STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Health & Rehabilitation Center	353 Tyler St Gary, IN 46402

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 10770 Based on observation, record review, and interview, the facility failed to ensure a resident's preferences were honored related to turning up the volume on the television set for 1 of 1 resident reviewed for activities. (Resident 43) Finding includes: During random observations on 7/18/24 at 9:55 a.m. and 1:10 p.m., on 7/19/24 at 7:55 a.m. and 9:00 a.m., and on 7/22/24 at 9:00 a.m., Resident 43 was observed in his room in bed. At those times, the television was turned on and observed on top of a tall wardrobe closet and the volume was turned off. There was an air return vent observed by the television set making a very loud noise. During an interview on 7/19/24 at 9:00 a.m., the resident indicated he could not hear the television. The record for Resident 43 was reviewed on 7/19/24 at 2:48 p.m. Diagnoses included but were not limited to, stroke, type 2 dm, epilepsy, vascular dementia, anemia, major depressive disorder, and high blood pressure The Significant Change Minimum Data Set (MDS) assessment, dated 5/19/24, indicated the resident was not cognitively intact for daily decision making. The resident was interviewed for his daily preferences and activities and indicated it was somewhat important to read books, listen to music, keep up with the news, and do things with other people. An Activity Assessment, dated 3/27/24, indicated the resident enjoyed movies, television, and going outside when the weather permitted. An Activity Assessment, dated 5/30/24, indicated the resident enjoyed music, parties, and television. During an interview on 7/24/24 at 8:55 a.m., the Director of Nursing indicated she moved the television and gave the resident the remote control and ensured the volume was turned up so he could hear. 3.1-3(u)(1)

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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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. 10770 Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified of the onset of a new bruise and medication changes for 2 of 2 residents reviewed for notification of change. (Residents C and B) Findings include: 1. During a phone interview on 7/19/24 at 11:20 a.m., Resident C's Power of Attorney (POA) indicated she was notified on 7/17/24 the resident had a large purple bruise across her chest. The record for Resident C was reviewed on 7/22/24 at 10:50 a.m. Diagnoses included but were not limited to, respiratory failure, joint stiffness, COPD (chronic obstructive pulmonary disease), Parkinson's disease, heart disease, atrial fibrillation, anemia, and dementia. The 6/24/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and wore oxygen while a resident. A Nurses' Note, dated 7/14/24 at 6:39 p.m., indicated the resident was found sitting next to the bed Indian style. The resident indicated she was praying and the indwelling catheter was in the bed. The resident's POA, and physician were notified. Nurses' Notes, dated 7/15 and 7/16/24, indicated there was no documentation of any injury related to the previous fall. Nurses' Notes, dated 7/17/24 at 2:51 p.m., indicated upon assessment, the resident was noted with a dark purple discoloration measuring 23 centimeters (cm) by 15 cm and extending down and under the left breast. The resident denied any pain or discomfort and was not able to recall when the discoloration first appeared. The resident's POA and physician were notified. During an interview on 7/24/24 at 8:55 a.m., the Director of Nursing indicated the bruise was more than likely from the fall she had on 7/14/24. During an interview on 7/24/24 at 11:00 a.m., the Unit 4 Manager indicated she did her own investigation into the bruise on the resident's left breast area. She interviewed CNA 3 who worked on 7/14/24 when the fall happened. CNA 3 indicated she noticed the bruise hours after the fall and told LPN 2 while CNA 2 was standing there and witnessed the conversation. The Unit Manager interviewed LPN 4 who worked on 7/13/24 on the 3-11 shift. He told the Unit Manager the bruise was not there on 7/13/24 because the resident removed her blouse and he could see her chest. The Unit Manager indicated she spoke with LPN 2 about the fall and LPN 2 told her nothing about the bruise. LPN 3 was interviewed as well and she informed the Unit Manager that she had seen the bruise on 7/15/24 but just assumed everyone knew about it and it was from the fall. During an interview on 7/24/24 at 2:00 p.m., the Unit 4 Manager indicated the resident's POA was notified on 7/17/24 (3 days after the bruise was first observed). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The closed record for Resident B was reviewed on 7/19/24 at 10:59 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, depressive disorder with psychotic symptoms, schizophrenia, dementia, and intellectual disabilities. The 5/31/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and received antipsychotic and antidepressant medication while at the facility. A Nurse Practitioner (NP) Behavior Progress Note, dated 9/29/23, indicated the Social Service Director (SSD) reported the resident had been increasingly more agitated and physically aggressive with staff. She was taken to an outside psychiatrist by her brother and new medications were started. The resident had a history of auditory/visual hallucinations and today she reported having both, seeing black figures float across the room and hearing a voice in her head. Staff reported she was not sleeping well at night as well and was currently on 1 to 1 supervision for aggressive behavior. The plan was to discontinue Haloperidol (an antipsychotic medication) 10 milligrams (mg) three times a day and Perphenazine (an antipsychotic medication) 8 mg twice a day. The patient was to start on Zyprexa (an antipsychotic medication) 15 mg at bed time and Klonopin (a medication used to treat panic disorder and anxiety) 1 mg twice a day. Physician's Orders, dated 9/29/23, indicated Klonopin 1 mg two times a day and Zyprexa 15 mg at bed time. There was no documentation in the clinical record the resident's brother (her guardian) was notified of the change in medication. During an interview on 7/24/24 at 8:55 a.m., the Nurse Consultant indicated the NP from the behavioral company did not come to the facility any more. She indicated there was no documentation the resident's brother was notified of the new medication changes. The 7/1/21 Notification of Changes policy, provided by the Nurse Consultant on 7/24/24 at 2:05 p.m., indicated the nurse will immediately notify the resident, resident's physician, and the resident representative for the following: a significant change in the resident's physical status. This citation relates to Complaints IN00436685 and IN00439030. 3.1-5(a)(2)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 10770 Based on record review and interview, the facility failed to ensure a Functional Maintenance Program (FMP) was in place for continued ambulation and range of motion after a resident was discharged from physical therapy for 1 of 2 residents reviewed for rehabilitation services. (Resident C) Finding includes: During a phone interview on 7/19/24 at 11:20 a.m., Resident C's Power of Attorney (POA) indicated the resident used to walk with a walker before she entered the nursing home and now she could not walk. The record for Resident C was reviewed on 7/22/24 at 10:50 a.m. Diagnoses included but were not limited to, respiratory failure, joint stiffness, COPD (chronic obstructive pulmonary disease), Parkinson's disease, chronic bronchitis, and dementia. The 4/5/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident used a walker in the last 7 days and walking 10 feet was not attempted due to her medical condition. The resident needed substantial to maximum assist for transfers. The 6/24/24 Significant Change MDS assessment indicated the resident was moderately impaired for daily decision making. The resident had no limitation in range of motion to her upper and lower extremities and walking was not attempted due to her medical condition. The resident needed substantial to maximum assist for transfers. A Physical Therapy Discharge Note, dated 3/1/24, indicated at the time of discharge the resident met the goal of being able to walk 50 feet with stand by assist using the rolling walker. The discharge recommendation from therapy was 24 hour nursing care and a restorative nursing program (RNP). A RNP/FMP was recommended to facilitate the patient maintaining the current level of performance, and in order to prevent decline, the development of and instruction in the RNP had been completed with the IDT (interdisciplinary team) for passive range of motion and ambulation. There was no documentation from 3/1-7/18/24 the resident received passive range of motion or ambulation exercises. A Restorative Nursing Review, dated 4/26/24, indicated no restorative nursing program was indicated at that time. The resident did not need passive or active range of motion and the section for how the resident walked in the room and the corridor with and without support indicated the activity did not occur during the assessment. During an interview on 7/24/24 at 10:15 a.m., the Restorative Nurse indicated the RNP did not start back up until 4/1/24. She did an assessment of the resident's physical limitations on 4/26/24 but did not have the information from therapy regarding needing a program for ambulation at that time. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/24 at 11:00 a.m., the Unit 4 Manger indicated she had never seen the resident walk with therapy. The therapy department did not relay the information regarding the RNP or the FMP for ambulation and passive range of motion for the resident after her therapy had been discontinued. During an interview on 7/24/24 at 11:15 a.m., the Director of Nursing indicated nursing staff do not have access to therapy progress notes. This citation relates to Complaint IN00439030. 3.1-38(a)(1)(B)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48383 Based on observation, record review, and interview, the facility failed to ensure a dependent resident received assistance with activities of daily living (ADL's) related to the removal of facial hair for 1 of 2 residents reviewed for ADL's. (Resident 282) Finding includes: On 7/18/24 at 11:47 a.m., on 7/19/24 at 9:40 a.m. and 11:36 a.m., and on 7/22/24 at 2:17 p.m., Resident 282 was observed in bed. At those times, the resident had long black facial hair above her top lip. During an interview at the time of observation on 7/19/24, the resident indicated she did not want facial hair. The record for Resident 282 was reviewed on 7/19/24 at 11:02 a.m. The diagnoses included, but were not limited to, epilepsy (seizure disorder), diabetes, depression, anemia, hypokalemia (low potassium), and psychotic disorder. The Quarterly Minimum Data Set (MDS) Assessment, dated 5/14/24. Indicated the resident was cognitively intact for daily decision making. The resident had impairment on both sides of the upper and lower extremities and used a wheelchair. The resident required dependent assistance with toileting hygiene and lower body dressing. Bathing required substantial/maximum assistance. Personal hygiene required partial/moderate assistance. A Care Plan, dated 7/18/24, indicated the resident had an ADL self-care performance deficit related to impaired mobility. The resident required extensive assistance by 1-2 staff members for personal hygiene and oral care. During an interview on 7/22/24 at 2:38 p.m., the Activity Aide 1 indicated the resident liked the nursing staff to stay on top of her facial hair. During an interview on 7/23/24 at 9:20 a.m., the Director of Nursing (DON) indicated she understood the concern and the resident was shaved on 7/22/24. 3.1-38(a)(3)(D)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 10326 Based on observation, record review, and interview, the facility failed to administer medications according to physician's orders related to not following parameters for 2 of 6 residents reviewed for unnecessary medications (Residents H and J), failed to ensure areas of bruising and rashes were assessed and monitored for 2 of 2 residents reviewed for non-pressure related skin conditions (Residents C and G), failed to ensure new onset edema (swelling) was assessed and monitored for 1 of 1 resident reviewed for edema (Resident K), and failed to provide transportation to physician's appointments for 3 of 4 residents reviewed for transportation to outside appointments (Residents D, E, and F). Findings include: 1. The record for Resident H was reviewed on 7/22/24 at 3:59 p.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes, and vascular dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 6/17/24, indicated the resident was cognitively impaired for daily decision making. A Physician's Order, dated 6/25/24, indicated the resident was to receive Metoprolol Succinate (a blood pressure medication) 50 milligrams (mg) daily. The medication was to be held if the resident's systolic blood pressure (top number) was less than 110 or her pulse was less than 60. The July 2024 Medication Administration Record (MAR), indicated the resident's blood pressure was documented at the time of administration, however, the resident's pulse was not documented from 7/1-7/23/24. The June 2024 MAR, indicated the resident's pulse was not documented from 6/25-6/30/24 at the time of administration. During an interview on 7/23/24 at 4:10 p.m., the Director of Nursing indicated she would have to clarify with the physician to see if he wanted the systolic blood pressure and pulse both monitored prior to giving the medication. 2. The record for Resident J was reviewed on 7/22/24 at 1:10 p.m. Diagnoses included, but were not limited to, end stage renal disease, dependent on renal dialysis, hypertension, and hypotension (low blood pressure). The Annual Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident was cognitively intact. A Care Plan, dated 11/2/23 and reviewed on 7/19/24, indicated the resident had hypotension with episodes of syncope (fainting) related to dialysis. Interventions included, but were not limited to, administer medications per physician's order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated 5/3/24, indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) give 5 milligrams (mg) every 8 hours as needed (PRN) related to hypotension. Administer if the resident's systolic (top number) blood pressure was lower than 110 and diastolic (bottom number) blood pressure was lower than 80. The June 2024 Medication Administration Record (MAR), indicated the resident's systolic blood pressure was below 110 and/or his diastolic blood pressure was below 80 on the following dates and times and the PRN Midodrine was not administered: 9:00 a.m.: - 6/5 94/69 - 6/7 109/63 - 6/8 104/76 - 6/15 103/71 - 6/22 108/78 Evening: - 6/1 109/73 - 6/7 91/62 - 6/10 105/74 - 6/15 101/68 - 6/16 106/64 The July 2024 MAR, indicated the resident's systolic blood pressure was below 110 and/or his diastolic blood pressure was below 80 on the following dates and times and the PRN Midodrine was not administered: 9:00 a.m. - 7/6 94/70 - 7/7 108/75 - 7/10 92/62 - 7/14 105/77 - 7/19 90/52 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 7/20 101/75 Evening: - 7/11 101/71 - 7/13 89/56 - 7/18 108/62 - 7/22 100/78 A Physician's Order, dated 5/14/24, indicated the resident was to receive Irbesartan (a medication used to treat high blood pressure) 300 mg at bedtime. The medication was to be held if the systolic blood pressure was less than 110. The July 2024 MAR, indicated the resident's blood pressure on 7/11 was 101/71 and on 7/22 his blood pressure was 100/78. The medication was not held and was administered on both days. During an interview on 7/23/24 at 4:10 p.m., the Director of Nursing indicated the medications weren't held or administered per parameters. 10770 3. The record for Resident C was reviewed on 7/22/24 at 10:50 a.m. Diagnoses included but were not limited to, respiratory failure, joint stiffness, COPD (chronic obstructive pulmonary disease), Parkinson's disease, heart disease, atrial fibrillation, anemia, and dementia. The 6/24/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and wore oxygen while a resident. A Nurses' Note, dated 7/14/24 at 6:39 p.m., indicated the resident was found sitting next to the bed Indian style. The resident indicated she was praying and the indwelling catheter was in the bed. The resident's POA and physician were notified. Nurses' Notes, dated 7/15 and 7/16/24, indicated there was no documentation of any injury related to the previous fall. Nurses' Notes, dated 7/17/24 at 2:51 p.m., indicated upon assessment, the resident was noted with a dark purple discoloration measuring 23 centimeters (cm) by 15 cm and extending down and under the left breast. The resident denied any pain or discomfort and was not able to recall when the discoloration first appeared. The resident's POA and physician were notified. An IDT (interdisciplinary team) Review Note, dated 7/18/24 at 8:28 a.m., indicated the resident's skin discoloration to the left breast was believed to be from the most recent fall. During an interview on 7/24/24 at 8:55 a.m., the Director of Nursing indicated the bruise was more than likely from the fall she had on 7/14/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/24 at 11:00 a.m., the Unit 4 Manager indicated she did her own investigation into the bruise on the resident's left breast area. She interviewed CNA 3, who worked on 7/14/24 when the fall happened. CNA 3 indicated she noticed the bruise hours after the fall and told LPN 2 while CNA 2 was standing there and witnessed the conversation. The Unit Manager interviewed LPN 4, who worked on 7/13/24 on the 3-11 shift. He told the Unit Manager the bruise was not there on 7/13/24 because the resident removed her blouse and he could see her chest. The Unit Manager indicated she spoke with LPN 2 about the fall and LPN 2 told her nothing about the bruise. LPN 3 was interviewed as well and she informed the Unit Manager she had seen the bruise on 7/15/24, but just assumed everyone knew about it and it was from the fall. The Unit Manager indicated when the bruise was first observed, an assessment and a measurement should have been completed. 4. During an observation on 7/18/24 at 1:26 p.m., Resident K's legs were discolored and swollen. The resident lifted up his sweat pants and deep indentations were observed at the point where the elastic bands were resting on his skin. The resident was wearing plain socks to both feet. During an interview at that time, the resident indicated he was supposed to get those special socks to wear, but he had not yet received them. The record for Resident K was reviewed on 7/19/24 at 3:02 p.m. Diagnoses included, but were not limited to, heart failure, acute respiratory failure, atrial flutter, high blood pressure, COPD (chronic obstructive pulmonary disease), type 2 diabetes, and anemia. The 5/5/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, The resident had no current skin issues. A Care Plan, revised on 4/2/24, indicated the resident had heart failure. The approaches were to monitor for dependent edema of the legs and feet. A Nurse Practitioner (NP) Progress Note, dated 7/11/24, indicated patient is seen today for follow up visit. Bilateral lower extremity edema 2 plus. TED hose ordered. Wear while awake and take off for sleep. (sic) The physical exam indicated the resident had pitting edema to both lower extremities. Physician's Orders, dated 7/11/24, indicated to measure for TED hose (stockings specially designed to help prevent blood clots and swelling in the legs) for bilateral lower extremity swelling. Physician's Orders, dated 7/15/24, indicated TED hose to bilateral lower extremities, apply in the morning and remove at night for edema. The Head to Toe Weekly Skin Assessments, dated 7/6, 7/13, and 7/17/24, indicated the resident had no new or existing skin issues. Nursing Progress Notes, dated 7/1-7/17/24, indicated there was no documentation or an assessment of the resident's legs or edema. The Treatment Administration Record (TAR) for 7/2024, indicated the TED hose were signed out as being donned on 7/18/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/22/24 at 2:45 p.m., the Unit 3 Manager indicated the resident did refuse to wear his TED hose at times and she had to convince him today to put them on. There was no documentation in nursing progress notes or on the head to toe skin assessments of the pitting edema to the resident's lower legs. 48055 5. During an observation in the activity room on 7/23/24 at 3:45 p.m., Resident D was interviewed. He indicated he was bummed out about missing his urology appointment yesterday. Resident D was told he had to reschedule his appointment because the facility did not have transportation to get him there. He indicated this appointment was important to him. Resident D's record was reviewed on 7/23/23 at 3:45 p.m. Diagnoses included, but were not limited to, chronic pain syndrome, benign prostatic hyperplasia with lower urinary tract symptoms, acute kidney failure, feeling of incomplete bladder emptying, and retention of urine. The Quarterly Minimum Data Set (MDS) assessment, dated 6/21/24, indicated the resident was cognitively intact. A Care Plan, dated 6/11/24, indicated Resident D had difficulty with toileting with occasional urinary incontinence episodes. Resident D had an Urology appointment scheduled for 7/22/24, which was rescheduled for 8/19/24 due to the facility not having the ability to transport the resident. During an interview with the Director of Nursing on 7/23/24 at 2:01 p.m., she indicated the payer source was an issue for a Medicaid resident regarding transportation. The facility currently had the nursing staff outsourcing the transportation needs for those residents until they got insurance in place for the newly hired driver, which may take a few weeks, resulting in some residents missing their appointments. 6. Resident E's record was reviewed on 7/23/23 at 3:19 p.m. Diagnoses included, but were not limited to, acute kidney failure, hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 7/4/24, indicated the resident was cognitively intact. A Care Plan, dated 5/14/24, indicated Resident E had hypertensive heart disease with heart failure, and chronic kidney disease. Resident E had an Nephrology appointment scheduled for 7/22/24, which was rescheduled for 8/22/24 due to the facility not having the ability to transport the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing on 7/23/24 at 2:01 p.m., she indicated the payer source was an issue for a Medicaid resident regarding transportation. The facility currently had the nursing staff outsourcing the transportation needs for those residents until they got insurance in place for the newly hired driver, which may take a few weeks, resulting in some residents missing their appointments. 7. Resident F's record was reviewed on 7/23/24 at 2:30 p.m. Diagnosis included but not limited to, acute respiratory failure with hypoxia, tracheotomy status, and pneumonia unspecified organism. The Admission Minimum Data Set (MDS) assessment, dated 4/23/24, indicated cognitive skills for daily decision making for the resident were severely impaired. A Care Plan, dated 6/20/24, indicated Resident F had a tracheotomy, post cardiac arrest, and respiratory failure with hypoxia. Resident F had an Pulmonary appointment scheduled for 7/3/24 that was rescheduled for 7/17/24. During an interview with the Director of Nursing on 7/23/24 at 10:10 a.m., she indicated their facility driver resigned and they were outsourcing transportation, which had caused a few residents to miss their scheduled appointments. 48383 8. On 7/18/24 at 11:01 a.m., Resident G was observed in bed. There was a rash all over the resident's face. The skin on top of the forehead was red, dry, and cracking. On 7/19/24 at 9:32 a.m. and 2:11 p.m., Resident G was observed in bed. At those times, the resident had a red rash on around their face. On 7/22/24 at 10:05 a.m. and 2:16 p.m., the resident was observed in bed. The rash on the resident's face was red, dry, and scabbed in areas. The record for Resident G was reviewed on 7/19/24 at 10:50 a.m. The diagnoses included, but were not limited to, fibromyalgia, heart failure, lupus, depression, anxiety, schizoaffective disorder, gout, hypertension (high blood pressure), insomnia (difficulty sleeping) and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment, dated 6/13/24, indicated the resident was severely impaired for daily decision making. The resident had impairment on both sides of the upper and lower extremities. A Care Plan, dated 6/11/24, indicated the resident had impaired skin integrity related to impaired mobility, and fibromyalgia. Interventions were to administer calmoseptine every shift, observe and assess skin with daily care, and report changes to nurse for further assessment and intervention. There was no physician order for Calmoseptine ointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated 11/4/23, indicated vital signs and a weekly skin check assessment were to be completed on every night shift, every Wednesday . A skin assessment and vitals were to be completed every Saturday. A Head to Toe Weekly Skin Assessment, dated 7/18/24, indicated the resident's skin was intact and they had no existing skin issues. During an interview on 7/22/24 at 2:22 p.m., the Director of Nursing (DON) indicated Resident G's rash was assessed on 7/21/24 and a call to the physician was made to get a treatment put in place. The facility would continue to monitor the resident's skin condition going forward. This citation relates to Complaint IN00433844 and IN00439030. 3.1-37(a) 3.1-37(b)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 10326 Based on observation, record review, and interview, the facility failed to ensure meal consumption logs were completed for a resident with a history of significant weight loss for 1 of 2 residents reviewed for nutrition. (Resident 68) Finding includes: On 7/23/24 at 12:32 p.m., Resident 68 was observed in his room seated on the side of his bed. He was served an open faced turkey sandwich, potatoes, and cauliflower. The resident was eating his lunch with his fingers. The record for Resident 68 was reviewed on 7/19/24 at 2:10 p.m. Diagnoses included, but were not limited to, lung cancer, dysphagia (difficulty swallowing), and vascular dementia with behavior disturbance. The 5 day Medicare Minimum Data Set (MDS) assessment, dated 6/21/24, indicated the resident was severely impaired for daily decision making and he needed set up or clean up assistance with eating. He also received a mechanically altered diet. A Care Plan, revised on 6/20/24, indicated the resident had a nutritional problem or potential nutritional problem related to a past medical history of stroke, abnormal finding of the lung field, dementia with behavioral disturbance, and vitamin B12 deficiency. The resident had a history of significant weight changes and alterations in his ability to swallow requiring an altered diet and fluid consistency. The resident weighed 149 pounds on 6/5/24 and 135 pounds on 7/8, which indicated a 9.4% weight loss in 1 month. The resident weighed 159 pounds on 1/9/24, indicating a 14.5% weight loss in 6 months. The Food Consumption Logs, dated 6/24-7/23/24, indicated no dinner intake was documented on 6/25, no breakfast or lunch intake was documented on 7/3, 7/12, and 7/13, and there was no documentation of intake for any meal on 7/18/24. During an interview on 7/23/24 at 4:10 p.m., the Director of Nursing indicated the food consumption logs should have been completed for each meal. 3.1-46(a)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 10770 Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate and a resident was transported to the Pulmonologist's office for an appointment for 1 of 2 residents reviewed for respiratory care. (Resident C) Finding includes: During a phone interview on 7/19/24 at 11:20 a.m., Resident C's POA (power of attorney) indicated her mother had missed a cardio/pulmonologist appointment due to the facility not having transportation. The appointment was made over a year ago for the resident to be evaluated for a c-pap (continuous positive airway pressure) machine (a machine used that used mild air pressure to keep breathing airways open while sleeping). During random observations on 7/22/24 at 1:20 p.m., 3:30 p.m., and 4:48 p.m., the resident was observed wearing oxygen per nasal cannula at 0.75 liters per minute. The resident was connected to a portable oxygen tank. During random observations on 7/23/24 at 7:50 a.m. and 11:55 a.m., the resident was observed wearing oxygen per nasal cannula at 2 liters per minute on the portable tank. The record for Resident C was reviewed on 7/22/24 at 10:50 a.m. Diagnoses included but were not limited to, respiratory failure, COPD (chronic obstructive pulmonary disease), Parkinson's disease, chronic bronchitis, heart disease, atrial fibrillation, and dementia. The 6/24/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making and wore oxygen while a resident. A Care Plan, revised on 6/27/24, indicated the resident had COPD. Physician's Orders, dated 6/17/24, indicated continuous oxygen at 3 liters per minute per nasal cannula. Nurses' Notes, dated 7/17/24 at 12:04 p.m., indicated the resident had an appointment that afternoon to see a cardio/pulmonologist. Due to last minute transportation issues, the appointment had to be rescheduled for 8/7/24 at 12:30 p.m. The resident's daughter (POA) was made aware of the change due to her being the family member who requested the appointment. During an interview on 7/23/24 at 1:50 p.m., the Director of Nursing indicated the oxygen flow rate should be on as ordered by the physician. The transportation coordinator resigned and did not give notice to the facility, therefore, some residents were left without a ride to their appointments. The resident missed her appointment on 7/17/24 due to transportation issues. This citation relates to Complaints IN00439030 and IN00433844. 3.1-47(6)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48383 Based on observation, record review, and interview, the facility failed to ensure nonpharmacological interventions were offered, documented, and the pain assessment lacked a pain scale when monitoring for 1 of 1 resident reviewed for pain. (Resident 45) Finding includes: During an interview on 7/18/24 at 10:52 a.m., Resident 45 indicated he was having pain in his stomach and penis and the nurses would not give him Tylenol. On 7/19/24 at 11:29 a.m., the resident was observed lying in bed. He indicated he was in a lot of pain but did not request medicine since the nursing staff always refused his requests. On 7/22/24 at 2:15 am., the resident was observed in bed. He indicated he still had pain in his lower stomach and penis and was not offered Tylenol when pain was expressed to the staff. The record for Resident 45 was reviewed on 7/19/24 at 10:56 a.m. The diagnoses included, but were not limited to, stroke, hypertension (high blood pressure), anxiety, hemiplegia (paralysis on one side of the body), benign prostatic hyperplasia (enlarged prostate gland), and opioid abuse. The Quarterly Minimum Data Set (MDS) assessment, dated 5/25/24, indicated the resident was cognitively intact for daily decision making. The resident had impairment on one side of the upper and lower extremities and used a wheelchair. A Care Plan, dated 7/19/24, indicated the resident had a history of alcohol abuse, cocaine abuse and opioid abuse. Interventions included ensuring medication was swallowed to prevent pocketing medication and reevaluate plan of care regarding pain management. A Care Plan, dated 5/17/24, indicated the resident was at risk of pain due to history of left knee pain, gastrointestinal discomfort (indigestion), general discomfort, and testicle pain. Interventions were to monitor daily physical symptoms associated with pain and to offer comfort measures as well as pain medication as needed. A Physician's Order, dated 5/17/24, indicated to give one 5 milligram (mg) tablet of oxybutynin chloride by mouth twice a day for bladder hyperactivity related to benign prostatic hyperplasia. A Physician's Order, dated 5/17/24, indicated to monitor pain level every shift and if pain were present, to monitor, assess, and treat trying non-pharmacological interventions prior to medicating if appropriate. The physician was to be notified for uncontrolled pain and interventions and outcomes were to be documented every shift. A Physician's Order, dated 5/17/24, indicated to administer one Ibuprofen (pain/anti-inflammatory medication) 800 milligram (mg) tablet every 12 hours as needed by mouth for pain. The order was discontinued on 7/9/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Progress Note, dated 7/9/24 at 8:49 a.m., indicated the resident had a vape pen and Motrin pills found in his wheelchair. The physician was notified and new orders were received to discontinue the resident's ibuprofen due to constant drug seeking behavior. The Medication Administration Record (MAR) pain assessment was signed out as completed every shift for the month of July 2024. The pain assessment did not include a pain level or if non pharmacological or pharmacological interventions were administered and effective. During an interview on 7/22/24 at 2:34 p.m., LPN 1 indicated the resident complained of pain this morning, but he didn't have anything for pain ordered, not even Tylenol. She asked another nurse and asked the Unit Manager for clarification since she was new to that hall, and was told the resident had his pain medicine discontinued. She was going to call the physician to see about getting him something for his pain, but did not get around to it yet. During an interview on 7/22/24 at 2:25 p.m., the Director of Nursing (DON) indicated the resident was pocketing pills and they had found medication in his wheelchair. The physician discontinued the resident's ibuprofen due to constant drug seeking behavior. The resident had seen his urologist and pain clinic recently with no new orders. The facility did not have any pharmacological or nonpharmacological interventions documented or in place. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 10770 Based on observation, record review, and interview, the facility failed to ensure each resident saw the dentist at least yearly for 2 of 2 residents reviewed for dental care. (Residents K and D) Findings include: 1. On 7/18/24 at 1:23 p.m., Resident K's teeth were observed to be decayed. During an interview at that time, the resident indicated he has asked to see a dentist but still has not. The record for Resident K was reviewed on 7/19/24 at 3:02 p.m. Diagnoses included, but were not limited to, heart failure, acute respiratory failure, atrial flutter, high blood pressure, COPD (chronic obstructive pulmonary disease), type 2 diabetes, and anemia. The 5/5/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident had no oral issues with his teeth. There was no care plan for any dental issues. An Oral Assessment, dated 3/12/24 and completed by a dental hygienist, indicated the patient had intact teeth, broken teeth, missing teeth and root tips on both arches. The patient also had inflamed or bleeding gums or loose natural teeth. A dental consent was signed by the resident on 4/12/24. There were no visits from the actual dentist in the last year. During an interview on 7/22/24 at 10:35 a.m., the Social Service Director indicated he had the resident sign the consent form for the dentist in April 2024 and he was scheduled to see the dentist on 7/25/24. The dentist was last in the facility on 6/24/24, however, the resident was not seen at that time. During an interview on 7/24/24 at 8:55 a.m., the Nurse Consultant provided a dental action plan, dated 2/1/24, however, the resident still had not seen the dentist as of the action plan. 48383 2. During an interview on 7/18/24 at 10:45 a.m., Resident D indicated they spoke with social services because they wanted top teeth and had requested to see the dentist. Upon observation at that time, the residents was missing top teeth. The record for Resident D was reviewed on 7/19/24 at 11:04 a.m. The diagnoses included, but were not limited to, heart failure, stroke, diabetes, anxiety disorder, kidney failure, and urinary retention. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 6/21/24, indicated the resident was cognitively intact for daily decision making. The resident had impairment on one side of the upper and lower extremities and used a wheelchair. A Care Plan, dated 6/10/24, indicated the resident had oral and dental problems related to missing teeth and a history of a broken jaw. The resident's dental consent form was signed on 4/12/24. During an interview on 7/22/24 at 10:49 a.m., the Social Service Director (SSD) indicated Resident D had not been seen by the dentist since his admitted on 2/25/22. New dental consents were signed in April for all residents to see the dentist. The dentist was last in the facility on 6/24/24. He would try to get Resident D added to the next dental visit scheduled on 7/25/24. During an interview on 7/24/24 at 8:55 a.m., the Nurse Consultant provided an dental action plan, dated 2/1/24, however, the resident still had not seen the dentist as of the action plan. 3.1-24(a)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 10770 Based on observation and interview, the facility failed to ensure food was served and prepared under sanitary conditions related to touching food with ungloved hands, dirty food preparation equipment and greasy pipes for 1 of 1 residents observed for dining and 1 of 1 kitchens observed. (Resident L and the main kitchen) Findings include: 1. During a dining observation on 7/18/24 at 1:10 p.m., Resident L was observed in bed waiting for lunch. At that time, CNA 2 removed the lid off of the resident's tray. Resident L was served a hot dog on plain white bread. The CNA put ketchup on the hot dog and with her bare hands, broke the hot dog and bread in half and handed Resident L half of the sandwich to eat. During an interview at that time, the CNA was aware she should not use her bare hands to cut food in half. During an interview on 7/23/24 at 11:55 a.m., the Dietary Manager indicated staff were to use utensils to cut the resident's food in half. 2. During the brief kitchen sanitation tour on 7/18/24 at 9:22 a.m. with the Dietary Manager (DM), the following was observed: a. The deep fryer had a heavy accumulation of grease on the top and inside. The back splash had a large build up of burned food and both sides of the fryer had a large accumulation of grease and food drippings. b. The convection oven was observed with a large amount of burned food on the bottom and on the racks. The oven doors were greasy and dirty as well as the outside of the oven including the legs. c. The wells of the steam table were rusted with peeling and floating metal pieces. The shelf under the table where the pots and pans were housed was dirty with food crumbs and grease. d. The two standing fan blades and screens were dirty and dusty. Both fans were turned on and blowing towards the steam table and the dish machine. During an interview on 7/23/24 at 11:55 a.m., the DM indicated all of the above was in need of cleaning. This citation relates to Complaint IN00435118. 3.1-21(i)(3)