

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155496	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2024
NAME OF PROVIDER OR SUPPLIER  Valley View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  333 W Mishawaka Rd Elkhart, IN 46517	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38845</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 resident's Level One PASARR (Preadmission Screening and Resident Review) assessment was completed accurately and failed to complete an updated Level 1 review. (Resident 66)</p> <p>Finding includes:</p> <p>A record review was completed on 4/18/2024. Resident 66 was admitted on [DATE].</p> <p>The resident's March and April 2023 medication orders included the medication Quetiapine (antipsychotic) 50 mg (milligrams) 1 tablet by mouth nightly for psychosis.</p> <p>The Medication Administration Records (MARs), dated March and April 2023, indicated the resident had received the antipsychotic medication daily.</p> <p>A Preadmission Screening and Resident Review form, dated 4/7/2023, indicated Resident 66's diagnoses included major depressive disorder and dementia. There were no known mental health behaviors that affect interpersonal interactions. There were no known or suspected developmental conditions or diagnoses that affects intellectual and /or adaptive functioning. Mental Health Medications- List any antidepressants, mood stabilizers, antipsychotics, or other mental health medications prescribed currently or other mental health medications prescribed currently or within the past 6 months. No medications were listed on the form.</p> <p>A Notice of PASARR Level 1 Screen Outcome form, dated 4/7/2023, indicated Resident 66's Level 1 PASARR showed no Level II was required to be completed. The Algorithm outcome indicated: Rationale: The Level 1 screen indicates that a PASARR disability is not present because of the following reason: There is no evidence of a PASARR condition of an intellectual /developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be completed.</p> <p>During an interview on 4/24/2024 at 11:29 A.M., the Corporate Nurse indicated the Level 1 was not completed accurately and a new Level 1 should have been completed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/24/2024 at 8:37 A.M., the Corporate Nurse provided the policy titled, PASRR- Pre-admission screening and resident review, dated 8/14/2020, and indicated the policy was the one currently used by the facility. The policy indicated, . PASRR regulation requires resident reviews when there is a significant change in a NF residents's physical or mental condition</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38845</p> <p>Based on record review, observation and interview, the facility failed to develop comprehensive/person centered care plans for residents with behaviors and dementia care, for 6 of 23 residents whose care plans were reviewed. (Residents 66, 17, 77, 5, E &amp; F)</p> <p>Findings include:</p> <p>1. A record review was completed on 4/22/2024 at 10:27 A. M. Resident 66's diagnoses included, but were not limited to, dementia, depression anxiety, mood disorder and psychosis.</p> <p>A Quarterly MDS (Minimum Data Set) assessment, dated 3/18/2024, indicated the resident was moderately cognitively impaired.</p> <p>A current Care Plan, dated 3/27/2023, indicated the resident was at risk for Psychosocial well-being related to: Adjustment to new admission, Anxiety, Loss of Independence, dementia with behavioral disturbances, paranoia, auditory hallucinations, anxiety, and depression.</p> <p>A current Care Plan, dated 4/2/2023, indicated the resident had a behavior problem related to Psychosocial issues, dementia with behavioral disturbances, auditory hallucinations, agitation, anxiety, depression, paranoia, adjustment to new facility, history of saying she is here to work; now ready to go home; history of layering her clothing; history of disorganized thoughts; history of putting clothing in room trash can; history of expressions of frustrations to others. Packs personal belongings and repeatedly asks to leave. Exit seeking behavior, asking for the door codes and a history of repeating questions. At times redirection is unsuccessful. She prefers to wear make up and likes to put it on herself. History of pulling peers hair and pushing peer.</p> <p>Interventions included, but were not limited to: Administer medications as ordered. Observe and document signs/symptoms, and effectiveness and side effects. Educate resident / resident representative to medication effectiveness and side effects. Approach, speak in calm manor. Behavioral health consults as needed. Communicate with resident / resident representative regarding behaviors, and treatment. Encourage active support by family / resident representatives. Encourage Resident to express feelings. Encourage resident to participate in activities of choice. Encourage to maintain as much independence and control / decision making as possible. Intervene as necessary to protect the rights and safety of others. Minimize potential for disruptive behaviors by offering tasks that divert attention. Monitor behavioral episodes, and attempt to determine underlying causes. Observe and anticipate resident's needs: thirst, food, body positioning, pain, toileting needs. Offer resident activities of books, magazines, and if applicable with time and weather out side walks. Praise any indication of progress in behaviors.</p> <p>During an interview, on 4/22/2024 at 2:02 P.M., the Corporate Nurse indicated the care plan was not person centered and should have been.</p> <p>49994</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. A clinical record review was completed on 4/19/2024, at 11:51 A.M. Resident 17's diagnoses included, but were not limited to: Cerebral palsy, Type 2 diabetes, depression, anxiety, hallucinations, and dementia.</p> <p>A current Care Plan, dated 8/30/2021, indicated the resident had a behavior problem related to dementia as evidence by, repetitively packing her belongings and staying in her room, sitting on the floor, believing there were bugs in her toes, picking her toenails off, yelling at people who were not there, talking to and carrying a doll. Interventions included, but were not limited to, administer medications as ordered, observe and document signs and symptoms of effectiveness and side effects of medications, educate resident and resident representative on medication, speak in a calm manor, communicate with resident regarding behaviors and treatment, encourage active support, encourage resident to express feelings, encourage resident to participate in activities, and encourage resident to maintain as much decision making as possible.</p> <p>During an interview, on 4/22/2024 at 1:59 P.M., the Corporate Infection Prevention Nurse indicated the care plans were not person centered and they should have been.</p> <p>3. A clinical record review was completed on 4/18/2024 at 3:08 P.M. Resident 77's diagnoses included, but were not limited to: Alzheimer's, dementia, major depressive disorder, psychosis, hallucinations, and psychotic disorder with delusions.</p> <p>A Care Plan, dated 10/27/2023, indicated the resident had the potential to urinate and defecate on floors, become aggressive with care, a history of becoming physically and verbally aggressive, and a history of inappropriate boundaries. Interventions included but were not limited to 1:1 at all times with a staff, speak in a calm manner, intervene as necessary, minimize potential for disruptive behaviors by offering tasks that divert attention, observe and anticipate resident's needs, observe behavioral episodes and attempt to determine the underlying cause.</p> <p>During an interview, on 4/22/2024 at 1:59 P.M., the Corporate Infection Prevention Nurse indicated the care plans were not person centered and they should have been.</p> <p>48145</p> <p>4. During an interview on 4/18/2024 at 10:05 A.M., Resident 5 became frustrated when she could not remember what she had eaten for breakfast. Resident 5's frustration was eased when asked about her child.</p> <p>A record review was completed on 4/19/2024 at 3:15 P.M. Resident 5's diagnoses included, but were not limited to: dementia, anxiety disorder, major depressive disorder, post traumatic stress disorder, chronic pain, and delusional disorders.</p> <p>A current Care Plan, dated 3/14/2024, indicated Resident 5 had a behavior problem related to disease process, family dynamic, loss of independence, nursing home admission, pain and psychosocial issues. The interventions were: observe and anticipate resident's needs: thirst, food, body positioning, pain and toileting needs, and praise any indication of progress in behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A current Care Plan, dated 3/21/2024, indicated Resident 5 had impaired cognitive function related to dementia. The interventions were: encourage resident to be involved in daily decision making and keep routine as consistent as possible in order to decrease confusion.</p> <p>During an interview on 4/22/2024 at 10:05 A.M., Qualified Medication Aide (QMA) 12 indicated Resident 5 did exhibit frustration over being confused sometimes and the staff used the resident's Care Plan to identify interventions to help her. QMA 12 was not able to identify interventions in Resident 5's Care Plan that were person-centered.</p> <p>An interview with the Corporate Nurse was completed on 4/22/2024 at 10:30 A.M. The Corporate Nurse indicated Resident 5 did not have person-centered interventions for the Care Plans.</p> <p>5. During an observation on 4/18/2024 at 10:07 A.M., Resident E's hair was oily and she had long fingernails on both of her hands. Resident E's finger nails were dirty on her right hand.</p> <p>An observation of Resident E was completed on 4/19/2024 at 9:45 A.M. Resident E's hair was oily and she had long fingernails on both of her hands. Resident E's finger nails were dirty on her right hand.</p> <p>Resident E's record review was completed on 4/22/2024 at 9:00 A.M. Resident E's diagnoses included, but were not limited to: vascular dementia, major depressive disorder, mood disorder, anxiety disorder, cerebral vascular accident, contracture of left wrist and left hand, and contracture of muscle of left lower leg and left lower hand.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 2/17/2024, indicated Resident E had severe cognitive impairment, had rejected care 1-3 days and was dependent on staff for bathing and personal hygiene.</p> <p>Resident E's record included documentation she had received bed baths on 4/1/2024, 4/4/2024, 4/8/2024, 4/15/2024, and 4/18/2024, but lacked the documentation that she had refused hair or nail care during any bed baths.</p> <p>A current Care Plan, dated 12/1/2023, indicated Resident E had an Activities of Daily Living self care performance deficit, required assistance with Activities of Daily Living and had a history of refusing nail care from staff. The interventions included, but were not limited to: Resident E is dependent for shower or bath and helper does all of the effort, and Resident E is dependent for personal hygiene care and helper does all of the effort.</p> <p>During an interview on 4/19/2024 at 10:44 A.M., CNA 6 indicated hair and nail care were performed during showers and bed baths. Residents were allowed to refuse care, but staff would make three attempts to complete showers, baths, hair and nail care. CNA 6 indicated the third attempt was done with a nurse, and if the resident still rejected care, the number of attempts and refusal for care was documented on the shower sheets.</p> <p>During an interview on 4/19/2024 at 10:50 A.M., the Director of Nursing indicated there were no shower sheets in the shower book for Resident E.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Corporate Nurse was completed on 4/22/2024 at 10:34 A.M. The Corporate Nurse indicated Resident E did not have person-centered interventions for the Care Plan to address rejection of care.</p> <p>6. During an interview on 4/19/2024 at 10:20 A.M., Resident F indicated she did not always receive two showers a week. Resident F's hair appeared dirty and a strong smell of body odor was observed during the interview.</p> <p>Resident F's record review was completed on 4/19/2024 at 11:23 A.M. Her diagnoses included, but were not limited to: chronic obstructive pulmonary disease, major depressive disorder, asthma, chronic respiratory failure with hypoxia, vertigo, bipolar disorder, congestive heart failure and chronic pain.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 3/9/2024, indicated Resident F had intact cognition and required maximal assistance for showering and personal hygiene.</p> <p>Documentation indicated Resident E received a shower on 4/3/2024 and 4/10/2024, but refused a shower on 4/6/2024, 4/13/2024 and 4/17/2024.</p> <p>A current Care Plan, dated 2/20/2024, indicated Resident F had impaired skin integrity or is at risk of altered skin integrity related to congestive heart failure, body size, and morbid obesity, and often refuses showers. The interventions included, but were not limited to: complete [NAME] at risk assessment upon admission, readmission, quarterly, and as needed and complete weekly skin checks.</p> <p>During an interview on 4/19/2024 at 10:44 A.M., CNA 6 indicated hair and nail care were performed during showers and bed baths. Residents were allowed to refuse care, but staff would make three attempts to complete showers, baths, hair and nail care. CNA 6 indicated the third attempt was done with a nurse, and if the resident still rejected care, the number of attempts and refusal for care was documented on the shower sheets.</p> <p>The shower sheets for Resident F were requested from the Director of Nursing on 4/19/2024 at 10:50 A.M., but none were provided prior to exiting the survey.</p> <p>An interview with the Corporate Nurse was completed on 4/22/2024 at 10:36 A.M. The Corporate Nurse indicated Resident F did not have person-centered interventions for the Care Plan to address rejection of care.</p> <p>On 4/22/2024 at 1:57 P.M., an undated policy was received from the Corporate Nurse, titled, Plan of Care Overview, and identified as the policy currently used by the facility. The policy indicated, .the Plan of Care, also Care Plan is written treatment provided for a resident that is resident-focused and provides for optimal personalized care . planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to their daily routines</p> <p>This citation relates to Complaint IN00431942.</p> <p>3.1-35(a)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48145</p> <p>Based on observation, record review and interview, the facility failed to ensure residents requiring assistance with Activities of Daily Living (ADL) receive adequate assistance with hair and nail care and bathing for 2 of 5 residents reviewed for ADLs. (Residents E and M)</p> <p>Findings include:</p> <p>1. During an observation on 4/18/2024 at 10:07 A.M. Resident E's hair was oily and she had long fingernails on both her hands. Resident E's finger nails were dirty on her right hand.</p> <p>An observation of Resident E was completed on 4/19/2024 at 9:45 A.M. Resident E's hair was oily and she had long fingernails on both her hands. Resident E's finger nails were dirty on her right hand.</p> <p>Resident E's record review was completed, on 4/22/2024 at 9:00 A.M. Resident E's diagnoses included, but were not limited to: vascular dementia, major depressive disorder, mood disorder, anxiety disorder, cerebral vascular accident, contracture of left wrist and left hand, and contracture of muscle of left lower leg and left lower hand.</p> <p>A Quarterly Minimum Data Set (MDS) assessment , dated 2/17/2024, indicated Resident E was dependent on staff for bathing and personal hygiene.</p> <p>Resident E's record included documentation she had received bed baths on 4/1/2024, 4/4/2024, 4/8/2024, 4/15/2024, and 4/18/2024.</p> <p>Resident E's record lacked the documentation to indicate she had refused hair or nail care.</p> <p>A current Care Plan, dated 10/6/2020, indicated Resident E had contractures and impaired functional range of motion of left side related to cerebral vascular accident. The interventions included, but were not limited to: daily hand washing, and weekly nail care.</p> <p>A current Care Plan, dated 12/1/2023, indicated Resident E had an ADL self care performance deficit, required assistance with ADL's and had a history of refusing nail care from staff. The interventions included, but were not limited to: Resident E is dependent for shower or bath and helper does all of the effort, and Resident E is dependent for personal hygiene care and helper does all of the effort.</p> <p>During an interview on 4/19/2024 at 10:44 A.M., CNA 6 indicated hair and nail care were performed when a shower or bed bath was given. If a resident refused a bed bath, shower, hair or nail care, CNA 6 would try again at a later time. If the resident still refused care, CNA 6 would have the nurse try to convince the resident to accept care. If the resident still refused care on the third attempt, the refusal and number of attempts would be documented on the residents shower sheets. CNA 6 indicated Resident E's hair was dirty and her fingernails were long on both hands and finger nails were dirty on the right hand.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 4/19/2024 at 10:50 A.M., The Director of Nursing indicated there were no shower sheets in the shower book for Resident E.</p> <p>38845</p> <p>2. During an observation on 4/18/2024 at 10:53 A.M., Resident M had a large growth of whiskers and needed to be shaved.</p> <p>A record review for Resident M was completed on 4/22/2024 at 2:38 P.M. Diagnoses included, but were not limited to dementia, protein malnutrition and Wernicke's encephalopathy.</p> <p>A Significant Change MDS (Minimum Data Set) assessment, dated 3/15/2024, indicated the resident required staff assist for all ADLs (activities of daily living) and it was very important to choose between a tub bath, shower or bed baths.</p> <p>A current Care Plan, dated 3/27/2024, indicated the resident had an ADL self care performance deficit related to requires assistance with ADLs, disease process due to weakness, and encephalopathy.</p> <p>Resident M's shower documentation, from 3/1/2024 to 4/21/2024, indicated the resident had received a shower on 3/2, 3/9, 3/16, 4/3 and 4/6/2024. A bed bath on 4/13 and refused on 4/20/2024. On dates: 3/6, 3/13, 3/20, 3/27, and 3/30/2023, NA (not applicable) was documented.</p> <p>During an interview on 4/19/2024 at 11:18 A.M., CNA 3 indicated staff had to attempt care 3 times, then tell the nurse, and it should be documented on the sheet when residents refuse care.</p> <p>During an interview on 4/22/2024 at 10:02 A.M., QMA 4 indicated the Resident M would refuse care at times.</p> <p>During an interview on 4/24/2024 at 9:03 A.M., the Corporate Nurse indicated the resident should have received 2 showers per week.</p> <p>On 4/24/2024 at 9:15 A.M., the Corporate Nurse provided the policy titled, Routine Nursing Care, undated, and indicated the policy was the one currently used by the facility. The policy indicated .Routine Resident Care: care that is not necessarily medically or clinically based but necessary for quality of life promoting dignity and independence, as appropriate . 3. Routine care by a nursing assistant included but is not limited to the following: i. Assisting or provides personal care. 1. bathing</p> <p>On 4/24/2024 at 11:30 A.M., the Corporate Nurse provided the policy titled, Nail and Hair Service, and indicated the policy was the one currently used by the facility. The policy indicated .This facility will provide routine care for resident hygiene and for the psychosocial well being of the resident .routine care also includes nail hygiene services including routing trimming, cleaning and filing .a. Residents will have routine nail hygiene and hair hygiene as part of the bath or shower</p> <p>This citation relates to Complaint IN00431942.</p> <p>3.1-38(a)(3)</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>48145</p> <p>Based on observation, record review and interview, the facility failed to maintain oxygen equipment in a sanitary manner related to a dirty air filter on an oxygen concentrator for 1 of 2 residents who were reviewed for the use of oxygen. (Resident 21)</p> <p>Finding includes:</p> <p>An observation of Resident 21 was completed on 4/17/2024 at 02:52 P.M. Resident 21 was wearing a nasal cannula connected to an oxygen concentrator. The oxygen concentrator's filter had a thick layer of dust.</p> <p>During an observation on 4/19/2024 at 1:30 P. M., Resident 21 was wearing a nasal cannula connected to an oxygen concentrator. The oxygen concentrator's filter had a thick layer of dust.</p> <p>During an observation of Resident on 4/22/2024 at 2:14 P.M., Resident 21 was wearing a nasal cannula connected to an oxygen concentrator. The oxygen concentrator's filter had a thick layer of dust.</p> <p>A record review for Resident 21 was completed on 4/22/2024 at 2:45 P.M. His diagnoses included, but were not limited to: chronic respiratory failure with hypoxia, congestive heart failure, and chronic obstructive pulmonary disease.</p> <p>A Physician's Order, dated 11/6/2023, indicated to administer oxygen at 2 to 4 liters for shortness of breath.</p> <p>A Physician's Order, dated 11/12/2023, indicated to clean the oxygen concentrator filter with soap and water weekly and as needed, at bedtime every Sunday.</p> <p>During an interview on 04/24/2024 at 9:37 A.M., LPN 5 indicated the oxygen concentrator's filter was dirty.</p> <p>During an interview on 04/24/2024 at 10:30 A.M., the Corporate Nurse indicated the filter on oxygen concentrator should have been cleaned weekly.</p> <p>On 4/24/2024 at 10:27 A.M., an undated policy was received from the Corporate Nurse, titled, Oxygen Therapy Using Concentrators, and identified as the policy currently used by the facility. The policy indicated . III. Care and Maintenance a. Filters and machines are to be cleaned once a week: i. Perform hand hygiene and done gloves ii. Remove filter iii. Rinse with running water until clean iv. Squeeze water from filter v. Dry with towel (cloth or paper)</p> <p>3.1-18(b)</p>

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NAME OF PROVIDER OR SUPPLIER  Valley View Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  333 W Mishawaka Rd Elkhart, IN 46517	

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>48145</p> <p>Based on interview and record review the facility failed to assess a resident upon return from dialysis procedures for 1 of 1 resident reviewed for dialysis. (Resident 34)</p> <p>Finding includes:</p> <p>A record review for Resident 34 was completed on 4/19/2024 at 2:08 P.M. Diagnoses included, but were not limited to, end stage renal dialysis and dependence on dialysis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 2/26/2024, indicated Resident 34's cognition was intact and she received dialysis services.</p> <p>Physician orders included, but were not limited to:</p> <ul style="list-style-type: none"> <li>- 4/29/2022 Obtain pre-dialysis weight, and post dialysis weights on every Monday, Wednesday, and Friday, related to end stage renal disease.</li> <li>- 8/25/2022 Dialysis Monday, Wednesday, and Friday at [name of] Dialysis Center.</li> </ul> <p>A Care Plan problem, initiated on 10/6/2020 and revised on 6/21/2023, indicated Resident 34 had end stage renal disease and required hemodialysis with the potential for complications. Interventions included, but were not limited to:</p> <ul style="list-style-type: none"> <li>-If the resident refuses to go to dialysis, provide education as to the risks of skipping treatment i.e., hyperkalemia, cardiac arrhythmias, risk for cardiac failure, hyperphosphatemia, weakening of bones, increased risk for heart disease.</li> <li>-Monitor vital signs and report abnormal findings to medical provider, nephrologist, dialysis center, resident and/or resident representative.</li> </ul> <p>Post-dialysis evaluations were not completed on the following dates:</p> <p>1/3/24</p> <p>1/5/24</p> <p>1/8/24</p> <p>1/10/24</p> <p>1/15/24</p> <p>1/19/24</p> <p>1/22/24</p> <p>(continued on next page)</p>

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F 0698  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>1/24/24</p> <p>1/26/24</p> <p>1/29/24</p> <p>2/2/24</p> <p>2/5/24</p> <p>2/7/24</p> <p>2/9/24</p> <p>2/12/24</p> <p>2/16/24</p> <p>2/19/24</p> <p>2/26/24</p> <p>During an interview on 4/23/2024 at 2:35 P.M., LPN 5 indicated a post-dialysis assessment should be done each time a resident returned from dialysis.</p> <p>During an interview on 4/23/2024 at 2:38 P.M., LPN 13 indicated he looked at dialysis paperwork and documented on the post-dialysis assessment each time a resident returned from dialysis.</p> <p>During an interview on 4/24/2024 at 9:35 A.M., the Corporate Nurse indicated that post-dialysis assessments were not completed upon return to the facility on the dates listed above.</p> <p>A current policy titled Hemodialysis Care and Monitoring provided by the Corporate Nurse, on 4/24/2024 at 8:45 A.M., included, but was not limited to, 37b. Nurse to complete the post-dialysis evaluation upon return from dialysis center</p> <p>3.1-37(a)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>38845</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication cart was kept locked when unattended during a random observation of the medication cart. This had the potential to affect the 22 residents residing on the memory care unit. (400 Hall Medication Cart)</p> <p>Finding includes:</p> <p>During a random observation on 4/18/2024 at 11:10 A.M., the 400 hall medication cart on the memory care unit was unlocked with no staff in the vicinity.</p> <p>During an interview on 4/18/2024 at 11:12 A.M., LPN 14 indicated the cart should have been locked.</p> <p>On 4/24/2024 at 8:37 A.M., the Corporate Nurse provided the policy titled, Storage of Medications, dated 8/2020, and indicated the policy was the one currently used by the facility. The policy indicated .Medications and biologicals are stored safely, securely, and properly . 2. Medication rooms, carts and medication supplies are locked when they are not attended by persons with authorized access</p> <p>3.1-25(m)</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>49994</p> <p>Based on observation, interview, and record review, the facility failed to provide residents with appropriate serving sizes for 1 of 4 residents reviewed for pureed meals.</p> <p>Finding includes:</p> <p>During an observation of the dining room on 4/17/2024 at 12:55 P.M., there were four residents who received pureed meals. When the last resident received their meal, QMA 4 removed the lid of the bowl and there was approximately one tablespoon of green beans in the resident's bowl.</p> <p>During an interview, on 4/17/2024 at 12:56 P.M., QMA 4 indicated there was not 1/2 cup of pureed green beans in the bowl.</p> <p>During an interview on 4/17/2024 at 1:25 P.M., the Dietary Manager (DM) indicated the portion of green beans that was served was not a full serving of 1/2 cup. After telling the cook to remove what was in the bowl and then scoop out a full amount of the green beans, the DM indicated the amount did not meet the dietary requirements.</p> <p>On 4/18/2024 at 8:50 A.M., the Corporate Infection Prevention Nurse provided the pureed menu for week four, which indicated the lunch meal was for pureed cheese ravioli and pureed green bean salad using a #10 scoop which equaled 1/2 cup. She indicated they did not have a policy for specific portion sizes, they went by the menu.</p> <p>1.3-20(a)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>38845</p> <p>Based on observation, interview and record review, the facility failed to store food and maintain equipment in a sanitary manner related to foods not sealed tightly, mold in a refrigerator, cookware with chipped Teflon and a resident's personal water container with mold (Resident G). This deficient practice had the potential to affect 84 of 84 residents who received meals out of the kitchen.</p> <p>Findings include:</p> <p>1. During an interview on 4/18/2024 at 11:32 A.M., Resident G indicated he had a plastic water container that he used to use, but the water from the bathroom where the staff would get the water from turned his straw black. Resident G indicated staff had never washed it. He had stopped them from using it and had a water pitcher staff would put ice in now.</p> <p>A plastic clear water jug with a plastic ringed straw sitting in the container was observed on the resident's night stand. The straw was noted to have black around the rings of the straw.</p> <p>A record review was completed on 4/23/2024 at 5:00 P.M. Resident G was cognitively intact.</p> <p>During an observation on 4/24/2024 at 9:57 A.M. the Corporate Nurse, the container was on the resident's night stand.</p> <p>During an interview on 4/24/2024 at 9:58 A.M., the Corporate Nurse indicated the container was dirty and should have been sanitized, and it was not dirty due to the water, but was moldy.</p> <p>49994</p> <p>2. On 4/17/2024 at 9:37 A.M., a kitchen tour was conducted with the Dietary Manager (DM). The following was observed: a buildup of ice on the floor of a freezer, mold on a refrigerator shelf, one dented can of pumpkin, and a bag of whipped topping and parmesan cheese not sealed appropriately.</p> <p>During an interview on 4/22/2024 at 10:14 A.M., the DM indicated areas should be clean and food stored and sealed properly,</p> <p>3. During a follow-up tour of the kitchen on 4/22/2024 at 10:11 A.M., the following was observed: two skillets with a buildup of grease on the inside and four skillets missing Teflon.</p> <p>During an interview on 4/22/2024 at 10:14 A.M., the DM indicated he understood that chipped Teflon could get into the food and the skillets should be removed.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/18/2024 at 8:47 A.M., the Corporate Infection Prevention Nurse provided the policy titled, Environment, dated 9/2017, and indicated the policy was the one currently used by the facility. The policy indicated . Procedures: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas and surfaces</p> <p>On 4/18/2024 at 8:47 A.M., the Corporate Infection Prevention Nurse provided the policy titled, Food Storage: Dry Goods, dated 9/2017, and indicated it was the one currently used by the facility. The policy indicated . Procedures: 5. All packaged and canned food items will be kept clean, dry, and properly sealed .</p> <p>On 4/18/2024 at 8:47 A.M., the Corporate Infection Prevention Nurse provided the policy titled, Food Storage: Cold Foods, dated 4/2018, and indicated it was the one currently used by the facility. The policy indicated . Procedures: 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination .</p> <p>This citation relates to Complaint IN00430346.</p> <p>3.1.21(i)(3)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure a safe, clean and comfortable environment was maintained related to missing dresser drawer handles, a missing bathroom door knob, broken window blinds, and mold in a closet, as well as dirty microwaves, drawers, an oven, and cabinets/drawers for 2 of 4 halls observed. (200 &amp; 400 halls)</p> <p>Findings include:</p> <p>An environmental tour was conducted on 4/24/2024 at 11:16 A.M. with the Maintenance Director, Administrator and the (AIT) Administrator in training.</p> <p>1. The following was observed on the 400 hall:</p> <ul style="list-style-type: none"> <li>- room [ROOM NUMBER]: there was a broken window blind.</li> <li>- room [ROOM NUMBER]: the dresser was missing 8 handles.</li> <li>- room [ROOM NUMBER]: the bathroom door had no handle.</li> <li>- room [ROOM NUMBER]: there was a window blind setting on the floor and not covering the window.</li> </ul> <p>- The 400 unit dining room had 4 broken blinds, an oven that was not plugged in with dried food particles in the oven and the oven door had dried grease stains, and kitchenette drawers and cabinets had various different items stored along with non-food items that were dirty.</p> <p>- A storage closet holding activity items and other items had no lock, had a hole in the ceiling where insulation and water had leaked onto the floor and where mold had grown on the wall.</p> <p>2. The following was observed on the 200 hall:</p> <ul style="list-style-type: none"> <li>- The Activity room had a microwave that was dirty with dried food substance and rust along the bottom and inside on the ceiling of the unit.</li> </ul> <p>During an interview, on 4/24/2024 at 11:40 A.M., the Administrator indicated the blinds/doors were being replaced, the kitchenette items (microwaves/drawers/cabinets) should be clean, and the storage room should be locked.</p> <p>On 4/24/2024 at 12:16 P.M., the Corporate Nurse indicated they had no specific policy regarding the environment and it would fall under resident rights.</p> <p>This citation relates to Complaint IN00430346.</p> <p>3.1-19(f)</p>