STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Health Campus	6685 East 117th Avenue Crown Point, IN 46307

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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. 32582 Based on observation, record review and interview, the facility failed to ensure residents were assessed to self-administer medication and had a physician's order to self-administer medication for 2 of 2 residents observed self-administering medications. (Residents 41 and 201) Findings include: 1. During a random observation on 2/17/25 at 9:09 a.m., Resident 41 was observed seated in her wheelchair in her room. There was a medicine cup with several pills on her overbed table in front of her. Several minutes later, the pills were again observed on the resident's table. The resident asked if she had to take all of them. RN 1 entered the room and then assisted the resident with taking the medications. During an interview on 2/17/25 at 9:13 a.m., the nurse indicated she had left them with the resident because she was taking her time, and she should not have left the medications with the resident. The resident's record was reviewed on 2/17/25 at 9:20 a.m. There was no self-medication administration assessment and no Physician's order to self-administer medications. 2. On 2/17/25 at 9:35 a.m., RN 1 was observed passing medications to Resident 201. The resident was in her bed. On her nightstand, there was a tube of antibiotic ointment and loperamide tablets (anti diarrhea medication). The resident indicated she had diarrhea from the antibiotics she was taking. The RN did not remove the medications. The resident's record was reviewed on 2/17/25 at 10:00 a.m. There was no self-medication assessment, physician's order to self-administer medications, or orders for the antibiotic ointment or loperamide. During an interview on 2/18/25 at 8:45 a.m., the Director of Nursing indicated the resident's companion had brought the medications and had been educated that all medications needed to have a physician's order. 3.1-11

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed and in place for residents with significant weight loss for 2 of 24 care plans reviewed. (Residents 75 and 85) Findings include: 1. Resident 75's record was reviewed on 2/18/25 at 10:55 a.m. Diagnoses included, but were not limited to, heart failure, spinal stenosis, iron deficiency anemia and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was cognitively intact and was dependent on staff assist for toileting and bed mobility. He had a weight loss of 5% or more in a month or 10% or more in 6 months and was not on a physician-prescribed weight loss regimen. The resident's admission weight on 8/8/24 was 324.4 pounds. The resident's weight on 11/5/24 was 293.6 pounds and on 2/5/25, was 246.5 pounds. This was a weight loss of 30.8 pounds, a 24% change, in six months. A Dietary Note, dated 2/13/25, indicated the resident had a significant weight loss. The resident had reported difficulty chewing foods and holding cups. His diet had been downgraded to pureed and Speech and Occupational Therapy had been ordered. There was not a care plan in place to related to the significant weight loss. During an interview on 2/21/25 at 2:50 p.m., the Director of Nursing indicated there was no care plan related to the significant weight loss. 32788 2. The record for Resident 85 was reviewed on 2/19/24 at 9:54 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease, general anxiety disorder, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/24/25, indicated the resident was cognitively impaired and had a significant weight loss. A care plan, updated 7/30/24, indicated the resident was on a regular diet. The interventions included to provide supplements per orders. There was no care plan related to significant weight loss. The resident's weight on 7/19/24 was 154 pounds and on 2/3/25 was 135 pounds. The Culinary Nutritional Comprehensive Assessment, dated 11/1/24, indicated the resident had a significant weight loss x 90 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Culinary Nutritional Quarterly Assessment, dated 1/29/25, indicated the resident had a significant weight loss x 180 days. During an interview on 2/21/25 at 1:44 p.m., the Director of Nursing indicated there should have been a care plan in place for weight loss. 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45666 Based on observation, record review, and interview, the facility failed to ensure care plans were updated for 1 of 24 resident care plans reviewed. (Resident 7) Finding includes: On 2/17/25 at 2:46 p.m., Resident 7 was observed in a wheelchair. Her left hand appeared to be contracted (a condition where the fingers or palm of the hand are involuntarily bent or curled in). The resident was unable to communicate if she was able to open her hand or if she wore any splinting devices. The record for Resident 7 was reviewed on 2/20/25 at 10:25 a.m. Diagnoses included, but were not limited to, cerebral palsy, mild intellectual disabilities, and hemiplegia and hemiparesis (paralysis and weakness) following a stroke affecting the left side. The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/24, indicated the resident was moderately cognitively impaired, had a functional limitation in range of motion on one side of the upper extremities, and required assistance from staff with toileting, showering, and transfers. The February 2025 Physician Order Summary indicated the resident may participate in restorative programs if indicated. A Care Plan, dated 8/22/24, indicated the resident had an ambulation activity of daily living (ADL) self-care performance deficit. Interventions included, but were not limited to, ambulation program with restorative to assist resident by ambulating up to 50 feet with platform walker and gait belt. A Care Plan, dated 8/30/24, indicated the resident was to maintain range of motion. Interventions included, but were not limited to, restorative to instruct and supervise active range of motion (AROM) to the bilateral lower extremities (BLE), 10 repetitions twice daily for 6 to 7 days per week. The CNA Task List indicated restorative was to ambulate the resident up to 50 feet as tolerated with left hand platform walker and restorative was to instruct and supervise AROM to the BLE 10 repetitions twice daily for 6 to 7 days per week. There was no restorative therapy documented for the last 30 days reviewed. During an interview on 2/21/25 at 1:43 p.m., the Director of Nursing indicated the facility has not had restorative therapy since September 2024 and the Care Plan should have been removed. The resident had cerebral palsy and was seen by therapy in the past with no recommendations for splinting devices. 3.1-35(c)(1)

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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. 45666 Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed for non-pressure skin condition treatments and non-pressure skin areas were assessed and monitored for 2 of 5 residents reviewed for skin conditions, non-pressure related. (Residents 1 and 16). Findings include: 1. During an interview and observation on 2/17/25 at 9:42 a.m., Resident 1 indicated she had a sore area on her right upper chest. She had it for the last couple of weeks and told the staff about it the night before. The area was observed to be a large scab with the surrounding skin red in color. On 2/20/25 at 11:09 a.m., Resident 1 had a 4 by 4 padded gauze covering the area on her right upper chest. The resident indicated the staff put a cream on it the night before and was keeping it covered so her top would not rub the area. Resident 1's record was reviewed on 2/19/25 at 11:10 a.m. Diagnoses included, but were not limited to, hereditary motor and sensory neuropathy (affecting the peripheral nerves) and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 2/2/25, indicated the resident was cognitively intact for daily decision making. She had an impairment to range of motion on one side of the upper extremities. She was totally dependent for toileting and transfers and required maximal assistance with showering/bathing. The Skin Check Assessment, dated 2/14/25, indicated there were no skin concerns. During an interview on 2/19/25 at 2:59 p.m., the Wound Nurse indicated she was unaware of the scabbed area until Tuesday (2/18/25) when the resident told her about the area, she was then assessed by the Nurse Practitioner (NP) and received orders for a treatment to the area. During an interview on 2/21/25 at 1:40 p.m., the Director of Nursing indicated she would follow up with the Wound Nurse regarding the scabbed area. There was no further information provided. 2. Resident 16's record was reviewed on 2/18/25 at 3:11 p.m. Diagnosis included, but were not limited to, lymphedema, venous insufficiency, and non-pressure chronic ulcer of the right and left calf. The Quarterly Minimum Data Set (MDS) assessment, dated 1/6/25, indicated the resident was moderately cognitively impaired and required assistance from staff for activities of daily living (ADL) care. The current Care Plan indicated the resident had a non-pressure wound to her right lower shin, venous ulcers to the right and left posterior calf, and a history of a neoplasm tumor to the left lower shin. Interventions included, but were not limited to, observe the areas at least daily, document weekly until resolved, and complete the treatments as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 10/24/24, indicated to cleanse the left lower shin area with normal saline, pat dry, apply hydrofera blue to the wound bed and cover with a dry dressing every Monday, Wednesday, and Friday and as needed. The December 2024 and January 2025 Treatment Administration Records (TARs) indicated the treatment was not completed as ordered on 12/18/24, 12/25/24, 1/1/25, 1/17/25, 1/22/25, and 1/24/25. A Physician's Order, dated 12/6/24, indicated to cleanse the left posterior calf area with normal saline, apply calcium alginate to the wound bed, cover with an abdominal (ABD) pad, wrap with kerlix and secure with tape every Monday, Wednesday, and Friday. The December 2024 and January 2025 TARs indicated the treatment was not completed as ordered on 12/18/24, 12/25/24, 1/1/25, and 1/8/25. A Physician's Order, dated 12/6/24, indicated to cleanse the right posterior calf area with normal saline, pat dry, apply calcium alginate to the wound bed, cover with an ABD pad, wrap with kerlix, and secure with tape every Monday, Wednesday, and Friday. The December 2024 and January 2025 TARs indicated the treatment was not completed as ordered on 12/18/24, 12/25/24, 1/1/25, and 1/8/25. A Physician's Order, dated 12/9/24, indicated to cleanse the right shin with normal saline, pat dry, apply hydrofera blue to the wound bed and cover with a dry dressing every Monday, Wednesday, and Friday. The December 2024 and January 2025 TARs indicated the treatment was not completed as ordered on 12/18/24, 12/25/24, 1/1/25, 1/8/25, 1/17/25, and 1/22/25. A Physician's Order, dated 1/10/25, indicated to cleanse the right posterior calf with normal saline, pat dry, apply xeroform to the wound bed, cover with an ABD pad, wrap with kerlix, then secure with tape every Monday, Wednesday, and Friday. The January 2025 TAR indicated the treatment was not completed as ordered on 1/17, 1/22, and 1/24/25. A Physician's Order, dated 1/10/25, indicated to cleanse the left posterior calf with normal saline, pat dry, apply xeroform to the wound bed, cover with an ABD pad, wrap with kerlix and secure with tape every Monday, Wednesday, and Friday. The January 2025 TAR indicated the treatment was not completed as ordered on 1/17, 1/22, and 1/24/25. During an interview on 2/19/25 at 1:40 p.m., the Wound Nurse indicated there should have been a progress note corresponding to any day the resident refused a treatment. The resident had frequently refused treatments in the past. During an interview on 2/21/25 at 1:50 p.m., the Director of Nursing had no further information to provide. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Wound Assessment, indicated 3. New wounds and/or other skin impairments/abnormalities will be assessed and documented in the medical record upon being observed. 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32582 Based on observation, record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing related to weekly wound assessments not completed and a physician's treatment order not updated for 2 of 2 residents reviewed for pressure ulcers. (Residents D and 4) Findings include: 1. On 2/19/25 at 10:42 a.m., the Wound Nurse was observed providing care for a pressure ulcer on Resident D's left heel. There was a round, dime-sized scabbed area on the left heel. The nurse indicated it was a healing stage 4 pressure ulcer. The resident's record was reviewed on 2/18/25 at 3:05 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, depression and chronic respiratory failure. The Quarterly Minimum Data Set assessment, dated 12/24/24, indicated the resident had severe cognitive impairment, was dependent for toileting, eating, bed mobility and transfers and had a stage 4 pressure ulcer. The Pressure Injury Care Plan, dated 5/29/24, indicated the resident had a history of pressure ulcers and the potential to develop additional pressure ulcers. Interventions included, but were not limited to, provide daily skin monitoring and weekly skin checks. A Skin and Wound Evaluation, dated 12/19/24, indicated there was a stage 4 pressure ulcer on the left heel that measured 0.9 centimeters (cm) x 1.4 cm, scab, no drainage. There were no additional skin and wound evaluations. During an interview on 2/19/25 at 2:56 p.m., the Wound Nurse indicated she did not do weekly wound assessments because it was just a scab. During an interview on 2/21/25 at 2:50 p.m., the Director of Nursing indicated there should be weekly wound assessments. The current policy, Wound Assessment, indicated, .5. A complete wound assessment will be completed weekly for all wounds and skin impairments/abnormalities using the Skin and Wound Program in the electronic medical record 2. On 2/19/25 at 2:16 p.m., the Wound Nurse was observed providing treatment to a pressure ulcer on Resident 4's right lower leg. The nurse removed the old dressing. She cleansed the wound with normal saline and gauze, then applied calcium alginate (an absorbent wound material) to the wound bed and covered the wound with a border dressing. The resident's record was reviewed on 2/19/25 at 9:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus and schizophrenia. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Significant Change Minimum Data Set assessment, dated 1/30/25, indicated the resident had moderate cognitive impairment, was dependent on bed mobility and toileting, and had a stage 4 pressure ulcer. A Physician's Order, dated 12/27/24, indicated the right lower leg treatment was to clean with normal saline and pat dry, apply Hydrofera Blue (an antimicrobial wound foam) to the wound bed and cover with a dry dressing every Monday, Wednesday and Friday. During an interview on 2/19/25 at 2:56 p.m., the Wound Nurse indicated the physician had changed the order a couple weeks ago and she had overlooked changing it in the medical record, but had just . updated it. 3.1-40

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48055 Based on observation, record review, and interview, the facility failed to ensure an order for a palmar guard and a resting hand splint device was followed and in place for a resident with a right hand contracture for 1 of 1 resident reviewed for range of motion. (Resident 42) Finding includes: During random observations on 2/17/24 at 2:17 p.m., on 2/19/25 at 9:26 a.m., and on 2/20/25 at 10:35 a.m., Resident 42 was observed lying in bed. At those times, the resident was observed with her right hand clenched against her chest. On 2/19/25 at 2:01 p.m., CNA 1 indicated the resident could not open her right hand without forcing her hand open or using a hot water towel to open the resident's hand. She had never used a palm protector and did not know if the resident was supposed to have a palm protector applied to her right hand. The record for Resident 42 was reviewed on 2/17/25 at 2:17 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, generalized muscle weakness, and stiffness. The Quarterly Minimum Data Set (MDS) assessment, dated 1/29/25, indicated the resident was cognitively impaired. An Occupational Therapy (OT) Plan and Treatment Note, dated 1/7/25-2/17/25, indicated Resident 42 was recommended to wear a palmar guard and a resting hand splint on the right hand and on the right wrist at all times except bathing and exercise in order to develop and establish a wearing schedule, reduce pain caused by joint deformity, and reduce pain caused by muscle tightening. During an interview on 2/21/25 at 2:37 p.m., Physical Therapist (PT) 1 indicated that the nursing staff were educated and a schedule for splinting was supposed to be implemented for Resident 42. The schedule for the splint/soft palm protector was to wear daily and take off for showers and baths. There was also a restorative program that was written for the resident. During an interview on 2/21/25 at 3:02 p.m., the Assistant Director of Nursing indicated she thought therapy had tried to apply the splint and found her hand to be too tight, so they were attempting to possibly discontinue the splint order. She indicated that the nursing staff did not put a splint order in for the resident. 3.1-42(a)(2)

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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 5 residents reviewed for accidents. (Resident 34) Finding includes: On 2/19/25 at 1: 49 p.m., Resident 34 was observed seated in his wheelchair in the unit dining room. There were no anti-rollback bars or anti-tippers noted to the wheelchair. On 2/19/25 at 2:50 p.m., Resident 34 was observed seated in his wheelchair propelling himself around the unit dining room. There were no anti-rollback bars or anti-tippers noted to the wheelchair. On 2/20/25 at 10:11 a.m., Resident 34 was observed seated in his wheelchair and was brought to the unit dining room by a CNA. There were no anti-rollback bars or anti-tippers noted to the wheelchair. The record for Resident 34 was reviewed on 2/19/25 at 2:56 p.m. Diagnoses included, but were not limited to, Alzheimer's Disease, hypertension, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/24, indicated the resident was cognitively impaired. He had two or more falls with minor injury since the prior assessment and was dependent on staff for transfers. A Care Plan, dated 10/1/24, indicated the resident was at risk for falls. An intervention, dated 11/9/24, indicated to apply front and rear anti-tippers to the wheelchair. A Care Plan Note, dated 11/11/24 at 2:51 p.m., indicated the resident had a fall on 11/9/24 while attempting to self-transfer. Anti-tippers were put in place to the resident's wheelchair as an intervention. During an interview on 2/21/25 at 1:51 p.m., the Director of Nursing (DON) indicated anti-tippers were added to the resident's wheelchair on 11/11/24 per the completed work order. She had determined staff had been putting the resident in his roommate's wheelchair by mistake, which did not have anti-tippers. He was now in the correct wheelchair. A facility policy, titled Fall Prevention, indicated, .Residents are identified as at risk for falls, clinically appropriate interventions will be put into place to reduce the risk for falls and/or to prevent recurrence of falls . 3.1-45(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45666 Based on record review and interview, the facility failed to ensure urinary output was recorded and the physician was notified for low urinary output as ordered for 1 of 1 resident reviewed for urinary catheters. (Resident 37) Finding includes: The record for Resident 37 was reviewed on 2/20/25 at 10:38 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, history of urinary tract infections (UTIs), urethral stricture (narrowing of the urethra), and obstructive and reflux uropathy (disorders of the bladder causing problems with urine flow). The Quarterly Minimum Data Set (MDS) assessment, dated 12/22/24, indicated the resident was severely cognitively impaired and had an indwelling urinary catheter. The current February 2025 Care Plans indicated the resident had an indwelling urinary catheter. An intervention indicated to monitor and document intake and output. The current February 2025 Physician Order Summary indicated monitor Foley catheter output every shift. If output was less than 300 milliliters (ml), notify the physician. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 2/2025, indicated the Foley output was not documented for the following dates and shifts: - 1st shift: 2/4/25 - 2nd shift: 2/1, 2/2, and 2/9/25 - 3rd shift: 2/1 and 2/11/25 The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 2/2025, indicated the Foley output was less than 300 ml on the following shifts: - 1st shift: 2/2, 2/9, 2/10, and 2/16/25 - 2nd shift: 2/3, 2/6, 2/8, 2/10, 2/11, and 2/17/25 - 3rd shift: 2/5, 2/6, and 2/9/25 There was no documentation of the physician being contacted when the Foley output was less than 300 milliliters. During an interview on 2/21/25 at 1:45 p.m., the Director of Nursing indicated she had no further information to provide. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-41(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on record review and interview, the facility failed to monitor weekly weights and document nutritional intake for fluids, meals, and supplements as ordered for residents with significant weight loss for 3 of 3 residents reviewed for nutrition. (Residents 75, 85 and C) Findings include: 1. Resident 75's record was reviewed on 2/18/25 at 10:55 a.m. Diagnoses included, but were not limited to, heart failure, spinal stenosis, iron deficiency anemia and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was cognitively intact and was dependent on staff assist for toileting and bed mobility. He had a weight loss of 5% or more in a month or 10% or more in 6 months and was not on a physician-prescribed weight loss regimen. The resident's admission weight on 8/8/24 was 324.4 pounds. The resident's weight on 11/5/24 was 293.6 pounds and on 2/5/25, was 246.5 pounds. This was a weight loss of 30.8 pounds, a 24% change, in six months. A Physician's Order, dated 11/19/24, indicated to check a weekly weight. The 2025 Medication Administration Record (MAR) indicated the following weekly weights: 1/13/25: n/a 1/20/25: n/a 1/27/25: 256 pounds 2/3/25: n/a 2/10/25: 246.5 pounds 2/17/25: blank During an interview on 2/21/25 at 1:55 p.m., the Director of Nursing indicated there were no additional weekly weights available. 32788 2. On 2/20/25 at 11:36 a.m. Resident 85 was observed seated at a table in the unit dining room eating lunch. He had a mighty shake open in front of him but was not drinking it. The record for Resident 85 was reviewed on 2/19/24 at 9:54 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease, general anxiety disorder, and major depressive disorder. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 1/24/25, indicated the resident was cognitively impaired and had a significant weight loss. A Care Plan, updated 7/30/24, indicated the resident was on a regular diet. The interventions included to provide supplements per orders. There was no care plan related to significant weight loss. The resident's weight on 7/19/24 was 154 pounds and on 2/3/25 was 135 pounds. The Culinary Nutritional Comprehensive Assessment, dated 11/1/24, indicated the resident had a significant weight loss x 90 days. A Nurse Practitioner (NP) Note, dated 12/31/24 at 3:01 p.m., indicated the resident's weight was continuing to decline. The mighty shake was increased from two to three times a day and a 2 cal supplement was added twice a day. A Physician's Order, dated 9/16/24, indicated mirtazapine (Remeron, an antidepressant medication also used as an appetite stimulant) 45 milligrams at bedtime for insomnia and appetite stimulant. Physician's Orders, dated 12/31/24, indicated to give 2 cal supplement twice a day and a mighty shake with meals for weight loss. The Culinary Nutritional Quarterly Assessment, dated 1/29/25, indicated the resident had a significant weight loss x 180 days. The Medication Administration Record (MAR), dated 2/2025, indicated the mighty shake and 2 cal supplements had been administered, however, there was no amount or percentage consumed documented. There was only a check mark documented with each administration. During an interview on 2/21/25 at 1:44 p.m., the Director of Nursing indicated the supplement orders had not been put in the computer correctly to leave an area for the percentage consumed to be documented. She had now updated the orders. 45666 3. Resident C's record was reviewed on 2/20/25 at 11:20 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/24, indicated the resident was severely cognitively impaired and was dependent on staff for all ADLs including eating, toileting, personal hygiene, and transfers. She received hospice care. The resident weighed 155.4 pounds on 8/1/24 and 139 pounds on 2/1/25. The current Care Plans indicated the resident needed assistance with ADLs due to cognitive deficit and was totally dependent on staff for all ADL care. The resident had a nutritional problem and was admitted to hospice. Interventions included, but were not limited to, monitor intake and record. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The February 2025 Physician's Order Summary indicated the resident received super cereal in the morning and a Mighty Shake with meals for supplement. The February 2025 Medication and Treatment Administration Records indicated the Mighty Shake was administered with meals, but did not include how much of the supplement was consumed. The CNA Task: Nutritional Intake was reviewed for the last 30 days (1/23-2/20/25). The following meals were not documented: - Breakfast: 1/28, 2/17, and 2/18/25 - Lunch: 1/28, 2/17, and 2/18/25 - Dinner: 1/24, 1/27, 2/1, 2/4, 2/6, 2/16, and 2/18/25 The CNA Task: Fluid Intake was reviewed for the last 30 days (1/23-2/20/25). The frequency of documentation was at each meal and as needed. There were no documented amounts of fluids consumed at the following meals: - Breakfast: 2/11, 2/17, and 2/18/25 - Lunch: 2/11, 2/17, and 2/18/25 - Dinner: 2/11, 2/16, and 2/18/25 During an interview on 2/21/25 at 9:27 a.m., the Director of Nursing indicated she had no further information to provide. 3.1-46(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 45666 Based on record review and interview, the facility failed to provide proper feeding tube (gastrostomy tube) (g-tube) care as per professional standards, related to a lack of documentation of tube feeding administration for a resident with a history of weight loss for 1 of 2 residents reviewed for tube feeding. (Resident 47) Finding includes: Resident 47's record was reviewed on 2/20/25 at 8:32 a.m. Diagnoses included, but were not limited to, vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 1/7/25, indicated the resident was severely cognitively impaired. She had a feeding tube and was receiving hospice care. The current Care Plans indicated the resident was as risk for dehydration related to the g-tube use. Interventions included, but were not limited to, administer all tube feedings and fluids via g-tube per order. The resident had a g-tube related to dysphagia after a stroke. Interventions included, but were not limited to, registered dietician (RD) to evaluate quarterly and as needed and tube feedings per order. The resident had a potential nutritional problem. Interventions included, but were not limited to, RD to evaluate and make diet changes as needed, supplements as ordered, and monitor signs and symptoms of malnutrition such as significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. A Dietary Note, dated 1/15/2025 at 6:20 p.m., indicated the resident was not receiving any food by mouth and only received tube feeding. She weighted 151.8 pounds (lbs) on 10/11/24, 146.8 lbs on 12/1/24 and 140. 2 lbs on 12/18/24. With significant weight loss evident, it was recommended to increase the duration of the tube feeding to 18 hours at 45 ml per hour with Jevity 1.5 formula. The current February 2025 Physician's Order Summary indicated enteral feed of Jevity 1.5 per g-tube via pump at 45 milliliters per hour. Start the infusion at 2:00 p.m. and turn off at 8:00 a.m. or until total volume was infused for 18 hours. Record all fluid administered through the g-tube every shift. The February 2025 Medication and Treatment Administration Records indicated the tube feeding was not administered on the following days: - 7:00 a.m. to 3:00 p.m.: 2/9, 2/10, and 2/13/25 - 11:00 p.m. to 7:00 a.m.: 2/11 and 2/17/25 During an interview on 2/21/25 at 1:34 p.m., the Director of Nursing indicated the nurse had just forgotten to sign off on the tube feeding administration. 3.1-44(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and treatment related to incorrect oxygen flow rates and not monitoring an oxygen level for 2 of 3 residents reviewed for respiratory care. (Residents 75 and 74) Findings include: 1. On 2/17/25 at 11:12 a.m. and 2/18/25 at 2:58 p.m., Resident 75 was observed lying in his bed with his nasal cannula in place and oxygen flowing at a rate of 3 liters per minute (lpm). Resident 75's record was reviewed on 2/18/25 at 10:55 a.m. Diagnoses included, but were not limited to, heart failure, spinal stenosis, iron deficiency anemia and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was cognitively intact and was dependent on staff assist for toileting and bed mobility. A Physician's Order, dated 11/5/24, indicated to administer oxygen at 2 lpm continuously. On 2/19/25 at 10:05 a.m., the resident was observed with LPN 2. The nurse indicated the oxygen was incorrectly set between 2.5 and 3 lpm and she adjusted it to 2 lpm at that time. 48055 2. On 2/18/25 at 10:33 a.m., Resident 74 was observed in his wheelchair wearing oxygen per nasal cannula. Resident 74's oxygen concentrator was set at 2.5 liters of oxygen. On 2/19/25 at 2:51 p.m., Resident 74 was observed in his wheelchair, his oxygen was set to 2.5 liters. On 2/20/25 at 10:52 a.m., the resident was observed with the ADON. She indicated the oxygen was set to 4 liters. She adjusted the oxygen to 2 liters at that time. The record for Resident 74 was reviewed on 2/18/25 at 10:33 a.m. Diagnoses included, but were not limited to, chronic combined systolic congestive and diastolic heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 1/9/25, indicated the resident was cognitively intact. A Physician's Order, dated 10/10/24, indicated oxygen use at 2 liters via nasal cannula to be administered every 24 hours as needed for hypoxia. Administer oxygen if oxygen saturation falls below 92%. An Assessment of Resident 74's vital record tasks indicated Resident 74's oxygen saturation levels were last checked on 1/20/25, and the resident was saturating at 98% room air. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/25 at 10:57 a.m., the Assistant Director of Nursing verified that Resident 74 should be on 2 liters of oxygen. She indicated she would turn the concentrator to the correct rate immediately. The ADON indicated that Resident 74's oxygen saturation levels were last documented on 1/20/25. She indicated she would get a current oxygen saturation level on the resident immediately. 3.1-47(a)(6)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32582 Based on observation, record review and interview, the facility failed to ensure routine and emergency drugs were received in a timely manner and procedures for accurate dispensing were provided for 2 of 2 residents reviewed for pharmacy services. (Residents 32 and 77) Findings include: 1. On 2/17/25 at 2:00 p.m., Resident 32 was observed seated in her recliner in her room. She indicated she had an itching rash on both arms and her left leg for about a week. She had requested to see the Nurse Practitioner. The resident's record was reviewed on 2/20/25 at 1:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, asthma and colostomy. The Quarterly Minimum Data Set assessment, dated 1/25/25, indicated the resident was cognitively intact and was independent for toileting, transfers, bed mobility and eating. A Physician's Progress Note, dated 2/18/25, indicated the resident was seen that day for a complaint of itching. She had about five red patches to her upper arms and left leg. An order was given for triamcinolone cream twice daily for 14 days to the affected areas. A Progress Note, dated 2/21/25 at 6:15 a.m., indicated the resident was upset the triamcinolone cream had not arrived yet. The pharmacy was called and indicated they would check on it. During an interview on 2/21/25 at 9:25 a.m., the Director of Nursing (DON) indicated medications ordered from the pharmacy should be received within 24 hours. At 3:43 p.m., the DON indicated the pharmacy received the order on 2/18/25 and sent it out via a delivery service on 2/19/25. There was a back up pharmacy for emergency medications. The resident received the medication on 2/21/25. 48055 2. On 2/21/25 at 9:35 a.m., a family interview was held with Resident 77's son. He indicated that he was the power of attorney for his mother and he believed that his mother may have been receiving a discontinued medication named Sertraline (Sertraline is used to treat depression, panic attacks, obsessive compulsive disorder, post-traumatic stress disorder, and social anxiety disorder). He indicated that he believed the medication was in the medication cart and was possibly being administered to his mother during daily medication pass times. The record for Resident 77 was reviewed on 2/21/25 at 9:35 a.m. Diagnoses included, but were not limited to, anxiety disorder, unspecified, other forms of tremors, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, and mood disturbance. The Admission Minimum Data Set assessment, dated 11/20/24, indicated the resident was cognitively impaired. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 1/23/25, indicated Sertraline HCl Oral Tablet 25 milligrams (mg). The Sertraline was also discontinued on 1/23/25. On 2/21/25 at 9:40 a.m., it was observed that the medication cart was found to have Resident 77's discontinued Sertraline HCl 25 milligrams in the weekly cycled medication roll. There was a hand written note that indicated not to administer Resident 77's Sertraline when passing daily medications to the resident. During an interview on 2/21/25 at 9:41 a.m., LPN 2 indicated she had called the pharmacy several times to inform them to stop sending the Sertraline order. She indicated the medication continued to be delivered, so she wrote a note to inform the other nursing staff not to administer the discontinued Sertraline medication to Resident 77. During an interview on 2/21/25 at 3:48 p.m., the DON indicated the pharmacy was interfaced with the facility and received all new and discontinued medication orders. She spoke with the pharmacy and the pharmacist informed her that the medication was originally discontinued, however another pharmacy staff member reordered the Sertraline, which caused the Sertraline to be delivered to the facility weekly. 3.1-25(o)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on record review and interview, the facility failed to ensure non-pharmacological interventions were attempted prior to giving narcotic pain medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 75) Finding includes: Resident 75's record was reviewed on 2/18/25 at 10:55 a.m. Diagnoses included, but were not limited to, heart failure, spinal stenosis, iron deficiency anemia and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was cognitively intact and was dependent on staff assist for toileting and bed mobility. The resident had pain that occurred almost constantly, did not receive prn (as needed) pain medication or non-medication interventions for pain. A Pain Care Plan, dated 8/8/24, indicated the resident had chronic pain due to spinal stenosis. Interventions included, but were not limited to, encourage resident to try different pain-relieving methods such as positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, ultra sound, muscle stimulation. A Physician's Order indicated to give Norco (an opioid pain medication) 5 milligrams (mg)/325 mg, every six hours as needed for pain. A Physician's Order, dated 11/19/24, indicated to monitor pain: non-pharmacological interventions documentation as follows: ice; heat; reposition; elevate; massage; spiritual /meditation; visual imagery; music; other. The 2025 Medication Administration Record (MAR) indicated the resident received seven Norco in January and eight in February. The January and February 2025 MARs lacked documentation to indicate any non-pharmacological interventions had been attempted prior to the administration of the Norco. During an interview on 2/21/25 at 1:55 p.m., the Director of Nursing indicated there was no documentation non-pharmacological interventions has been attempted. 3.1-48(a)(4)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 45666 Based on record review and interview, the facility failed to ensure the residents' medical records included documentation the resident or resident representative was provided education on the benefits and potential risk associated with the COVID-19 vaccination and documentation why the vaccine was not administered for 4 of 5 residents reviewed for COVID-19 vaccinations. (Residents 53, B, 201, and 300) Findings include: 1. Resident 53's record was reviewed on 2/21/25 at 9:55 a.m. The COVID-19 vaccination had not been documented as offered or administered since 9/22/22. There was no documentation education on the benefits and potential risk of the the COVID-19 vaccine had been provided to the resident or the resident's representative. 2. Resident B's record was reviewed on 2/21/25 at 10:10 a.m. The resident received the first COVID-19 vaccination on 2/26/22. The COVID-19 vaccination had not been documented as offered or administered since 2/26/22. There was no documentation education on the benefits and potential risk of the the COVID-19 vaccine had been provided to the resident or the resident's representative. 3. Resident 201's record was reviewed on 2/21/25 at 10:00 a.m. The COVID-19 vaccination had not been documented as offered or administered. There was no documentation education on the benefits and potential risk of the the COVID-19 vaccine had been provided to the resident or the resident's representative. 4. Resident 300's record was reviewed on 2/21/25 at 10:05 a.m. The COVID-19 vaccination had not been documented as offered or administered. There was no documentation education on the benefits and potential risk of the the COVID-19 vaccine had been provided to the resident or the resident's representative. During an interview on 2/20/25 at 2:42 p.m., the Infection Preventionist (IP) indicated she had offered vaccinations at the time of admission. She did not offer vaccinations at other times. The COVID-19 vaccination was not available from their pharmacy, so she had been trying to set up a clinic with the county health department, but she was having difficulty getting it completed. She was not aware she needed to periodically ask the long term residents if they were interested in receiving the COVID-19 vaccinations when eligible, she had only been offering the influenza vaccine when those were available. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/24/25 at 1:22 p.m., the Director of Nursing indicated the IP had been trying to get things set up and in place so that they could have a COVID-19 vaccination clinic. They had not hosted a clinic lately. She did not provide any further information. A policy titled COVID-19 Vaccination Policy, indicated .Procedure .4.2 COVID-19 vaccinations will be offered as per CDC (ACIP) and/or FDA guidelines unless such immunization is medically contraindicated. This will include additional doses or booster doses when appropriate and available .4.5 Prior to administration of the vaccine, the person receiving the immunization, or representative, will be provided with a copy of the CDC's current vaccine information statement .4.9 The resident's medical record will include documentation that the resident was provided education regarding the benefits and potential side effects of the immunization .