STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. Building B. Wing	03/28/2025

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49229 Based on interviews and record review, the facility failed to ensure a resident's choice of code status was documented consistently in the medical record for 1 of 3 residents reviewed for code status (Resident 70). Finding includes: During an interview, on [DATE] at 2:02 P.M., LPN 7 indicated Resident 70 was a full code. During an interview, on [DATE] at 10:00 A.M., the Social Service Designee (SSD) indicated Resident 70 was his own representative, had not been deemed incompetent and was capable of making his own legal decisions. The SSD indicated Resident 70 had reported to her he wanted to be a full code. The clinical record of Resident 70 was reviewed on [DATE] at 9:27 A.M. The resident's diagnoses included but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting the dominant right side, chronic obstructive pulmonary disease, cerebrovascular disease, hypertension, other reflux and obstructive uropathy, dysarthria, and dysphagia. A Quarterly Minimum Data Set assessment, dated [DATE], indicated Resident 70 was cognitively intact. A Physician Order, dated [DATE], indicated Resident 70 had a CPR status (a life-saving emergency procedure used when someone's breathing or heartbeat has stopped, combining chest compressions and rescue breaths to restore blood circulation and oxygenation). A current Care Plan, dated [DATE], indicated Resident 70 had a full code status. A POST (Physician Orders for Scope of Treatment) form (a medical order form that documents a patient's treatment preference as medical orders that can be easily understood and enacted by health care providers), dated [DATE], indicated Resident 70 had a status of Do Not Attempt Resuscitation (no life-sustaining measures if a person's heart or breathing stops). Resident 70's code status was unclear in the medical record. \ (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	On [DATE] at 1:00 P.M., the Administrator provided a policy titled,Cardiopulmonary Resuscitation (CPR), undated, and indicated the policy was the one currently used by the facility. The policy indicated .facility staff should verify the presence .the resident's wishes with regard to CPR, upon admission .if the resident's wishes are different than the admission orders .facility staff should document the resident's wishes in the medical record . 3XXX,d+[DATE](l)(5)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49229 Based on observation, interview and record review, the facility failed to ensure showers, hair care and/or nail care were provided for 2 of 6 residents. (Resident L- showers and hair care, Resident K- nail care) Findings include: 1. During an observation and interview, on 3/23/2025 at 1:51 P.M., Resident L indicated she could not recall the last shower she had been offered and had had bed baths only. She indicated the last bed bath she had received was given about a week ago. Resident L had a mass of hair that was matted. The matted hair was the size of a softball and was located at her back of her head. Resident L indicated she had only been offered disposable shower caps in regards to shampooing and does not remember the last time her hair was washed in a shower or was brushed. During an observation and interview, on 3/25/2025 at 9:14 A.M., Resident L indicated she still had not had a shower. The back of Resident L's hair still had a softball-sized hair matt present. During an interview, on 3/25/2025 at 11:10 A.M., CNA 9 indicated she had frequently offered her residents daily bed baths due to the bed bound status of many of the facility's residents. CNA 9 indicated she provided a disposable hair shampoo bonnet,as well as hair care, after a resident's bed bath. CNA 9 indicated she had attempted to brush out Resident L's hair matts 2 days ago but the resident's hair had become tangled again within a few days. During an observation and interview, on 3/26/2025 at 9:58 A.M., Resident L was observed with uncombed hair with a visible, large softball-sized tangled hair matt in the posterior of her head. The resident indicated she could not remember the last time had staff assisted her with brushing her hair. During an interview, on 3/26/2025 at 10:10 A.M., CNA 10 indicated she had showered residents twice a week unless the resident's care plan dictated the resident was to be cleaned more frequently. During an interview, on 3/26/2025 at 11:22 A.M., the Divisional Director of Risk Management indicated Resident L was showered and had her hair brushed and braided. During an interview, on 3/26/2025 at 3:33 P.M., CNA 11 indicated she bathed her residents twice a week and it included a disposable shampoo cap and nail care if the resident was not diabetic. The clinical record of Resident L was reviewed on 3/25/2025 at 10:15 A.M. The resident's diagnoses included, but were no limited to: multiple sclerosis, adult failure to thrive, chronic pain syndrome, hypertension, repeated falls, bipolar disorder, anxiety, cannabis use and borderline personality disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated the resident was cognitively intact, was dependent for showering and/or bathing and required substantial assistance for personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current Care Plan, revised 3/17/2025, indicated Resident L had an Activity of Daily Living (ADL) Self-Care Performance deficit. Interventions included, but were not limited to: shower/bathe- Resident L was dependent with two or more helpers to do all the effort of the task and personal hygiene- Resident L required substantial assistance for more than half the effort of the task. The shower documentation, dated 2/13/2025 thru 3/27/2025, indicated Resident L was only documented as having received showers on the following dates: -2/13/2025, 2/21/2025, 3/4/2025, 3/7/2025, 3/10/2025, 3/14/2025, 3/21/2025 and 3/25/2025. Resident L had not received 5 of the scheduled 13 showers during the time frame. It was unclear why Resident L had not received hair care to prevent her hair from becoming matted. 47419 2. A record review was completed on 3/27/2025 at 10:22 A.M. for Resident 22. Diagnoses included, but were not limited to dementia. An Annual Minimum Data Set (MDS) assessment, dated 1/20/2025, indicated Resident 22's cognition was severely impaired and was dependent for shower/bathing needs. A current Care Plan, revised on 1/22/2025, indicated Resident 22 was dependent for shower/bathing and staff performed all care tasks. Observations on 3/23/2025 at 12:11 P.M., 3/25/2025 at 9:16 A.M., and 3/27/2025 at 1:45 P.M., indicated Resident 22's toenails were very long and had grown past the end of her toes. During an interview on 3/27/2025 at 1:48 P.M. CNA 14 indicated a shower included washing a resident's hair with shampoo, washing their body, drying their body, applying lotion, got dressing the reisdent. She indicated nail care was included in the showering process. CNA 14 indicated Resident 22 had received a shower twice a week and if she refused, they re-approached the resident and reported the refusal to the nurse. During an interview on 3/27/2025 at 1:52 P.M., LPN 8 indicated the nurse was responsible for trimming toenails and if a podiatrist was needed, they let the Social Worker know to add the resident to the list for the podiatry visit. During an interview on 3/27/2025 at 2:11 P.M., the Social Worker Designee indicated the nursing staff let her know who needed to see the podiatrist. She indicated the nusing staff had not reported that Resident 22 needed to be seen by the podiatrist. On 3/28/2025 at 1:10 P.M., the Director of Nursing (DON) provided an undated policy title, Foot Care and indicated it was the policy currently used by the facility. The policy indicated, . Foot care is often performed in conjunction with shower/bathing . In some residents, foot care including trimming of nails should only be performed by a professional 3.1-38(a)(3)(A) 3.1-38(a)(3)(B)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48145 Based on observation, interview and record review, the facility failed to change the dressings of residents who had a peripherally inserted central catheter (PICC) line for 3 of 3 residents whose PICC lines were reviewed. (Residents B, D and C) Findings include: 1. During an observation on 3/24/2025 at 3:02 P.M., Resident B's PICC line dressing was dated, 3/14/2025 and was rolled up with the insertion site exposed. Resident B indicated the dressing had not been changed in over a week. During an interview on 3/24/2025 at 3:05 P.M., LPN 6 indicated the PICC line dressing should not be rolled up and the dressing should have been changed after seven days. Resident B's record review was completed on, 3/25/2025 at 8:30 A.M. Diagnoses included, but were not limited to: subacute osteomyelitis of the left ankle and foot, Type 1 diabetes mellitus, methicillin-resistant staphylococcus aureus, below-knee amputation of right leg. An Admission Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated Resident B had intact cognition. A current Physician's order, dated 3/14/2025, indicated Resident B's PICC line dressing was to be changed every Friday on day shift (6:00 A.M.-2:00 P.M.). A current Care Plan, initiated on 3/5/2025, indicated Resident B was on intravenous (IV) antibiotics for treatment of osteomyelitis. The goal for the Care Plan was to be free of infection at insertion site. Interventions included, but were not limited to: visually inspect IV site each shift. Resident B's record lacked the documentation he had refused any dressing changes. 47419 2. A record review was completed on 3/25/2025 at 2:45 P.M. for Resident D. Diagnoses included, but were not limited to, pneumonia. An Admission Minimum Data Set (MDS) assessment, dated 3/8/2025, indicated Resident D's cognition was intact. A Physician Order, dated 3/14/2025, indicated the PICC line dressing was to be changed once weekly, on Fridays. During an observation on 3/24/2025 at 11:07 A.M., the dressing for a peripherally inserted central catheter (PICC), a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart, in Resident 76's left upper arm, was peeled up along all edges of the transparent dressing and was dated 3/3/2025. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/24/2025 at 11:07 A.M., the Unit Manager indicated the dressing should have been changed every week. 49229 3. During an observation, on 3/24/2025 at 10:08 A.M., Resident C had a PICC (peripherally-inserted central catheter) (a long, thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart and used for long-term intravenous access for medications, fluids, or blood draws, and can stay in place for weeks or months) visible to his right upper arm with a dressing dated 3/14 which was peeling up slightly at the very base of the dressing. During an interview, on 3/24/2025 at 11:06 A.M., LPN 6 indicated Resident C's PICC dressing should have been changed weekly. During an observation and interview, on 3/25/2025 on 11:34 A.M., observed Resident C's right upper arm without the presence of a PICC or a dressing, the inside of Resident C's right upper arm had a quarter-sized purple/green bruise without a hematoma or drainage. Resident C indicated his PICC was removed yesterday. The clinical record of Resident C was reviewed on 3/26/2025 at 1:25 P.M. The resident's diagnoses included, but were no limited to: cerebral ischemia, cerebral amyloid angiopathy, morbid obesity, chronic kidney disease, systolic and diastolic congestive heart failure, venous insuffiency, chronic venous hypertension, obstructive sleep apnea, ischemic cardiomyopathy, paroxysmal atrial fibrillation, occlusion and stenosis of bilateral carotid arteries, ventral hernia, spinal stenosis and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/2025, indicated Resident C was cognitively intact. The MDS assessment indicated the resident had been receiving IV medications. A Physician Order, dated 1/29/2025, indicated the PICC line site dressing was to be changed weekly on Fridays. A current Care Plan, revised on 2/10/2025, indicated Resident C had received intravenous antibiotics due to osteomyelitis (bone infection). Interventions included but were not limited to: change the dressing weekly for the PICC line. During an interview, on 3/28/2025 at 9:00 A.M., LPN 7 indicated in the chart that everything in the electronic medical record would turn green when all tasks and medications were completed. LPN indicated there was a QMA (qualified medication aide) on the hall on 3/21/2025 and the QMA had clicked on the PICC dressing change without having done the PICC dressing change yet. LPN 7 had then charted the PICC dressing change task in error due to being in a different mindset with the QMA on the hall. On 3/28/2025 at 1:00 P.M., the Administrator provided a policy, Pharmscript Infusion Intravenous Access Line Maintenance Protocol, dated 2/7/2020 and indicated the policy was the one currently used by the facility. The policy indicated .PICC dressing changes on admission or 24 hours post-insertion, then weekly and as needed . This citation relates to complaint IN00455837. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-47(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48145 Based on record review and interview, the facility failed to provide medications to residents as ordered by the Physician for 4 of 6 residents whose medications were reviewed. In addition, the facility failed to appropriately store medications in 1 of 3 Medication Carts reviewed. (Residents F, N, O, C & 100 Hall Medication Cart) Findings include: 1. Resident F's record review was complete on [DATE] at 10:10 A.M. Diagnoses included, but were not limited to: Parkinson's disease, anxiety disorder, insomnia, history of myocardial infarction and major depressive disorder. A current Physician's order, dated [DATE], indicated Resident F was to receive the following mediations: - 0.4 milligram (mg)/hour transdermal nitroglycerin patch (treats chest pain) every morning. -20 mg of omeprazole (treats heartburn) every morning. A current Physician's order, dated [DATE], indicated Resident F was to receive 50 mg of trazodone (sleep aid) at bedtime. A [DATE] Medication Administration Record (MAR) indicated Resident F had not received the 0.4 mg nitroglycerin patch or the 50 mg of omeprazole on [DATE] and he had not received his trazodone on [DATE]. Resident F's record lacked the documentation he had refused his medications or a Physician had been notified that he had missed doses of his medications. 2. Resident N's record review was completed on [DATE] at 11:30 A.M. Diagnoses included, but were not limited to: dementia with psychotic disturbance, major depressive disorder, generalized anxiety disorder and anorexia. Current Physician's orders for Resident N included orders for the following medications: - 7.5 mg milligrams (mg) of mirtazapine (appetite stimulant) at bedtime. - 10 mg of melatonin (sleep aid) at bedtime. A [DATE] Medication Administration Record (MAR) indicated Resident N had not received 7.5 mg of mirtazapine or 10 mg of melatonin on ,d+[DATE], ,d+[DATE] or [DATE]. Resident N's record lacked the documentation she had refused her medications or a Physician had been notified that she had missed doses of her medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident O's record review was complete on [DATE] at 1:30 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 with diabetic neuropathy, cerebral palsy, hypertension, and dementia. Current Physician's orders for Resident O included orders for the following medications: - 5 units of insulin glargine at bedtime. - 5 milligrams (mg) of terazosin (controls high blood pressure) at bedtime. - 2 to 10 units of Novolog (insulin) daily at 4:00 P.M., depending on her blood sugar test results. A [DATE] Medication Administration Record (MAR) indicated Resident O had not received 5 units of insulin glargine or 5 mg of terazosin on ,d+[DATE] or [DATE], and she had not received her 4:00 P.M. dose of novolog on [DATE]. Resident O's record lacked the documentation she had refused her medications or a Physician had been notified that she had missed doses of her medications. During an interview on [DATE] at 1:13 P.M., the Director of Nursing (DON) indicated she believed all the medications had been given but the staff had forgotten to sign off on the administration. She indicated staff should sign off on the medication after it was given. 49229 3. The clinical record of Resident C was reviewed on [DATE] at 1:25 P.M. The resident's diagnoses included, but were no limited to: cerebral ischemia, cerebral amyloid angiopathy, morbid obesity, chronic kidney disease, systolic and diastolic congestive heart failure, venous insuffiency, chronic venous hypertension, obstructive sleep apnea, ischemic cardiomyopathy, paroxysmal atrial fibrillation, occlusion and stenosis of bilateral carotid arteries, ventral hernia, spinal stenosis and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident C was cognitively intact. The MDS assessment indicated the resident had received insulin, anticoagulants, diuretic and an anticonvulsant. Physician Orders for Resident C, included but were not limited to: -Atorvastatin Calcium Oral Tablet 80 MG (milligram) (Atorvastatin Calcium) -Give 1 tablet by mouth at bedtime, -Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/mL (milliliter) (Insulin Glargine) - Inject 10 units subcutaneously at bedtime, - Insulin Lispro Injection Solution 100 unit/mL (Insulin Lispro) - Inject subcutaneously before meals with sliding scale, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Santyl External Ointment 250 unit/Gm(gram) (Collagenase) - Apply to rIght lower extremity topically every evening shift for wound care. Cleanse wound to right lateral inferior lower leg with normal saline, pat dry, spread a santyl nickel thick on adaptic and place on wound, cover with ABD pads and wrap with Kerlix, secure with tape and apply TubiGrip G daily until healed, - Ertapenem Sodium Injection Solution reconstituted 1 gram IV (intravenously) in the morning, and - Vancomycin Hydrochloride Intravenous Solution 1000 mg/ 250 mL 1 gram every day. The [DATE] Medication Administration Record for Resident C indicated the following missed medications and treatments: -Atorvastatin Calcium Oral Tablet 80 mg on ,d+[DATE] - Ertapenem Sodium 1 gram on ,d+[DATE] and ,d+[DATE] - Lantus SoloStar Subcutaneous Solution Pen-injector 10 units at bedtime on ,d+[DATE], ,d+[DATE] and , d+[DATE] - Santyl External Ointment 250 unit/G on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE] and ,d+[DATE] - Vancomycin Hydrochloride Intravenous Solution 1000 mg/ 250 mL 1 gram: on ,d+[DATE]. During an interview, on [DATE] at 1:14 P.M., the Director of Nursing (DON) indicated she believed the missing and undocumented medications and treatments on the Medication Administration Records had been given. The DON indicated the medications and treatments should have been signed off only after it had been given or completed. 44111 4. On [DATE] at 10:37 A.M., a medication storage observation was completed with QMA 12 on the 100 Hall cart, cart one and the following was observed: -Two opened bottles of eye drops not in a pharmacy labeled container sitting on top of a packages of nicotine patches and in with a box of antibiotic oral medication. On [DATE] at 10:45 A.M., a medication storage observation was completed with QMA 12 on the 100 Hall cart, cart two and the following was observed: -An open bottle of eye drops undated and not in a pharmacy labeled container. -An open Humalog pen with an open date of [DATE]. During an interview on [DATE] at 10:55 A.M., QMA 12 indicated eye drops should not have been mixed with other types of medication and it should have been in a pharmacy labeled container. She indicated that the insulin pen was used to administer insulin that morning and should not have been used since it was expired. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:10 P.M., the DON provided a policy titled, Storage of Medication, ,d+[DATE], and indicated the policy was the one currently used by the facility. The policy indicated .1. The provider pharmacy dispenses medication in container that meet regulatory requirements, including standards set forth by the United States Pharmacopoeia (USP) Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medication to the original container. 4. Orally administered medication are stored separately from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Eye mediations are stored separately per facility policy. 6. The nurse will check the expiration date of each medication before administering it. 7. No expired medication will be administered to a resident . On [DATE] at 3:12 P.M., the ED provided a policy titled, Medication Administration, undated, and indicated the policy was the one currently used by the facility. The policy indicated . I. Procedure: dd. Medications will be charted when given. IV. Documentation a. Documentation of medication will be current for medication administration. b. Documentation will follow accepted standards of nursing practice . This citation relates to complaints IN00452428 and IN00455837. 3XXX,d+[DATE](g)(1)(o) 3XXX,d+[DATE](b)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44111 Based on observation, interview and record review, the facility failed to store and serve food in a sanitary manner in the pantries, dining rooms, and kitchen. This had the potential to affect 81 of 81 residents who consumed food from the kitchen, pantries and dining room. Findings include: 1. During the initial kitchen tour with dietary aide 2 on 3/23/2025 at from 10:00 A.M. - 10:30 A.M., the following was observed: -the reach-in freezer had an unsealed and undated bag of [NAME] fish and potato patties, unsealed boxes of chicken patties, biscuits, cinnamon rolls, frozen cookie dough, pretzels, 2 boxes of dinner rolls, and an employee's bottle of water. - the refrigerator had opened unsealed bags of mozzarella cheese and parmesan cheese, an undated package of hot dogs, celery and an undated pan of broccoli/cauliflower mix. -the dry goods room had an undated package of elbow noodles, an open package of hamburger buns and an open container of powdered milk. During an interview at 10:10 A.M. the dietary aide indicated all food should be dated and properly sealed and no employee beverages should be stored in the freezer. 2. During a return trip to the kitchen on 3/23/2025 at 11:05 A.M., the following was observed: -A soup bowl was noted lying on top of the brown sugar and powdered sugar in the bins. -Seven spice lids were open on a shelf and a bottle of Dawn dishwashing soap was stored next to the spices. During an interview on 3/23/2025 at 11:10 A.M., the Dietary Manager indicated there should not have been any bowls in the bins, the lids to the spices should have been closed and the dish soap should not have been on that shelf with the spices. 3. During an observation of meal service in the Main Dining Room on 3/23/2025 at 12:15 P.M., the following was observed: -Punch and lemonade pitchers were on a cart with the lids off. -CNAs served the beverages from the pitchers without the lids. -CNA served meal plates with their thumb on the eating surface of the dinner plates. (continued on next page)

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	155496	A. Building B. Wing	03/28/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/23/2025 at 12:41 P.M., CNA 13 indicated he should have served the meal plate with his thumb/hand underneath the plates and the beverage pitchers should have had lids on them. 4. During an observation of the Memory Care's Pantry refrigerator on 3/24/2025 at 9:27 A.M., the following was observed: -Four containers of fruit/cottage cheese, an opened container of sour cream and bag of shredded cheese were unlabeled. During an interview on 3/24/2025 at 9:27 A.M., the Mobile Dietary Manager indicated the items should have been labeled with a name and date. On 3/24/2025 at 9:07 A.M., the ED provided a policy titled, Safe Handling for Foods from Visitors, revised on 2/2023, and indicated the policy was the one currently used by the facility. The policy indicated .4. Label foods with the resident name and the current date . And a policy titled, Food Storage: Cold Foods,revised 2/2023. The policy indicated .5. All foods will be stored and wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . And a policy titled, Food Storage: Dry Goods, revised 2/2023. The policy indicated .5. All packaged and canned food items will be kept clean, dry, and properly sealed. 6. Storage area will be neat, arranged for easy identification, and date marked as appropriate . 3.1-21(3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49229 Based on observation, record review and interview, the facility failed to ensure accurate documentation of PICC (peripherally-inserted central catheter) dressing changes for 3 of 3 residents reviewed. (Residents C, D and B) Findings include: 1. During an observation, on 3/24/2025 at 10:08 A.M., Resident C had a PICC line to his right upper arm with a dressing, dated 3/14/25, peeling up slightly at the very base. The clinical record of Resident C was reviewed on 3/26/2025 at 1:25 P.M. The resident's diagnoses included, but were not limited to: cerebral ischemia, cerebral amyloid angiopathy, morbid obesity, chronic kidney disease, systolic and diastolic congestive heart failure, venous insuffiency, chronic venous hypertension, obstructive sleep apnea, ischemic cardiomyopathy, paroxysmal atrial fibrillation, occlusion and stenosis of bilateral carotid arteries, ventral hernia, spinal stenosis and diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 2/19/2025, indicated Resident C was cognitively intact. The MDS assessment indicated the resident had been receiving insulin, anticoagulants, diuretic, an anticonvulsant and IV(intravenous) medications. A Physician Order, dated 1/29/2025, indicated the PICC line site dressing change was to be done weekly on Fridays. The March Treatment Administration Record 2025 indicated the PICC line dressing change was completed on 3/21/2025 but Resident C's PICC line dressing was dated 3/14. During an interview, on 3/24/2025 at 11:06 A.M., LPN 6 indicated Resident C's PICC line dressing should have been changed weekly. During an interview, on 3/28/2025 at 9:00 A.M., LPN 7 indicated in the chart that everything in the electronic medical record would have turned green when all tasks and medications were completed. LPN 7 indicated there was a QMA (qualified medication aide) on the hall on 3/21/2025 and LPN 7 indicated she may have clicked on the PICC dressing change without having done the PICC dressing change yet. LPN 7 had charted the PICC dressing change in error due to being in a different mindset with the QMA on the hall. During an interview, on 3/28/2025 at 1:14 P.M., the Director of Nursing (DON) indicated the medications or treatments should have been signed off only after they had been given or completed. 47419 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation of Resident D's peripherally inserted central catheter (PICC), a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart, on 3/24/2025 at 11:07 A. M., the date on the dressing over the insertion site was 3/3/2025. During an interview on 3/24/2025 at 11:07 A.M., the Unit Manager indicated the PICC line dressing should have been changed weekly. Documentation on the Treatment Administration Record (TAR) indicated the dressing was changed on 3/14/2025 and 3/21/2025. During an interview on 3/27/2025 at 9:59 A.M., LPN 8 indicated the dressing should have been changed on 3/14/2025 and she was not sure how her initials had been documented on the TAR as having chnaged the dressing. LPN 8 indicated she must have documented it accidentally. During an interview on /28/2025 at 11:23 A.M., LPN 4 indicated PICC line dressings should be changed weekly. His initials on the TAR on 3/21/2025 was more than likely because he had passed it off to the next shift but he should not have signed off that he had xompleted the dressing change. 48145 3. During an observation on 3/24/2025 at 3:02 P.M., Resident B's PICC dressing was dated, 3/14/2025 and was rolled up with the insertion site exposed. Resident B indicated the dressing had not been changed in over a week. During an interview on 3/24/2025 at 3:05 P.M., LPN 6 indicated the PICC dressing should not be rolled up and the dressing should have been changed after seven days. Resident B's record review was completed on, 3/25/2025 at 8:30 A.M. Diagnoses included, but were not limited to: subacute osteomyelitis of the left ankle and foot, Type 1 diabetes mellitus, methicillin-resistant staphylococcus aureus, below-knee amputation of right leg. A current Physician's order, dated 3/14/2025, indicated Resident B's PICC dressing was to be changed every Friday on day shift (6:00 A.M.-2:00 P.M.). A current Care Plan, dated 3/5/2025, indicated Resident B was on intravenous (IV) antibiotics for the treatment of osteomyelitis. The goal was to be free of infection at the insertion site. Interventions included, but were not limited to: visually inspect IV site each shift. Resident B's March 2025 Medication Administration Record (MAR), indicated LPN 7 had changed the PICC dressing on 3/21/2025. Resident B's record lacked the documentation he had refused any dressing changes. During an interview on 3/28/2025 at 8:58 A.M., LPN 7 indicated it was her initials on Resident B's PICC dressing change for 3/21/2025 on March 2025's MAR. She indicated the process for signing off on a task was to mark the task complete in the Electronic Medical Record after the task was completed and she had made a mistake by signing off on the PICC dressing change when the task had not been completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/28/2025 at 2:30 P.M., the Director of Nursing (DON) provided an undated policy, titled, Clinical Documentation Standards and identified it as the policy currently used by the facility. The policy indicated, . Nurses will follow the basic standard of practice for documentation including, but not limited to providing a timely and accurate account of resident information in the medical record . b. The nurse is expected to: i. Document accurately and truthfully to the best of his/her knowledge This citation relates to complaint IN00455837. 3.1-50 (a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47419 Based on observation, interview, and record review the facility failed to follow the standards of practice for infection control for 1 of 1 resident reviewed for tracheostomy care (Resident 3), for 2 of 3 residents reviewed for PICC line care (Residents B and 76) and 2 residents observed for mediction administration. (Resident K and 13) Findings include: 1. During an observation on 3/24/2025 at 9:27 A.M. Resident 3's tracheostomy stoma dressing was dirty with yellowish/brown stains and was not dated. A record review was completed on 3/25/2025 09:53 A.M. for Resident 3. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and tracheostomy. A Quarterly Minimum Data Set MDS) assessment, dated 1/10/2025, indicated Resident 3's cognition was intact and received tracheostomy care. Physician Orders included, but were not limited to, an order on 3/13/2025 to cleanse the tracheostomy site with normal saline, pat dry, apply gauze and secure with tape until healed. A current Care Plan revised on 8/8/2024, indicated the tracheostomy was discontinued and care to the stoma was to be done per physician orders. During an observation of tracheostomy stoma care and dressing change on 3/25/2025 at 1:38 P.M., LPN 8 used proper infection control measures to cleanse and dress the site but put the old dressing in the the Resident 3's trash. She did not take the trash out of the room and dispose of it properly. During an interview on 3/25/2025 at 1:45 P.M., LPN 8 indicated she should have removed the trash and put it in the soiled utility room's Biohazard box. 2. During an observation on 3/24/2025 at 11:07 A.M., the dressing for a peripherally inserted central catheter (PICC), a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart, in Resident 76's left upper arm, was peeled up along all edges of the transparent dressing and was dated 3/3/2025. A record review was completed on 3/25/2025 at 2:45 P.M. for Resident 76. Diagnoses included, but were not limited to, pneumonia. An Admission Minimum Data Set (MDS) assessment, dated 3/8/2025, indicated Resident 76's cognition was intact. A Physician Order, dated 3/14/2025, indicated the PICC line dressing should be changed once weekly on Friday. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/24/2025 at 11:07 A.M., the Unit Manager indicated the dressing should have been changed every week. 48145 3. During an observation on 3/24/2025 at 3:02 P.M., Resident B's PICC dressing was dated, 3/14/2025, and was rolled up with the insertion site exposed. Resident B indicated the dressing had not been changed in over a week. During an interview on 3/24/2025 at 3:05 P.M., LPN 6 indicated the PICC dressing should not be rolled up and the dressing should have been changed after seven days. Resident B's record review was completed on, 3/25/2025 at 8:30 A.M. Diagnoses included, but were not limited to: subacute osteomyelitis of the left ankle and foot, Type 1 diabetes mellitus, methicillin-resistant staphylococcus aureus, below-knee amputation of right leg. An Admission Minimum Data Set (MDS) assessment, dated 3/11/2025, indicated Resident B had intact cognition. A current Physician's order, dated 3/14/2025, indicated Resident B's PICC dressing was to be changed every day shift (6:00 A.M.-2:00 P.M.) on Fridays. A current Care Plan, dated 3/5/2025, indicated Resident B was on intravenous (IV) antibiotics for treatment of osteomyelitis. The goal for the Care Plan was to be free of infection at insertion site. Interventions included, but were not limited to: visually inspect IV site each shift. Resident B's record lacked the documentation he had refused any dressing changes. 44111 4. During an observation of medication administration of eye drops on 3/24/2025 at 9:58 A.M., for Resident K, LPN 4 donned gloves and entered the room with oral medication and eye drops. The eye drops were placed on the bedside table without a barrier. LPN 4, with gloved hands, handed Resident K nine oral medications one at a time. LPN 4, with same gloved hands, then wiped crust away from both of Resident K ' s eyes and then applied the eye drops without washing her hands or changing her gloves. During an interview on 3/24/2025 at 10:08 A.M., LPN 4 indicated he should have sanitized his hands before donning the gloves and should not have used the same gloves after administering oral medication and wiping of the eyes to administer eye drops. LPN 4 indicated he should have brought the eye drops into the room in the pharmacy provided bag. 5. During an observation on 3/24/2025 at 10:16 A.M., LPN 4 took a glucometer that was just used by Resident 13 with ungloved hands, cleaned it with a Sani-wipe and did not wash his hands afterwards. During an interview on 3/24/2025 at 10:17 A.M., LPN 4 indicated he should have washed his hands prior to disinfecting glucometer, put on gloves and then performed hand hygiene after glove removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an observation on 3/24/2025 at 11:20 A.M., LPN 6 placed a glucometer on the bedside table without a barrier and did not perform hand hygiene after removing her gloves after administering insulin. During an interview on 3/24/2025 at 11:23 A.M., LPN 6 indicated she should have placed a barrier under the glucometer and performed hand hygiene after glove removal. On 3/24/2025 at 12:38 P.M., the ED provided a policy titled, Eye Drop Administration, dated 9/2018, and indicated the policy was the one currently used by the facility. The policy indicated . 4. Remove the cap, taking care to avoid touching the dropper tip. Place the cap on the barrier or a clean, dry surface. 13. Remove and dispose of gloves. Discard any barrier used for carrying or storing the medication and supplies. Wash hands thoroughly with antimicrobial soap and water or facility-approved hand sanitizer . And a policy titled, Blood Sugar Monitoring, dated 2018. The policy indicated .d. Turn on machine and place on a hard surface, with a clean barrier under device. f. (v)Remove gloves and perform hand hygiene . And a policy titled, Standard Precautions.3/2016. The policy indicated .II, When to perform hand hygiene B. Before and after direct contact with a resident's skin. C. After contact with blood, body fluids or excretions, mucous membranes, non-intact skin or wound dressings. G. After glove removal . And policy titled, Blood Glucose Point of Care Testing, dated 2018. The policy indicated, .Clean and Store Equipment a. Place a clean barrier under glucometer until disinfected. c. Perform hand hygiene prior to disinfecting. d. [NAME] gloves. e. Perform cleaning and disinfection procedure. f. Remove gloves and perform hand hygiene . On 3/28/2025 at 1:00 P.M., the Administrator provided a policy, Pharmscript Infusion Intravenous Access Line Maintenance Protocol, dated 2/7/2020 and indicated the policy was the one currently used by the facility. The policy indicated .PICC dressing changes on admission or 24 hours post-insertion, then weekly and as needed . 3.1-18(l)