STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155495	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paddock Springs	2695 Sheldon Street Warsaw, IN 46582

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49229 Based on record review and interview, the facility failed to notify the physician of medications held for 1 of 1 resident reviewed for physician notification (Resident 4). Finding includes: The clinical record for Resident 4 was reviewed on 10/9/2024 at 1:27 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, chronic kidney disease, heart failure, schizoaffective disorder, psychotic disorder with known delusions, hypertension, bipolar disorder, depression, anxiety, diabetes mellitus, dementia and borderline personality disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 7/18/2024, indicated the resident was taking an antidepressant medication, an antianxiety medication and a diuretic medication. The current Physician's Orders for Resident 4, initiated on 8/22/2023, included Bumetanide medication (diuretic) 1 mg (milligram) 1 tablet orally, twice a day for chronic systolic and diastolic congestive heart failure. A current Care Plan, revised on 7/17/2024, indicated Resident 4 received diuretic medication. Interventions included, but were not limited to: medications per physician orders and report adverse drug reaction as needed. The June 2024 Medication Administration Record (MAR) indicated Resident 4 had the evening Bumetanide dose held due to low blood pressure on the following dates: 6/22/2024 and 6/24/2024. The August MAR indicated Resident 4 had the evening Bumetanide dose held due to low pressure on 8/4/2024. The September MAR indicated Resident 4 had Bumetanide dose held on 9/21/2024 in the evening for low blood pressure, on 9/22/2024 in the morning for low blood pressure and on 9/22/2024 in the evening for a low heart rate. There was no documentation the physician had been notified of the need to hold the Bumetanide medication due to Resident 4's low blood pressure or heart rate. During an interview, on 10/11/2024 at 10:59 A.M., QMA 1 indicated there was no policy or physician orders for parameters to hold diuretics for blood pressure or heart rate for Resident 4. QMA 1 indicated nursing staff should have notified the MD to obtain hold order for the Bumetanide medication. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 10/11/2024 at 1:30 P.M., the Director of Nursing (DON) indicated staff should have notified the provider and documented the notification in the Electronic Medical Record (EMR). On 10/11/2024 at 1:34 P.M., the DON provided a policy titled, Physician: Provider Notification Guidelines, dated 12/31/2023 and indicated the policy was the one currently used by the facility. The policy indicated, ensure the resident's physician or practitioner is aware of .change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care . 3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)

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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. 38845 Based on record review, observation and interview, the facility failed to ensure interventions were in place to prevent a deep tissue injury (DTI) wound after admission for 1 of 2 residents reviewed for pressure ulcers. (Resident 105) Finding includes: The record for Resident 105 was reviewed on 10/10/2024 at 1:37 P.M. Diagnoses included, but were not limited to, right hip fracture, diabetes, chronic congestive heart failure and depression. A Hospital Transfer form, dated 10/4/2024, indicated Resident 105 had no skin issues to his heels at the time he was transferred to the facility. Resident 105 had been hospitalized for an acute right hip fracture with surgical repair. A facility Admission Observation form, dated 10/4/2024, indicated Resident 105's pedal (feet) pulses were present to both feet and the resident had weakness to both lower extremities. Under the section of the form, titled, Skin impairment, Yes was documented and the form indicated an Occurrence progress note was to be completed and include an assessment. There was no skin impairment assessment completed for Resident 105's right heel upon admission. A pressure ulcer risk assessment, dated 10/4/2024, indicated Resident 105 was a low to moderate risk to develop pressure injuries. A Baseline Care Plan, dated 10/4/2024, indicated a goal for the resident not to develop a pressure ulcer, or if a pressure ulcer was present, the wound would not worsen. Interventions included, but were not limited to, turn and reposition for care and use devices to optimize independent repositioning and transfers. There were no interventions to provide pressure relief to the resident's heels. A Wound Management Detail Report, dated 10/4/2024, indicated Resident 105 had a DTI (deep tissue injury, damage to the soft tissue beneath the skin caused by pressure or shear forces) to the right heel that was present on admission. The wound measured 5 cm (centimeter) length x 5 cm width. There was no other description of the wound. Physician's Orders, dated 10/4/2024, included: Skin prep (fast drying protective dressing) to the right heel 3 times a day as a preventative measure. There was also an order for a preventative foam dressing to the right heel and it was to be changed every 3 days. The orders included instructions to provide pressure relief to the resident's right heel. A Care Plan, initiated on 10/6/2024, indicated Resident 105 was at risk for skin breakdown related to: (the area to indicate where the area was located was left blank). Interventions included, but were not limited to, avoid shearing skin during positioning, turning, and transferring, conduct weekly skin assessments, pay particular attention to resident's bony prominences, encourage and assist the resident to turn and reposition for comfort and as needed and to keep bed linens clean and dry. The plan did not specifically include interventions to prevent pressure on the resident's heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, initiated on 10/10/2024, indicated the resident had a pressure ulcer, DTI, to the right heel. Interventions included, but were not limited to: Assess and record the condition of the skin surrounding the pressure ulcer, administer analgesics per physicians order, observe and report signs of infection (e.g., localized pain, redness, swelling, tenderness, drainage, odor, and fever), observe for and report signs of pain related to the pressure ulcer, pressure reducing cushion to the wheelchair, treatment per physicians order, notify physician if treatment is not effective, weekly skin assessment, measurement and observation of the pressure ulcer and record, keep the resident as clean and dry as possible, minimize skin exposure to moisture and use a lifting device as needed for bed mobility (e.g. lift sheet, etc.) There were no specific interventions to ensure pressure relief to the resident's right heel. An NP Progress Note, dated 10/11/2024, indicated the resident had undergone a right hip replacement on 9/28/2024. The facility's wound nurse had called and discussed concerns regarding a possible DTI for Resident 105 on 10/6/2024. The wound NP indicated she had given the facility's wound nurse recommendations for the skin prep treatment and routine offloading procedures. The note indicated when she had assessed the resident on 10/11/2024, she noted a stage II pressure ulcer to the resident's right heel. She wrote treatment orders and recommended off-loading heel booties. During an observation, on 10/11/2024 at 9:32 A.M., Resident 105 was observed with shoes on both feet, seated in his wheelchair. The resident's shoes were positioned on the footrest pedals of the wheelchair. During an observation, on 10/11/2024 at 10:40 A.M. with the Wound Nurse Practitioner (NP) and the facility wound nurse, the following was observed on Resident 105's right heel: an opened wound approximately 5 cm (length) x 5 cm (width) with red granulation tissue and specs of a dark purple/black color in the middle and along the right side of the wound bed. The open wound had a white ring around the outside edge of the wound. The Wound NP indicated the area did not have any dead/necrotic tissue and staged it as a stage II pressure ulcer (an open sore or blister that indicated partial thickness loss of the skin). During an interview, on 10/11/2024 at 1:25 P.M., the Director of Nursing (DON) indicated the pressure area to the heel was not present on admission. The nurse had made a mistake when she documented it as present on admission as an ulcer. There was no other documentation in the chart that indicated the DTI was found on admission. The DON indicated the nurse realized she had coded the wound incorrectly on the Wound Management Detail Report, completed on 10/4/2024. The nurse had contacted the Wound NP and the wound should have been identified as in-house acquired. When questioned as to why the current care plan for the foot ulcer did not include specific interventions to prevent pressure on the resident's heels, such as floating his heels, the DON indicated the resident's mattresses were pressure relieving. During an observation, on 10/15/2024 at 12:02 P.M., Resident 105 was seated in the dining room with his feet covered with regular socks and his heels/feet resting on the floor. During an interview, on 10/15/2024 at 1:47 P.M., Resident 105 indicated he wore socks on his feet when he went to bed, but did not wear anything else on his feet. Resident 105 did not indicate staff ever placed a pillow underneath his lower legs to elevate his heels or staff placed booties on his feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 10/16/2024 at 9:03 A.M., Resident 105 was observed in his wheelchair. His right foot was resting on the floor with a foam dressing adhered to the middle of his foot and his heel exposed. There were no offloading booties in his room, even though the NP had recommended them on 10/11/2024. During an interview, on 10/16/2024 at 9:05 A.M., RN 5 indicated there were no booties located in the room and the resident should have had a bootie on his right foot. On 10/11/2024 at 2:45 P.M., the Director of Nursing provided the policy titled, Guidelines for Pressure Prevention, dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated . To maintain good skin integrity and avoid development of pressure ulcers. Care plan interventions shall be implemented based on risk factors identified in the nursing assessment. Interventions may include, but not be limited to: .float heels as needed .Elevate heels off the bed- avoid use of heel protectors On 10/11/2024 at 2:45 P.M., the Director of Nursing provided the policy titled, Guidelines for General Wound and Skin Care, dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated .5. Evaluate the need for a pressure reduction surface for bed/chair .or float heels/boots 3.1-40

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38845 Based on record review and interview, the facility failed to administer a physician ordered medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 12) Finding includes: The record for Resident 12 was reviewed on 10/11/2024 at 10:17 A.M. Diagnoses included, but were not limited to: heart failure, dementia, anxiety, depression and Bipolar disorder. The current Physician's orders for Resident 12 included an order for the resident to receive Lorazepam 0.5 mg daily for anxiety and agitation. The Medication Administration Record (MAR), dated August 2024, indicated the resident was to receive Lorazepam 0.5 mg daily for anxiety and agitation. The MAR indicated the resident did not receive the ordered Lorazepam from 8/4/2024 through 8/12/2024. On the section labeled Reasons/Comments was documented Med Not Available, from 8/4/2024 to 8/12/2024, for the Lorazepam. During an interview, on 10/15/2024 at 10:26 A.M., the Director of Nursing indicated the physician should have been notified of the missed doses. During an interview, on 10/15/2024 at 1:38 P.M., the Director of Nursing indicated the nurse should have obtained the medication from the facility's Emergency Drug Kit (EDK) and called the Pharmacy. During an interview, on 10/15/24 at 1:49 P.M., LPN 11 indicated if a medication was not available in the medication cart, she would get in the EDK (emergency drug kit) to get the medications or call the pharmacy. On 10/15/2024 at 4:05 P.M., the Director of Nursing provided the policy titled, Unavailable Medications, undated, and indicated the policy was the one currently use by the facility. The policy indicated .The facility must make every effort to ensure that medications are available to meet the needs of each resident .B. Facility personnel shall: 1). Notify the attending physician of the situation and explain circumstances, expected availability and optional therapy(ies) that are available . 2). Obtain a new order and cancel/discontinue the order for the non-available medication. 3). Notify the pharmacy of the replacement order 3.1-25(a)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45120 Based on interview and record review, the facility failed to clarify conflicting hospital discharge orders and previous medication orders for appropriate dosing of a blood pressure medication. This deficient practice resulted in a significant medication error which required hospitalization for 1 of 3 residents reviewed for hospitalization . (Resident 9) Finding includes: A record review was completed for Resident 9 on 10/10/2024 at 8:29 A.M. Diagnoses included, but were not limited to: congestive heart failure, hypertensive heart disease with heart failure, and essential hypertension Resident 9's record indicated she returned to the facility on [DATE] at 1:30 P.M. after a hospitalization for sepsis, urinary tract infection and acute kidney injury. A hospital Discharge Documentation form, dated 6/24/24, was provided to the facility from the hospital for her readmission to the facility. The form listed Resident 9's hospital discharge medications, including the following medication order: lisinopril (medication to treat high blood pressure) 20 milligrams, one-half tablet (10 mg) every day. There was another section of the form titled Discharge Plan which stated lisinopril 20 milligrams 40 milligrams equals two tablets daily. The Medication Administration Record (MAR), dated June 2024, indicated an order for lisinopril 40 milligrams, 2 tablets (80 mg). Lisinopril 80 milligrams was marked as administered to the resident on 6/25/2024 and 6/26/2024. On 6/26/2024, the order was discontinued and a new order for lisinopril 40 milligrams, administer 10 milligrams once a day was written. This dose was given on 6/27/2024. A Nurse's Note, dated 6/27/2024 at 2:10 P.M., indicated Resident 9 was lethargic, could not keep her eyes open, her blood pressure continued to drop and she had increased shortness of breath. An order was received to send Resident 9 to the emergency room for an evaluation and treatment. A History and Physical Report from the hospital, dated 6/27/2024, indicated the Emergency Medical Services (EMS) reported Resident 9 had altered mental status, bradycardia (slow heartbeat) and hypotension (low blood pressure). Resident 9 was found with a systolic (top number of a blood pressure reading indicating maximum pressure in the arteries) blood pressure of 60, a heart rate of 30, and the EMS administered atropine 0.5 milligrams resulting in an increase of her blood pressure to 75/36 mmHg (millimeters of mercury) and pulse to 50 bpm (beats per minute). The report indicated the nursing home staff had reported Resident 9's blood pressure had been running low since her readmission to the facility with the systolic blood pressure ranging from 103-121. The staff also reported Resident 9 had blood pressures of 95/61 mmHg and 96/60 mmHg. The staff reported Resident 9's blood pressure had dropped to 98/50 mmHg and her lisinopril medication had been held on 6/25/2024 and 6/26/2024. The report indicated there was significant confusion regarding the Discharge Documentation and the lisinopril dosage. Resident 9 was readmitted to the hospital on 6/27/24 with diagnoses including, but not limited to: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- Hypotension secondary to medications with subsequent bradycardia and hypotension with a degree of dehydration. - Acute kidney injury due to hypoperfusion with bradycardia and hypotension and most likely a degree of dehydration. A Minimum Data Set (MDS) assessment, dated 9/24/2024, indicated Resident 9 had moderate cognitive impairment. During an interview, on 10/11/2024 at 10:54 A.M., Pharmacy Technician 26 indicated on 6/25/2024, the pharmacy dispensed lisinopril 40 milligrams 2 tablets for Resident 9's daily medication packaging. During an interview, on 10/15/2024 at 9:14 A.M., RN 5 indicated when Resident 9 returned from the hospital on 6/24/2024, there were many discrepancies with her medications. Resident 9 was on lisinopril 10 milligrams prior to her hospitalization and should have been on 10 milligrams when she returned to the facility, but another nursing staff member had erroneously transcribed the order for 80 milligrams from the discharge plan. RN 5 indicated the staff should have used the Discharge Documentation orders, not the Discharge Plan for readmission physician orders. Resident 9 was sent back to the hospital for low blood pressures mixed with her other co-morbidities. A professional reference from the National Library of Medicine, https://www.ncbi.nlm.nih.gov/books/NBK482230/, indicated the recommended initial adult dose of lisinopril was 10 mg daily and could be increased to 40 mg daily. Potential side effects included impaired renal (kidney) function and hypotension. A professional reference at Mayoclinic.org indicated the same adult dosing parameters of 10 - 40 mg per day with the added geriatric warning: . elderly patients are more likely to have age-related kidney problems, which may require caution and an adjustment in the dose for patients receiving lisinopril. A policy, titled Guidelines for Medication Orders, was provided by the Director Nursing as current on 10/15/2024 at 1:14 P.M., and was. The policy indicated, .Procedures .2. A current list of orders will be maintained in the electronic clinical record of each resident .4. Medication orders a. When recording medication orders specify: 1. The type, route, dosage, frequency, strength, of the medication and reason 3.1-48(c)(2)

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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. 38845 Based on observation, interview and record review, the facility failed to ensure infection control practices were followed related to lack of changing gloves and handwashing during perineal care and when administering insulin for 1 of 1 resident observed for incontinence care and 1 of 1 resident observed for insulin injection. (Resident 15) Findings include: 1. During an observation, on 10/10/2024 at 7:25 A.M. Certified Nursing Assistant (CNA) 7 was observed to provide incontinence/catheter care to Resident 15. She washed her hands and donned gloves. She used a washcloth and cleaned the catheter. CNA 7 turned the resident over to her right side, and with wet wipes, she washed the residents' buttocks. There was a smear of feces around the resident's rectum. She then placed the dirty wipes on the soiled brief and removed the brief. Lastly, the aide applied a clean brief and pulled up the resident's pants. CNA 7 then removed her gloves and placed them in the trash can and washed her hands. During an interview, CNA 7 indicated she should have removed her gloves and washed her hands after washing the resident's buttocks. 2. During an observation on 10/10/2024 at 8:55 A.M., QMA 8 washed her hands and donned gloves. She cleansed an area on the resident's right lower abdomen with an alcohol pad and with an opened hand, she fanned the area she had just cleansed During an interview, on 10/10/2024 at 8:56 A.M., QMA 8 indicated she should not have fanned the area. On 10/25/2024 at 4:05 P.M., the Director of Nursing provided the policy titled, Perineal Care for Incontinence, dated 12/31/2023, and indicated the policy was the one currently used by the facility. The policy indicated .7. Pay particular attention to infection prevention and control techniques when performing pericare, to prevent the introduction of contamination that may lead to a urinary tract infection A policy for glove use was requested but none was not provided prior to the survey exit. On 10/15/2024 at 4:05 P.M., the Director of Nursing provided a policy titled, Injectable Medication Administration, with a revision date of 11/2018, and indicated the policy was the one currently used by the facility. The policy indicated: .Expose the area to be injected and clean with an alcohol wipe 3.1-18(b)(1)