STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155667	A. Building B. Wing	09/22/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to dishes stored upright above and below the steam table, on a cart across from the 3-compartment sink and transporting uncovered food on room trays down the hallway. This had the potential to affect all 62 residents who received food from the Kitchen and 6 residents who received room trays on Oak Branch 2 unit. (Kitchen, Oak Branch 2) Findings include:1. The initial Kitchen tour was completed on 9/15/25 at 9:12 a.m., with the Dietary Manager (DM). The following was observed.a. Plates and bowls were stored upright above the steam table.b. Pans were stored upright on a shelf below the steam table.c. Plates and bowls were stored upright on a cart at the end of the steam table across from the 3-compartment sink.During an interview at the time of the tour, the DM indicated the dishes and pans should have been stored inverted and not upright.2. On 9/16/25 at 12:24 p.m., the staff were observed serving residents lunch on the Oak Branch 2 Unit. CNA 1 was observed placing plates of food and drinks for 6 residents onto a cart. The plates and drinks were covered. She then proceeded to place 6 plates each with a piece of cake onto the cart. The cakes were not covered. She then proceeded down the hallway to the end of Oak Branch 2 to deliver the room trays.During an interview on 9/16/25 at 12:31 p.m., CNA 2 indicated she did not have anything to cover the plates of cake with before she transported them down the hallway.During an interview on 9/16/25 at 12:34 p.m., [NAME] 1 indicated another dietary staff member had prepped the cakes and should have covered them. Staff should not have taken them down the hallway uncovered.A policy titled, Food Safety Requirements and received as current from the Dietary Manager on 9/19/25, indicated, .5. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not limited to: a. Covering all foods when traveling a distance (i.e., down a hallway, to a different unit or floor).3.1-21(i)(3)

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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(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. Based on observation, record review, and interview, the facility failed to ensure residents were assessed for self-administration of medications and had a physician's order to self-administer medications, for 2 of 2 residents reviewed for self-administration of medication. (Residents 14 and 65)Findings include: 1. On 9/16/25 at 9:16 a.m., Resident 14 was observed seated in her wheelchair in her room. The nebulizer machine was on, and she had the mouthpiece in place to her mouth. There were no staff present in the room or near the room. LPN 2 was observed at the Nurse's Station, down the hall. The resident's record was reviewed on 9/17/25 at 9:34 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/25, indicated the resident was cognitively intact. A Physician's Order, dated 4/1/25, indicated ipratropium-albuterol solution 0.5 mg (milligrams)-3 mg/3 ml (milliliters) two times a day. There was a lack of any physician's order for self-administration of the medication or any self-administration of medication assessment. During an interview on 9/18/25 at 10:03 a.m., the Director of Nursing (DON) was made aware of the resident self-administering the nebulizer treatment. The nebulizer policy was requested. A facility policy, titled, Nebulizer, received from the DON as current, indicated .14. Observe resident during the procedure for any change in condition. 2. During a random observation on 9/16/25 at 9:49 a.m., Resident 65 was observed in his bed watching television. On the bedside table, there was a bottle of fluticasone nasal spray (allergy nasal spray) with no medication label or instructions for use. Resident 65 indicated that it was an over-the-counter medication that he took himself whenever he needed it for his allergies. Resident 65's record was reviewed on 9/16/25 at 3:33 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/25, indicated the resident was cognitively intact for daily decision making. The current September 2025 Physician's Order Summary indicated there was no order for the fluticasone nasal spray. The record lacked a completed self-administration of medication assessment. During an interview on 9/16/25 at 3:49 p.m., the Director of Nursing indicated she had no further information to provide. A facility policy titled, Resident Self Administration of Medications, indicated, .A resident may only self-administer medications after the campus's interdisciplinary team has determined which (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications may be self-administered safely .4. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form .8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage . 3.1-11(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessments were accurately completed related to antiplatelet and antianxiety medications for 1 of 16 MDS assessments reviewed. (Resident 6) Finding includes:Resident 6's record was reviewed on 9/18/25 at 2:42 p.m. Diagnoses included, but were not limited to, history of traumatic brain injury, anemia, anxiety disorder, and cognitive communication deficit. The Quarterly Minimum Data Set (MDS) assessment, dated 6/12/25, indicated the resident was severely cognitively impaired. In the 7-day look-back period, the resident received antianxiety, antidepressant, anticoagulant, antibiotic, diuretic, and opioid medications. A Physician's Order, dated 5/31/25, indicated clopidogrel (antiplatelet medication) 75 milligrams 1 tablet once daily. There was no order for an antianxiety or anticoagulant medication in the June 2025 Physician's Order Summary. During an interview on 9/19/25 at 10:36 a.m., the Director of Nursing indicated the MDS assessment needed to be modified. The resident had not taken an antianxiety or anticoagulant medication. The clopidogrel should have been coded as an antiplatelet medication. 3.1-31(i)

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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 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. 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, diuretics, and opioid medications for 2 of 16 care plans reviewed. (Resident 6 and 44) Findings include: 1. Resident 6's record was reviewed on 9/18/25 at 2:42 p.m. Diagnoses included, but were not limited to, history of traumatic brain injury, anemia, anxiety disorder, and cognitive communication deficit. The Quarterly Minimum Data Set (MDS) assessment, dated 6/12/25, indicated the resident was severely cognitively impaired. The resident had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not a prescribed weight-loss regimen. In the 7-day look-back period, the resident received antianxiety, antidepressant, anticoagulant, antibiotic, diuretic, and opioid medications. The resident's weight on 6/6/25 was 120.2 pounds and on 12/2/24 was 134.0 pounds. The September 2025 Physician's Order Summary indicated the resident was receiving Lasix (diuretic medication) 20 milligram (mg), 1 tablet daily, hydrocodone/acetaminophen (opioid medication) 5-325 mg 0.5 tablet every 12 hours as needed, mirtazapine (antidepressant medication) 15 mg tablet give 7.5 mg every evening for appetite stimulant, Med Pass (supplement) 120 milliliters three times a day, fortified potatoes every afternoon for supplement, and Health shake twice a day for supplement. There were no person-centered comprehensive care plans and interventions initiated for the diuretic medications, opioid medications, and nutritional status. During an interview on 9/19/25 at 10:36 a.m., the Director of Nursing indicated the care plans needed to be updated. 2. Resident 44's record was reviewed on 9/17/25 at 11:03 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, heart failure, and chronic kidney disease. The admission Minimum Data Set (MDS) assessment, dated 7/24/25, indicated the resident was cognitively intact. On 08/04/2025, the resident weighed 292 pounds. On 09/09/2025, the resident weighed 266.6 pounds which was an 8.7% weight loss. The September 2025 Physician's Order Summary indicated the resident received Pro-Stat (dietary supplement) 30 milliliters in the morning. A Nutrition/Dietary Note, dated 9/11/25 at 10:46 p.m., indicated the resident had weight fluctuation with significant 9% loss over 30 days related to diuresis. The resident was on a diuretic and received a nutritional supplement. There were no new recommendations, and the resident would continue to be seen in NAR (nutrition-at-risk). There were no person-centered comprehensive care plans and interventions initiated for nutrition, weight loss, or diuretic medication use. During an interview on 9/18/25 at 10:03 a.m., the Director of Nursing indicated the care plans needed to be updated for the resident. 3.1-35(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, the facility failed to provide twice weekly showers/bathing for a resident who was dependent on staff for activities of daily living (ADLs) for 1 of 1 resident reviewed for ADLs. (Resident 3)During an interview on 9/15/25 at 10:53 a.m., Resident 3 indicated he was not receiving showers as he should. Resident 3's record was reviewed on 9/18/25 at 11:52 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (paralysis and weakness) following a stroke affecting the left non-dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/25, indicated the resident was cognitively intact. The resident required maximal assistance for showering/bathing. The Resident Preferences document, dated 5/13/25, indicated the resident preferred a shower on Monday and Thursday evenings. The previous 60 days of shower sheets were requested. There were documented showers or bed baths on 6/21, 7/3, 7/7, 7/10, 7/17, 7/21, 7/24, 7/28, 8/4, 8/18, 8/21, 8/25, and 9/4/25. There were no documented showers received after 9/4/25. During an interview on 9/19/25 at 3:20 p.m., the Director of Nursing indicated she was unable to find any more shower sheets. The resident had a history of refusals; however, the staff were not documenting a shower refusal. 3.1-38(b)(2)

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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. Based on observation, record review, and interview, the facility failed to ensure signs and symptoms of constipation were addressed for 1 of 1 resident reviewed for constipation, skin treatments were completed as ordered and compression stockings were applied as ordered for 2 of 3 residents reviewed for non-pressure related skin conditions. (Residents 10, 16, and 13) Findings include:1. On 9/16/25 at 9:08 a.m., Resident 10 was observed lying in bed. The resident indicated she would sometimes go for 4-5 days without having a bowel movement. Sometimes the nurses would give her a laxative, and she still would not always have a bowel movement for days. Record review for Resident 10 was completed on 9/18/25 at 10:38 a.m. Diagnoses included, but were not limited to, multiple sclerosis, anemia, hypertension, neurogenic bladder, anxiety, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/25, indicated the resident was cognitively intact. The resident had an impairment on both sides of her upper and lower extremities for a functional limitation in range of motion. The resident was dependent on staff for toileting hygiene and transferring. The resident was always incontinent with bowels and received scheduled pain medication. A Care Plan, dated 3/23/25, indicated the resident had a self-care performance deficit related to decreased mobility, multiple sclerosis, anxiety, depression, and neurogenic bladder. An intervention included for staff to provide assistance as needed for toileting. The September 2025 Physician's Order Summary (POS) indicated the resident had the following orders:- hydrocodone/apap (opioid pain medication) 10-325 mg (milligrams) at bedtime- Milk of Magnesia (laxative) 30 ml (milliliters) every 24 hours as needed for bowel management The Bowel and Bladder Elimination Task for the past 30 days indicated the resident did not have a bowel movement from 8/27-9/1/25 and again 9/8-9/11/25. The record lacked any indication the resident had received the as needed laxative on the above dates when there was no bowel movement. During an interview on 9/18/25 at 3:23 p.m., the Director of Nursing (DON) indicated she was unable to provide any documentation the resident had received any as needed laxative when she went multiple days without having a bowel movement. A policy titled, Bowel Elimination Management and received as current from the Administrator on 9/22/25, indicated, .3. Licensed nurses will review bowel movement charting each shift. 4. If the resident does not have a bowel movement in 3 days, the resident will be assessed and a bowel protocol initiated. 2. Resident 16's record was reviewed on 9/17/25 at 10:40 a.m. Diagnoses included, but were not limited to, hypertension, anxiety disorder, and Alzheimer's disease. The Annual Minimum Data Set (MDS) assessment, dated 8/23/25, indicated the resident was cognitively impaired, required substantial/maximal assist with bathing and partial/moderate assist with personal hygiene and dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note, dated 8/20/25 at 10:11 p.m., indicated the resident was noted to have a small red non-blanchable area to the left inner buttock. The Wound Nurse was made aware. A Nurse's Note, dated 8/21/35 at 6:51 p.m., indicated there was a non-blanchable area to the left inner buttocks and wound care evaluated the area on 8/20/25. A Nurse's Note, dated 8/22/25 at 1:01 p.m., indicated the Nurse Practitioner was notified of the resident's skin issue and a new order for antifungal cream twice daily was received. The record lacked any wound assessments for the left buttock area. The Medication and Treatment Administration Records, dated 8/2025, lacked any documentation the antifungal cream had been ordered or administered. During an interview on 9/18/25 at 1:11 p.m., the DON indicated the resident did not have any current wounds. The antifungal treatment had not been completed as ordered. 3. During observations on 9/18/25 at 9:47a.m. and on 9/19/25 at 11:39 a.m., Resident 13's feet and legs were visibly red and swollen and she was not wearing compression stockings to her lower legs. Record review for Resident 13 was completed on 9/16/25 at 3:48p.m. Diagnoses included, but were not limited to, hypertension, Alzheimer's disease, dementia, anxiety, depression, and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 6/3/25, indicated the resident was moderately cognitively impaired. The resident required substantial maximal assistance for dressing and transfers. A Care Plan, dated 3/28/25, indicated the resident had hypertension. An intervention included to monitor for and document any edema (swelling) and to notify the physician. A Physician's order, dated 9/7/25, indicated to apply knee high compression stockings to both legs. The resident was to have them applied during the day and removed in the evening. During an interview on 9/18/25 at 9:47 a.m., CNA 1 indicated midnight shift was responsible for applying the resident's compression stockings. The resident's compression stockings were too tight sometimes so they would apply geri-sleeves (a protective sleeve for the arms or legs) on the resident instead. She was unaware the resident did not currently have her compression stockings in place. 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. 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 a physician's order for wound care not followed during a wound care observation for 1 of 4 residents reviewed for pressure ulcers. (Resident 44) Finding includes: Resident 44's record was reviewed on 9/17/25 at 11:03 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, heart failure, and chronic kidney disease. The admission Minimum Data Set (MDS) assessment, dated 7/24/25, indicated the resident was cognitively intact. The resident had an unstageable wound. A Physician's Order, dated 7/19/25, indicated cleanse the right heel with wound cleanser, pat dry, apply betadine, cover with ABD (abdominal) pad, and wrap with Kerlix (bandage wrap) every evening shift. During an observation of wound care on 9/19/25 at 1:39 p.m., Agency LPN 3 was observed performing wound care to Resident 44's right heel. Agency LPN 3 performed hand hygiene and donned a gown and gloves. She removed the old dressing, which was a bordered gauze (adhesive dressing) with no date. There was no ABD or Kerlix wrap covering the wound. The nurse performed hand hygiene and donned new gloves. She cleansed the area with wound cleanser and gauze, removed her gloves, donned new gloves, and patted the wound dry with clean gauze. She then applied the ABD pad and wrapped with Kerlix. The nurse did not apply the betadine to the wound. During an interview on 9/19/25 at 1:48 p.m., Agency LPN 3 indicated the old dressing did not have the ABD pad or Kerlix. During the wound care, she should have applied betadine. During an interview on 9/18/25 at 1:11 p.m., the Director of Nursing indicated she had no further information to provide. 3.1-40(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. Based on observation, record review, and interview, the facility failed to ensure a resident who required nebulizer breathing treatments was assessed prior to, during, and/or after the treatment for effectiveness of the treatment for 1 of 1 resident reviewed for respiratory care. (Resident 14)Finding includes:On 9/16/25 at 9:16 a.m., Resident 14 was observed seated in her wheelchair in her room. The nebulizer machine was on, and she had the mouthpiece in place to her mouth. There were no staff present in the room or near the room. LPN 2 was observed at the Nurse's Station, down the hall.The resident's record was reviewed on 9/17/25 at 9:34 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and osteoarthritis.The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/25, indicated the resident was cognitively intact.A Physician's Order, dated 4/1/25, indicated ipratropium-albuterol solution 0.5 mg (milligrams)-3 mg/3 ml (milliliters) two times a day. There were no orders for a pre or post nebulizer treatment assessment.There was lack of documentation any respiratory assessment had been completed prior to or after the administration of the nebulizer treatment.During an interview on 9/18/25 at 10:03 a.m., the Director of Nursing (DON) was made aware there were no documented pre or post nebulizer treatment assessments. She was unable to provide any further documentation.A facility policy, titled, Nebulizer, received from the DON as current, indicated .6. Obtain resident's vital signs, and perform respiratory assessment to establish a baseline.Documentation.4. Resident vital signs and respiratory assessment.3.1- 47(a)(6)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, record review, and interview, the facility failed to ensure residents with dementia received appropriate treatment and services related to lack of care planning with individualized interventions and activity assessments not completed for 2 of 3 residents reviewed for dementia care. (Residents 7 and 16) Findings include:1. On 9/18/25 at 11:41 a.m., Resident 7 was observed up ambulating in the hallway near the Nurse's Station. She stopped to ask LPN 2 what was for lunch. LPN 2 invited the resident to participate in the current activity that was going on, the resident agreed and went to the activity area.Resident 7's record was reviewed on 9/18/25 at 11:23 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, general anxiety disorder, and multiple sclerosis.The Annual Minimum Data Set (MDS) assessment, dated 8/30/25, indicated the resident was cognitively impaired. She had received antipsychotic and antidepressant medications.A Care Plan, updated 5/28/25, indicated the resident had impaired cognitive function or impaired thought processes related to dementia. The interventions included, to communicate with the resident, family, and caregivers regarding the resident's capabilities. There was lack of documentation to indicate the care plan was individualized, person centered, and included resident specific interventions.A Care Plan, updated 9/7/25, indicated the resident was appropriate for the secured dementia unit. The interventions included, encourage family to provide items that are familiar to the resident and provide activities of interest to the resident. There was lack of documentation to indicate the care plan was individualized, person centered, and included resident specific interventions.There was no activity assessment completed for the resident.During an interview on 9/19/25 at 3:40 p.m., the Director of Nursing indicated an activity assessment had not been completed for the resident. 2. On 9/16/25 at 10:00 a.m., Resident 16 was observed lying in bed with her eyes closed.Resident 16's record was reviewed on 9/17/25 at 10:40 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, psychotic disorder, and anxiety disorder.The Annual Minimum Data Set (MDS) assessment, dated 8/23/25, indicated the resident was cognitively impaired. She had delusions and verbal behaviors 1-3 days during the assessment period. She had received antipsychotic, antianxiety, and antidepressant medications.A Care Plan, updated 9/15/25, indicated the resident had behaviors of believing the past was the present and believing the boys were playing jokes and or tricks on her. The interventions included to provide a program of activities that is of interest and accommodated the resident's status. There was lack of documentation to indicate the care plan was individualized, person centered, and included resident specific interventions.A Care Plan, updated 3/31/25, indicated the resident had impaired cognitive function and impaired thought processes related to dementia. The interventions included the use of antianxiety medication. There was lack of documentation to indicate the care plan was individualized, person centered, and included resident specific interventions.A Care Plan, updated 9/6/25, indicated the resident was appropriate for the secured dementia unit. The interventions included, encourage family to provide items that are familiar to the resident and provide activities of interest to the resident. There was lack of documentation to indicate the care plan was individualized, person centered, and included resident specific interventionsThere was no activity assessment completed for the resident.During an interview on 9/18/25 at 1:11 p.m., the Director of Nursing indicated an activity assessment had not been completed for the resident. The Activity Director thought she just had to complete the MDS activity section and not a full assessment.3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155667	A. Building B. Wing	09/22/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to lack of hand hygiene with glove changes during wound care and improper personal protective equipment (PPE) worn in an Enhanced Barrier Precaution (EBP) room while accessing a peripheral intravenous central catheter (PICC) line. (Residents 44 and 1) Findings include: 1. During an observation of wound care on 9/19/25 at 1:39 p.m., Agency LPN 3 was observed performing wound care to Resident 44's right heel. Agency LPN 3 performed hand hygiene and donned a gown and gloves. She removed the old dressing, performed hand hygiene, and donned clean gloves. She cleansed the area with wound cleanser and gauze, removed her gloves, and then donned new gloves without performing hand hygiene. She continued to pat the area dry with clean gauze and then applied the ABD pad and wrapped with Kerlix. During an interview on 9/19/25 at 1:48 p.m., Agency LPN 3 indicated she should have performed hand hygiene with every glove change. During an interview on 9/18/25 at 1:11 p.m., the Director of Nursing indicated she had no further information to provide. A facility policy titled, Hand Hygiene Policy, indicated, .6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . 2. On 9/17/2025 at 3:54 p.m., LPN 1 was observed preparing to administer an antibiotic to Resident 1 via a PICC (peripherally inserted central catheter) line. The LPN gathered her supplies and walked to the resident's room. There was a sign outside the resident's room that indicated the resident was on EBP (enhanced barrier precautions). There was a bin outside the room that contained PPE (personal protective equipment) which included gowns. The LPN applied gloves and then primed the tubing attached to the medicine ball with the antibiotic. She cleaned the PICC line port with an alcohol wipe and flushed the tubing with 10 cc (cubic centimeter) of normal saline. The nurse then attached the tubing from the medication ball to the PICC line port. The nurse did not apply a gown when she hooked up the medication via the PICC line. Record review for Resident 1 was completed on 9/17/25 at 3:56 p.m. The September 2025 Physician's Order Summary (POS) indicated an order for cefazolin (antibiotic) 2000 mg (milligrams) intravenously three times a day for an infection. There was also an order for EBP which indicated staff were to wear gloves and a gown when providing care with high-risk activities. During an interview on 9/17/25 at 4:00 p.m., LPN 1 indicated the only time she was told to wear a gown was when she was completing wound care. A policy titled, Enhanced Barrier Precautions and received as a current from the Administrator on 9/22/25, indicated, .EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.4. High-contact resident care activities include.g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy / ventilator tubes, hemodialysis catheters, PICC lines, midline catheters. 3.1-18(b)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy to reduce antibiotic resistance related to antibiotics started without indication for use for 2 of 2 residents reviewed for urinary tract infections. (Resident 44 and 3) Findings include: 1. Resident 44's record was reviewed on 9/17/25 at 11:03 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, heart failure, and chronic kidney disease. The admission Minimum Data Set (MDS) assessment, dated 7/24/25, indicated the resident was cognitively intact. A Progress Note, dated 9/4/25 at 1:33 p.m., indicated the nurse practitioner was notified of the resident's high blood sugar and new orders were received for a urinalysis (urine test) with culture and sensitivity. A urinalysis result, dated 9/5/25 at 4:05 p.m. and reported on 9/8/25 at 7:01 a.m., indicated the resident's urine was positive for enterococcus faecium (bacteria) vancomycin-resistant strain (VRE) 50-100,000 colonies per milliliter. The bacteria had resistance to ciprofloxacin and was susceptible to nitrofurantoin. A Physician's Order, dated 9/5/25, indicated ciprofloxacin (antibiotic) 250 milligram tablet twice daily for 10 days. A Physician's Order, dated 9/8/25, indicated nitrofurantoin (antibiotic) 100 milligram capsule twice daily for 7 days. There were no documented signs or symptoms of a urinary tract infection. During an interview on 9/19/25 at 9:47 a.m., the Director of Nursing indicated she was unable to find documentation of the resident's signs or symptoms of a urinary tract infection. 2. During an interview on 9/15/25 at 10:53 a.m., Resident 3 indicated he had been having some signs and symptoms of a urinary tract infection and he had them previously. There was a urine sample cup observed on a table in the resident's room. Resident 3's record was reviewed on 9/18/25 at 11:52 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (paralysis and weakness) following a stroke affecting the left non-dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 6/30/25, indicated the resident was cognitively intact. The resident required maximal assistance for showering/bathing. A Progress Note, dated 8/27/25 at 6:51 a.m., indicated a urinalysis sample was collected via a clean urinal. The urine was malodorous, clear, yellow, and free of sediment. The urinalysis with culture and sensitivity, dated 8/26/25 at 5:00 a.m. and reported on 8/29/25 at 8:37 a.m., indicated the urine was positive for proteus mirabilis (bacteria) 10-50,000 colonies/milliliter. A Physician's Order, dated 9/1/25, indicated cephalexin (antibiotic) 500 milligram tablet three times a day. A Physician's Order, dated 9/3/25, indicated cephalexin 500 mg tablet three times a day for 5 days. A Physician's Order, dated 9/12/25, indicated urinalysis with culture and sensitivity. There were no documented signs or symptoms of a urinary tract infection. During an interview on 9/19/25 at 9:47 a.m., the Director of Nursing indicated with each infection a document was to be filled out to show that the resident's infection met criteria for antibiotic use. The resident did have an outstanding order for another urinalysis that was not completed. A facility policy titled, Antibiotic Stewardship Policy, indicated, .a. Antibiotic use protocols: i. Nursing team members shall assess residents who are suspected to have an infection and notify the physician .iii. The community uses the CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool to define infections .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post in a timely manner the daily staffing sheet which indicated how many staff were working in the facility and the facility census. This had the potential to affect the 62 residents who resided in the facility. Finding includes: On 9/16/25 at 9:32 a.m., the daily staffing sheet located at the Oak Branch Nurses' station was dated 9/14/25. On 9/16/25 at 12:30 p.m., the daily staffing sheet was at the Oak Branch Nurses' station was dated 9/15/25. During an interview on 9/16/25 at 3:50 p.m., the Director of Nursing indicated the Staff Coordinator thought the previous day's staffing levels were supposed to be posted daily.