STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Demotte	10352 N 600 E County Line Rd Demotte, IN 46310

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32664 Based on observation, record review, and interview, the facility failed to ensure residents were assessed for self-administration of medications and had a Physician's Order to self-administer medications, for 2 of 2 residents reviewed for self-administration of medication. (Residents 9 and 32) Findings include: 1. During a medication pass observation on 9/19/24 at 11:12 a.m., LPN 1 was observed preparing Resident 9's medications. The nurse indicated the resident was to have a nebulizer breathing treatment. She poured a plastic vial of ipratropium-albuterol (medication to help control the symptoms of lung disease) 3 ml (milliliters) into a medicine cup attached to an oxygen mask. She then placed the oxygen mask over the resident's face, turned on the treatment machine, and told the resident to take a few deep breaths. She then told the resident she would be back in to remove the breathing treatment in about 10 minutes. The LPN then proceeded to leave the room and walked back to the medication cart to prepare the next resident's medication. The LPN was not observed checking the resident's oxygen saturation or lung sounds prior to administering the nebulizer treatment. During an interview after leaving the resident's room, the LPN indicated she did not check his oxygen saturation or lung sounds. She was unaware if the resident had a self-administration assessment completed. She further indicated she did not normally stay in the resident's rooms while they were receiving the breathing treatments. Record review for Resident 9 was completed on 9/19/24 at 11:40 a.m. Diagnosis included, but were not limited to, hypertension, anxiety, and dyspnea (shortness of breath). The record lacked any indication there was a Physician's Order or a medication self-administration assessment completed for the resident to self administer his breathing treatment without supervision. During an interview on 9/19/24 at 11:44 a.m., the Regional [NAME] President of Operations indicated the residents were not to be left alone during a breathing treatment unless they had a Physician's Order and a self-administration assessment completed. A policy titled, Nebulizer-Medication Administration, and received as current from the facility on 9/19/24, indicated, .4. Obtain baseline pulse, respiratory rate and lung sounds .12. Remain with resident for the treatment unless the resident has been assessed and authorized to self-administer . (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43293 2. On 9/17/24 at 10:49 a.m., Resident 32 was observed walking out of her bathroom, to her bed. There was a medication cup on her dresser that contained 4 pills. One bottle of saline nasal spray and one bottle of Fluticasone Propionate Suspension (a nasal spray for allergies), both labeled with Resident 32's name, were observed on her bathroom counter. The resident indicated the nurse left the pills for her that morning and that she administered her own nasal sprays. Resident 32's record was reviewed on 9/17/24 at 1:18 p.m. Diagnoses included, but were not limited to, obsessive-compulsive disorder, hypothyroidism, and allergic rhinitis. An Annual Minimum Data Set (MDS) assessment, dated 7/10/24, indicated the resident was cognitively intact. An Interdisciplinary Team (IDT) note, dated 12/4/2023, indicated the IDT met to review the resident and determined the resident was able to self-administer supplements and eye drops. The Physician's Orders indicated the resident may self-administer supplements, eye drops, saline nasal spray. There were no orders for self-administration of prescribed oral medications or Fluticasone Propionate Suspension. During an interview on 9/17/24 at 10:52 a.m., LPN 2 indicated she left 4 pills in a medication cup on the residents' dresser around 8:00 a.m. because she was told the resident could take them herself. The medications were [NAME] oil, Levothyroxine (a thyroid medication), fluvoxamine maleate (a medication for obsessive-compulsive disorder), and Advil (Ibuprofen). During an interview on 9/19/24 1:31 p.m., the Regional VP of Operations indicated the assessment to self-administer should be done every 6 months, and the medications should not be left at the bedside, but he would check the policy. A policy titled, Medication Administration General Guidelines, and received as current from the facility on 9/19/24, indicated, .12. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications .16. The resident is always observed after administration to ensure was completely ingested. If only a partial dose is ingested, this noted on the MAR, and action is taken as appropriate . 3.1-11(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on record review and interview, the facility failed to ensure a resident involved in a physical altercation with another resident received psychosocial follow up care for 1 of 3 residents reviewed for abuse. (Resident 136) Finding includes: The closed record for Resident 136 was reviewed on 9/19/24 at 9:30 a.m. The resident was admitted to the facility on [DATE] and discharged to home on 9/8/24. Diagnoses included, but were not limited to, unspecified dementia, hypertension and depression. He resided on the locked memory care unit. The Admission Minimum Data Set assessment, dated 8/29/24, indicated the resident had severe cognitive impairment. An IDOH (Indiana Department of Health) Facility Reported Incident, dated 9/5/24, indicated another resident had approached Resident 136 and struck him numerous times. The residents were immediately separated and assessed for injuries. The other resident was sent to the hospital for aggressive behaviors to be evaluated, and Resident 136 was to be monitored for signs of psychosocial distress. There was no documentation the resident had been monitored for psychosocial distress following the incident. The resident was discharged to home on 9/8/24. During an interview on 9/19/24 at 10:37 a.m., the Social Service Director indicated residents were normally monitored for 72 hours after an altercation for psychosocial distress. For some reason, this event had not been triggered and he was not monitored after the altercation. The current Abuse Prevention and Reporting policy was reviewed and did not have specific guidelines for monitoring psychosocial distress. 3.1-28(d)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45666 Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 1 of 3 residents reviewed for hospitalization . (Resident 27) Finding includes: Resident 27's record was reviewed on 9/18/24 at 3:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and elevation of levels of liver transaminase levels (liver enzymes). The Quarterly Minimum Data Set (MDS) assessment, dated 7/23/24, indicated the resident was moderately impaired for daily decision making. A Nurses' Note, dated 7/12/24 at 6:47 p.m., indicated the Physician was in to see the resident and new orders to send the resident to the hospital were obtained due to elevated liver enzymes. The Responsible Party was notified and report was called to the hospital. The resident was sent with appropriate paperwork. A Physician Order Note, dated 7/12/24 at 6:48 p.m., indicated the resident was seen due to elevated liver enzymes. The resident indicated he had nausea and emesis, but he did not inform staff. He had epigastric (upper abdomen) pain with palpation (touch). The resident was sent to the hospital. There was no documentation to indicate the State approved transfer form was completed and sent with the resident. There was no documentation to indicate the resident's Responsible Party had received written notification of the resident's transfer to the hospital. During an interview on 9/19/24 at 9:42 a.m., the Regional [NAME] President of Operations indicated there was no documentation related to the State transfer form being sent with the resident or to the resident's Responsible Party. A policy titled, Notice of Transfer and Discharge indicated .Prior to discharge or transfer, the facility will: Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility will send a copy of the notice to a representative of the Office of the State Long-term Care Ombudsman . 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 45666 Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were sent the facility's bed-hold and reserve bed payment policy before and upon transfer to the hospital for 1 of 3 residents reviewed for hospitalization . (Resident 27) Finding includes: Resident 27's record was reviewed on 9/18/24 at 3:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and elevation of levels of liver transaminase levels (liver enzymes). The Quarterly Minimum Data Set (MDS) assessment, dated 7/23/24, indicated the resident was moderately impaired for daily decision making. A Nurses' Note, dated 7/12/24 at 6:47 p.m., indicated the Physician was in to see the resident and new orders to send the resident to the hospital were obtained due to elevated liver enzymes. The Responsible Party was notified and report was called to the hospital. The resident was sent with appropriate paperwork. A Physician Order Note, dated 7/12/24 at 6:48 p.m., indicated the resident was seen due to elevated liver enzymes. The resident indicated he had nausea and emesis, but he did not inform staff. He had epigastric (upper abdomen) pain with palpation (touch). The resident was sent to the hospital. There was no documentation to indicate the facility's bed-hold policy was sent to the resident and/or their Responsible Party. During an interview on 9/19/24 at 9:42 a.m., the Regional [NAME] President of Operations indicated there was no documentation related to the bed-hold policy being sent to the resident and/or their Responsible Party. 3.1-12(a)(25)(A)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788 Based on observation, record review, and interview, the facility failed to ensure a resident with abnormal lab results received timely intervention for 1 of 3 residents reviewed for hospitalization (Resident 68), medications were given as ordered for 2 of 5 residents reviewed for unnecessary medications (Residents 24 and 55), and skin discolorations were assessed and monitored for 1 of 2 residents reviewed for non-pressure skin conditions. (Resident 37) Findings include: 1. On 9/18/24 at 9:31 a.m., Resident 68 was observed lying in bed with his eyes closed. Normal Saline 0.9% intravenous fluids were infusing at 100 ml (milliliters) per hour to his left upper arm PICC (peripherally inserted central catheter, intravenous access) line. The record for Resident 68 was reviewed on 9/18/24 at 9:43 a.m. Diagnoses included, but were not limited to, cerebral infarction, chronic kidney disease, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 8/30/24, indicated the resident was cognitively impaired. The resident was hospitalized on [DATE] and returned to the facility on [DATE]. The resident was again hospitalized on [DATE] and returned to the facility on [DATE]. A Care Plan, updated 3/4/24, indicated the resident was at risk for decreased cardiac output related to atrial fibrillation, hyperlipidemia, and hypertension. An intervention, dated 3/4/24, indicated to monitor lab values and report results to the Physician. A Care Plan, updated 3/4/24, indicated the resident was at risk for dehydration related to diuretic use. An intervention, dated 3/26/24, indicated to obtain labs and diagnostics as ordered and follow up with Physician as indicated. A Nurse Practitioner Note, dated 6/28/24 at 1:34 p.m., indicated the resident was seen for evaluation due to reported delusions, headaches, vomiting, and weight loss. The assessment indicated chronic kidney disease and sub-acute cholecystitis. Some lab tests and a KUB (x-ray of the kidney, ureter, bladder) were ordered for 6/28/24 and repeat lab tests were ordered for 7/1/24. A Progress Note, dated 6/28/24 at 3:54 p.m., indicated the KUB results and lab results were reported to the Nurse Practitioner. The lab results indicated the following tests were collected on 7/1/24 at 7:09 a.m. and reported on 7/1/24 at 7:59 p.m.: comprehensive metabolic panel (electrolytes), PT/INR (prothrombin time, blood clotting test), TSH (thyroid stimulating hormone), CBC (complete blood count), lipid panel (cholesterol and triglycerides), vitamin D 25-OH, folate, vitamin B12, and hemoglobin A1C (blood sugar levels). There was a lack of any documentation the lab results from 7/1/24 had been communicated with the Physician or Nurse Practitioner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse Practitioner Note, dated 7/2/24 at 3:26 p.m., indicated she had reviewed the 7/1/24 lab results. The BUN (blood urea nitrogen, a kidney function lab test) was 69 (elevated), the creatinine (a kidney function lab test) was 3.3 (elevated), the potassium was 5.6 (elevated), the alkaline phosphatase (a liver function lab test) was 800 (elevated), and the white blood cell count was 12 (elevated). She had spoken with the Nurse Practitioner who had been on call 7/1/24 and she had not been made aware of these lab results. The resident was to be sent out to the emergency room (ER) for renal failure. A Progress Note, dated 7/2/24 at 3:29 p.m., indicated the Nurse Practitioner had ordered to send the resident to the ER for abnormal labs. A Progress Note, dated 7/2/24 at 3:30 p.m., indicated 911 had been called to transport the resident to the ER. A Progress Note, dated 7/2/24 at 3:47 p.m., indicated EMS (Emergency Medical Services) was at the facility and the resident was going to the ER for evaluation and treatment. The hospital Admission History and Physical, dated 7/2/24, indicated the resident was admitted for acute kidney injury. The chief complaint indicated acute renal failure and electrolyte abnormalities were found on follow up labs. Hyperkalemia (high potassium) and hyponatremia (low sodium) were mild and improved with IV (intravenous) hydration and the renal function was also improving. During an interview on 9/18/24 at 10:50 a.m., the Regional [NAME] President of Operations indicated he would look into the situation. No further information was provided. 32883 45666 2. Resident 24's record was reviewed on 9/18/24 at 9:33 a.m. Diagnoses included, but were not limited to, dementia and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 8/13/24, indicated the resident was cognitively intact. A Care Plan, dated 3/14/22, indicated the resident was at risk for decreased cardiac output related to hypertension (high blood pressure). Interventions included, but were not limited to, administer medications as ordered. A Physician's Order, dated 5/18/24, indicated lisinopril 20 milligram (mg) tablet once daily. A Physician's Order, dated 5/18/24, indicated amlodipine besylate 5 mg tablet once daily. A Physician's Order, dated 5/18/24, indicated hold lisinopril and amlodipine if systolic blood pressure (top number) is less than 110 every shift for hypotension. The August and September 2024 Medication Administration Record indicated the lisinopril and amlodipine were not held per the Physician's Order on the following dates and times: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/7/24 at 7:00 a.m., blood pressure 106/68 - 8/11/24 at 7:00 a.m., blood pressure 109/71 - 8/16/24 at 7:00 a.m., the medication was not administered and a blood pressure was not documented - 9/13/24 at 7:00 a.m., the medication was not administered and a blood pressure was not documented During an interview on 9/19/24 at 9:42 a.m., the Regional [NAME] President of Operations indicated he had no further information to provide. 3. Resident 55's record was reviewed on 9/18/24 at 11:51 a.m. Diagnoses included, but were not limited to, hypertension, chronic kidney disease, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 8/26/24, indicated the resident was cognitively intact for daily decision making. The current Care Plans, indicated the resident had hyperlipidemia, hypertension, and received hemodialysis three times per week. A Care Plan, dated 5/7/24, indicated the resident was at risk for decreased cardiac output related to hyperlipidemia, hypertension, and hypotension. Interventions included, but were not limited to, administer medications as ordered. The September 2024 Physician Order Summary indicated the resident received gabapentin 100 milligrams (mg) 1 capsule three times a day, midodrine 10 mg tablet three times a day, and sevelamer carbonate 800 mg 2 tablets with meals. The August and September 2024 Medication Administration Record (MAR) indicated the medications were not administered as ordered on the following dates and times: Midodrine: - 8:00 a.m. on 8/2, 8/5, 8/6, 8/10, 8/11, 8/16, 8/25, and 9/5/24 - 12:00 p.m. on 8/1, 8/3, 8/5, 8/6, 8/8, 8/10, 8/12, 8/13, 8/15, 8/16, 8/17, 8/23, 8/24, 8/27, 8/29, 8/31, 9/3, 9/5, 9/7, 9/8, 9/10, 9/12, 9/14, 9/17, and 9/19/24 - 4:00 p.m. on 8/5, 8/10, 8/17, and 8/19/24 - 6:00 p.m. on 8/22, 8/23, 8/25, 9/2, 9/5, 9/8, and 9/9/24 Gabapentin: - 8:00 a.m. on 8/21/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12:00 p.m. on 8/1, 8/3, 8/6, 8/8, 8/10, 8/13, 8/15, 8/17, 8/20, 8/21, 8/24, 8/27, 8/29, 8/31, 9/3, 9/5, 9/7, 9/10, 9/12, 9/14, 9/17, and 9/19/24 - 8:00 p.m. on 9/9/24 Sevelamer carbonate: - 12:00 p.m. on on 8/1, 8/3, 8/6, 8/8, 8/10, 8/13, 8/15, 8/17, 8/24, 8/27, 8/29, 8/31, 9/3, 9/5, 9/7, 9/10, 9/12, 9/14, 9/17, and 9/19/24 A Physician's Order, dated 8/21/24, indicated midodrine 10 mg tablet three times a day, hold if systolic blood pressure (top number) is above 130. The August and September 2024 Medication Administration Record (MAR) indicated the midodrine was not held as ordered on the following dates and times: - 8/22/24 at 9:00 a.m., blood pressure 134/60 - 8/22/24 at 12:00 p.m., blood pressure 150/76 - 8/28/24 at 9:00 a.m., blood pressure 142/80 - 8/28/24 at 6:00 p.m., blood pressure 167/93 - 9/1/24 at 9:00 a.m., blood pressure 144/78 - 9/10/24 at 6:00 p.m., blood pressure 138/71 - 9/12/24 at 6:00 p.m., blood pressure 141/86 During an interview on 9/19/24 at 9:42 a.m., the Regional [NAME] President of Operations indicated he had no further information to provide. 4. During an observation and interview on 9/16/24 at 2:51 p.m., Resident 37 indicated she had gone to the hospital and they tried to put multiple intravenous lines into both arms, but they were not successful. The resident's bilateral forearms were observed with large discolorations. Resident 37's record was reviewed on 9/17/24 at 2:48 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness) affecting the left nondominant side and major depressive disorder with psychotic features. The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact for daily decision making. A Weekly Skin Observation assessment, dated 9/11/24 at 8:03 a.m., indicated the general skin observation was warm, dry (normal) with no foot concerns. There were no skin problems. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Weekly Skin Observation assessment, dated 9/18/24 at 2:10 p.m., indicated the general skin observation was warm, dry (normal) with no foot concerns. There were no skin problems. During an interview on 9/19/24 at 9:42 a.m., the Regional [NAME] President of Operations indicated there was no documentation of the bruising in the resident's record and the staff had now implemented a new order for monitoring of the bilateral forearm bruising. A policy titled, Skin Condition Assessment & Monitoring - Pressure and Non-Pressure, indicated . Non-pressure skin conditions (bruises/contusions .etc.) will be assessed for healing progress and signs of complications or infection weekly .A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. 3.1-37(a)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45666 Based on observation, record review, and interview, the facility failed to ensure a resident received ancillary services to maintain vision and hearing in a timely manner, for 1 of 1 residents reviewed for vision/hearing. (Resident 27) Finding includes: During an interview on 9/16/24 at 10:43 a.m., Resident 27 indicated he could not hear or see and required outside services, however, the facility had not done anything to help him with hearing or vision services at the time. Resident 27's record was reviewed on 9/18/24 at 3:01 p.m. Diagnoses included, but were not limited to, encephalopathy (brain disease), legal blindness, and hearing loss. The Quarterly Minimum Data Set (MDS) assessment, dated 7/23/24, indicated the resident was moderately impaired for daily decision making. He had moderate difficulty with the ability to hear and did not have hearing aids. He had highly impaired vision and did not have corrective lenses. A Care Plan, dated 3/25/24, indicated the resident had a behavior problem related to being hard of hearing and yelling out and speaking loudly. A Care Plan, dated 2/20/24, indicated the resident had impaired communication related to hearing deficits. A Physician's Order, dated 7/26/24, indicated to add the resident to the eye doctor list for the next rounds, as he requested an evaluation. An Ancillary Services Consent for vision, hearing, and podiatry services, dated 2/19/24, had verbal consent written for all services. During an interview on 9/18/24 at 3:11 p.m., the Social Services Director (SSD) indicated the resident and/or the Responsible Party had given verbal consent for the three ancillary services, however the Ancillary Service Company indicated they needed a signed consent and order to treat. Ancillary Service Company would not accept a verbal consent to treat. The SSD indicated the current list for the ancillary services did not include Resident 27 at this time for both audiology and optometry services. The SSD assessed needs for services on a quarterly basis and would address this with the resident and/or their Responsible Party at the next Care Plan Meeting. During an interview on 9/19/24 at 1:30 p.m., the Regional [NAME] President of Operations indicated the current process for ancillary services to come in and treat the residents started in March of 2024 and the facility staff had just sent off a new consent to treat with ancillary services. (continued on next page)

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	155572	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Demotte	10352 N 600 E County Line Rd Demotte, IN 46310

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled, Policy on On-site Health Care Services, indicated .It is the policy of the facility to assist resident sin arranging health services on site as needed per resident request. Facility will make appointments for ancillary services as requested by resident. On-site services available: .b) audiologist c) optometry . 3.1-39(a)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32788 Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 7 residents reviewed for accidents. (Resident 21) Finding includes: On 9/16/24 at 10:23 a.m., Resident 21 was observed seated in her wheelchair near the front Nurse's Station. Observation of her room at that time, indicated there were no non-skid strips to the floor anywhere in her room or bathroom. On 9/18/24 at 9:27 a.m., Resident 21 was assisted by staff to her room and was seated in her wheelchair. There were no non-skid strips observed to the floor anywhere in her room or bathroom. The record for Resident 21 was reviewed on 9/19/24 at 11:05 a.m. Diagnoses included, but were not limited to, dementia with psychotic disturbance, chronic obstructive pulmonary disease, and anxiety disorder. The Quarterly MDS (Minimum Data Set) assessment, dated 8/15/24, indicated the resident was cognitively impaired. She had one fall with major injury and one fall with no injury since the prior assessment. A Care Plan, updated 10/23/23, indicated the resident had a potential for falls. An intervention, dated 7/22/24, indicated non-skid strips in front of the bed and in the bathroom. An Indiana Department of Health reportable incident, dated 7/20/24, indicated the resident was found on the floor in the bathroom. The resident indicated she had spilled her drink while attempting to go to the bathroom and slipped in the liquid. She complained of right shoulder pain and was sent to the hospital for evaluation. She was found to have an anterior displaced fracture of sternal end of right clavicle. A Fall IDT (interdisciplinary team) Note, dated 7/22/24 at 10:18 a.m., indicated the resident had attempted to transfer herself to the toilet and slipped in iced tea that she had spilled on the floor. The suggested new intervention was to place non-skid strips in front of the bed and toilet and place lids on all cups. During an interview on 9/18/24 at 10:50 a.m., the Regional [NAME] President of Operations indicated he would review the fall interventions. A facility policy, titled Fall Prevention Program, indicated, .Safety interventions will be implemented for each resident identified at risk .Accident/Incident reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-45(a)

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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. 32582 Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to oxygen not administered as ordered or monitored for 1 of 1 residents reviewed for respiratory care. (Resident 7) Finding includes: On 9/17/24 at 9:44 a.m., Resident 7 was observed seated in her recliner. There was an oxygen concentrator next to her that was turned on. The oxygen tubing and nasal cannula were lying on the floor. The resident indicated she only used the oxygen at night. On 9/18/24 at 11:53 a.m. the resident was observed seated in her room. The oxygen concentrator was off and the oxygen tubing was in a plastic bag. The resident's record was reviewed on 9/18/24 at 10:25 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, diabetes mellitus, schizoaffective disorder and depression. The Quarterly Minimum Data Set assessment, dated 8/15/24, indicated the resident had moderate cognitive deficits, required substantial assistance for transfers and moderate assistance for bed mobility. A Physician's Order, dated 8/31/24, indicted to administer oxygen at 3 liters per minute continuously per nasal cannula. The September 2024 Medication Administration Record (MAR) did not have any documentation related to oxygen being administered or refused. During an interview on 9/18/24 at 2:01 p.m., LPN 1 indicated the resident would refuse to use her oxygen and it was only ordered as needed. She was not aware the order was for continuous oxygen. There was no place on the MAR to document if the oxygen was refused or in use. 3.1-47(a)(6)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788 Based on observation, record review, and interview, the facility failed to provide the necessary care and services for residents who received hemodialysis, related to not monitoring the dialysis access site, for 1 of 1 resident reviewed for dialysis. (Resident 231) Finding includes: On 9/16/24 at 10:19 a.m., Resident 231 was seated in his wheelchair near the front Nurse's Station. He had his dialysis bag on his lap and indicated he was waiting to leave for dialysis. He went to dialysis on Mondays, Wednesdays, and Fridays. He had a catheter to his right chest that was used for dialysis. The record for Resident 231 was reviewed on 9/19/24 at 11:05 a.m. Diagnoses included, but were not limited to, end stage renal disease, hypertension, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 7/10/24, indicated the resident was cognitively intact and received hemodialysis services. The resident was hospitalized on [DATE] and readmitted to the facility on [DATE]. The Physician's Order Summary, dated 9/2024, indicated there were no current orders for when/where the resident was receiving dialysis or for monitoring of the dialysis catheter. There were previous orders, discontinued on 9/3/24, for dialysis services and dialysis catheter monitoring. These orders had not been continued upon readmission on 9/13/24. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 9/2024, lacked any monitoring of the dialysis catheter for 9/13/24, 9/14/24, 9/15/24, 9/16/24, and 9/17/24. During an interview on 9/18/24 at 10:50 a.m., the Regional [NAME] President of Operations indicated he would review the dialysis orders. A Facility Policy, titled Dialysis Monitoring and Observation, received as current, indicated, .7. If the resident has a catheter for dialysis the nurse will assess the catheter site for any signs of drainage and condition of the dressing to the site every shift .Documentation: .3. Assessment of dialysis catheter site for any signs of drainage and condition of the dressing to the site every shift . 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 32664 Based on observation and interview, the facility failed to ensure medications were properly stored for 2 of 4 medication carts observed. (ACU Cart, and [NAME] 1 Cart) Findings include: 1. On 9/20/24 at 2:33 p.m., the ACU Medication Cart was observed with Agency QMA 1. There were multiple pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The QMA indicated that was the first day she had worked on the cart. 2. On 9/20/24 at 2:47 p.m., the [NAME] 1 Medication Cart was observed with RN 2. There were multiple pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The RN indicated that nursing was responsible to clean the carts. During an interview on 9/20/24 at 2:45 p.m., the Assistant Director of Nursing indicated the Director of Nursing was usually responsible to make sure the carts were cleaned. 3.1-25(j) 3.1-25(o)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788 Based on observation, record review, and interview, the facility failed to ensure abnormal lab results were reported to the Physician for 1 of 3 residents reviewed for hospitalization (Resident 68). Finding includes: On 9/18/24 at 9:31 a.m., Resident 68 was observed lying in bed with his eyes closed. Normal Saline 0.9% intravenous fluids were infusing at 100 ml (milliliters) per hour to his left upper arm PICC (peripherally inserted central catheter, intravenous access) line. The record for Resident 68 was reviewed on 9/18/24 at 9:43 a.m. Diagnoses included, but were not limited to, cerebral infarction, chronic kidney disease, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 8/30/24, indicated the resident was cognitively impaired. The resident was hospitalized [DATE] and returned to the facility on [DATE]. The resident was again hospitalized on [DATE] and returned to the facility on [DATE]. A Care Plan, updated 3/4/24, indicated the resident was at risk for decreased cardiac output related to atrial fibrillation, hyperlipidemia, and hypertension. An intervention, dated 3/4/24, indicated to monitor lab values and report results to the Physician. A Care Plan, updated 3/4/24, indicated the resident was at risk for dehydration related to diuretic use. An intervention, dated 3/26/24, indicated to obtain labs and diagnostics as ordered and follow up with Physician as indicated. A Nurse Practitioner Note, dated 6/28/24 at 1:34 p.m., indicated the resident was seen for evaluation due to reported delusions, headaches, vomiting, and weight loss. The assessment indicated chronic kidney disease and sub-acute cholecystitis. Some labs and a KUB (x-ray of the kidney, ureter, bladder) were ordered for 6/28/24 and repeat labs were ordered for 7/1/24. A Progress Note, dated 6/28/24 at 3:54 p.m., indicated the KUB results and lab results were reported to the Nurse Practitioner. The lab results indicated the following labs tests were collected on 7/1/24 at 7:09 a.m. and reported on 7/1/24 at 7:59 p.m.: comprehensive metabolic panel (electrolytes), PT/INR (prothrombin time, blood clotting test), TSH (thyroid stimulating hormone), CBC (complete blood count), lipid panel (cholesterol and triglycerides), vitamin D 25-OH, folate, vitamin B12, and hemoglobin A1C (blood sugar levels). There was lack of any documentation the lab results from 7/1/24 had been communicated with the Physician or Nurse Practitioner. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse Practitioner Note, dated 7/2/24 at 3:26 p.m., indicated she had reviewed the 7/1/24 lab results. The BUN (blood urea nitrogen, a kidney function lab test) was 69 (elevated), the creatinine (a kidney function lab test) was 3.3 (elevated), the potassium was 5.6 (elevated), the alkaline phosphatase (a liver function lab test) was 800 (elevated), and the white blood cell count was 12 (elevated). She had spoken with the Nurse Practitioner who had been on call 7/1/24 and she had not been made aware of these lab results. The resident was to be sent out to the emergency room (ER) for renal failure. A Progress Note, dated 7/2/24 at 3:29 p.m., indicated the Nurse Practitioner had ordered to send the resident to the ER for abnormal labs. A Progress Note, dated 7/2/24 at 3:30 p.m., indicated 911 had been called to transport the resident to the ER. A Progress Note, dated 7/2/24 at 3:47 p.m., indicated EMS (Emergency Medical Services) was at the facility and the resident was going to the ER for evaluation and treatment. The hospital Admission History and Physical, dated 7/2/24, indicated the resident was admitted for acute kidney injury. The chief complaint indicated acute renal failure and electrolyte abnormalities were found on follow up labs. Hyperkalemia (high potassium) and hyponatremia (low sodium) were mild and improved with IV (intravenous) hydration and the renal function was also improving. During an interview on 9/18/24 at 10:50 a.m., the Regional [NAME] President of Operations indicated he would look into the situation. No further information was provided. A Facility Policy, titled Physician-Family Notification-Change in Condition, received as current, indicated, . The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse practitioner; and if known, notify the resident's legal representative or an interested family member when there is: .B. A significant change in the resident's physical, mental, or psychosocial status [i.e. deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications] .C. A need to alter treatment significantly [i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment]; A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences .or commence a new form of treatment to deal with a problem . 3.1-49(f)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 32664 Based on observation, interview, and record review, the facility failed to ensure multiple use equipment was disinfected after use on residents for 1 of 8 residents reviewed during a medication administration observation. (Resident 9 and LPN 1) Finding includes: During a medication pass observation on 9/19/24 at 11:12 a.m., LPN 1 was observed preparing Resident 9's medications. The nurse indicated she had to check the resident's blood pressure prior to giving him his medications. She removed a blood pressure wrist cuff from her medication cart and took it into the resident's room. She then proceeded to apply the blood pressure cuff to the resident's right wrist and turn on the machine. The blood pressure was completed and the LPN removed the blood pressure cuff and returned the blood pressure cuff to the medication cart. The LPN then proceeded to prepare and administer the residen'ts medication before moving onto the next residents. The LPN was not observed to clean the blood pressure cuff before or after applying it to the resident's wrist. During an interview after the observation, LPN 1 indicated she normally would clean the blood pressure cuff before and after using it on a resident and she did not. During an interview on 9/19/24 at 11:44 a.m., the Regional [NAME] President of Operations indicated the LPN should have cleaned the blood pressure cuff prior to using it on the resident. A policy titled, Cleaning & Sanitizing - Wheelchairs and Other Medical Equipment, received as current from the facility on 9/19/24, indicated, .5. Devices/equipment used for more than one resident shall be cleaned between each resident . 3.1-18(b)