| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155667 | A. Building<br>B. Wing | 10/22/2024 |

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| Oak Grove Christian Retirement Village | 221 W Division St<br>Demotte, IN 46310 |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582<br><br>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 2 residents reviewed for hospitalization . (Resident 15)<br><br>Finding includes:<br><br>Resident 15's record was reviewed on 10/17/24 at 9:50 a.m. Diagnoses included, but were not limited to, heart failure, diabetes mellitus and fluid overload.<br><br>The Quarterly Minimum Data Set assessment, dated 7/27/24, indicated the resident was significantly impaired for daily decision making.<br><br>Progress Notes indicated the resident was sent to the hospital on 8/24/24 and returned to the facility on [DATE].<br><br>There was no documentation to indicate the State approved transfer form was completed and sent with the resident.<br><br>There was no documentation to indicate the resident's Responsible Party had received written notification of the resident's transfer to the hospital.<br><br>During an interview on 10/17/24 at 9:20 a.m., RN 4 indicated when residents were sent out to the hospital they were sent with a face sheet, a copy of the DNR, bed hold policy and transfer/ discharge papers. Copies were made and given to medical records.<br><br>During an interview on 10/17/24 at 2:20 p.m., the Director of Nursing indicated they were unable to locate the State approved transfer form.<br><br>3.1-12(a)(6)(A)(ii)<br><br>3.1-12(a)(6)(A)(iii) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582<br><br>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 2 residents reviewed for hospitalization . (Resident 15)<br><br>Finding includes:<br><br>Resident 15's record was reviewed on 10/17/24 at 9:50 a.m. Diagnoses included, but were not limited to, heart failure, diabetes mellitus and fluid overload.<br><br>The Quarterly Minimum Data Set assessment, dated 7/27/24, indicated the resident was significantly impaired for daily decision making.<br><br>Progress Notes indicated the resident was sent to the hospital on 8/24/24 and returned to the facility on [DATE].<br><br>There was no documentation to indicate the facility's bed hold policy was completed and sent with the resident.<br><br>There was no documentation to indicate the resident's Responsible Party had received written notification of the facility's bed hold policy.<br><br>During an interview on 10/17/24 at 9:20 a.m., RN 4 indicated when residents were sent out to the hospital they were sent with a face sheet, a copy of the DNR, bed hold policy and transfer/ discharge papers. Copies were made and given to medical records.<br><br>During an interview on 10/17/24 at 2:20 p.m., the Director of Nursing indicated they were unable to locate the bed hold policy.<br><br>3.1-12(a)(12)(A) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>43293<br><br>Based on observation, record review, and interview, the facility failed to ensure care plans were reviewed and revised to include changes related to IV (intravenous) fluids for 1 of 22 resident care plans reviewed. (Resident D)<br><br>Finding includes:<br><br>Resident D was observed in bed on 10/15/24 at 9:44 a.m. There were no IV supplies or equipment in her room. The resident indicated she had not had an IV since returning to the facility from the hospital on 9/14/24.<br><br>Resident D's record was reviewed on 10/17/24 at 1:44 p.m. Diagnoses included, but were not limited to, malignant neoplasm of kidney, urinary tract infection, pathological fracture, bone cancer, paraplegia, and neuromuscular dysfunction of the bladder.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident was cognitively intact.<br><br>A Care Plan, dated 9/14/24, indicated the resident needed IV fluids for dehydration. Interventions included, but were not limited to, administer IV fluids, monitor IV site and arm every shift, and complete flushes per orders.<br><br>There were no Physician's Orders for IV fluids.<br><br>During an interview on 10/22/24 at 2:55 p.m., the Director of Nursing (DON) indicated the resident was not receiving IV fluids, and the care plan would need to be modified.<br><br>3.1-35(c)(1) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>32582<br><br>Based on record review and interview, the facility failed to ensure parameters were in place for Physician notification related to weight monitoring for a resident with three times a week weights for 1 of 1 resident reviewed for edema. (Resident 15)<br><br>Finding includes:<br><br>Resident 15's record was reviewed on 10/17/24 at 9:50 a.m. Diagnoses included, but were not limited to, heart failure, diabetes mellitus and fluid overload.<br><br>The Quarterly Minimum Data Set assessment, dated 7/27/24, indicated the resident was significantly impaired for daily decision making.<br><br>A Physician's Order, dated 4/22/24, indicated to weigh the resident every Monday, Wednesday and Friday related to congestive heart failure. There were no parameters in place for when to notify the Physician of a change in weight.<br><br>The current Fluid Maintenance Care Plan indicated the resident was at risk for fluid volume overload due to congestive heart failure. Interventions included, but were not limited to, monitor electrolytes, assess for presence of edema, follow fluid volume restriction orders and monitor input and output.<br><br>During an interview on 10/18/24 at 10:50 a.m., the Director of Nursing indicated she had contacted the Nurse Practitioner and received orders to notify him if there was a five pound increase in a week. She indicated it had not been on the previous order.<br><br>The Weight Monitoring Policy, revised on 9/4/24, indicated, .The care plan should address the following, to the extent possible: .d. Time frame and parameters for monitoring<br><br>3.1-37 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>45666<br><br>Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the treatment and services necessary to promote healing related to updating and following Physician's Orders for wound care for 1 of 3 residents reviewed for pressure ulcers (Resident 20).<br><br>Finding includes:<br><br>During an observation of Resident 20's wound care on 10/21/24 at 10:54 a.m., the Wound Care Nurse was observed changing the dressings on the right heel, right ankle, and right lower leg. She entered the room, washed her hands with soap and water, and donned a gown and gloves. She removed the old dressings from the right lower leg, right ankle, and right heel, each dated 10/19/24. She removed her gloves and donned new gloves, without performing hand hygiene between glove use. She sprayed wound cleanser to gauze and cleaned the right lower leg and then threw away the gauze. She removed more gauze, sprayed it with wound cleanser and cleaned the right ankle. She removed more gauze, sprayed it with wound cleanser and cleaned the right heel. She opened a foam dressing, reached into her pocket and removed a marker, wrote the date on the foam dressing, and continued to perform wound care. She applied honey wound gel to the foam dressing and placed it over the right heel wound. She continued to apply the dressings to the right ankle and right lower leg by putting drops of Tetracyte (topical antibiotic) to the open areas, an oil emulsion dressing, and then a calcium alginate dressing over the top with rolled gauze to hold the dressing in place. She dated the dressing, removed her gloves, and washed her hands.<br><br>Resident 20's record was reviewed on 10/17/24 at 11:47 a.m. Diagnoses included, but were not limited to, cellulitis to the right lower limb, acute kidney failure, and heart failure.<br><br>The Significant Change in Status Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident was significantly impaired for daily decision making. He required assistance from staff for transfers and bed mobility.<br><br>A Physician's Order, dated 9/26/24, indicated apply medical grade honey gel to right heel and cover with border gauze on Tuesday, Thursday, and Saturday.<br><br>A Wound Care Progress Report, dated 10/10/24, indicated the resident had an unstageable right lateral heel pressure ulceration measuring 4.5 centimeters (cm) by 3.5 cm by 0.1 cm. Treatment orders included to apply Tetracyte to the wound bed, followed by medical grade honey and calcium alginate. Cover the wound with bordered gauze daily and as needed for soiled or loose dressing.<br><br>During an interview on 10/21/24 at 11:26 a.m., the Wound Care Nurse indicated the wound care was ordered for three times a week. She was unaware of daily treatment changes.<br><br>During an interview on 10/22/24 at 2:14 p.m., the Administrator indicated she had no further information to provide.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A policy titled, Wound Treatment Policy, indicated .1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.<br><br>3.1-40(a)(2) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>32664<br><br>Based on observation, record review, and interview, the facility failed to ensure an indwelling Foley (urinary) catheter collection bag for a resident with a history of infection was covered and not hanging off the top of a garbage can for 1 of 1 residents reviewed for urinary catheters. (Resident C)<br><br>Finding includes:<br><br>On 10/16/24 at 10:37 a.m., Resident C was observed sitting in a recliner in her room. The resident's urinary catheter bag was uncovered and hanging off the top of a garbage can sitting next to her. The uncovered bag was touching the top and the side of the garbage can. The garbage can was observed with trash in the can.<br><br>On 10/16/24 at 3:15 p.m., the Assistant Director of Nursing (ADON) was asked to observe the resident's catheter bag. Resident C was observed sitting in a recliner in her room. The resident's urinary catheter bag was uncovered and hanging off the top of a garbage can sitting next to her. The uncovered bag was touching the top and the side of the garbage can. The garbage can was observed with trash in the can.<br><br>Record review for Resident C was completed on 10/16/24 at 3:10 p.m. Diagnoses included, but were not limited to, cancer, hypertension, depression, and COPD (chronic obstructive pulmonary disease).<br><br>The Annual Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident was moderately cognitively impaired. The resident required a substantial maximal assistance with toileting, hygiene, and transfers. The resident had an indwelling urinary catheter.<br><br>A Care Plan, dated 12/1/23, indicated the resident had an indwelling urinary catheter with potential for infection. An intervention included for catheter care as ordered.<br><br>The October 2024 Physician's Order Summary indicated the resident had the following orders:<br><br>- catheter care every shift<br><br>- ensure catheter bag was below the waist, covered, and the tubing was not touching the floor<br><br>A Physician's Order, dated 8/20/24 and discontinued 8/27/24, indicated Cipro (antibiotic) 250 mg (milligrams) twice a day for 7 days for a urinary tract infection.<br><br>During an interview on 10/16/24 at 3:15 p.m., the ADON indicated the resident's catheter bag should not have been attached to the garbage can.<br><br>3.1-41(a)(2) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>32664<br><br>Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and treatment related to respiratory equipment not changed as ordered and incorrect flow rate of oxygen (O2) administered for 3 of 4 residents reviewed for respiratory care. (Residents B, C, and D)<br><br>Findings include:<br><br>1. On 10/15/24 at 10:16 a.m., Resident B was observed sitting in a wheelchair in her room. An oxygen concentrator was next to the resident. The water humidification bottle on the concentrator was dated, 10/6/24. The resident's night stand drawer was open and a nebulizer treatment mask was observed, dated 10/6/24.<br><br>Record review for Resident B was completed on 10/16/24 at 3:02 p.m. Diagnoses included, but were not limited to, heart failure, respiratory failure, and COPD (chronic obstructive pulmonary disease).<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 8/19/24, indicated the resident was moderately cognitively impaired. The resident required oxygen therapy.<br><br>A Care Plan, dated 11/19/23, indicated the resident had a diagnosis of COPD and was dependent on supplemental oxygen. An intervention included to administer oxygen.<br><br>The October 2024 Physician's Order Summary (POS), indicated the following orders:<br><br>- DuoNeb (medication used to treat airway narrowing) 3 ml (milliliters), inhale 1 vial four times daily with nebulizer machine<br><br>- Change respiratory equipment: O2 tubing, humidifier, nebulizer tubing every week.<br><br>During an interview on 10/15/24 at 10:59 a.m., LPN 1 indicated the nebulizer mask and humidifier bottle was outdated and should have been changed.<br><br>2. On 10/16/24 at 10:37 a.m., Resident C was observed sitting in a recliner in her room. The resident had a nasal cannula in place and attached to an oxygen concentrator. The concentrator was set at a flow rate between 2 and 2.5 liters.<br><br>On 10/16/24 at 3:15 p.m., the Assistant Director of Nursing (ADON) was asked to observe the resident's oxygen flow rate. Resident C was observed sitting in a recliner in her room. The resident had a nasal cannula in place and attached to an oxygen concentrator. The concentrator was set at a flow rate between 2 and 2.5 liters.<br><br>Record review for Resident C was completed on 10/16/24 at 3:10 p.m. Diagnoses included, but were not limited to, cancer, hypertension, depression, and COPD.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Annual Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident was moderately cognitively impaired. The resident required a substantial maximal assistance with dressing and transfers. The resident required oxygen therapy.<br><br>A Care Plan, dated 6/2/23, indicated the resident had a diagnosis of COPD and used oxygen via nasal cannula. An intervention included for oxygen as ordered.<br><br>The October 2024 POS indicated an order for oxygen at 3 liters continuously.<br><br>During an interview on 10/16/24 at 3:15 p.m., the ADON indicated the resident's oxygen was set at 2.5 liters and not at the correct flow rate.<br><br>43293<br><br>3. Resident D was observed in bed on 10/15/24 at 9:44 a.m. There was an oxygen concentrator near the foot of her bed, which the resident indicated she only used at night. The water bottle in the concentrator was labeled 10/6/24.<br><br>Resident D's record was reviewed on 10/17/24 at 1:44 p.m. Diagnoses included, but were not limited to, malignant neoplasm of kidney, UTI, pathological fracture, bone cancer, paraplegia, and neuromuscular dysfunction of bladder.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident was cognitively intact.<br><br>During an interview on 10/15/24 at 11:00 a.m., LPN 1 indicated the water bottle should be changed every week, and that the resident's bottle was outdated.<br><br>A policy titled, Oxygen Administration and received as current from the facility on 10/22/24, indicated, .4 c. Equipment setting for the prescribed flow rates .5 b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. c. Change humidifier bottle when empty, and weekly per facility policy . 5 d. If applicable, change nebulizer tubing and delivery devices weekly .<br><br>This citation relates to Complaint IN00442131.<br><br>3.1-47(a)(6) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>45666<br><br>Based on record review and interview, the facility failed to establish and/or maintain a system that accounted for, periodically reconciled, and ensured the disposition of all controlled drugs, related to inaccurate documentation of narcotic medications for 1 of 3 residents reviewed for narcotics. (Resident 211) This had the potential to affect all residents who received narcotic medications.<br><br>The deficient practice was corrected by 9/26/24, prior to the start of the survey, and was therefore past noncompliance. The facility thoroughly investigated the narcotic documentation irregularities and possible staff involvement, notified the appropriate entities, re-educated current staff on misappropriation and narcotic documentation, and implemented audits for narcotic documentation accuracy.<br><br>Finding includes:<br><br>The record for Resident 211 was reviewed on 10/18/24 at 9:16 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, Alzheimer's disease, and absence of right leg above knee.<br><br>The Quarterly Minimum Data Set assessment indicated the resident was cognitively intact for daily decision making and received a routine pain medication regimen. She took opioid medications.<br><br>A Physician's Order, dated 8/18/22, indicated oxycodone-acetaminophen 10-325 milligram tablet every 6 hours for pain management.<br><br>The Facility Reported Incident, dated 9/25/24 at 10:30 a.m., indicated during an investigation into documentation irregularities, the Administrator began to suspect that 4 tablets of oxycodone were missing. Immediately an investigation was initiated, the pharmacy was notified and asked to conduct an audit. The Medical Director and the resident's physician, resident's family and the police department were all notified. Routine surveillance of medication records were being conducted for preventative measures. The follow up indicated the audits of medication records revealed three residents with suspect medication administrations. All families were informed of the suspected misappropriate of narcotics or potential medication error. The results of the investigation did not conclusively identify an individual responsible for the missing medication. Other issues that were identified as a result of the investigation had been determined to be a violation of the medication administration and documentation policy. The employee involved was addressed in accordance with progressive discipline. All nurses were re-educated regarding misappropriation and medication administration and documentation policy. Routine audits would be conducted by the Director of Nursing (DON) or her designee and the results would be submitted to QAPI monthly. The QAPI team would determine if audits should be amended or discontinued.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Investigation Summary, dated 9/25/24, indicated on 9/24/25 at approximately 3:15 p.m., LPN 1 brought Resident 211's narcotic sign out sheet to the DON and informed her of irregularities. LPN 1 stated that she gave the dose recorded on 9/21/24 at 12:00 a.m. and stated that the following recorded administrations used her initials, but she did not give the doses. The next two lines are concealed by whiteout and new documentation was written over it. This was a new narcotic sheet and the 9/21/24 6:00 a.m. dose was the first for the current sheet and medication card.<br><br>The Narcotic Sheet, dated 9/19/24 at 12:20 p.m., indicated a new card for oxycodone/acetaminophen tablet 10-325 milligram with 30 pills was received. The first dose recorded was 9/20/24 at 6:00 a.m. signed out by LPN 1. The date was written over a whited out area. The next two doses for 9/20/24 at 12:00 p.m. and 6:00 p. m. were also written over a whited out area and signed out by LPN 1. Two more doses were signed out by LPN 1 on the sheet for 9/21/24 at 12:00 a.m. and 6 a.m.<br><br>The previous Narcotic sheet, dated 9/14/24 at 8:30 p.m., indicated oxycodone/acetaminophen tablet 10-325 milligrams. Doses were signed out as administered on 9/20/24 at 6:00 a.m., 12:00 p.m., and 6:00 p.m., and 9/21/24 at 12:00 a.m.<br><br>During an interview on 10/18/24 at 10:32 a.m., the Administrator indicated she had performed audits on all of the narcotics in house after this was brought to her attention. She also looked at the corresponding Medication Administration Records (MAR) and noticed some discrepancies with one of the nurses, RN 5, not putting the medications administered in the MAR, but checking it off on the narcotic count sheets as well as being a primary nurse to administer as needed narcotics. RN 5 no longer worked in the facility after the information was discovered. The facility was unable to determine who removed the medications from the card or who altered the narcotic count sheet. There was now ongoing auditing as well as education provided to all the nursing staff regarding misappropriation of medication, documentation of medication administration, narcotic count sheet accuracy, narcotic medication ordering/discontinuance, and controlled substances. The audits were being conducted weekly on all narcotic sheets and corresponding MARs in house.<br><br>During an interview on 10/18/24 at 11:22 a.m. the Director of Nursing indicated she had not been doing any type of auditing prior to the event taking place regarding narcotic medications and had no further information to provide.<br><br>3.1-25(b)(3) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155667 | A. Building<br>B. Wing | 10/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oak Grove Christian Retirement Village | 221 W Division St<br>Demotte, IN 46310 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582<br><br>Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being related to lack of non-pharmacological interventions used prior to giving anti-anxiety medication and lack of monitoring for side effects of an antidepressant for 2 of 5 residents reviewed for unnecessary medications. (Residents 37 and 48)<br><br>Findings include:<br><br>1. Resident 37's record was reviewed on 10/18/24 at 9:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, depression and asthma.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 7/19/24, indicated the resident had significant cognitive impairment and received anti-anxiety medications.<br><br>A Physician's Order, dated 6/24/24, indicated to give alprazolam (anti-anxiety medication), 0.25 milligrams (mg) every six hours as needed for as needed for anxiety.<br><br>A Physician's Order, dated 6/21/24, was for an anxiety protocol every shift: 1) Address physical needs 2) Change environment 3) Redirect thoughts 4) All of the above.<br><br>The September and October 2024 Medication Administration Record (MAR) indicated alprazolam had been given on 9/3, 9/10, 9/21, 9/22 and 10/13. There was no documentation on the MAR or in Progress Notes indicating any non-pharmacological interventions had been attempted prior to giving the medication.<br><br>During an interview on 10/21/24 at 11:10 a.m., the Director of Nursing (DON) provided medication administration notes that indicated non-pharmacological interventions had been attempted on 9/3 and 10/13. There was no documentation for the remaining days.<br><br>2. Resident 48's record was reviewed on 10/17/24 at 11:22 a.m. Diagnoses included, but were not limited to, unspecified dementia, depression and multiple sclerosis.<br><br>The Significant Change MDS, dated [DATE], indicated the resident had moderate cognitive impairment and received antidepressant medications.<br><br>A Physician's Order, dated 8/13/24, indicated to give sertraline (an antidepressant), 100 mg daily for depression.<br><br>A Physician's Order, dated 8/12/24, indicated to give buproprion (an antidepressant), 150 mg daily for depression.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Psychotropic Medication Care Plan, dated 5/22/24, indicated the resident was at risk for adverse effects related to psychotropic medication that included sertraline and buproprion. Interventions included, but were not limited to, observe for any signs of adverse effects from antidepressant use such as dry mouth, blurred vision, constipation, fatigue and drowsiness.<br><br>There was no physician's order or documentation in the resident's record to indicate she was being monitored for adverse side effects.<br><br>During an interview on 10/21/24 at 9:45 a.m., the DON indicated antipsychotic and antidepressant medication side effects should be monitored every shift and there should be a physician's order in place for that monitoring. She indicated there was not an order in place.<br><br>The policy, Psychotropic Medication Policy, revised 8/23/24, indicated, .7. Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drug The policy also indicated, .8. Residents who use psychotropic drugs will be observed for side effects of the medication and, .14. The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record<br><br>3.1-48(a)(3)<br><br>3.1-48(b)(2) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>32582<br><br>Based on observation, record review and interview, the facility failed to ensure a sanitary kitchen related to dishwasher temperatures not reaching the required temperature and lack of temperature monitoring for a high temperature dish machine. This had the potential to affect all 52 residents who received meals from the Main Kitchen.<br><br>Finding includes:<br><br>The initial kitchen tour was completed on 10/15/24 at 9:00 a.m. with the Dietary Manager (DM). The DM indicated the dishwasher was a high temperature dish machine. A wash cycle was observed and the wash temperature was 105 degrees (Fahrenheit) and the rinse was 191 degrees. The DM indicated the wash cycle should be 180 degrees and he was unsure about the rinse cycle.<br><br>The Dish Machine Temperature Log for October 2024 was reviewed. The log indicated, High Temperature Machine Wash 160 degrees, Rinse 180 degrees. Report any variations to the Food Service Supervisor or Administrator.<br><br>Breakfast wash/rinse temperatures were recorded as follows:<br><br>10/2- 128/185<br><br>10/4- 130/187<br><br>10/9- 127/187<br><br>10/10-129/134<br><br>10/11- 138/187<br><br>10/14- 156/176<br><br>Lunch temperatures were recorded as follows:<br><br>10/14- 178/185<br><br>Dinner temperatures were recorded as follows:<br><br>10/2- 180/183<br><br>10/3- 181/185<br><br>10/5- 181/187<br><br>10/6- 180/187<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 10/9- 129/134<br><br>10/10- 129/134<br><br>10/11- 118/184<br><br>There were no additional temperatures recorded for breakfast, lunch or dinner in October.<br><br>During an interview on 10/22/24 at 3:05 p.m., the DM indicated the manufacturer had come to the facility on Tuesday to reset the dishwasher and temperatures were now in range.<br><br>The policy, Dishwasher Temperature, indicated, .Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or refilled for cleaning purposes.<br><br>3.1-21(3) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>43293<br><br>Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to the lack of a resident's name on a self-medication administration assessment for 1 of 5 residents reviewed for unnecessary medications. (Resident 23)<br><br>Finding includes:<br><br>The record for Resident 23 was reviewed on 10/16/24 at 2:46 p.m. Diagnoses included, but were not limited to, repeated falls, hemiplegia (paralysis on one side of the body) due to a stroke, aphasia (loss of language use), hypertension, and right foot drop.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 8/6/24, indicated the resident had moderate cognitive impairment, and required set up assistance for most activities of daily living.<br><br>A Physician's Order, dated 8/2/24, indicated the resident could self-administer Econazole nitrate powder (an antifungal medication) topically, twice daily to the groin and scrotum.<br><br>A Self-Administration of Medication Evaluation, dated 8/2/24 and received from the Assistant Director of Nursing (ADON), failed to document a resident's name.<br><br>During an interview on 10/21/24 at 3:30 p.m., the ADON indicated the evaluation was for Resident 23, but she accidentally wrote her own name on the form instead of his.<br><br>3.1-50(a)(1)(2) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>45666<br><br>Based on observation and interview, the facility failed to ensure infection control guidelines were in place and implemented related to hand hygiene and glove use during a wound treatment for 1 of 1 treatments observed. (Wound Care Nurse and Resident 20)<br><br>Finding includes:<br><br>During an observation of Resident 20's wound care on 10/21/24 at 10:54 a.m., the Wound Care Nurse was observed changing the dressings on the right heel, right ankle, and right lower leg. She entered the room, washed her hands with soap and water, and donned a gown and gloves. She removed the old dressings from the right lower leg, right ankle, and right heel, each dated 10/19/24. She removed her gloves and donned new gloves, without performing hand hygiene between glove use. She sprayed wound cleanser to gauze and cleaned the right lower leg and then threw away the gauze. She removed more gauze, sprayed it with wound cleanser and cleaned the right ankle. She removed more gauze, sprayed it with wound cleanser and cleaned the right heel. She did not perform hand hygiene or change gloves between caring for each wound. She opened a foam dressing, reached into her pocket and removed a marker, wrote the date on the foam dressing, and continued to perform wound care without sanitizing her hands and changing gloves. She applied honey wound gel to the foam dressing and placed it over the right heel wound. She continued to apply the dressings to the right ankle and right lower leg by putting drops of Tetracyte (topical antibiotic) to the open areas, an oil emulsion dressing, and then a calcium alginate dressing over the top with rolled gauze to hold the dressing in place. She dated the dressing, removed her gloves, and washed her hands.<br><br>During an interview on 10/21/24 at 11:26 a.m., the Wound Care Nurse indicated she was supposed to do hand hygiene between glove use, put on new gloves between caring for each wound, and she should have changed gloves after reaching into her pocket.<br><br>During an interview on 10/22/24 at 12:57 PM, the Administrator indicated she had no further information to provide. A corresponding policy was requested at the time, but was never received.<br><br>3.1-18(b) |