STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Newburgh	5233 Rosebud Lane Newburgh, IN 47630

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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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Based on interview and record review, the facility failed to ensure as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were preauthorized by a licensed nurse for 2 of 5 resident reviewed for unnecessary medications. (Resident 66 and Resident 87) Findings include: 1. On 6/30/25 at 11:09 A.M., Resident 66's clinical record was reviewed. Diagnoses included, but were not limited to, gastroesophageal reflux disease (GERD). The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 5/15/25, indicated Resident 66 was cognitively intact and required setup assistance for eating. Current physician orders included, but were not limited to: ondansetron (an antinausea medication) 4 milligrams (mg) - Give one tablet by mouth every six hours as needed (PRN) for nausea and vomiting, dated 2/19/25 Resident 66's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that ondansetron 4 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/10/25 at 11:33 A.M. given by QMA 15 6/9/25 at 11:54 A.M. given by QMA 3 2. On 6/30/25 at 8:45 A.M., Resident 87's clinical record was reviewed. Diagnoses included, but were not limited to, generalized anxiety disorder and osteoarthritis. The most recent Annual Minimum Data Set (MDS) Assessment, dated 5/9/25, indicated Resident 87 had severe cognitive impairment, required setup assistance for eating, and received an antianxiety medication during the 7-day look back period. Physician orders included, but were not limited to: lorazepam (an antianxiety medication) - Give 0.5 milligrams (mg) by mouth every 24 hours as needed (PRN) for generalized anxiety disorder, dated 4/28/25 with a stop date of 5/5/25 (continued on next page)

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	155670	A. Building B. Wing	07/03/2025

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Tylenol Arthritis Pain Extended Release (a pain reliever) - Give 650 mg by mouth every 24 hours PRN for arthritis pain, dated 4/23/25 Resident 87's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that lorazepam 0.5 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/1/25 at 12:17 P.M. given by QMA 3 5/4/25 at 5:17 P.M. given by QMA 5 Resident 87's Medication Administration Record (MAR) from 5/1/25 through 6/30/25 included, but was not limited to, the following dates that Tylenol 650 mg PRN was administered by a QMA without authorization from a licensed nurse: 5/13/25 at 12:17 P.M. given by QMA 7 6/13/25 at 8:04 A.M. given by QMA 9 During an interview on 7/2/25 at 8:51 A.M., QMA 5 indicated that a QMA must have nurse authorization before administering a PRN medication and that authorization was documented in a progress note. On 7/3/25 at 10:04 A.M., the Administrator provided a Qualified Medication Aide Job Description, dated March 2025, that indicated Administer PRN drugs, as allowed, when authorized by a licensed nurse . Keep medical records current by charting pertinent resident conditions timely and routine charting as scheduled, with co-signature by a licensed nurse. On 7/3/25 at 10:04 A.M., the Administrator provided an undated Qualified Medication Aide Scope of Practice that indicated Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: . Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact . 3.1-35(g)(2)

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	155670	A. Building B. Wing	07/03/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents dependent on staff for assistance with activities of daily living (ADL) tasks were provided showers or baths for 4 of 5 residents reviewed for ADL care. (Resident 27, Resident 97, Resident 11, and Resident 36) Findings include: 1. During an interview on 6/29/25 at 9:37 A.M., Resident 27 indicated he hadn't had any baths lately. Resident 27 had a strong, pungent smell surrounding him. On 6/30/25 at 10:06 A.M., Resident 27's clinical record was reviewed. Resident 27 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, diabetes mellitus. The most recent Annual Minimum Data Set (MDS) Assessment, dated 5/28/25, indicated Resident 27 was cognitively intact and dependent on staff for toileting, bathing, and transfers. The Point of Care (a charting system for Certified Nurse Aides) Task Response indicated Resident 27's scheduled shower days were Tuesday and Friday. The Point of Care ADL report and written shower sheets indicated Resident 27 had not received or refused a shower or complete bed bath on the following days during June 2025: 6/3/25 6/10/25 2. On 6/30/25 at 8:41 A.M., Resident 97's clinical record was reviewed. Resident 97 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, diabetes mellitus. The most recent admission Minimum Data Set (MDS) Assessment, dated 6/12/25, indicated Resident 97 was cognitively intact and required substantial assistance (staff does at least half of the effort) from staff for toileting and bathing. The Point of Care (a charting system for Certified Nurse Aides) Task Response indicated Resident 97's scheduled shower days were Sunday and Thursday. The Point of Care ADL report and written shower sheets indicated Resident 97 had not received or refused a shower or complete bed bath on the following days during June 2025: 6/8/25 3. During an interview on 6/29/25 at 12:52 P.M., Resident 11 indicated she was supposed to get her showers in the morning on Mondays and Thursdays. She indicated that she preferred her showers in the mornings due to seizures that often occurred in the afternoon. She indicated that she didn't always get showers twice a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/30/25 at 1:38 P.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, epilepsy. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 4/9/25, indicated Resident 11 was cognitively intact and required partial to moderate assistance of staff (staff does less than half of the effort) for bathing. An Activity Preferences Interview, dated 9/18/24, indicated that it was very important for Resident 11 to choose between a shower and a bed bath. A care plan conference was conducted on 6/12/25. Care plans were reviewed. Current care plans included, but were not limited to: Resident 11 needs assistance with activities of daily living related to cognitive impairment, seizure disorder, chronic pain, dated 9/13/23 The Point of Care (a charting system for Certified Nurse Aides) Task Response for Showering indicated Resident 11 received showers on Mondays and Thursdays during the day. The Point of Care ADL report and written shower sheets indicated Resident 11 had not received or refused a shower or complete bed bath on the following days during June 2025: 6/5/25 6/9/25 6/12/25 4. During an interview on 6/29/25 at 10:24 A.M., Resident 36 indicated she preferred bed baths. She indicated she was not sure what days she was supposed to get them but was often told by staff that they would get to her if they had time. She indicated she did not receive a bed bath twice a week. At that time, Resident 36's hair looked oily. On 6/30/25 at 2:23 P.M., Resident 36's clinical record was reviewed. Diagnoses included, but were not limited to, end stage renal disease (ESRD). The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 4/22/25, indicated that Resident 36 was cognitively intact and required substantial to maximal assistance of staff (staff does more than half of the effort) for bathing. An Activity Preferences Interview, dated 7/18/24, indicated that it was very important for Resident 36 to choose between a shower and a bed bath. A care plan conference was conducted on 5/1/25. Care plans were reviewed. Current care plans, included, but were not limited to: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 36 needs assistance with activities of daily living related to asthma, ESRD with hemodialysis, diabetes, dated 7/12/24 The Point of Care (a charting system for Certified Nurse Aides) Task Response for Showering indicated Resident 36 received bed baths on Sundays and Thursdays during the day. The Point of Care ADL report and written shower sheets indicated Resident 36 had not received or refused a shower or complete bed bath on the following days during June 2025: 6/12/25 6/29/25 During an interview on 7/2/25 at 8:53 A.M., Certified Nurse Aide (CNA) 11 indicated that residents got showers twice a week. If they refused, the aide asked twice and then the nurse would ask a third time. All showers, bed baths, and refusals got documented on a shower sheet and in Point of Care. On 7/3/25 at 10:04 A.M., the Administrator provided a Showers policy, dated 1/2/24, that indicated It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice . Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. Partial baths may be given between regular shower schedules as per facility policy. 3.1-38(a)(2)(A) 3.1-38(b)(2)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to ensure care according to professional standards of a gastro/jejunal feeding tube (G-Tube) in 1 of 1 residents reviewed for tube feeding. The resident was not checked for residual as ordered prior to feedings. (Resident 44) Finding includes: On 6/30/25 at 11:15 A.M., Licensed Practical Nurse (LPN) 17 was observed administering a feeding to Resident 44 via his G-Tube. LPN 17 did not check for residual prior to the administration. On 6/30/25 at 10:00 A.M., Resident 44's clinical record was reviewed. Diagnoses included, but were not limited to, tracheostomy, neoplasm of larynx, and dysphagia, oropharyngeal phase. The current Quarterly Minimum Data Set (MDS) Assessment, dated 5/12/25, indicated Resident 44 was cognitively intact. The resident had a feeding tube, and needed supervision of staff for hygiene, dressing, and transferring Current physician orders included, but were not limited to: Enteral feed, five times a day, administer 250 milliliters (ml), TwoCal HN 2.0 (a nutritionally complete, high-calorie formula) by gravity. Check placement of G-Tube prior to administration of medication and tube feeding, hold feeding for residual greater than 150 ml, dated 5/19/25. A risk for complications of tube feeding care plan, dated 2/6/25, included, but were not limited to, the following interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record, dated 2/6/25. Tube feeding and water flushes as per physician orders, dated 2/6/25 During an interview on 6/30/25 at 11:15 A.M., LPN 17 indicated she did not always check residuals before the feedings. During an interview on 06/30/25 5:40 P.M., a family member indicated that staff did not always check residuals prior to administering feedings and medications. During an interview on 7/1/25 at 10:00 A.M., the Director of Nursing (DON) indicated that staff should check residuals prior to each feeding. On 7/3/25 at 10:04 A.M., the Administrator provided a current Enteral Feeding policy, dated 1/2/24, that indicated .in accordance with the facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location, tube placement will be verified before beginning a feeding and before administrating medications . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-47(a)(2)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure proper airway management for 1 of 1 residents reviewed with a laryngectomy. A self-assessment for care was not performed, documentation was not accurate, and the facility did not have the correct parts for the laryngectomy tube ([NAME] Tube). (Resident 44) Finding includes: On 6/29/29/25 at 11:00 A.M., Resident 44's [NAME] Tube was observed laying on the resident's bed. The resident realized it was out and the resident placed it back into the laryngectomy stoma (surgical incision and removal of the larynx). On 6/30/25 at 10:00 A.M., Resident 44's clinical record was reviewed. Diagnoses included, but were not limited to, tracheostomy, neoplasm of the larynx, esophageal fistula post tracheostomy, and absence of the larynx. The current Quarterly Minimum Data Set (MDS) Assessment, dated 5/12/25, indicated Resident 44 was cognitively impaired. Resident 44 had a laryngectomy, had a g-tube for tube feeding, and needed supervision with hygiene, transferring, and dressing. Current Physicians orders: If [NAME] tube TPE (tracheoesophageal Puncture) outer part of [NAME] tube comes out place red rubber catheter in place and send to ER every day and night shift ordered 2/10/2025 [NAME] tube monitoring: monitor for placement and function of [NAME] tube every shift every shift ordered 2/11/2025 Monitor [NAME] site for s/sx (signs and symptoms) of infection every shift every shift ordered 2/11/2025 stoma site to be cleansed with normal saline around TPE; remove [NAME] tube and cleanse with NS (Normal Saline) and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reinsert every day and night shift ordered 2/25/2025 ENHANCED BARRIER PRECAUTIONS: Gloves and gown prior to the high-contact care activity. Face protection when performing activity with risk of splash or spray. (Change PPE [Personal Protective Equipment] and complete hand hygiene prior to caring for another resident). every shift for PEG, [NAME]-tube ordered 3/5/25 The clinical record lacked physician orders for the resident to perform his own stoma care. The care plans were reviewed in a care plan conference on 5/5/25. The care plan lacked an intervention that indicated the resident was capable of performing his own stoma care. A [name of hospital] Speech Pathologist progress note, dated 2/4/25, indicated that the resident was educated on laryngectomy care, voice prosthesis insertion, and other products. The note indicated that the patient and a family member would keep the integrity of the fistula and would keep it clean. The Speech Pathologist indicated that the resident was not independent with care and was interested in placement in a Skilled Nursing Facility due to the amount of care that the resident needed. There was no documentation that noted the resident was assessed or observed the resident skills for caring for the stoma. The resident was admitted to the facility on [DATE]. A nursing admission note, dated 2/5/25, indicated that the resident had a tracheostomy and not a laryngectomy. The note lacked measurement and assessment of the stoma. A [name of hospital] Speech Pathologist progress note, dated 2/11/25, indicated that the resident had thick secretions and developed an abscess in the stoma which was irritated by the [NAME] Tube. The [NAME] Tube was removed by the therapist and instructed the resident not to use the [NAME] Tube and the housing. The progress notes indicated that there would be a referral sent to an Ear, Nose and Throat (ENT) physician regarding the status of the stoma. It was also noted that the therapist instructed the former Director of Nursing (DON) on the care of the laryngectomy stoma that was first thought to be a tracheostomy. Instructions included the daily care of the stoma, when to contact the therapist, and to place a 20 French red rubber catheter if the prosthesis fell out and then send the resident to the emergency room (ER). (continued on next page)

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	155670	A. Building B. Wing	07/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 6/7/25 at 5:48 P.M., indicated that the staff sent the resident to the hospital because the [NAME] Tube had a missing piece that needed to be replaced. ER documentation, dated 6/7/25, indicated the resident was evaluated. The ER did not have the equipment needed to replace the part that was missing and it needed to be ordered. The physician indicated that the fistula was stable and could be left open, so the resident was to be sent back to the facility with orders to be sent to the ENT clinic that week. The June Medication Administration Record / Treatment Administration Record (MAR/TAR) indicated that staff performed all stoma care and the resident did not perform any of his own stoma care. The clinical record lacked an assessment of the resident's skills for laryngectomy care and tube. During an interview on 6/30/25 at 11:20 A.M., Resident 44 indicated the staff did not clean his stoma and he was supposed to have it cleaned two to three times a day. The resident was very upset about that not being done. At that time, he was observed lying in bed with his [NAME] tube placed beside him in the bed. During an interview on 6/30/25 at 2:15 P.M., Licensed Practical Nurse (LPN) 17 indicated that the resident wanted to do the stoma care himself most of the time. She indicated that she documented that she did it even when the resident did it. During an interview on 6/30/25 at 3:15 P.M., LPN 23 indicated the [NAME] Tube should be in all the time and that the resident was non-compliant with care. She indicated that the nursing staff had an in-service training for trach care. During an interview on 6/30/25 at 5:40 P.M., a family member indicated that she had performed stoma care for the resident several times and that the facility did not have the right equipment for the [NAME] Tube. The family indicated that they had been dealing with that problem since the resident had been admitted to the facility. The family member also indicated that the facility was supposed to order the equipment needed for the [NAME] Tube. The staff treated the stoma as a trach on admission. During an interview on 7/1/25 at 9:15 A.M., the DON indicated that the resident had a [NAME] Tube. Nursing staff was to clean the stoma and the outer part of the device every shift with saline. She indicated that the resident sometimes wanted to do the care himself, and there should be documentation in the progress notes when that happened. She indicated that the resident went to the ER on [DATE] and a red catheter was placed. She indicated that during that visit the ENT on call did not have a part for the tube and it would have to be ordered. She also indicated that there should be an order for the resident to do his own care. On 7/1/25 at 1:30 P.M., the DON provided a staff skills evaluation, dated 2/10/25, for tracheostomy care and gastro feeding tube care. During an interview on 7/2/25 at 12:31 P.M., the DON indicated staff were trained verbally on how to care for the [NAME] Tube by the former DON. Care for a laryngeal tube was different from a tracheostomy tube so the Speech Pathologist from [name of hospital] instructed the former DON, and the former DON relayed the information verbally to staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. Building B. Wing	07/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/25 at 2:00 P.M, the DON provided a nursing staff skills check-off training list, dated 2/25/25, for the [NAME] Tube. On 7/3/25 at 10:04 A.M., the Administrator provided a current Tracheostomy Care policy, dated 1/2/24, but it lacked information regarding the care of a laryngectomy. On 7/3/25 at 10:04 A.M., the Administrator provided a current Comprehensive Care Plans policy, dated 11/1/24, that indicated .comprehensive care plans will describe, at a minimum .resident specific interventions that reflect the resident's needs . On 7/3/25 at 10:04 A.M., the Administrator provided a current Physician Orders policy, dated 1/2/24, that indicated .the purpose of the policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to the professional standards of quality . 3.1-35(a) 3.1-47(a)(6)

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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, interview, and record review, the facility failed to post a current Posted Nurse Staffing sheet for 1 of 5 days during the survey period. Finding includes: On 6/29/25 at 8:05 A.M., a Posted Nurse Staffing sheet was observed next to the reception window in the main lobby. It was dated 6/27/25. During an interview on 7/2/25 at 1:54 A.M., the Administrator indicated the scheduler filled out the Posted Nurse Staffing sheets. When the scheduler was not in the facility, she put the pre-filled out sheet behind the currently displayed sheet and night shift staff flipped it. During an interview on 7/3/25 at 10:31 A.M., the Administrator indicated that the facility did not have a policy for Posted Nurse Staffing, but they followed the federal regulation.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled for 4 of 5 medication carts reviewed and 1 treatment cart reviewed. (100 Hall Cart 1, 100 Hall Cart 2, 200 Hall Cart 1, 200 Hall Cart 2, 100 Hall Treatment Cart) Findings include: 1. On 6/29/25 at 8:00 A.M., the following loose pills and liquid medications were observed in 100 Hall Cart 1: 1 oblong white pill with numbers 1222 1 round white pill with the letter AM and numbers 520 1 blue oblong pill with letter ARI and number 5 1 small round peach pill 1 small round white pills with the number 15 1 large brown capsule 1 round white pill with the number 745 1 oval white pill with the number 22 1 small round white pill 1/2 small round white pill 1 small round peach pill 1 large white pill- Potassium 1 small white pill with letter A 1/2 oblong lavender pill 1 small white pill with the number 122 1 blue-green oblong with the number 54 1 large white pill (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Newburgh	5233 Rosebud Lane Newburgh, IN 47630

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3 containers of Clearlax with no open date 1 container of Milk of Magnesia with a large number of dried drippings 1 drawer with numerous spots of sticky red colored fluid on the bottom 2. On 6/29/25 at 8:31 A.M., the following loose pills were observed in 100 Hall Cart 2: 1 large round white pill with letters TCL and numbers 34 1 large round white pill with letters ATY and numbers 40 1 medication cup with 10 loose pills with no name or room number on the cup 1 small oval white with the letter LS and number 1 1 white capsule 1 peach oval pill with the letters LUPT with Numbers 30 1 small white pill 1 blue oval with letters [NAME] and numbers 571 1 large oblong white with numbers 16 1 small white oval with numbers 124 1 blue oblong pill with letters CL and numbers 29 1 large round white pill with the letters AL 1 large round white pill with the letters TLL and numbers 340 1 large orange capsule 3. On 6/29/25 at 8:45 A.M., the following liquid medications were observed in the 200 Hall Cart 1: 1 bottle of Milk of Magnesia with no open date 1 bottle of Milk of Magnesia with an expiration date of 2/25/25 4. On 6/29/25 at 9: A.M., the following loose pills and liquid medication were observed in the 200 Hall Cart 2: 1 large round oval with numbers 0005 1 bottle of chest congestion liquid with no open date (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 6/30/25 at 6:30 P.M., the following undated creams were observed in the Treatment Cart of the 100 Hall: House moisture cream with no label or open date Diflucan (Antifungal Cream) 1 Percent (%) with no open date During an interview on 6/29/25 at 8:15 A.M., Licensed Practical Nurse (LPN) 27 was not aware of how often to check the carts. She had never been shown how to do it. During an interview on 6/29/25 at 8:30 A.M., Qualified Medication Aide (QMA) 21 indicated there should be open dates on medications when opened. QMA 21 indicated she was not aware what the pills where in the medication cup or who they belonged to. She indicated that she would have to contact her charge nurse. During an interview on 6/29/25 at 8:46 A.M., LPN 23 indicated expired medications should be thrown away. During an interview on 6/30/25 at 6:35 P.M., QMA 21 indicated that house stock should have a resident name and open date on it. On 7/3/25 at 10:04 A.M., the Administrator provided a current Labeling of Medication policy, dated 2/22/22, that indicated .medications should be labeled with open date .medications will have a small auxiliary label attached . On 7/3/25 at 10:04 A.M., the Administrator provided a current Expiration Dating policy, dated 2/22/22, that indicated .medication must be checked by the facility regularly for expiration dates and deterioration .expired medication will be removed from use and destroyed per facility policy and procedures . On 7/3/25 at 10:04 A.M., the Administrator provided a current Medication Administration policy, dated 1/2/24, that indicated .medications are administrated by licensed nurses, or other staff authorized .as ordered by the physician and in accordance with professional standards of practice .observe resident consumption of medication . medications are not left unattended . 3.1-25(b)(4) 3.1-25(k) 3.1-25(o)

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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, interview, and record review, the facility failed to ensure the dishwasher was sanitizing dishes properly and staff knew how to properly test for sanitization for 1 of 1 kitchens in the facility. (Kitchen) Finding includes: During an observation on 6/29/25 at 8:15 A.M., the Kitchen Manager ran a dishwasher cycle. The wash cycle reached 155 degrees Fahrenheit (F), the rinse cycle reached 138 degrees F, and the sanitization level on the chlorine test strips read zero parts per million (ppm). The Kitchen Manager indicated the dishwasher was a low temperature dishwasher and the dishwasher sanitization had been testing fine the night before. Kitchen staff continued to put dishes through the dishwasher. During an observation on 6/29/25 at 12:58 P.M., staff members were observed serving lunch on dishes ran through the dishwasher. During an interview on 6/29/25 at 2:15 P.M., the Administrator indicated when the dishwasher was not working properly, staff should be hand washing dishes in the three-compartment sink or using disposable dishes to serve meals on. During an observation on 6/29/25 at 2:26 P.M., the Kitchen Manager indicated kitchen staff were now using the three-compartment sink to wash dishes. During an observation on 6/30/25 at 10:27 A.M., the Kitchen Manager showed a chlorine test strip that read between 50-100 ppm. The Kitchen Manager provided a Service Request that indicated the dishwasher sanitization pump was fixed and the dishwasher was in working order again. During an observation on 7/2/25 at 10:18 A.M., kitchen staff indicated it was hard to test the dishwasher sanitization. Staff had to put their hand under the running hot water inside the dishwasher to test for sanitization. The chlorine test strip read zero ppm. The Kitchen Manager asked the Dietitian for suggestions on how to test the water without burning her hand and the Dietitian indicated she was unfamiliar with how that dishwasher worked. During an observation on 7/2/25 at 2:03 P.M., staff were observed serving lunch on dishes washed through the dishwasher that morning. During an observation on 7/3/25 at 8:37 A.M., the dishwasher manufacturer representative was in the facility and indicated the dishwasher was in working order again and that the sanitization was reading 50-100 ppm. The Kitchen Manager indicated the dishwasher manufacturer representative showed staff how to properly test if the dishwasher sanitization was working. On 6/29/25 at 2:15 P.M., the Administrator provided a policy titled Sanitization, dated 10/08, that indicated Dishwashing machines must be operated using the following specifications: Low Temperature Dishwasher (Chemical Sanitization) a. Wash Temperature 120 degrees F, b. Final rise with 50 parts per million (ppm) hypochlorite (chlorine) for at least 10 seconds. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.1-21(i)(2) 3.1-21(i)(3)

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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 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** 2. On 6/30/25 at 8:11 A.M., Resident 98's clinical record was reviewed. Resident 98 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, congestive heart failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/22/25, indicated Resident 98 was cognitively intact and was dependent on staff (staff does all of the effort) for toileting, bathing, and transfers. Physician orders included, but were not limited to: Metoprolol 50 milligrams (mg) Extended Release (ER) - Give one tablet by mouth one time a day; Start Date 9/1/21. Care plans included, but were not limited to: (Resident) is at risk for impaired cardiac output; Observe for signs/symptoms of cardiac dysfunction such as . increased or decreased heart rate or blood pressure. Document abnormal findings and notify physician. Date Initiated: 9/29/21 The electronic Medication Administration Record (eMAR) on 4/13/25 indicated Resident 98 had an abnormal low blood pressure of 68/53 and an abnormal high heart rate of 133. The clinical record lacked a rechecked blood pressure, or a notification to the physician of abnormal vitals. During an interview on 7/3/25 at 12:20 P.M., the Administrator indicated a second blood pressure was obtained and was within normal limits, but was not documented. The Administrator was unable to provide the second set of vitals obtained. On 7/3/25 at 10:04 A.M., the Administrator provided a Change in Condition / Physician Notification policy, revised 3/19/25, that indicated The charge nurse will document timely regarding the change in resident's/patient's condition, interventions, and notifications. On 7/3/25 at 10:04 A.M., the Administrator provided a Comprehensive Care Plan policy, revised 5/16/24, that indicated We will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident/patient and/or representative. On 7/3/25 at 10:04 A.M., the Administrator provided a Fall Prevention policy, dated 1/2/24, that indicated When any resident experiences a fall, the facility will .document all assessments and actions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/25 at 10:04 A.M., the Administrator provided a Documentation in the Medical Record policy, dated 1/2/24, that indicated Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred . Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. Documentation shall be timely and in chronological order. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3) Based on observation, interview, and record review, the facility failed to ensure documentation was complete and accurate for 1 of 2 residents reviewed for falls and 1 of 1 residents reviewed for death. (Resident 95 and Resident 98) Findings include: 1. On 7/1/25 at 9:29 A.M., Resident 95's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and traumatic subdural hemorrhage. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 6/5/25, indicated that Resident 95 was cognitively intact, required partial to moderate assistance of staff (staff does less than half of the effort) to roll left to right and for a sit to stand transfer, and had one fall with injury since the prior assessment. A care plan conference was completed on 5/5/25. Falls and care plans were reviewed. A current risk for falls care plan, dated 3/31/25, included, but was not limited to, the following interventions: Door to room will be left open for visualization, dated 5/5/25 A nursing progress note, dated 5/4/25 at 8:02 A.M., indicated that Resident 95 sustained an unwitnessed fall. He was noted to be soiled with bowel movement. A nursing progress note, dated 5/4/25 at 8:18 A.M., indicated that at 9:30 P.M., Resident 95 had an unwitnessed fall while attempting to go to the closet. An Interdisciplinary Team (IDT) note, dated 5/5/25 at 10:55 A.M., indicated the fall on 5/3/25 at night was reviewed. Door to room will be left open for visualization was added to the care plan at that time. An IDT note, dated 5/5/25 at 11:24 A.M., indicated the fall on 5/4/25 was reviewed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation that the physician and resident representative was notified of the falls on 5/3/25 and 5/4/25 or that the resident was assessed after the fall on 5/3/25 at 9:30 P.M. until the next morning. An SBAR (Situation, Background, Assessment, Recommendation) note, dated 5/6/25 at 8:05 A.M., indicated that Resident 95 had a witnessed fall while attempting to get the TV remote from under his bed. The clinical record lacked documentation of an IDT meeting to review that fall or an intervention added to the care plan. On 7/1/25 at 11:00 A.M., Resident 95's door was observed closed. On 7/2/25 at 8:51 A.M., Resident 95's door was observed closed. On 7/2/25 at 9:32 A.M., the Director of Nursing (DON) provided risk management reports dated 5/3/25 at 9:30 P.M. and 5/4/25 at 7:25 A.M. The reports indicated that the resident was assessed, and the Nurse Practitioner (NP) and resident representative were notified of the falls at the time the resident fell. The risk management reports indicated they were not part of the medical record. At that time, the DON indicated that staff should put all fall incident report information into a progress note because the risk management report did not cross over into the clinical record. During an interview on 7/2/25 at 1:26 P.M., the DON indicated Resident 95 did not actually fall on 5/6/25. The nurse that charted the SBAR was instructed to chart it as a fall by the former DON, but it wasn't a fall because the resident was intentionally getting on the ground to look for the TV remote and he was able to stand back up by himself with the assistance of the side of the bed. During an interview on 7/3/25 at 8:29 A.M., the Administrator indicated that Resident 95 preferred his door closed and the facility failed to remove that intervention from the care plan. On 7/3/25 at 9:23 A.M., the DON provided a risk management report, dated 5/21/25 at 7:20 A.M., that indicated the resident and resident representative were educated on safety for fall interventions and the resident representative indicated to leave the door closed if that was what the resident preferred. The risk management report indicated it was not part of the medical record. At that time, the DON indicated that the facility failed to document the discussion with the resident representative and change of intervention in the clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection prevention practices were implemented during laundry services during 1 of 1 observations of laundry services. (Laundry Room) Finding includes: During an observation on 7/1/25 at 11:12 A.M., the Corporate Manager emptied the washer without wearing an apron and items in the washer were placed against her shirt and top of pants as well as her arms. During an interview on 7/3/25 at 9:22 A.M., the Director of Nursing indicated that when staff transferred clean laundry they should ensure laundry was not touching their uniforms. On 7/3/25 at 10:04 A.M., the Administrator provided a policy titled Personal Laundry Handling and Processing, dated 1/25, that indicated Items should be moved from the washer to the dryer as promptly as is practicable in a manner that minimized the risk of contamination and/or re-soiling. 3.1-18(b)(1)