STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155662	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Hartsfield Village	503 Otis R Bowen Dr Munster, IN 46321

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 10770 Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to uncovered foley (urinary) catheter bags with urine being seen from the hallway for 1 of 1 residents reviewed for dignity. (Resident 73) Finding includes: During random observations on 5/28/24 at 2:52 p.m. and 4:10 p.m., Resident 73 was observed in bed. At those times, his indwelling foley catheter bag was uncovered and hanging on the side of the bed. The urine in the bag could be seen from the hallway. On 5/29/24 at 8:20 a.m., 1:00 p.m., and 3:00 p.m., the resident's foley catheter bag was uncovered and the urine in the bag could be seen from the hallway. On 5/30/24 at 9:34 a.m., and 3:00 p.m., the resident's foley catheter bag was uncovered and the urine in the bag could be seen from the hallway. The record for Resident 73 was reviewed on 5/29/24 at 2:30 p.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, atrial fibrillation, benign prostatic hyperplasia (an enlarged prostate), chronic kidney disease, acute cystitis, and Urinary Tract Infection (UTI). The 3/23/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling foley catheter. A Care Plan, dated 12/17/23, indicated the resident had potential complications related to an urinary indwelling catheter. Physician's Orders, dated 2/12/24, indicated foley catheter 16 French for urinary retention. During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing (ADON) 1 indicated the foley catheter bag should have been covered in a dignity bag. The current 1/1/24 Standards of Care for the Resident with an Indwelling Urinary Catheter policy provided by the Administrator on 5/31/24 at 2:25 p.m., indicated the drainage bag was to be covered with a dignity bag. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-3(t)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	Allow residents to self-administer drugs if determined clinically appropriate. 10770 Based on observation, record review, and interview, the facility failed to ensure a self-medication administration assessment was completed for residents with medications at the bedside, for 4 of 4 random observations. (Residents 6, 73, 88, and 82) Findings include: 1. During random observations on 5/28/24 at 3:50 p.m., 5/29/24 at 8:20 a.m., 1:00 p.m., and 3:00 p.m., and on 5/30/24 at 9:32 a.m., Resident 6 was observed in her room. At those times there was a Breo hand held inhaler, antibiotic ointment cream, and healing ointment cream observed on the window sill. The record for Resident 6 was reviewed on 5/29/24 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes, COPD, heart disease, high blood pressure, anxiety and depression. The 4/26/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no self-administration of medication assessment located in the clinical record. The Physician Order Summary for the month of 5/2024 indicated there were no orders for the Breo inhaler or the antibiotic creams. There were no orders for the resident to self-administer her own medication or the healing cream. During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing 1 indicated there were no residents on the unit who were able to self-administer their own medications. 2. During random observations on 5/28/24 at 10:30 a.m., 11:47 a.m., 2:52 p.m., and 4:10 p.m., there was a bottle of Nystatin powder observed on Resident 73's night stand. The record for Resident 73 was reviewed on 5/29/24 at 2:30 p.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, atrial fibrillation, benign prostatic hyperplasia (an enlarged prostate), chronic kidney disease, acute cystitis, and Urinary Tract Infection (UTI). The 3/23/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no self-administration of medication assessment located in the clinical record. Physician's Orders, dated 4/19/24, indicated Nystatin powder 100,000 unit/gram 1 application topical to scrotum for yeast twice a day upon rising and before bed. There was no Physician's Order to self-administer his own medications or to leave the medication at the bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing 1 indicated there were no residents on the unit who were able to self-administer their own medications. The Nystatin powder was not supposed to be left in the resident's room. 3. During random observations on 5/28/24 at 10:36 a.m., 11:47 a.m., 2:55 p.m., and 4:10 p.m., 5/29/24 at 8:20 a.m., 1:00 p.m., and 3:00 p.m., and 5/30/24 at 9:35 a.m., there was bottle of Nystatin powder on Resident 88's dresser. The record for Resident 88 was reviewed on 5/30/24 at 9:40 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, and anxiety disorder. The 3/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. There was no self-administration of medication assessment located in the clinical record. Physician's Orders, dated 5/13/24, indicated Nystatin powder 100,000 unit/gram apply to abdominal folds twice a day. There was no Physician's Order to self-administer her own medications or to leave the medication at the bedside. During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing 1 indicated there were no residents on the unit who were able to self-administer their own medications. The Nystatin powder was not supposed to be left in the resident's room. 48383 4. On 5/28/24 at 10:45 a.m., there were 3 containers of glucose tablets on the resident's night stand next to the bed. The resident indicated she would take them at night if her blood sugar dropped. On 5/28/24 at 11:50 a.m., glucose tablets were observed in the same place on the resident's nightstand. On 5/29/24 at 1:00 p.m. and 3:00 p.m., the resident was observed in her room, glucose tablets remained on the nightstand. On 5/29/24 at 1:37 p.m., the resident was not in her room, the 3 containers of glucose tablets were on the resident's nightstand. On 5/31/24 at 8:30 a.m., the resident's systane eye drops were not available in the medication cart. The resident indicated the eye drops were in her room but she couldn't give them to herself. The bottle of eye drops was observed on the window ledge. There was no medication label on the bottle and there was no box for the medication in the room. LPN 2 removed the eye drops from the resident's room and indicated she would order a new bottle from the pharmacy The record for Resident 82 was reviewed on 5/29/24 at 1:00 p.m. The diagnoses included, but were not limited to, diabetes, depression, weakness, Alzheimer's disease, thyroid disorder, and anemia. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admission Minimum Data Set (MDS) assessment, dated 4/20/24, indicated the resident was cognitively intact for daily decision making. The resident received insulin 7 of 7 days for the last look back period. A Care Plan, dated 4/14/24, indicated the resident had the potential for hypo/hyperglycemia due to diabetes. A Physician's Order, dated 4/13/23, indicated to administer a 4-gram glucose chewable tablet as needed for a blood sugar less than 60 with symptoms of hypoglycemia. A Physician's Order, dated 4/13/23, indicated to administer Systane eye drops once a day in both eyes. There was no self-medication administration assessment. There was no Physician order to self-administer medications. During an interview on 5/30/24 at 1:15 p.m., ADON 1 indicated there were no residents on the unit who were able to self-administer their own medications. There was no additional information provided. 3.1-11

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48055 Based on record review and interview, the facility failed to thoroughly investigate and resolve grievances in writing from a resident's family member for 1 of 1 resident reviewed for grievances. (Resident B) Finding includes: During an interview with Resident B and her husband on 5/28/24 at 2:57 p.m., they indicated he had a care plan meeting with staff to ensure the staff got his wife dressed and out of bed daily. He indicated the staff left the resident in her room and in the bed several times. Resident B's husband had filed a grievance with the administrator and had not received anything from the staff regarding his complaint. The husband indicated he had requested grievance information and had requested meeting several times to talk about his concerns. The resident's husband also indicated he felt the administrator had avoided responding to him regarding his concerns for his wife's care. The record for Resident B was reviewed on 5/28/24 at 10:00 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, weakness, dysphagia, oral phase, other lack of coordination, other speech and language deficits following cerebral infarction, unspecified protein-calorie malnutrition, dysphagia following other cerebrovascular disease, morbid (severe) obesity due to excess calories, type 2 diabetes mellitus without complications, hypothyroidism, unspecified, depression, unspecified. The Admission Minimum Data Set (MDS) assessment, dated 4/29/24, indicated the resident was cognitively intact. Informal notes for resident B, received from the Administrator on 5/31/24 when asked for grievances, indicated the following: 5/6/24: Resident B's husband complained that his wife was in her wheelchair for one hour and spent 23 hours in the bed. He also complained that his wife did not attend the activities because she was in the bed. He stated the CNA told him that she could not transfer his wife unless she was agreeable to the care or transfer. The resident indicated he felt his wife was being kept in bed to make her too tired to attend activities. He also felt the staff did not communicate between shifts. There was no documentation of an investigation, summary, decision of confirmed or not confirmed, corrective action, or date a written decision was issued. 5/8/24: the resident's husband believed the staff continually changed the plan for the resident. Resident B's husband indicated that he wanted more showers for his wife instead of bed baths. The Director of Rehab discussed the involvement of therapy in shower sessions and continually communicated changes to nursing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	5/15/24: a care plan meeting was conducted. Resident B's husband was pleased with the therapy involvement in showers. 5/17/24: Resident B's husband was visibly upset and indicated the CNA's knew nothing about the orders for his wife. The staff attempted to calm Resident B's husband down and were unsuccessful. 5/20/24: Resident B's husband was visibly upset and waiting in the lobby for staff. Resident B's husband indicated the CNA's told him his wife was not scheduled for a shower for that day. Staff confirmed that Resident B's shower days were Monday and Thursday. The staff followed up with Resident B and her husband, and Resident B received her shower for 5/20/24. 5/24/24: Resident B's husband was waiting in the lobby for staff to arrive. Resident B's husband told staff he felt the staff was not listening to him. He began being disruptive and using aggressive language. Security asked Resident B's husband to leave the building until he felt calm enough to visit. 5/27/24: Resident B's husband informed the staff of a concern from Resident B, which related to a dining area attendant. Staff indicated they spoke to Resident B, and Resident B was not familiar with the concern. Staff reassured the resident that they were available if Resident B had any concerns. 5/28/24: the ADON told the Administrator that Resident B expressed to her that she might like to limit visits from her husband. Facility staff offered to help facilitate a conversation with Resident B and her husband. Resident B declined and indicated she would talk to her husband. The administrator reached out to the ombudsman for further support. A message was left and follow up plans were indicated. 5/30/24: the administrator checked in with Resident B and she indicated she was comfortable and had no concerns at this time. The staff indicated that they would continue to monitor the resident. There was no documentation to indicate written follow up from the facility was provided to Resident B and/or Resident B's representative regarding the concerns and/or grievances filed. There was no formal grievance form available for the resident or family member to use. During an interview on 5/31/24 at 4:10 p.m. with the Administrator, she indicated she allowed the staff to have full autonomy when it came to handling the concerns of their residents. She did not keep a grievance log and did not track grievances, she allowed the staff to handle the resolutions for the residents. During an interview on 6/3/24 at 4:20 p.m. with the Administrator, she indicated Resident B's husband did tell her his concerns, he also emailed his concerns to her, and expressed his desire to schedule a meeting to discuss his concerns. A Policy titled, Grievance Policy, provided by the Administrator on 6/3/234 at 3:30 p.m., indicated . The facility has named the Administrator or his/her designee as the Grievance Official. The Grievance Official shall oversee the grievance process, receiving, and tracking grievances through to their conclusions. In addition, the Grievance Official shall: Provide written outcomes to the resident/residents representative if requested . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	This Federal tag relates to Complaint IN00434235. 3.1-7(a)(2) 3.1-7(a)(3)(b)

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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 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 ensure areas of bruising and skin tears were assessed and monitored for 4 of 6 residents reviewed for skin conditions non-pressure related. (Residents 26, 60, 168, and 6) Findings include: 1. On 5/29/24 at 9:45 a.m., Resident 26 was observed in her room in bed. An area of reddish purple discoloration was observed on top of the resident's right hand and in between her ring and middle finger. During an interview at that time, the resident indicated she hit her hand on the door frame. The record for Resident 26 was reviewed on 5/29/24 at 3:56 p.m. Diagnoses included, but were not limited to, Guillain-Barre syndrome and history of falling. The Admission Minimum Data Set (MDS) assessment, dated 5/8/24, indicated the resident had short and long term memory problems and was dependent on staff for transfers. The 5/2024 Physician's Order Summary (POS) indicated there was no order to monitor the bruising. The resident was to have weekly skin assessments on Wednesday. There was no documentation in the nursing progress notes nor on the 5/2024 Medication Administration Record (MAR) related to the discoloration. The weekly skin assessment was signed out as being completed on 5/8, 5/15, 5/22, and 5/29/24 on the 5/2024 MAR. There were special instructions to complete a head to toe assessment and document and measure any bruises or skin tears noted. There was no documentation related to the bruising. During an interview on 5/30/24 at 2:45 p.m., Assistant Director of Nursing (ADON) 1 indicated bruises should have been documented when they were observed. A Physician's Order, dated 5/31/24, indicated to monitor the bruise to the right and left third metacarpophalangeal joint until resolved every shift. 2. On 5/29/24 at 9:43 a.m., Resident 60 was observed in her room seated in her chair. A light purple discoloration was observed on the top of her right hand. The record for Resident 60 was reviewed on 5/29/24 at 1:34 p.m. Diagnoses included, but were not limited to, atrial fibrillation (irregular heartbeat) and hypertensive heart disease with heart failure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/24, indicated the resident was cognitively intact. She needed partial to moderate assistance for transfers. The 5/2024 Physician's Order Summary (POS) indicated there was no order to monitor the bruising. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation in the nursing progress notes nor on the 5/2024 Medication Administration Record (MAR) related to the discoloration. During an interview on 5/30/24 at 2:45 p.m., Assistant Director of Nursing (ADON) 1 indicated bruises should have been documented when they were observed. A Physician's Order, dated 5/30/24, indicated to monitor the bruise to the right hand until resolved every shift Nurses' Notes, dated 5/31/24 at 8:37 a.m., indicated the resident had bruising to the right hand, light purple in color and no pain was noted with tactile stimulation. The resident's family stated the bruise was from a previous IV insertion. 3. On 5/29/24 at 9:36 a.m., Resident 168 was observed in his room seated in a high back wheelchair. The resident was observed with multiple areas of reddish/purple discoloration to his bilateral arms and a dressing was in place to his left upper arm. The record for Resident 168 was reviewed on 5/29/24 at 2:18 p.m. Diagnoses included, but were not limited to, Parkinson's disease, atrial fibrillation (irregular heartbeat), and anemia. The 5 day Minimum Data Set (MDS) assessment, dated 5/21/24, indicated the resident was cognitively intact and required partial to moderate assistance with transfers. A Care Plan, dated 5/14/24, indicated the resident was at risk for complications associated with aspirin and antiplatelet therapy. Interventions included, but were not limited to, observe skin with each encounter for bruising and skin tears. The Admission assessment dated , 5/14/24, indicated the resident had bruises to the left upper arm, left antecubital, left lower arm, left wrist, left hand, right upper arm, right antecubital, front of neck, right side of neck, right elbow, right wrist, and right hand A Physician's Order, dated 5/20/24, indicated the resident was to have weekly skin assessments on Mondays. The 5/2024 Physician's Order Summary (POS), indicated there was no order to monitor the bruising and there was no order for the dressing to the left upper arm. There was no documentation in the nursing progress notes nor on the 5/2024 Medication Administration Record (MAR) related to the discoloration. During an interview on 5/30/24 at 2:45 p.m., Assistant Director of Nursing (ADON) 1 indicated bruises should have been documented when they were observed. A Physician's Order, dated 5/30/24, indicated the resident's left arm was to be cleansed with normal saline, pat dry, and apply foam dressing every Monday, Wednesday, and Friday and as needed (PRN). A Physician's Order, dated 5/30/24, indicated to monitor the bruises to the resident's left forearm every shift until resolved. (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 5/31/24, indicated to monitor the scattered bruising to the resident's right forearm every shift until resolved. 10770 4. During random observations on 5/28/24 at 4:00 p.m. and on 5/29/24 at 8:20 a.m., Resident 6 was observed in bed. At those times a bandaid was noted to her left forearm with no date on it. Dried blood could be seen underneath the bandage. On 5/29/24 at 1:00 p.m. and 3:00 p.m., the resident was sitting up in her wheelchair beside the bed in her room. The bandaid was no longer there and a skin tear was observed to the left arm. The skin was rolled back and was bloody. On 5/30/24 at 9:32 a.m., the resident was observed sitting up in the wheelchair in her room. At that time, a clean bandaid was observed over the skin tear. The record for Resident 6 was reviewed on 5/29/24 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes, COPD, heart disease, high blood pressure, anxiety and depression. The 4/26/24 Significant Change Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 4/7/24, indicated the resident was at risk for skin breakdown. The approaches were to notify the nurse and physician of any skin changes and observe the skin with a.m. and p.m. care. There was no documentation in the nursing progress notes regarding any skin tear to the left forearm. During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing 1 indicated she was unaware the resident had a skin tear on her left arm. There should have been an assessment of the area and physician's orders to treat and monitor the area. During an interview on 5/30/24 at 2:00 p.m., the Hospice Nurse indicated the resident had a scab on that arm when she was first admitted , she told the staff to leave it open to air. She was unaware the area had reopened. Nursing Progress Notes, dated 5/30/24 at 2:11 p.m., indicated a new skin tear was noted on the left forearm that measured 2 centimeters (cm) by 1.6 cm. Nursing Progress Notes, dated 5/30/24 at 2:34 p.m., indicated the Nurse Practitioner was notified of the new skin tear and orders to cleanse with normal saline and apply an adaptive bandage was ordered. During an interview on 5/30/24 at 3:00 p.m., RN 1 indicated she had been taking care of the resident today and was unaware she had a skin tear to the left arm. She was not given any information when she came on shift from the night nurse. She measured the skin tear, notified the doctor, family and received an order to treat. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-37(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. 10770 Based on observation, record review, and interview, the facility failed to ensure foley (urinary) catheter bags and tubing were kept off the floor, for 2 of 2 residents reviewed for catheters. (Residents 73 and 93) Findings include: 1. During random observations on 5/28/24 at 10:30 a.m. and 11:47 a.m., Resident 73 was observed sitting in a wheelchair. At those times, his indwelling foley catheter bag was observed on the floor under the wheelchair. The catheter tubing was above his waist. On 5/29/24 at 3:00 p.m., and on 5/30/24 at 3:00 p.m., the resident was observed in bed. At those times, the foley catheter bag was touching the floor. On 6/3/24 8:50 a.m., the resident was observed sitting in the wheelchair in his room eating breakfast. At that time, the foley catheter bag was in a dignity bag under the wheelchair, however, the tubing was dragging on the floor. The record for Resident 73 was reviewed on 5/29/24 at 2:30 p.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, atrial fibrillation, benign prostatic hyperplasia (an enlarged prostate), chronic kidney disease, acute cystitis, and Urinary Tract Infection (UTI). The 3/23/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling foley catheter. A Care Plan, dated 12/17/23, indicated the resident had potential complications related to an urinary indwelling catheter. The approaches were to maintain the catheter bag and tubing below the bladder level. Physician's Orders, dated 2/12/24, indicated foley catheter 16 French for urinary retention. Physician's Orders, dated 4/16/24, indicated give Macrobid (an antibiotic) 100 milligrams (mg) daily for chronic UTI. During an interview on 5/30/24 at 1:15 p.m., Assistant Director of Nursing (ADON) 1 the foley catheter bag and/or tubing should not have been on the floor. 48383 2. On 5/28/24 at 1:30 p.m., Resident 93 was sitting in his wheelchair in front of the nurse's station. The resident had a Foley catheter and the tubing was observed on the floor. On 5/28/24 at 2:29 p.m., Resident 93 was observed in the same place. He was watching television by the nurse's station. The Foley catheter tubing remained on the floor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Hartsfield Village	503 Otis R Bowen Dr Munster, IN 46321

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/24 at 3:00 p.m., Resident 93 was observed sitting in his wheelchair in front of the television in the common area. The catheter tubing was observed on the floor. The record for Resident 93 was reviewed on 5/29/24 at 3:47 p.m. The diagnoses included, but were not limited to, anemia, hypertension (high blood pressure), urinary retention, arthritis, dementia, anxiety, and depression. The resident was dependent with toileting hygiene. The resident had an indwelling catheter. The Admission Minimum Data Set (MDS) Assessment, dated 4/12/24, indicated the resident was not cognitively intact for daily decision making. A Care Plan, dated 5/15/24, indicated the resident had a potential for complications related to a urinary indwelling catheter. A Physician's Order, dated 5/15/24, had indicated to insert a Foley catheter related to urinary retention. During an interview on 5/31/24 at 10:50 a.m., ADON 2 indicated the indwelling foley catheter tubing should not have been on the floor. A policy titled, Standards of Care for the Resident with an Indwelling Catheter, was provided as current by the Administrator on 5/31/24 at 2:25 p.m. The policy indicated, .Secure the catheter to the patients thigh using a securement device. Hang the collection bag below the level of the bladder to prevent urine reflux to the bladder. To maintain free urinary flow the catheter drainage tube is to be free of kinks . 3.1-41(a)(2)

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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. 10326 Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 1 of 1 resident reviewed for oxygen. (Resident 60) Finding includes: On 5/28/24 at 1:58 p.m. and 4:05 p.m., Resident 60 was observed in her room. She had oxygen per nasal cannula in use. The resident's oxygen concentrator was set at 3 1/2 liters. On 5/29/24 at 9:42 a.m. and 1:21 p.m., the resident was again observed in her room with oxygen by the way of a nasal cannula in use. The resident's oxygen concentrator was set at 3 1/2 liters. On 5/30/24 at 9:40 a.m., the resident was observed in her room. Oxygen per nasal cannula was in use and the oxygen concentrator was set at 3 1/2 liters. The record for Resident 60 was reviewed on 5/29/24 at 1:34 p.m. Diagnoses included, but were not limited to, pneumonia, emphysema, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 5/10/24, indicated the resident was cognitively intact and received oxygen therapy. A Care Plan, dated 5/3/24, indicated the resident required the use of oxygen therapy due to emphysema, congestive heart failure, chronic obstructive pulmonary disease, respiratory failure, pneumonia, and asthma. Interventions included, but were not limited to, oxygen as ordered. A Physician's Order, dated 5/3/24, indicated the resident was to receive oxygen at 4 liters per minute per nasal cannula continuously every shift. During an interview on 5/30/24 at 2:45 p.m., Assistant Director of Nursing (ADON) 1 indicated she would check the resident's oxygen concentrator. 3.1-47(a)(6)

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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. 10770 Based on record review and interview, the facility failed to ensure blood pressure medication was not administered outside of the physician-ordered parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 88) Finding includes: The record for Resident 88 was reviewed on 5/30/24 at 9:40 a.m. Diagnoses included, but were not limited to, heart failure, high blood pressure, and anxiety disorder. The 3/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. Physician's Orders, dated 4/1/24, indicated Verapamil (a medication used to treat chest pain and lower the blood pressure) 120 milligrams (mg) give 60 mg twice a day and hold if the systolic blood pressure (top number) was under 140. The 4/2024 Medication Administration Record (MAR) indicated the Verapamil 60 mg was administered on the following dates with a blood pressure outside of the ordered parameters: 4/4 at 9:00 p.m. blood pressure of 139/79 4/6 at 9:00 p.m. blood pressure of 122/73 4/7 at 9:00 a.m. blood pressure of 133/74 4/8 at 9:00 a.m. blood pressure of 136/84 4/8 at 9:00 p.m. blood pressure of 130/80 4/9 at 9:00 p.m. blood pressure of 127/89 4/10 at 9:00 a.m. blood pressure of 126/70 4/10 at 9:00 p.m. blood pressure of 122/80 4/11 at 9:00 a.m. blood pressure of 135/81 4/11 at 9:00 p.m. blood pressure of 133/71 4/12 at 9:00 a.m. blood pressure of 122/82 4/12 at 9:00 p.m. blood pressure of 131/79 4/16 at 9:00 p.m. blood pressure of 132/72 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/17 at 9:00 a.m. blood pressure of 130/72 4/20 at 9:00 p.m. blood pressure of 138/83 4/22 at 9:00 p.m. blood pressure of 137/89 4/25 at 9:00 p.m. blood pressure of 131/71 4/26 at 9:00 p.m. blood pressure of 124/79 4/27 at 9:00 a.m. blood pressure of 122/79 4/29 at 9:00 p.m. blood pressure of 133/81 4/30 at 9:00 p.m. blood pressure of 114/83 The 5/2024 MAR indicated the Verapamil 60 mg was administered on the following dates with a blood pressure outside of the ordered parameters: 5/2 at 9:00 p.m. blood pressure of 127/80 5/3 at 9:00 a.m. blood pressure of 128/79 5/5 at 9:00 p.m. blood pressure of 120/70 5/15 at 9:00 p.m. blood pressure of 129/79 5/17 at 9:00 p.m. blood pressure of 113/71 5/20 at 9:00 p.m. blood pressure of 130/77 5/24 at 9:00 a.m. blood pressure of 130/78 During an interview on 5/31/24 at 10:32 a.m., Assistant Director of Nursing 1 indicated nursing staff should have followed the physician's orders for the administration of the Verapamil. 3.1-48(a)(3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48055 Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to dialysis day, dialysis chair time, and dialysis pick up time, for 1 of 1 resident reviewed for dialysis. (Resident 268) Finding include: 1. The record for Resident 268 was reviewed on 5/28/24 at 1:15 p.m. Diagnoses included, but were not limited to, fracture of nasal bones, subsequent encounter for fracture with routine healing, end stage renal disease, retention of urine, unspecified, dependence on renal dialysis, benign prostatic hyperplasia with lower urinary tract symptoms. The Admission Minimum Data Set (MDS) assessment, dated 5/22/24, was incomplete and in process. The resident was admitted on [DATE]. A Physician's Order, dated 5/22/24, indicated the resident was to receive hemodialysis at [name of] Dialysis Center, on Monday, Wednesday, and Friday. The resident's dialysis pick up time was ordered for 3:00 p.m. The resident's dialysis chair time was ordered for 4:00 p.m. A Progress Note, dated 5/29/24, indicated the resident received dialysis services on Tuesday, Thursday, and Saturday. The progress notes and the resident's dialysis communication book indicated the resident's dialysis pick up time was signed out at 12:00 p.m., and the resident's dialysis chair time was signed out at 1:00 p.m. During an interview on 5/31/24 at 2:31 p.m. with Assistant Director of Nursing (ADON) 1, she indicated the resident's dialysis order has not been updated and she would correct the order. 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. 10326 Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place related to staff failing to sanitize hands in between glove changes for 1 of 1 glucometer use observed and staff failing to donn personal protective equipment (PPE) for a resident in contact precautions during a random infection control observation. (Residents 53 and 73) Findings include: 1. On 5/29/24 at 4:34 p.m., LPN 1 was preparing to complete a blood sugar check via glucometer for Resident 53. The LPN donned gloves and did not hand sanitize nor wash her hands prior. After obtaining the resident's blood sugar result, the LPN removed her gloves and donned a new pair of gloves, she did not hand sanitize in between glove changes. She proceeded to cleanse the glucometer with a germicidal wipe and she removed her gloves. Again, she did not use hand sanitizer. The LPN prepared the resident's medications and administered them. She sanitized her hands prior to leaving the resident's room. During an interview on 6/3/24 at 9:47 a.m., Assistant Director of Nursing (ADON) 2, indicated the LPN should have hand sanitized prior to donning her gloves and in between glove changes. The facility Hand Hygiene policy was provided by the Administrator on 6/3/24 at 10:03 a.m. The policy indicated to decontaminate hands after glove removal and before medication administration. 10770 2. During a random observation on 5/31/24 at 7:45 a.m., the Wound Nurse was observed standing over Resident 73 finishing a skin treatment. At that time, the Wound Nurse was wearing gloves on both hands. She did not have on an isolation gown. A sign posted on the wall outside of the resident's room indicated enteric/contact isolation: all staff must wash their hands with soap and water and don an isolation gown and gloves prior to entering the room. Another sign posted on the wall indicated enhanced barrier precautions (EBP): if contact was made, a gown and gloves was required prior to touching the resident. A 3 tiered container full of isolation gowns, gloves, and face masks was located right by the resident's room door. During an interview on 5/31/24 at 7:52 a.m., the Wound Nurse indicated she was aware she needed to wear an isolation gown when performing the wound treatment, however, she was in a hurry this morning. The record for Resident 73 was reviewed on 5/29/24 at 2:30 p.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, atrial fibrillation, benign prostatic hyperplasia (an enlarged prostate), chronic kidney disease, acute cystitis, and Urinary Tract Infection (UTI). The 3/23/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling foley catheter. Physician's Orders, dated 2/12/24, indicated foley catheter 16 French for urinary retention. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Physician's Orders, dated 5/22/24, indicated to cleanse the head of the penis with soap and water and apply triad wound paste every shift. Nursing Progress Notes, dated 5/24/24 at 2:34 p.m., indicated the resident had 3 foul smelling and mucus filled stool. A new order was obtained to collect a stool specimen. Nursing Progress Notes, dated 5/26/24 at 1:30 p.m., indicated the doctor was notified the resident tested positive for C-Difficile toxin. Physician's Orders, dated 5/26/24, indicated contact/enteric isolation. During an interview on 5/31/25 at 10:50 a.m., Assistant Director of Nursing 1 indicated the Wound Nurse should have donned an isolation gown prior to completing the resident's treatment to his penis area. The current 1/1/23 Prevention and Management of Multi-Drug Resistant Organisms policy, provided by the Director of Nursing on 6/3/24 at 1:30 p.m., indicated enhanced barrier precautions applied to residents with urinary catheters and gowns and gloves were required for high contact care activity. Contact Precautions applied to residents with infected Multi Drug Resistant Organisms and presence of acute diarrhea. 3.1-18(b)