orders for Scope of Treatment) document in the record. At the same time, the LPN indicated it should not have been so difficult and time consuming to find the code status for the resident. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/3/24 at 10:39 a.m., the Regional Director of Clinical Operations (RDCO) indicated the expectation was that the code status should be a physician's order and appear on the first page of the EMR. The POST form would be kept in the hard chart and scanned into the EMR, and available for the staff to locate. The nurses were all educated to first look in the hard chart during a code situation. During an interview, on 12/3/24 at 10:42 a.m., the Director of Nursing (DON) indicated she was not sure why the resident did not have an established code status in her EMR and/or a physician's order for her code status. It was the expectation that a code status would be easily available for staff in the resident's record. A care plan, dated 12/3/24, indicated the resident had a DNR (Do Not Resuscitate) code status. Interventions included, but were not limited to, code status will be established at time of admission and/or re-admission and would be reviewed quarterly and as needed. On 12/3/24 at 10:45 a.m., the RDCO provided a document, dated 2/3/23, titled, Advanced Directives (Resident's Right to Choose), and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Explanation and Compliance Guidelines .2. On admission, the facility will review any medical orders for life-sustaining treatment that the resident may have in place .4. Upon admission .copies will be made and placed on the .medical record as well as communicated to the staff .10. Any decision making regarding the resident's choices in their medical order for life-sustaining treatment .will be documented in the resident's medical record 3.1-4(f)(5)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34525 Based on record review and interview, the facility failed to ensure notification of a resident discharge had been reported to the Ombudsman (a person who investigates and resolves complaints and represents or protects the interests of another person or group) for 1 of 2 residents reviewed for hospitalization (Resident 6). Findings include: Resident 6's record was reviewed on 12/3/24 at 3:47 p.m. The profile indicated the resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis (hemiplegia refers to a severe or complete loss of strength, whereas hemiparesis refers to a relatively mild loss of strength) following a cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD-a common lung disease that makes it difficult to breathe), and congestive heart failure (CHF-a condition where the heart is unable to pump enough blood to the body's tissues). A change of condition assessment, dated 10/1/24, indicated the resident complained of new or worsening abdominal pain, shortness of breath, and had abnormal vital signs. A transfer document, dated 10/1/24, indicated the resident's physician had been notified of the change in condition and an order was obtained to send the resident to the hospital for evaluation and treatment related to abdominal pain. The resident had been sent out emergently, on 10/1/24 at 11:43 a.m. The record lacked documentation of the Ombudsman having been notified of the resident's discharge to the hospital. During an interview, on 12/5/24 at 9:51 a.m., the Social Services Director (SSD) indicated she had just come into her position in late November. She had completed and sent the November 2024 Ombudsman discharge notification on the first of December. She was not in her position during the time when the October 2024 notification was to be sent out. During an interview, on 12/5/24 at 11:10 a.m., the Regional Director of Clinical Operations (RDCO) indicated she had spoken with the SSD and they had determined that the notification for October 2024 had not been completed and sent. During an interview, on 12/6/24 at 11:24 a.m., the Ombudsman indicated she had not received an October 2024 notification of discharge document from the facility. On 12/5/24 at 11:18 a.m., the RDCO provided an undated document, titled, Bed Hold Policy, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: .1a. The nurse or designee will present the Acute Transfer Letter at time of transfer with a copy going to the resident and a copy going to the Business Office Manager. The designee will scan to the Ombudsman (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-12(a)(6)(A)(iv)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49068 Based on record reviews and interviews, the facility failed to ensure Minimum Data Set (MDS) resident assessments were completed timely for 2 of 2 residents reviewed for MDS records over 120 days old (Residents 42 and 2). Findings include: 1. On 12/4/24 at 9:32 a.m., Resident 42's record was reviewed. She was discharged on [DATE], and the record indicated her return was not anticipated. The record lacked documentation of a discharge MDS assessment being completed. On 12/9/24 at 2:13 p.m., Resident 42's record indicated that a discharge MDS assessment had been signed and completed on 12/9/24 with an export ready status. During an interview on 12/9/24 at 2:33 p.m., Employee 19 indicated they did an audit every few months and so did the corporate office. She was not aware they had missed completing the discharge MDS assessment in a timely manner for Resident 42 until 12/9/24 when the corporate office called and let her know. The corporate office maintained an audit log, but she did not, she would just go through and check things. 2. On 12/9/24 at 2:23 p.m., Resident 2's record was reviewed. She was discharged on [DATE], and the record indicated her return was not anticipated. The record indicated the discharge MDS assessment was not signed and completed until 12/2/24 and was not accepted until 12/3/24. During an interview on 12/9/24 at 2:33 p.m., Employee 19 indicated they did an audit every few months and so did the corporate office. The corporate office maintained an audit log, but she did not, she would just go through and check things. She was not familiar with Resident 2's discharge MDS situation, but knew the corporate office was the one who discovered it had not been completed in a timely manner. On 12/5/24 at 2:20 p.m., the Regional Director of Clinical Operations (RDCO) provided a copy of Section J of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, dated October 2023, .Discharge Assessment-Return Not anticipated .must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. Must be completed .within 14 days after the discharge date .must be submitted within 14 days after the MDS completion date

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to obtain and implement treatment orders upon admission for a stage 4 pressure ulcer (full thickness tissue loss with exposed muscle and/or bone) for 1 of 1 resident reviewed for pressure ulcers (Resident K). Findings include: On 12/9/24 at 11:00 a.m., the medical record of Resident K was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnosis included but not limited to, paraplegia (paralysis that occurs in the lower half of the body), osteomyelitis (an inflammation or swelling that occurs in the bone), enterocolitis (inflammation of the colon) to clostridium (bacterial infection in the colon), and pressure ulcer (bed sore) sacral (tail bone) region stage 4 (full thickness ulcer with the involvement of the muscle or bone). A Physician order, dated 10/28/24, indicated the following wound treatment was to be applied on day shift every Monday, Wednesday, Friday, and as needed. Staff were to cleanse the wound on the sacrum with wound cleanser, apply skin prep (application of a disinfectant to the skin) surrounding tissue or peri wound (skin directly around the wound), apply black foam (solid treatment foam) to wound bed (inside of the wound) and undermining area (areas under the skin surrounding the wound), cover with wound vacuum (a medical device that uses suction to help heal wounds by applying negative pressure to the wound area with a special dressing that creates a vacuum over a wound to aid in healing process), and apply drape (dressing). Staff were to bridge (join to another section) disc from hip to base of the wound, and secure with continuous 125mmhg (suction). A Physician order, dated 10/28/24, indicated if wound vacuum came off staff were to cleanse wound with wound cleanser, apply skin prep to surrounding tissue, apply calcium alginate (wound dressing) to wound bed and cover with super absorbent ABD pads and retention tape. Staff were to change the dressing daily. An admission Minimum Data Set (MDS) assessment, dated 10/31/24, indicated the resident was cognitively intact with a diagnosis of stage 4 wound which was present upon admission to the facility. A care plan, dated 10/29/24, indicated the resident had impaired skin integrity, or at risk for altered skin integrity. Interventions included but not limited to, encourage resident to turn and reposition or assist as needed and as resident allowed, provide appropriate off-loading mattress and off-loading cushion, if applicable. The care plan lacked documentation of an updated care plan reflecting medical treatment or presence of a stage 4 pressure wound. The medical record indicated that the resident was admitted to the facility on [DATE] with a stage 4 pressure wound on the sacrum. A physician order for treatment to the wound using a wound vacuum was obtained on 10/28/24. The wound treatment orders included an order to apply the wound vacuum as needed. The wound vacuum treatment was started on 10/30/24. The record lacked documentation of wound treatment for five days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound was assessed by the wound care provider on 10/28/24. The wound measured 7.5 cm (centimeters) long x (by) 5.60 cm x 3.10 cm. Wound evaluation was completed on 11/4/24. Wound measurements were 7.50 cm long x 5.60 cm wide x 2.50 cm deep. On 12/9/24 at 1:00 p.m., during an interview, Licensed Practical Nurse (LPN) 33 indicated the wound vacuum was discontinued due to continual contamination. The employee indicated the facility provided wound vac education as needed, and nurses had been trained in treatment and application of the wound vacuum. On 12/9/24 at 2:16 p.m., during interview, LPN 6 indicated Resident K was not admitted from the hospital with a wound vacuum device, and indicated the hospital usually discharged the resident with a dressing over the wound and the facility would contact the physician and obtain wound care orders. If the Nurse Practitioner (NP) was in the facility at the time of admission, the NP would enter an order for wet to dry wound dressing until the wound vacuum arrived. LPN 6 acknowledged the admitting nurse must contact the physician or NP and receive orders for wound care at the time of admission. The wound vacuum order was obtained and entered into the medical record on 10/28/24. It took 1 to 4 hours for delivery of the wound vacuum to the facility. The LPN acknowledged the documentation indicated the treatment was not started until 10/30/24 as per the schedule of Monday, Wednesday, Friday. LPN 6 indicated the medical record of Resident K contained a physician order to apply the wound vacuum as needed. If a treatment was completed as ordered the nurse would sign the treatment record. LPN 6 acknowledged the order was not signed as being completed in the medical record. On 12/9/24 at 3:08 p.m., the Regional Director of Clinical Operations (RDCO) provided an undated document, titled, Skin Care and Wound Management Overview, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: Application of treatment protocols based on clinical best practice standards for promoting wound healing .Treatment .3. Obtain a physician's order .5. Document treatment in the Treatment Administration Record (TAR) This citation relates to Complaint IN00446509. 3.1-40(a)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49068 Based on record review and interview, the facility failed to ensure there was sufficient weekend staffing for 1 of 4 fiscal year quarters reported for sufficient and competent nurse staffing (4/1/24-6/30/24). Findings include: On 12/2/24 at 11:00 a.m., the staffing data report was reviewed. The facility had reported low weekend staffing for the third fiscal year quarter (4/1/24-6/30/24). During an interview on 12/4/24 at 1:43 p.m., Certified Nursing Assistant (CNA) 13 indicated staff did not have enough time to complete their daily assignments, they needed more staff, and the biggest problem at the facility was with retaining staff. The facility asked her to stay late or work overtime nearly every day, but she declined because she wanted to avoid burnout. During an interview on 12/4/24 at 2:42 p.m., Licensed Practical Nurse (LPN) 15 indicated the facility did not have enough staff to do everything that needed to be done, and the staff they did have struggled to get things done. Each CNA had up to 2 halls on day and evening shifts, and on weekend shifts they were staffed even shorter. On 12/9/24 at 11:08 a.m., the staffing schedules were reviewed. The scheduling sheets for April, May, and June of 2024 did not include census, required number of staff, or assigned number of staff. During an interview with the Nurse Staff Scheduler on 12/9/24 at 1:09 p.m., she indicated they have had weekends with low weekend staffing and were aware that they triggered for low weekend staffing in the third fiscal year quarter. Since the third quarter, she was sure they had additional weekends with low weekend staffing. When she first started back in June, the scheduling template was different, now it included the daily census, required number of staff, and number of staff scheduled for each discipline and area. They had been trying to hire more staff, specifically for the night shift. They always keep the nursing staff requirements the same, and only changed CNA staffing based on census information. She indicated the low weekend staffing was usually due to CNA's. On 12/9/24 at 2:16 p.m., the Regional Director of Clinical Operations (RDCO) indicated they did not have a policy related to staffing. 3.1-17(a)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 35317 Based on observation, interview, and record review, the facility failed to ensure staff was competent in completing tasks accurately for 2 of 5 residents reviewed for medication administration (Residents 51 and M). Findings include: 1a. During the medication administration observation, on 12/6/24 at 7:50 a.m., Licensed Practical Nurse (LPN) 23 obtained a glucometer machine from the top of her medication cart and wiped it with an alcohol pad from front to back, she then placed it back down on the medication cart, she grabbed a lancet (medical tool for drawing blood and a cutting instrument used in surgery), test strip (a small disposable plastic strip that measures blood sugar levels), and a alcohol pad and proceeded into Resident 51's room. Upon entering the resident's room, she set the glucometer machine on the bedside table without a barrier underneath. The nurse put on gloves. She attempted to use the glucometer machine but had an error message and was unable to use it. She exited the resident's room and obtained a second glucometer machine from a different medication cart and wiped it down front to back with an alcohol pad. She entered back into the resident's room and set the second glucometer down on the bedside table without a barrier underneath. She obtained the resident's blood sugar and threw the lancet into the trash can in the resident's room. She left the room and placed both glucometers on the medication cart, one on top of the other with no barrier underneath. During the time the nurse was in the resident's room both medication carts were left unlocked in the hallway and the computer on top of the medication cart was left on and opened to the resident's information that contained her name, room number, and mediation orders. During an interview, on 12/6/24 at 7:52 a.m., LPN 23 indicated she wasn't sure if she needed to wipe down the glucometer machine and then grabbed an alcohol wipe and proceeded to wipe down the machine. The nurse indicated the residents do not have their own glucometer machines and they must share them between residents. 1b. During an observation, on 12/6/25 at 8:10 a.m., LPN 23 entered Resident 51's room to administer oral medications and left a medication cart unlocked along with the computer screen open to the resident's medication record. The record included the resident's name, room number, and medication orders. During an interview, on 12/6/24 at 8:16 a.m., LPN 3 indicated that bleach wipes should be used when cleaning the glucometer machines. Staff should also use a barrier when placing the glucometer on a bedside table since they are not clean. The nurse also indicated that a lancet should always be placed in a sharp container after use. LPN 3 indicated medication carts should always be locked when not in use and computers should be closed. During an interview, on 12/6/24 at 11:30 a.m., the Regional Director of Clinical Operations indicated LPN 23 was sent home for the remainder of her shift and would not return to the nursing schedule until she could complete nursing competency to prove she was able to care for the residents according to policy and procedure. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview, on 12/9/24 at 2:13 p.m., Licensed Practical Nurse (LPN) 3 indicated Resident M was not cognitively intact and he would have to administer her medication in pudding. He indicated Resident M would spit out the medication if they were given in applesauce. The nurse was not aware of anyone administering the mediation in coffee or other liquids. During an interview, on 12/9/24 at 2:16 p.m., LPN 31 indicated she would never put medications in liquid, she would only use pudding or applesauce. During an interview, on 12/9/24 at 2:23 p.m., Qualified Medication Aide (QMA) 30 indicated she typically worked the evening shift and would crush Resident M's bedtime medications in coffee because that was the only way he would take her medication for her. She indicated another staff member had told her to administer the medication in coffee, but she couldn't recall who it was. She had been administering the medications to the resident in coffee since she first started working as a QMA. The QMA indicated she had not been licensed for long as a QMA and wasn't aware if she was doing anything wrong giving the resident medications in coffee. During an interview, on 12/9/24 at 2:40 p.m., QMA 30 indicated she did add milk to the coffee so that it wasn't too hot for the resident to drink. If the resident didn't finish the coffee, she would throw out the remaining liquid. Resident M's record was reviewed on 12/9/24 at 2:58 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified fracture of right femur (a broken right thigh bone where the exact fracture is not specified), unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A quarterly Minimum Data Set (MDS) assessment, dated 10/4/24, indicated the resident was rarely understood. A physician order, dated 6/23/23, indicated may crush meds unless contraindicated. A physician order, dated 3/27/24, indicated to administer Depakote (medication used to treat seizures and bipolar disorder) ER (extended release) 24-hour 250 mg (milligrams) by mouth at bedtime for manic episodes. Review of nursing schedules indicated QMA 30 had worked on the unit Resident M resides on 6 times in the last 30 days. Review of QMA 30's license indicated she had been active since 7/25/24 as a QMA and was originally hired by the facility on 6/26/23 as a certified nurse's assistant. During an interview, on 12/9/24 at 3:10 p.m., the Regional Director of Clinical Operations indicated Depakote ER was on the list of do not crush medications and the QMA should not have crushed the medication in coffee. She indicated the QMA would be educated on the proper procedure. Review of pharmacy reference guide dated 8/24, indicated a list of medications that should not be crushed. Depakote ER tablet was on the list. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/24 at 11:59 a.m., the RDCO provided an undated document, titled, Staff Education and Competency Testing, and indicated it was the policy currently being used by the facility. The policy indicated, .Safety is the primary concern for out residents, staff and visitors. Education needs and competencies are evaluated/measured through clinical observation/skill demonstrations to maintain safe and effective nursing practice skills in care delivery to residents. Competency testing includes knowledge, skills, and ability and may be measured through a variety of methods including but not limited to direct observation knowledge testing, case studies, or other acceptable methods of academic learning .3) Infection control and prevention safety for PPE .a) Medication administration safe practices for nurses This citation relates to Complaint IN00448806. 3.1-14(i)

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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. 49068 Based on record reviews and interviews, the facility failed to ensure the correct supporting diagnosis was used to prescribe an antipsychotic for 1 of 5 residents reviewed for unnecessary medications (Resident 1), and failed to attempt a Gradual Dose Reduction (GDR) or provide evidence to support the denial of a GDR for 2 of 5 residents reviewed for unnecessary medications (Resident 48). Findings include: 1. On 12/5/24 at 9:02 a.m., Resident 1's record was reviewed for unnecessary medications. Her diagnoses included, but were not limited to, major depressive disorder (a mental health condition that can cause persistent low mood and loss of interest in activities), psychotic disorder with delusions (serious mental illness where people lose touch with reality and have abnormal thinking, and have false beliefs), agoraphobia (fear of being in places that may be difficult to escape or help would not be available) with panic disorder (anxiety that causes repeated unexpected panic attacks). On 12/5/24 at 9:36 a.m., Resident 1's pharmacy recommendations were reviewed. A pharmacy recommendation, dated 11/21/24, indicated the resident received Invega 9 mg daily for schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors, making it hard to function in daily life). A physician's order, dated 9/3/24, indicated to administer Invega (paliperidone)(a medication used to treat psychotic disorders), 9 milligrams (mg) extended release (ER) 24-hour tablet (medication is released slowly over a 24-hour period), 1 tablet by mouth in the morning for mood/schizophrenia. A historical physician's order, dated 5/30/24, indicated to administer paliperidone ER 6 mg, one tablet by mouth at bedtime for schizophrenia. On 10/5/24 at 10:37 a.m., Resident 1's Minimum Data Set Assessment, dated 10/20/24, was reviewed. The records assessment lacked documentation of a diagnosis for schizophrenia. A quarterly psychotropic medication evaluation form, dated 11/27/24, indicated that Resident 1 was being assessed for the use of an antipsychotic, Invega, and the supporting diagnosis was psychosis. Resident 1's electronic and paper records, lacked documentation for a diagnosis of schizophrenia. During an interview on 12/5/24 at 3:40 p.m., the Regional Director of Clinical Operations (RDCO) indicated the diagnosis was incorrect and she could not find any information indicating that the resident had a diagnosis of schizophrenia. She changed the order to match the psychiatric notes from when it was prescribed. When she looked at the order, she indicated that it looked like a nurse put in the previous medication order with the diagnosis and when it was changed the next nurse followed suit. 48226 (continued on next page)

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	155484	A. Building B. Wing	12/09/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 12/4/24 at 1:00 p.m., the medical record of Resident 48 was reviewed. Diagnosis included but not limited to, unspecified dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) with anxiety (a feeling of fear, dread, and uneasiness), anxiety disorder, schizoaffective disorder (a chronic mental health condition that involves symptoms of both schizophrenia and a mood disorder like major depressive disorder or bipolar disorder), bipolar type (a mental illness that causes unusual shifts in a person's mood), dependent personality disorder (a mental health condition where a person has an excessive need to be taken care of by others), major depressive disorder recurrent, severe with psychotic symptoms (a group of symptoms that indicate a loss of contact with reality), and obsessive compulsive disorder (a mental disorder that causes people to have unwanted, recurring thoughts and repetitive behaviors that they can't control). A care plan, dated 6/9/22, indicated the resident had a diagnosis of schizoaffective disorder and took an anti-psychotic medication. Intervention included but not limited to, non-pharmacological interventions to encourage resident to participate in activities of interest. Encourage to discuss feelings and staff to offer support and reassurance, and provide a calm environment. A care plan, dated 5/24/23 indicated the resident used anti-psychotic medication for schizoaffective disorder. Interventions included but not limited to, consult with pharmacy/medical provider to consider dosage reduction when clinically appropriate and provide anti-psychotic medication per medical provider's orders. A care plan, dated 8/8/23, indicated the resident had major depressive recurrent severe psychotic features, other specified obsessive compulsive and related disorder, dependent personality disorder, unspecified anxiety disorder, and visual hallucinations. Interventions included but were not limited to, monitor medication administration, notify medical health professional(s) if refusals occur, and ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms. Physician Orders, dated 11/11/23, ordered 1 tablet olanzapine 10 mg (milligrams) by mouth in the morning. A quarterly Minimum Data Set (MDS) assessment, dated 9/13/24, indicated the resident was not coded as to having bi-polar or psychosis disorder. The assessment indicated the resident was on psychotropic medication. The assessment was coded as GDR contraindicated. The assessment indicated that the resident was not cognitively intact and required assistance from the staff for all care needs. The medical record indicated pharmacy reviews had been completed monthly. On 1/6/24 a pharmacy review of psychotropic medication included a physician note indicating the resident had failed gradual dose reductions in the past. A review of psychotropic medication was completed in 7/21/24 and indicated a GDR was refused due to resident having positive mood behaviors. A progress note, dated 7/24/24, indicated a team meeting discussing the GDR for psychotropic medication was completed and the team disagreed with a dose reduction. The record lacked documentation of behaviors presented by the resident supporting the use of psychotropic medication or of clinical GDR related to psychotropic drug use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 2:10 p.m., during an interview, the Psychologist providing care to Resident 48 indicated a Gradual Dose Reduction (GDR) was not attempted for the resident due to failed previous GDR attempts. He indicated when the facility attempted to change the resident's medications the resident's family would take her home and discontinue all medications and then return the resident to the facility. He indicated this was considered a failed GDR. He indicated the resident continued to be symptomatic and acknowledged the supporting documentation was poor. On 12/4/24 at 2:21 p.m., during interview, Licensed Practical Nurse (LPN) 3 indicated the resident was at times fixed on different things, sometimes bodily functions and sometimes a runny nose. The resident wanted to talk about those issues, and she was difficult to re-direct at times. LPN 3 did not know if the resident had any reduction in medication. The documentation of behaviors was under the behavior tab in the medical record. They would also put a narrative in the nurses' notes and it would be recorded as a behavior note. On 12/4/24 at 2:25 p.m., during an interview, Certified Nurse Aide (CNA) 17 indicated documented behaviors would be entered into the Point of Care (POC) charting. The CNA indicated she had not noted any behaviors other than the resident yelled out and they would ask what she needed then she may yell out again. She indicated the resident yelled out instead of using the call light. She indicated the CNA Kardex, which was the assignment record, would indicate what behaviors the resident was being monitored for. On 12/5/2024 at 11:46 p.m., the Regional Director of Clinical Operations (RDCO)provided a document, titled, Medication Management, dated8/2020, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedures .a. For Antipsychotics: If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility should attempt a GDR in two separate quarters (with at lease one month between the attempts) within the first year, unless clinically contraindicated. After the first year the GDR must be attempted at least annually, unless clinically contraindicated .ii. The continued use is in accordance with relevant current standards of practice and the physician document the clinical rational for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating ab underlying medical or psychiatric disorder 3.1-48(b)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 35317 Based on observation, interview, and record review, the facility failed to ensure medication was labeled properly for 1 of 3 medication carts reviewed for medication storage (Resident 51). Findings include: On 12/6/24 at 8:13 a.m., the 200 B hall (front) medication cart contained an undated and opened Novolog (medication used to lower blood sugar) insulin pen. The insulin pen contained a label that indicated it was for Resident 51 and was delivered to the facility on [DATE]. During an interview, on 12/6/24 at 8:14 a.m., Licensed Practical Nurse (LPN) 23 indicated insulin was good for 30 days once opened and she was not aware of how long the Novolog pen for Resident 51 had been opened. During an interview, on 12/6/24 at 8:16 a.m., Licensed Practical Nurse (LPN) 3 indicated insulin pens should have an open date placed on them when they are used. LPN 3 indicated insulin was good for 28 days once opened. Resident 51's record was reviewed on 12/6/24 at 9:00 a.m. The profile indicated the resident's diagnosis included, but were not limited to, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar) with diabetic neuropathy (a type of nerve damage that occurs with diabetes). A physician order, dated 4/17/24, indicated to administer Novolog FlexPen (insulin medication) insulin pen 100 unit/ml (milliliter). Inject 15 units subcutaneously (under the skin) before meals. On 12/6/24 at 10:10 a.m., the RDCO (Regional Director of Clinical Operations) provided and identified a document as a current facility policy, titled, Storage of Medications, with a revised date 8/24. The policy indicated, .5. When the manufacturer has specified a usable duration after opening (.beyond use date), the nurse shall place a open date sticker on the medication and record the date opened and the new date of expiration 3.1-25(j)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35317 Based on observation, interview, and record review, the facility failed to ensure proper handwashing during 2 of 2 dining observations and 1 of 1 kitchen observations and the facility failed to ensure adequate dishwashing temperatures were maintained for 1 of 1 kitchen observations. Findings include: 1a. During a dining observation, on 12/2/24 at 11:59 a.m., Central Supply Aide washed her hands at the sink and tore off a piece of paper towel by unraveling it from a commercial size roll that was on the counter. She left drops of water on the top of the paper towel roll from where she ripped it off with her wet hands. She dried her hands and proceeded to turn off the water faucet with the same paper towel she dried her hands with. She then went to the kitchen window and obtained a tray to serve to a resident. During a dining observation, on 12/2/24 at 12:01 p.m., Certified Nurse's Assistant (CNA) 35 washed her hands at the sink and tore off a piece of paper towel by unraveling it from a commercial size roll that was on the counter. She obtained the paper towel with wet hands and the roll is now wet on top and wet down the side. She threw away the paper towel after drying her hands and lifted the lid of the trashcan with her bare hands, she then proceeded to obtain a lunch tray from the kitchen staff and served it to a resident. During a dining observation, on 12/2/24 at 12:06 p.m., CNA 35 washed her hands at the sink and tore off a piece of paper towel by placing her arm against the roll and ripping the paper towel with her other wet hand. She went to the kitchen window and obtained a tray to serve a resident their lunch. During a dining observation, on 12/2/24 at 12:08 p.m., Licensed Practical Nurse (LPN) 7 washed her hands at the sink and tore off a piece of paper towel by unraveling it from a commercial size roll that was on the counter. She dried her hands and turned off the water faucet with the same paper towel she dried her hands with. She proceeded to throw away the paper towel by lifting the lid of the trash can with her bare hands. She went to the kitchen staff and obtained a lunch tray and served a resident. During a dining observation, on 12/2/24 at 12:13 p.m., Central Supply Aide washer her hands at the sink and tore off a piece of paper towel by unraveling it from a commercial size roll, she dried her hands and turned off the water faucet with the same paper towel she dried her hands with. The paper towel roll contained drops of water on the top of the roll and was discolored on top where it had been previously wet and now dried. 1b. During a dining observation, on 12/5/24 at 11:43 a.m., CNA 35 washed her hands at the sink and tore off a piece of paper towel by holding to top of the roll with her left hand and ripping off a piece of paper towel with her right hand. The paper towel roll was wet on top where she touched it. She threw away the paper towel and began to serve coffee and juice to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 12/5/24 at 11:47 a.m., CNA 35 indicated the facility had a supply issue and was not able to get the sheets of paper towel that was used in the holder, they had to use the big rolls of paper towel for the last few days. During an interview, on 12/5/24 at 1:12 p.m., the Director of Nursing indicated she was not aware the staff were using a commercial paper towel roll in the dining room. She indicated it should not be used in the dining room because it would not be appropriate for proper hand hygiene. During an interview, on 12/5/24 at 1:44 p.m., the Regional Director of Clinical Operations indicated they had ordered the sheets of paper towel for the holder on 12/2/24 but it had not been delivered to the facility yet. She indicated staff should have used hand sanitizer in the dining room to serve trays to prevent contamination, the paper towel roll should not have been used for proper hand hygiene. 34525 2. During observation of pureed food (food prepared in a smooth, thick manner with no lumps that doesn't require chewing or biting before swallowing) preparation, with [NAME] 27, on 12/6/24 at 9:31 a.m., the [NAME] was observed performing handwashing. When he finished hand washing, he was observed to tear a piece of paper towel from a commercial size roll sitting on the counter next to the handwash sink. He touched the paper towel roll with his wet hands and wet marks were observed on the side and top of the paper towel roll. He then was observed to turn off the faucet with the same towel as he used to dry his hands. During an interview, on 12/6/24 at 9:33 a.m., the Dietary Manager (DM) indicated the paper towels for the dispenser were not available. She understood they had been ordered but had not yet been delivered. On 12/5/24 at 3:37 p.m., the Regional Director of Clinical Operations (RDCO) provided a document, with a review date of 6/24/2021, titled, Standard Precautions, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: .Practicing hand hygiene is a simple but effective way to prevent the spread of infections .This facility will adhere to CDC (Centers for Disease Control) guidelines and recommendations for hand hygiene .Procedure: .III. Procedure for Hand Hygiene .B. Using liquid soap and water .6. Dry hands thoroughly with clean paper towel. 7. Turn off faucet with clean, dry paper towel-discard 3. During the initial kitchen tour, on 12/2/24 at 9:51 a.m., the Dietary Manager (DM) indicated the facility used a high temperature dish machine. Observation of the dish machine indicated the wash temperature measured 148 degrees Fahrenheit (F) and the rinse temperature measured 155 F. At the same time, Dishwasher 26 indicated the temperature requirements for the dish machine were 150 F or above for the wash and 180 F for the rinse. The dish machine temperature gauges indicated a proper wash temperature of a minimum of 150 F and a rinse temperature of a minimum of 180 F. A second observation of the dish machine temperatures indicated a wash temperature of 155 F and a rinse temperature of 158 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 12/4/24 at 2:09 p.m., the DM indicated she had contacted the dish machine company on 12/2/24, and they came to the facility to look at the machine. The repair man indicated to her that the temperature had been hit and miss, at staying at the proper temperature. The temperature gauges were replaced. On 12/6/24 at 8:10 a.m., the Regional Director of Clinical Operations (RDCO) provided a service request document, dated 12/2/24. The document indicated the dish machine had been inspected and was found to have significant lime buildup. The temperature gauges were also inspected. A handwritten note, dated 12/2/24, by the DM, indicated the dish machine company had been contacted to inspect the dish machine. The temperature gauge had been replaced. on 12/5/24 at 11:46 a.m., the RDCO provided a document, with a revision dated of 9/2017, titled, Warewashing, and indicated it was the policy currently used by the facility. The policy indicated, .Procedures . 2. All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature .machines 3.1-21(a)(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. 35317 Based on observation, interview, and record review, the facility failed to ensure proper handling of the glucometer (small portable machine that's used to measure how much glucose [type of sugar] is in the blood) meter during medication administration pass for 1 of 4 residents reviewed during medication administration (Resident 51) and the facility failed to maintain a separation of clean and dirty mechanical lift pads and mop heads supplies in the laundry room for 1 of 1 laundry room observations. Findings include: 1. During the medication administration observation, on 12/6/24 at 7:50 a.m., Licensed Practical Nurse (LPN) 23 obtained a glucometer machine from the top of her medication cart and wiped it with an alcohol pad from front to back, she then placed it back down on the medication cart, she grabbed a lancet (medical tool for drawing blood and a cutting instrument used in surgery), test strip (a small disposable plastic strip that measures blood sugar levels), and a alcohol pad and proceeded into Resident 51's room. Upon entering the resident's room, she set the glucometer machine on the bedside table without a barrier underneath. The nurse put on gloves. She attempted to use the glucometer machine but had an error message and was unable to use it. She exited the resident's room and obtained a second glucometer machine from a different medication cart and wiped it down front to back with an alcohol pad. She entered back into the resident's room and set the second glucometer down on the bedside table without a barrier underneath. She obtained the resident's blood sugar and threw the lancet into the trash can in the resident's room. She left the room and placed both glucometers on the medication cart, one on top of the other with no barrier underneath. During an interview, on 12/6/24 at 8:16 a.m., LPN 3 indicated that bleach wipes should be used when cleaning the glucometer machines. Staff should also use a barrier when placing the glucometer on a bedside table since they are not clean. The nurse also indicated that a lancet should always be placed in a sharp container after use. Resident 51's record was reviewed on 12/6/24 at 9:00 a.m. The profile indicated the resident diagnosis included but were not limited to, type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A quarterly Minimum Data Set (MDS) assessment, dated 11/14/24, indicated Resident 51 had severe cognitive impairment and had received insulin injections in the last 7 days. Review of blood sugar logs indicated the nursing staff had obtained Resident 51's blood sugars four times a day. During an interview, on 12/6/24 at 11:30 a.m., the Regional Director of Clinical Operations (RDCO) indicated staff should use bleach wipes to clean glucometer machines and a barrier should be placed underneath when setting them down on a bedside table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/24 at 11:14 a.m., the RDCO provided an undated document, titled, Cleaning & Disinfection of Glucose Meter, and indicated it was the policy currently being used by the facility. The policy indicated, .This facility uses shared devices for glucose testing and will perform cleaning and disinfection procedures for each resident .i. One meter may be in use while the other meter is undergoing disinfection with the high-level antimicrobial wipe for wet contact time per the manufacture's guidelines .iii. Place the wrapped meter in a clean cup on the med cart for the appropriate length of time. iv. Allow meter to air dry prior to use .g. Place all used sharps immediately in the sharps safety disposal box .e. Place a clean barrier on resident bedside table, over bed table or other hard surface area when testing .i. Do not place a contaminated glucometer on top of the medication cart or other surface without a clean protective barrier 48226 2. On 12/6/24 at 2:15 p.m., during a laundry room observation with the Infection Preventionist Nurse and Laundry Supervisor, mechanical lift slings hung in the soiled linen area next to a washer. On 12/6/24 at 2:16 p.m., mop heads and cleaning linens were observed on an uncovered metal cart in the soiled linen area of the laundry room. Two bags of soiled linen were on the floor next to the uncovered cart. On 12/6/24 at 2:18 p.m., during an interview, the Laundry Supervisor indicated the slings were clean and indicated once they were washed they were hung in a covered laundry cart. She acknowledged they were on the soiled linen side of the laundry room. The supervisor indicated the mop heads and cleaning linens were clean but acknowledged they were in the soiled linen area. On 12/6/24 at 2:30 p.m., the Regional Director of Clinical Operations (RDCO) provided a document, titled, Infection Control Practices for Laundry Services, dated 2/24/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: 1. Laundry personnel will .a. Provide the storage, handling and processing of linen activities following practices to decrease the risk of spreading infection and exposure to blood borne pathogens . Folding and Transporting of Clean Linen .Clean linens shall be in a separate room area from soiled linen areas .Laundry area . a. In the laundry, the soiled linen processing area shall be clearly separated from areas where clean linen is handled 3.1-18(a) 3.1-18(b) 3.1-18(b)(1)