STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 46882 Based on observation, interview, and record review, the facility failed to ensure the residents right to participate in the development and implementation of his or her person-centered plan of care for 10 of 32 residents reviewed for narcotic use. The facility had implemented a facility-wide rule to crush all narcotics for every resident without resident input or obtaining a physician order to do so. (Resident 2, Resident 21, Resident 3, Resident 13, Resident 4, Resident 15, Resident 29, Resident 5, Resident 17, Resident 11) Findings include: On 8/27/24 at 2:40 P.M., Resident 5 complained of pain beyond a level of 10 on a 1-10 pain scale in her knees and back, and indicated no pain medications were currently ordered because she couldn't take it crushed in applesauce so it was discontinued. On 9/4/24 at 11:30 A.M., Resident 5's clinical record was reviewed. Diagnosis included, but was not limited to, pain. A nurse's note dated 2/19/24 at 9:00 P.M. indicated Resident 5 was yelling and screaming at staff due to having to crush her narcotics. Resident indicated she should not be punished because of others. Resident 5 refused her routine narcotics at that time. A nurse's note dated 3/28/24 at 9:39 P.M., indicated Physician 21 was made aware of resident's statement about her routine narcotics, also that she was refusing medication. Physician 21 gave an order to discontinue narcotic medications if she was refusing them. On 8/26/24 at 2:33 P.M., a sign was observed hanging at both nurse's stations that indicated Effective January 9, 2024 All narcotics/controlled medications will be crushed and placed in applesauce prior to administration for ALL RESIDENTS. NO EXCEPTIONS. We will be monitoring this process very closely. Per Medical Director . During an interview on 8/29/24 at 2:14 P.M., RN (Registered Nurse) 5 indicated narcotics were still being crushed because they thought some residents were hoarding the pills in their mouths then trading them with other residents. RN 5 indicated Resident 5 wanted the powder from her crushed narcotics poured into her mouth, but after a while she started refusing them because it tasted so bad and couldn't get the taste out of her mouth. (continued on next page)

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/3024 at 3:00 P.M., the DON (Director of Nursing) indicated Resident 15 and Resident 4 were drug seekers, and that was why the facility crushed narcotics. She indicated residents were acting like they were taking them in pill form, but were not swallowing them, so an order was obtained from the Medical Director to crush all narcotics. She indicated no one got any scheduled or prn (as needed) narcotics while on LOA (leave of absence) and they also did not release narcotics at discharge. On 9/4/24 at 9:51 A.M., the DON provided a list of residents that saw the Medical Director and a list of residents that saw Physician 21, and indicated those were the only two physicians that had residents at the facility. During an interview on 9/4/24 at 10:07 A.M., the DON indicated Resident 5 was not suspected of hoarding or selling narcotics, and that it was other residents that were suspected. She indicated they spoke with the Medical Director and made it policy that anyone on controlled medications would get them crushed. She was not sure if it was made an actual policy, but that's what was in place. She indicated the Administrator, Medical Director and DON had made the decision. On 9/4/24 at 10:18 A.M., the MAR (Medication Administration Record) for all residents was reviewed with the following information: The Medical Director had three residents on narcotics or controlled substances: Resident 2, Resident 21, and Resident 3. Resident 2 and Resident 21 did not have a current physician order to crush medications. Resident 3 had a current order to crush medications. Physician 21 had seven residents on narcotics or controlled substances: Resident 13, Resident 4, Resident 15, Resident 29, Resident 5, Resident 17, Resident 11. Resident 17 did not have a current order to crush medications. The other six residents had a current order to crush medications if necessary. During an interview on 9/4/24 at 10:30 A.M., the Administrator indicated the concern that initiated crushing narcotics was with residents, not staff. There was a widespread issue with residents. There was no proof of anything, but residents were talking about other residents pocketing/saving pills and either selling them to buy other substances or taking several at the same time. At that time, she indicated the residents had not been aware of the change to crush narcotics prior to it being put into place, and were not happy with it after the fact. During an interview on 9/4/24 at 9:34 A.M., the Administrator indicated they did not have a narcotic administration policy. On 9/4/24 at 10:15 A.M., Administrator provided an undated Resident Rights Policy which indicated You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility .You have the right to be informed, and participate in, your treatment. This includes the right to: .Participate in the development and implementation of your person-centered plan of care . (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/4/24 at 2:04 P.M., Administrator provided a note, signed by the Medical Director and Administrator, which indicated It is the policy of Hillside Manor to crush all controlled narcotic medications unless otherwise specified by the manufacturer. Additionally, residents will be evaluated on an individual basis for the need to send controlled medications with them on LOA. Effective: January 1, 2024. 3.1-3(a) 3.1-3(n)(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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46882 Based on observation, interview, and record review, the facility failed to determine that self-administration of medications was clinically appropriate for 1 of 2 residents reviewed with medication in their room. A resident had an Albuterol inhaler in her room without an order to keep at the bedside or a self-administer assessment. (Resident 5) Finding includes: On 8/29/24 at 11:40 A.M., an Albuterol inhaler (used for asthma to assist in opening airways) was observed lying on a table next to the recliner in Resident 5's room. At that time, RN 5 indicated the inhaler could be kept at the bedside. On 8/29/24 at 9:08 A.M., Resident 5's clinical records were reviewed. Diagnosis included, but were not limited to chronic obstructive pulmonary disease (COPD), and asthma. The most current Annual MDS (Minimum Data Set) assessment, dated 7/4/24, indicated Resident 5 was cognitively intact. Physician orders included, but were not limited to the following: Albuterol Aerosol HFA (hydrofluoralkane) inhaler, inhale 2 puffs every 4 hours as needed for SOB (shortness of breath)/Asthma, ordered 7/23/24 The physician's order did not indicate to keep the inhaler at the bedside. The clinical record lacked a self-administration assessment. During an interview on 9/4/24 at 12:58 P.M., the Administrator indicated residents with medications in their room have had an assessment done for self-administration of medications. On 9/4/24 at 12:58 P.M., the Administrator provided a Self-Administration of Medications policy, revised February, 2021, which indicated As part of the evaluation comprehensive assessment, the interdisciplinary team assess each resident's cognitive and physical abilities to determine whether self-administrating medications is safe and clinically appropriate for the resident . 3.1-11(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 50827 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) Assessment was completed for 5 of 14 residents reviewed for MDS Assessments. Residents taking antiplatelet medication, diuretics, and oxygen were not marked as administered. (Resident 16, Resident 15, Resident 7, Resident 25, and Resident 6). Findings included: 1. On 8/28/24 at 10:54 AM, Resident 16's clinical record was reviewed. Resident had diagnoses that included, but was not limited to, COPD (Chronic Obstructive Pulmonary Disease), anemia, and and atrial fibrillation. A Quarterly MDS (Minimum Data Set) Assessment, dated 5/29/24 indicated Resident 16 was cognitively intact. The Resident required limited assistance with bed mobility, transfers, and toileting. The MDS indicated Resident 16 was not taking an antiplatelet and had not been on oxygen. Current physician orders included, but were not limited to, aspirin (an antiplatelet medication) 81 MG (milligrams) 1 tablet 2 times per week, dated 7/24/24. The MAR (medication administration record) for August 2024 included the following order, dated 8/24/23: Oxygen at 2LPM (liters per minute) per nasal cannula to keep oxygen saturation above 90% at bedtime as needed. 2. On 8/30/24 at 10:43 A.M., Resident 28's clinical record was reviewed. Diagnosis included, but were not limited to, cerebral infarction, anemia, and heart failure. The most recent Admission MDS Assessment, dated 7/1/24, indicated that the resident was not cognitively intact. Resident was dependent or required extensive assistance with bed, transfer, and toileting mobility. Resident 28's MDS assessment indicated no current use of an antiplatelet medication or diuretic medication. Current physician included, but were not limited to: aspirin 81 MG 1 tablet by mouth daily, dated 7/24/24 furosemide (a diuretic) 20 MG 1 tablet by mouth daily, dated 7/24/24. 45933 3. On 8/27/24 at 10:56 A.M., Resident 25's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia, renal insufficiency, and thyroid disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 6/28/24 indicated Resident 25 was not on an antiplatelet medication. Current Physician Orders included, but were not limited to, one chewable tablet of Aspirin 81mg (milligrams) daily for cardiac prevention, dated 6/19/23. 4. On 8/28/24 at 2:16 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, depression, and cancer. The most recent State Optional and Quarterly MDS Assessment, dated 8/2/24 failed to indicate Resident 7 was not on an antiplatelet medication. Current Physician Orders included, but were not limited to, one tablet of Aspirin 81mg by mouth daily for clot prevention, dated 7/24/24. During an interview on 8/30/24 at 11:48 A.M., the DON (Director of Nursing) indicated she was unaware that Aspirin was an antiplatelet medication. At that time, she indicated the facility used the RAI (Resident Assessment Instrument) manual as their policy. 3.1-31(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46416 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident for 6 of 6 residents reviewed for unnecessary medications. Residents on antipyschotic, antidepressant, antianxiety, and diuretic medications and a resident on oxygen did not have care plans developed. (Resident 15, Resident 16, Resident 7, Resident 25, Resident 6, Resident 28) Findings include: 1. During an interview on 8/27/24 at 4:05 P.M., the Administrator indicated Resident 15 had a history of substance abuse and that was how he ended up in his condition. On 8/28/24 at 1:40 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, depression, chronic pain syndrome, and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/25/24, indicated Resident 15 was cognitively intact, totally dependent on 2 staff to assist him for bed mobility, transfers, toileting, and was taking opiod and antipyschotic medication. Current Physician's Orders included, but were not limited to, the following: Risperidone (an antipsychotic) 1 mg (milligram), give 1 tablet by mouth twice daily for depression/anxiety, ordered 7/18/23 Norco (a narcotic) 10/325 mg, give 1 tablet by mouth every 4 hours as needed for pain, ordered 7/29/24 The clinical record lacked a plan of care for his history of substance abuse and the resident taking an antipyschotic. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/30/24 at 3:00 P.M., the DON (Director of Nursing) indicated she was the only staff member that knew how to put resident care plans in the electronic health record. Resident 15 had a history of substance abuse. She indicated he was not care planned for it because the staff controls it and he can not break rules. If we have a concern, we might keep in mind who was here in case something happens, but we can not ask our visitors who they are because they have a right to be here. The facility can not violate the resident rights, and if there was a change in behavior or the resident was unresponsive, stoned or looked overmedicated, we would call the doctor. Resident 15 was in a wheelchair so they would have to transport him if he wanted to go outside of the facility. They are aware There are some OTC (over the counter) forms of 'pot', like THC (tetrahydrocannabinol-found in cannabis plant that produces a high when smoked) and CBD (cannabidiol-found in cannabis plant that does not cause a high when smoked) that anyone can buy, but until we have unquestionable probable cause we cannot accuse him of anything. He has the right to do it. All we can do is watch him everyday and watch who the people that he was hanging out with because we know who the high risk people might be. At that time, she indicated she would expect him to have an antipsychotic care plan since he was currently taking one. 50827 2 .On 8/28/24 at 10:54 A.M., Resident 16's clinical record was reviewed. Diagnosis included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), anemia, and atrial fibrillation. A Quarterly MDS (Minimum Data Set) Assessment, dated 5/29/24, indicated Resident 16 was cognitively intact. The resident required limited assistance bed mobility, transfer, and toileting. Current physician orders included, but were not limited to: aspirin (an antiplatelet) 81MG (milligrams) 1 tablet 2 times per week, dated 7/24/24. Eliquis (an anticoagulant) 5MG 1 tablet twice a day, dated 7/24/24. Furosemide (a diuretic) 20MG 1 tablet daily, dated 7/24/24 spironolactone (a diuretic) 25MG 1 tablet by mouth dated 7/24/24. The MAR (Medication Administration Record) for August 2024 included the following order: Oxygen at 2LPM (liters per minute) per nasal cannula to keep sats above 90% at bedtime as needed, dated 8/24/23. Resident 16's clinical record lacked a care plan for antiplatelet medications. Resident 16's clinical record lacked a care plan for anticoagulant medications. Resident 16's clinical record lacked a care plan for oxygen use. 3. On 8/30/24 at 10:43 A.M., Resident 28's clinical record was reviewed. Diagnosis included, but were not limited to, cerebral infarction, anemia, and heart failure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Admission MDS Assessment, dated 7/1/24, indicated the resident was not cognitively intact. Resident 28 was dependent or required extensive assistance with bed, transfer, and toileting mobility. The MDS indicated that Resident 28 was taking an antidepressant at the time of assessment. Current physician orders included, but were not limited to: aspirin (an antiplatelet) 81 MG 1 tablet by mouth daily, dated 7/24/24. Furosemide (a diuretic) 20 MG 1 tablet by mouth daily, dated 7/24/24. Sertraline (an antidepressant) 25 MG 1 tablet by mouth daily, dated 7/24/24. Resident 28's clinical record lacked a care plan for antiplatelet medications. Resident 28's clinical record lacked a care plan for diuretic medication. Resident 28's clinical record lacked a care plan for antidepressant use. On 9/3/24 at 3:03 PM, the DON (Director of Nursing) indicated that care plans should have been in place for antiplatelets, anticoagulants, diuretics, antidepressants, as well as oxygen use. 45933 4. On 8/28/24 at 2:16 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but was not limited to non-Alzheimer's dementia and depression. The most recent State Optional and Quarterly MDS (Minimum Data Set) Assessment, dated 8/2/24 indicated Resident 7 was on an antidepressant, but lacked documentation of Resident 7 being on an antiplatelet. Current Physician Orders included, but was not limited to: One tablet daily by mouth of escitalopram (antidepressant) for depression, dated 7/24/24. One tablet of Aspirin (antiplatelet) 81mg (milligrams) by mouth daily for clot prevention, dated 7/24/24. Resident 7's clinical record lacked an antidepressant and antiplatelet care plan. 5. On 8/27/24 at 10:56 A.M., Resident 25's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia, renal insufficiency, and thyroid disorder. The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 6/28/24 indicated Resident 25 was not on an antiplatelet medication. Current Physician Orders included, but were not limited to, one chewable tablet of Aspirin 81mg (milligrams) daily for cardiac prevention, dated 6/19/23. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 25's clinical record lacked an antiplatelet care plan. 6. On 8/28/24 at 11:10 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus and bipolar disorder. The most recent State Optional and Quarterly MDS Assessment, dated 8/9/24, indicated Resident 6 was on an antipsychotic and diuretic medication. Current Physician Orders included, but was not limited to, Seroquel (an antipsychotic) 100 mg one time a day at bedtime by mouth for insomnia, dated 7/25/24, and Lasix (a diuretic) 20 mg daily by mouth, dated 7/25/24. During an interview on 8/29/24 at 1:53 P.M., the DON (Director of Nursing) indicated she updated the care plans quarterly and with the MDS. At that time, she indicated she would expect a care plan to be implemented for each specific medication a resident is administered. On 9/4/24 at 12:58 P.M., a current Care Planning policy, dated 5/2013, was provided and indicated, A comprehensive care plan for each resident is developed . 3.1-35(a)

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	155708	A. Building B. Wing	09/04/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46882 Based on observation, interview and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised for 3 of 12 residents reviewed for care plans. A care plan was not revised to include bed rails as a fall intervention, and care plans were not revised after medications were discontinued. (Resident 2, Resident 16, Resident 15) Findings include: 1. On 8/26/24 at 2:10 P.M., Resident 2 was observed lying in bed with his eyes open, a 1/2 bed rail was up in the middle of the mattress, call light was lying on the bed and one side of the bed was against the wall. On 8/28/24 at 1:03 P.M., Resident 2's clinical record was reviewed. Diagnosis included, but were not limited to, unspecified intracranial injury, anxiety, depression, obsessive-compulsive behavior, and diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/28/24, indicated a severe cognitive impairment, required extensive assistance of two for bed mobility, transfers, and toilet use and limited assistance of one for eating. Current physician orders included, but were not limited to: 1/2 side rail to right upper side of bed to aide in transfer or safety, undated. A current potential for falls care plan, revised 9/20/23, lacked an intervention for side rails. During an interview on 8/30/24 at 9:33 A.M., LPN (Licensed Practical Nurse) 13 indicated Resident 2 used the bed rail as an enabler to help him roll. During an interview on 9/3/24 at 10:08 A.M., the DON (Director of Nursing) indicated Resident 2 should have a care plan for the side rail on his bed. 50827 2. On 8/28/24 at 10:54 A.M., Resident 16's clinical record was reviewed. Diagnosis included, but was not limited to, depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/29/24, indicated Resident 16 was cognitively intact. The resident required limited assistance with bed mobility, transfers, and toileting. The MDS also indicated that the resident was taking antidepressants. Current physician orders included, but were not limited to: venlafaxine (antidepressant) 75 MG 1 capsule at bedtime, dated 7/24/24. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 16's clincal record lacked a current order for Lexapro (antidepressant). A current antidepressant use care plan, dated 8/23/23, indicated the use of the antidepressant medication Lexapro. Resident 16's clinical record lacked a current care plan for venlafaxine. On 9/3/24 at 3:03 P.M., the DON (Director of Nursing) indicated she did not currently state medications by name in care plans because a resident might have a medication change and she would not have known the care plan needed updating. 46416 3. On 8/28/24 at 1:40 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, depression, chronic pain syndrome, and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/25/24, indicated Resident 15 was cognitively intact, totally dependent on 2 staff to assist him for bed mobility, transfers, toileting, and was not taking an antianxiety medication. Current Physician's Orders included, but were not limited to, the following orders: Hydroxyzine (antihistamine) 5 mg (milligrams), give 1 tablet by mouth twice daily, ordered 7/23/24. The resident was on Klonopin (an antianxiety medication) in the past, but it was discontinued 10/12/23. The resident's current care plans included, but were not limited to, an Antianxiety Care Plan, dated 9/19/23. During an interview on 8/30/24 at 3:00 P.M., the DON (Director of Nursing) indicated she was the only staff member that knew how to put resident care plans in the electronic health record. Resident 15's Antianxiety Care Plan was not revised because he was on an anxiety medication but the doctor took him off of it and now had him on Hydroxyzine which is not an antianxiety but that was why he took it. On 9/4/24 at 12:58 P.M., a current Care Plan Policy, dated 5/13/24, was provided by the Administrator and indicated . Each resident's care plan shall be reviewed at least monthly . The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status . 3.1-35(d)(2)(B) 3.1-35(e)

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	155708	A. Building B. Wing	09/04/2024

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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 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. 50827 Based on observation, interview, and record review, the facility failed to ensure effective services were provided to prevent the development of a facility-acquired stage three pressure injury and multiple stage two pressure injuries for Resident 28, who was admitted to the facility without pressure injuries, and were identified by the facility upon admission to be at risk to develop pressure injuries. (Resident 28) Findings included: On 8/28/24 at 9:35 A.M., Resident 28 indicated that his buttocks was hurting, and had been for 2 or 3 weeks. He indicated he had told staff about it. On 8/30/24 at 10:43 A.M., Resident 28's clinical record was reviewed. Diagnosis included, but were not limited to, cerebral infarction (damage to the brain from lack of blood flow due to a blood clot), anemia, and heart failure. The most recent Admission MDS (Minimum Data Set) Assessment, dated 7/1/24, indicated a moderate cognitive impairment. Resident 28 was dependent or required extensive assistance with bed, transfer, and toileting mobility. Resident had an indwelling urinary catheter and was always incontinent of bowel. Resident 28 did not have a pressure ulcer, but was at risk for pressure ulcers or injuries. Current physician orders for Resident 28 included but were not limited to: Apply Medihoney (medical grade honey used to treat wounds) to open area to buttock and coccyx, cover with dressing, change daily and as needed if soiled or dislodged dated 8/17/24. Apply Boudreauxs butt paste 4 oz (ounces) topically to buttocks and scrotum twice daily until healed then as needed, dated 8/17/24. Physician orders also included, but were not limited to: Cleanse area on right and left buttocks with normal saline, apply hydrogel and calcium alginate and cover with optifoam gently border every 3 days and as needed, dated 7/11/24 through 7/29/24. Hydrogel gel apply and cover with optifoam gentle border every 3 days and as needed, dated 7/29/24 through 8/17/24. The order did not indicate where to apply dressing. A current risk for potential/actual impairment to skin integrity care plan, dated 6/24/24, included, but was not limited to, the following interventions: Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage) and any other notable changes or observations, dated 6/24/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. Building B. Wing	09/04/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 28's clinical record lacked care plans that specifically listed actual pressure ulcers. A Braden Scale risk assessment form (pressure ulcer risk assessment) , dated 6/24/24, indicated the resident was at risk for pressure ulcers. Resident 28's clinical record lacked any additional pressure ulcer risk assessments. Resident 28's Medication Administration Record (MAR) for July 2024 indicated treatment to buttocks was not performed on 7/27/24. Resident 28's clinical record lacked record of wound treatments for August 2024. An admission nursing assessment, dated 6/24/24, indicated no open areas on resident's skin. A pressure ulcer record form, dated 8/19/24, indicated the following information: Site A, on coccyx area, first observed on 8/17/24, stage 2 (Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present), measured 1cm by 1cm and pink in color. Area had remained a stage 2 on 8/19/24. Site B, on left buttock, first observed 7/11/24, stage 2, measured 0.2cm by 0.2 cm, pink in color. Signed by Licensed Practical Nurse (LPN) 13. Area remained a stage 2 on 8/19/24. Site C, on right buttock, first observed 7/11/24, stage 2, measured 0.2cm by 0.2cm, pink in color Signed by LPN 13. Area remained a stage 2 on 8/19/24. All sites lacked any other pressure ulcer record forms prior to 8/19/24 or after 8/19/24. Weekly skin assessments were as follows with the following information: 8/3 (no year documented) no new skin alterations, treatment continues. 8/10 (no year documented) no new skin alterations. 8/19 (no year documented) no new skin alterations, see skin sheet. Resident 28's clinical record lacked any other weekly skin assessments since admission. On 8/30/24 at 12:50 P.M., DON (Director of Nursing) indicated she was not aware of Resident 28 having a wound or pressure ulcer. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/24 at 10:40 A.M., CNA 7 and QMA (Qualified Medication Aide) 3 were observed to provide incontinence care for Resident 28. Neither CNA or QMA washed hands or used hand sanitizer prior to putting gloves on to perform care. While CNA and QMA were performing incontinence care, Resident 28 was moaning indicating he was in pain. The resident was turned onto the left side, exposing two areas that were reddened, wet, draining, and missing layers of skin on the left buttock and coccyx area. There was no wound dressing or bandage in place at that time to either area. QMA 3 asked CNA 7 to go get a nurse to do a treatment on the residents' buttock. LPN 13 came to the resident's room with wound care supplies. LPN 13 did not wash hands prior to putting on gloves, then cleansed the areas with normal saline, applied Medihoney and covered the areas with a bordered dressing. When QMA 3 and CNA 7 finished incontinence care there were reddened spots with a layer of skin missing observed on the under side of the scrotum. LPN 13 indicated she was unaware of the open scrotal areas, and would need to measure them the next time they performed incontinence care to fill out a skin assessment sheet. LPN 13 then applied barrier cream to the scrotum. LPN 13, QMA 3, and CNA 7 then took their gloves off and failed to perform hand hygiene post care. On 8/30/24 at 2:06 P.M., CNA 7 indicated that she checked Resident 28 for incontinence at approximately 6:00 A.M. and again to 8:30 A.M. She noticed open areas on scrotum during the 8:30 A.M. check, notified LPN 13 and at that time LPN 13 told her to wait until next time she checked him for incontinence care and to let her know what they looked like (observed at 10:40 A.M.). On 8/30/24 at 2:21 P.M., Licensed Practical Nurse (LPN) 13 indicated that she was not notified or aware of any open areas on scrotum prior to this morning when doing wound care on Resident 28's coccyx, and that the facility protocol when made aware of any wounds would be to notify the doctor and the family of the wound, document assessment of the wound including measurements in skin book and nurses notes, and obtain orders for treatment of wound from the doctor. At that time, LPN 13 indicated she had not made any notifications related to Resident 28's new scrotal areas and it would be closer to 5 P.M. before she would be able to get measurements of Resident 28's wounds and would notify the physician at that time. On 9/3/24 at 10:30 A.M., a pressure ulcer record form dated 8/30/24 was reviewed and indicated 2 new areas first observed on 8/30/24 with the following information: Site A measured 0.3cm by 0.2 cm by 0.2 cm, stage 2, pink in color, treatment initiated. Signed by LPN 13. Record did not indicate where wound was located on the body. Site B first observed on 8/30/24 measured 0.2cm by 0.1 cm by less than 0.2 cm, stage 2, pink in color, treatment initiated. This was signed by LPN 13. Record did not indicate where wound was located on the body. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/3/24 at 1:52 P.M., LPN 13 was observed to perform a dressing change for Resident 28. LPN 13 removed a dressing from the coccyx that was dated 9/1/24. CNA 7 attempted to get what she indicated as a brand name of barrier cream off of the resident's scrotum and was unable to remove all of it. Due to the barrier cream, LPN 13 was only able to find one of the two open areas on the scrotum that she measured at 0.5cm (centimeters) by 1cm. LPN 13 indicated that open area would be considered a stage 2 wound. After cleansing and measuring the coccyx wound, LPN 13 indicated that it measured 2.1cm x 3.4 cm and would now be considered a stage 3 wound (Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed) . LPN 13 then indicated she had found a new stage 2 wound on the bottom of Resident's left buttock. On 9/4/24 at 11:02 A.M., the DON indicated when Resident 28 was admitted he was at risk for pressure ulcers, and she would only do another risk assessment for the resident if there was a significant change in health status or the resident went on hospice. She indicated Resident 28 should have been turned and repositioned, and shower sheets should have indicated any changes in skin condition that the nurse should have been aware of. At that time, the DON provided all shower sheets for Resident 28 that could be found, and all lacked any altered skin condition. The DON indicated when she was made aware of any pressure ulcers on a resident, she updated the resident's record to have an individual care plan for each wound. She indicated she had not been aware of Resident 28 having any new wounds until now. A current nondated pressure ulcer program policy was provided by the Administrator on 9/4/24 at 11:26 A.M. and indicated that upon admission, and at any change of condition and a quarterly, a new comprehensive assessment of the resident's overall risk factors for pressure ulcers including the Braden Scale assessment will be completed. An individual care plan will be developed and implemented to address those residents at risk for pressure ulcers and those with ongoing conditions. Each resident will have their skin assessed during the scheduled shower days by the CNA responsible for their care. Findings will be reported to charge nurse for review. Each week the wound nurse will assess and record measurements on all skin conditions and results will be reviewed. The DON will update the pressure wound log with current measurements each week. A weekly complete body assessment will be completed by the charge nurse at which time all skin alterations will be measured and placed on the appropriate skin sheet. 3.1-40(a)(1) 3.1-40(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on observation, interview, and record review, the facility failed to ensure each resident receives adequate supervision and assistive devices to prevent accidents for 2 random observations of residents having vapes (electronic cigarette) in their possession. (Resident 15, Resident 24) Findings include: 1. During a random observation on 8/29/24 at 10:17 A.M., 2 vapes (electronic cigarettes) were laying on Resident 15's bedside table while he was laying in his bed. At that time QMA (Qualified Medication Aide) 3 went into his room and back out leaving the vapes in the same place. Then the Dietary Manager brought ice water into the room and did not ask about the vapes. QMA 3 went back into the room and back out without asking the resident to return the vapes to the staff. On 8/28/24 at 1:40 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, depression, chronic pain syndrome, and anxiety. Resident 15 was admitted on [DATE] and was [AGE] years old. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/25/24, indicated Resident 15 was cognitively intact, totally dependent on 2 staff to assist him for bed mobility, transfers, and toileting. Current Physician's Orders included, but were not limited to, the following: Norco (narcotic pain medication) 10/325 mg (milligrams), give 1 tablet by mouth every 4 hours as needed for pain, ordered 7/29/24 A Behavior Care Plan, dated 1/11/24, indicated the resident asks staff to find his vape and when they remind him he can't keep a vape in his possession, he says never mind. The resident's clinical record lacked a plan of care for a history of substance abuse and risk of overdose. A Nurse Practitioner's Behavioral Health Progress Note, dated 8/20/24, indicated Resident 15 had abused multiple substances. During an interview on 8/27/24 at 4:05 P.M., the Administrator indicated Resident 15 has a history of substance abuse and that was how he ended up in his condition. She was not sure what the exact date was but Resident 15 allegedly got a vape from an unknown source with THC (tetrahydrocannabinol-found in cannabis plant that produces a high when smoked) in it. The resident smoked it at the facility and staff noticed a change of condition but did not know why so the Administrator was notified and she told them to do neuro (neurological) checks and contact the doctor. The resident's condition got worse and they sent him out to the hospital. She thought the toxicology report revealed THC but wasn't sure. The Administrator indicated she did not document anything because she could not prove that's what had happened. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation related to the incident. During an interview on 8/28/24 at 10:45 A.M., Resident 15 was not sure on exact date, but admitted he got a vape with THC in it from the local gas station and smoked it in the facility. 2. During a random observation on 8/28/24 at 2:20 P.M., Resident 24 was sitting in his room, in his wheelchair with the door open holding a blue vape. During a random observation on 8/30/24 at 3:45 P.M., Resident 24 was sitting in his room, in his wheelchair with the door open holding a pink vape. On 8/29/24 at 2:51 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, and tobacco use. The most recent Quarterly MDS Assessment, dated 8/16/24, indicated Resident 24's cognition was moderately impaired and an extensive assist of 2 staff for bed mobility, transfers, and toileting. A current Behavior Care Plan, dated 2/21/24 indicated Resident 24 forgets to turn vaping material back in after smoke times and included, but was not limited to, an intervention to remind resident to turn vaping material back into staff, dated 2/21/24 During an interview on 8/28/24 at 1:24 P.M., an anonymous resident indicated they had voiced to staff people were smoking and vaping in the building especially through the night. They indicated the smoke affected their allergies and the smoke hung thick enough in the air that they go outside in the mornings to get fresh air. During an interview on 8/28/24 at 2:20 P.M., RN (Registered Nurse) 5 indicated they did have a few residents who did not like to give vapes to staff to store. Resident 24 and Resident 15 were both named. While walking past Resident 24's room, RN 5 did not address him about having his vape in his possession. She indicated she didn't know what the policy was for vapes. She was not sure how to know which vapes contained THC, but indicated they were not allowed in the facility. During an interview on 8/30/24 at 3:49 P.M., the DON (Director of Nursing) indicated on 5/8/24, Resident 15 did not go to hospital but he indicated he Had been smoking weed. There was a vape in his room but staff didn't know for a fact that he had been using THC. At that time, she indicated if cigarettes or lighters were found in the room, they would be confiscated from the resident. If vapes were found in the room, they would not take them because it was their right to have them, but they were not supposed to smoke them in the facility, and only at smoke times. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/24 at 11:21 A.M., the SSD (Social Services Director) indicated May 2024 behavior documentation would be sitting on floor in SSD office to be filed downstairs. July and August were in a binder in her office, but there was no mention of behaviors from Resident 15 or Resident 24. She indicated vape refusals and drug seeking should be documented in the nurse notes and then staff would notify her by leaving messages about behaviors that happened. These behaviors would be discussed during the next morning meeting and the team would decide if it was a problem that needed monitoring. At that time, the Administrator indicated they were not able to find information related to vapes being combustible and wanted to change their policy for a while but hadn't. On 8/28/24 at 2:17 P.M., a current Smoking Policy, dated October 1, 2021, was provided by the DON and indicated . A smoking evaluation form is not necessary for e-cigarette use or vapes as there is not a risk of burning yourself. Vapes/E-cigarettes shall be used in the designated smoking area and must be kept at the nurses station . 3.1-45(a)(2)

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	155708	A. Building B. Wing	09/04/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 45933 Based on observation, interview, and record review, the facility failed to ensure a resident received necessary respiratory care and services in accordance with professional standards of practice. The facility failed to have an order for oxygen use, follow physician oxygenation orders, date oxygen tubing, and clean the oxygen filters for 4 of 5 residents reviewed for respiratory care. (Resident 5, Resident 23, Resident 14, Resident 6) Finding includes: 1. During an interview and observation on 8/26/24 at 1:47 P.M., Resident 6's oxygen tank was observed with debris on it and the filter was caked with dust. At that time, Resident 6 was in bed and indicated she only used the oxygen at night and the filter had not been cleaned by the facility. During an observation on 8/29/24 at 10:38 A.M., the same was observed. On 8/28/24 at 11:10 A.M., Resident 6's clinical record was reviewed. Current diagnoses included, but were not limited to, asthma and diabetes mellitus. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 8/9/24 indicated Resident 6 had moderate cognitive impairment and was not on oxygen. Resident 6's clinical record lacked a current order for oxygen. A current risk for altered respiratory status care plan, dated 11/9/23 included oxygen as ordered as an intervention. Resident 6's clinical record lacked documentation related to a sleep study. During an interview on 8/28/24 at 11:26 A.M., RN (Registered Nurse) 5 indicated Resident 6 was on oxygen at 2 liters per minute (LPM) at night due to the results of her sleep study. At that time, she indicated staff should notify the provider and the order should be placed in the clinical record. RN 5 indicated she could not find a current order for oxygen. 46882 2. On 8/28/24 at 2:30 P.M., Resident 5 was observed sitting in the dark in a recliner with her feet elevated, watching television while on her phone. An oxygen concentrator was sitting against the wall. There was no filter on the oxygen concentrator and the tubing in a plastic bag was undated. Resident 5 indicated staff brings her new tubing when she needs it, but she hadn't used the tubing in the bag very much yet. On 8/29/24 at 9:08 A.M., Resident 5's clinical records were reviewed. Diagnosis included, but were not limited to chronic obstructive pulmonary disease (COPD), emphysema, and asthma. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most current Annual MDS (Minimum Data Set) assessment, dated 7/8/24, indicated Resident 5 was cognitively intact, required extensive assistance of two for bed mobility, extensive assistance of one for transfers and toilet use, supervision with set up for eating, and oxygen use was marked no. Physician orders included, but were not limited to the following: Check O2 (oxygen) Sats (saturations) Q (every) shift, dated 5/10/20 Oxygen at 2 LPM (Liters Per Minute) per nasal cannula as needed to keep sats above 90%/ SOB (shortness of breath), dated 11/30/23 The physician orders lacked an order to change the oxygen tubing and clean the filter. A care plan for potential for ineffective airway clearance, SOB, and respiratory distress related to diagnosis of COPD, emphysema, and unspecified asthma indicated Resident 5 slept in her recliner per her life choice in order to prevent SOB while lying flat. Revised on: 2/26/20 Interventions included, but were not limited to, the following: Assess and monitor breath sounds and respirations as needed, revised on 5/4/21. Keep head of bed elevated at all times to prevent SOB while lying flat or allow resident to sleep in recliner per life choice, date initiated 2/26/20. O2 at 2 LPM NC (nasal cannula) with CPAP (continuous positive airway pressure) at HS (bedtime) prn (as needed), date initiated on 2/26/20 with revision on 8/29/24. The care plan lacked interventions to change the oxygen tubing and clean the filter. During an interview on 8/29/24 at 10:10 A.M., the DON (Director of Nursing) indicated the facility owns the oxygen machines. During an interview on 8/29/24 at 10:23 A.M., the DON indicated the oxygen tubing is changed by night shift every Sunday. During an interview on 8/29/24 at 11:36 A.M., RN (Registered Nurse) 5 indicated the oxygen tubing was changed weekly on night shift on Sunday, but it was not documented anywhere. The filters were cleaned weekly when the tubing was changed. On 8/29/24 at 11:40 A.M., RN 5 came into Resident 5's room to look at the oxygen machine and indicated there was not a filter on the machine and was not sure if there should be one. During an interview on 8/30/24 at 1:59 P.M., the DON indicated the resident used her oxygen occasionally. She did not know if the concentrator in Resident 5's room had a filter but would ask the maintenance man because she was pretty sure he took care of those. During an interview on 8/30/24 at 2:41 P.M., the DON indicated Resident 5 had a Companion 5 concentrator which had an internal filter that was changed by (name of medical company) once a year. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/30/24 at 2:58 P.M., the DON indicated the oxygen concentrator belonged to Resident 5, since she purchased it herself in January, 2024. The DON was not sure where it was purchased from or if it was new or used. During an interview on 9/3/24 at 11:53 A.M., Resident 5 indicated the oxygen concentrator belonged to the facility. She indicated she did not purchase it but has had it since January. She indicated she knew nothing about the machine and was not aware the filter needed to be checked. During an interview on 9/3/24 at 3:19 P.M., the Administrator indicated the oxygen concentrator in Resident 5's room did not belong to the facility, and Resident 5 purchased things off of the Internet all of the time. The Administrator indicated she would replace that concentrator with one of the facility's concentrators to make sure the filters were taken care of and put Resident 5's concentrator into storage. 3. On 8/26/24 at 2:10 P.M., Resident 23 was observed sitting up in a recliner with his feet on floor, oxygen on at 2 LPM (Liters Per Minute) per nasal cannula, filter on back of oxygen concentrator was covered in a white layer of dust, foam pieces on ears, and no dates on humidification bottle or tubing. On 8/28/29 at 10:19 A.M., Resident 23 was observed sitting up in a recliner with feet elevated, oxygen on at 2 LPM per nasal cannula with undated tubing and filter on oxygen concentrator covered in a white layer of dust. On 8/29/24 at 9:23 A.M., Resident 23 was observed sitting up in a recliner with eyes closed, oxygen on at 2 LPM per nasal cannula with undated tubing and filter on oxygen concentrator remained dust covered. On 9/3/24 at 9:55 A.M., Resident 23 was observed sitting up in a recliner with oxygen on at 2 LPM per nasal cannula with tubing dated 9/2/24 but filter on the back of the oxygen concentrator remained dust covered. On 8/28/24 at 2:10 P.M., Resident 23's clinical records were reviewed. Diagnosis included, but were not limited to chronic obstructive pulmonary disease (COPD) with acute exacerbation. The most current Annual MDS (Minimum Data Set) assessment, dated 7/3/24, indicated Resident 23 had moderate cognitive impairment, required extensive assistance of two for bed mobility, transfers and toilet use, supervision with set up for eating and used oxygen. Physician orders included, but were not limited to, the following: Oxygen at 2 LPM per nasal cannula at all times, dated 12/27/22 The physician orders lacked an order to change the oxygen tubing and clean the filter on the oxygen concentrator. A care plan for at risk for altered respiratory status/difficulty breathing related to COPD, revised on 9/22/23 included, but was not limited to the following interventions: (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Elevate head of bed to alleviate symptoms of shortness of breath while laying flat in bed, revised 9/22/23. Oxygen as ordered, revised on 1/9/24. The care plan lacked interventions to change the oxygen tubing and clean the filter. During an interview on 8/29/24 at 11:36 A.M., RN 5 indicated indicated the oxygen tubing was changed weekly on night shift on Sunday, but it was not documented anywhere. The filters were cleaned weekly when the tubing was changed. 38770 4. On 8/28/24 at 9:10 A.M., Resident 14 was observed sitting in a recliner with oxygen on via nasal cannula set at 3 lpm (liters per minute). The oxygen concentrator was observed with a filter on the left and right side of the machine, both caked with dust. At that time, Resident 14 indicated she had not observed staff ever cleaning the filters on the concentrator. On 8/28/24 at 10:29 A.M., Resident 14's clinical record was reviewed. Diagnosis included, but were not limited to, heart failure, anxiety, depression, asthma, and Congestive Heart Failure. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/24/24, indicated a mild cognitive impairment and oxygen use while a resident. Resident 14 lacked a current physician order for oxygen. A current Congestive Heart Failure care plan, dated 5/24/23, indicated, but was not limited to, an intervention to administer oxygen as ordered, dated 5/24/23. On 8/28/24 at 10:55 A.M., the Director of Nursing (DON) indicated the facility changed their pharmacy at the beginning of August and Resident 14's July orders had included oxygen. She indicated when the orders had been reconciled from July to August (previous pharmacy to current pharmacy), oxygen orders had not crossed over to the current orders. At that time, Resident 14's physician orders for July were reviewed with the DON, and indicated oxygen at 2 lpm per nasal cannula as needed, dated 11/13/23. She indicated at that time Resident 14 was supposed to have the same oxygen order currently. On 8/28/24 at 11:00 A.M., Registered Nurse (RN) 5 indicated there was no place currently to document oxygen administration, but should be in the Medication Administration Record (MAR). On 8/29/24 at 1:34 P.M., Resident 14 was observed sitting in a recliner with oxygen on via nasal cannula set at 2 lpm. On 8/30/24 at 10:29 A.M., Resident 14 was observed sitting in a recliner with oxygen on via nasal cannula set at 2 lpm. Resident 14 indicated at that time the oxygen has always been set at 3 lpm, and to her knowledge had not been changed from 2 lpm to 3 lpm since she had been there. At that time, Licensed Practical Nurse (LPN) 13 indicated she was unaware of what Resident 14's oxygen setting should be, and after reviewing the chart, indicated it should be set at 2 lpm. LPN 13 also indicated she was unaware of who what responsible for cleaning the filters on oxygen concentrators. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current Respiratory Therapy policy, revised 11/2011, indicated Change the oxygen cannula and tubing every seen (7) days, or as needed . Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. The policy indicated administration of oxygen should be documented in the resident's medical record. 3.1-47(a)(6)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46882 Based on observation, interview and record review, the facility failed to ensure all physician's orders were obtained from the pharmacy for 1 of 6 residents reviewed for medication administration and 3 of 5 residents reviewed for respiratory care. The facility lacked August 2024 physician orders for insulin and oxygen. (Resident 14, Resident 5, Resident 23, Resident 2) Findings include: 1. On 8/28/24 at 1:03 P.M., Resident 2's clinical records were reviewed. Diagnosis, included, but were not limited to unspecified intracranial injury and diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/28/24 indicated Resident 2 had a severe cognitive impairment. Resident 2 lacked a current physician order for Tresiba Flextouch 100 u/ml (units/milliliter) 6 u subcu (subcutaneous) once a day. At that time, RN (Registered Nurse) 5 indicated Resident 2 was on insulin daily. On 8/28/24 at 11:30 A.M., the DON (Director of Nursing) provided a copy of the August Blood sugar log which indicated Resident 2 received Tresiba 6 units subcu at bedtime from 8/1/24 through 8/27/24. 2. During the course of the survey, Resident 14, Resident 5, Resident 23's clinical records included oxygen orders for July. August MAR (Medication Administration Record)/ TAR (Treatment Administration Record) printed by the current pharmacy failed to include all previous oxygen related orders. 38770 3. On 8/28/24 at 9:10 A.M., Resident 14 was observed sitting in a recliner with oxygen on via nasal cannula set at 3 lpm (liters per minute). On 8/28/24 at 10:29 A.M., Resident 14's clinical record was reviewed. Diagnosis included, but were not limited to, heart failure, anxiety, depression, asthma, and Congestive Heart Failure. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/24/24, indicated a mild cognitive impairment and oxygen use while a resident. Resident 14 lacked a current physician order for oxygen. On 8/28/24 at 10:55 A.M., the Director of Nursing (DON) indicated the facility changed their pharmacy at the beginning of August and Resident 14's July orders had included oxygen. She indicated when the orders had been reconciled from July to August (previous pharmacy to current pharmacy), oxygen orders had not crossed over to the current orders. At that time, Resident 14's physician orders for July were reviewed with the DON, and indicated oxygen at 2 lpm per nasal cannula as needed, dated 11/13/23. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/24 at 3:36 P.M., the DON indicated the current pharmacy originally told the facility that they had been given the resident's Treatment Administration Record (TAR) and insulin orders, and the facility had lost them. She indicated she tried at that time to get the current month's missing orders from the pharmacy, and was having a hard time getting them sent. On 8/29/24 at 12:09 P.M., a current non-dated Provider Pharmacy policy was provided and indicated Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies . The provider pharmacy is responsible for rendering the required service in accordance with local,, state, and federal laws and regulations; facility policies and procedures; community standards of practice; and professional standards of practice . Maintaining a medication profile on each resident that includes all medications dispensed and facility-provided information 3.1-25(b)

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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. 46882 Based on observation, interview and record review, the facility failed to maintain safe and secure storage of medications for 2 of 2 medication carts observed and 1 of 2 medication storage rooms observed. Medications with no open date were observed in the medication carts, and refrigerator temperature logs were not filled out completely in the medication room. (Back Hall Medication Cart, Back Hall Medication Storage Room, Front Hall Medication Cart) Findings include: On 8/26/24 at 1:15 P.M., the following medications were observed during review of the Back Hall Medication Cart with RN 5: Resident 11 Albuterol Sulfate inhaler-no open date Resident 7 Breyna 160-4.5 mcg (microgram) inhaler-no open date Resident 20 Neo/Poly/HC (Neomycin-Polymyxin-Hydrocortisone) otic drops-started on 8/16/24, ended on 8/22/24, still in the drawer Resident 10 ferrous sulfate pill in medication cup with no identification Resident 28 Trelegy Ellipta with an open date of 5/21/24 Resident 28 allergy relief nasal spray-no open date Resident 28 a second Trelegy Ellipta with a tag to discard after 6 weeks-no open date and pen had been used On 8/26/24 at 1:45 P.M., the Back Hall Medication Storage Room was observed to have missing temperatures from the medication refrigerator temperature log. There were no refrigerator temperatures recorded for 8/10/24, 8/11/24, 8/17/24, 8/19/24, 8/24/24, and 8/25/24 for the month of August, 2024. On 8/26/24 at 2:00 P.M., the following medications were observed during review of the Front Hall Medication Cart with QMA (Qualified Medication Aide) 3: Resident 7 Ventolin inhaler- open date of 6/30/23 expiration date of 6/30/24 Resident 22 Polymyxin B TMP (trimethoprim) eye drops- no open date Resident 3 Artificial tears-No open date (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/3/24 at 9:00 A.M., the DON (Director of Nursing) indicated multidose medications, like eye drops, inhalers and insulin and insulin pens should have an open date on them. The medication refrigerator should have a temperature logged daily. On 8/30/24 at 9:53 A.M., the Administrator provided a current Medication Storage in the Facility Policy, dated 5/2013 which indicated .K. Medications requiring refrigeration or temperatures between 2 degrees C [Celsius] (36 degrees F [Fahrenheit]) and 8 degrees C (46 degrees F) are kept in a refrigerator with a thermometer to allow temperature monitoring .P. Refrigerator temps [temperatures] will be monitored QD [every day]. At that time the Administrator indicated they did not have a specific policy to put open dates on multidose medications, but it was their policy to put open dates on eye drops, inhalers, insulin pens, and any multidose medication. 3.1-25(j) 3.1-25(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46416 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for 1 of 1 kitchens observed. Staff did not wear hairnets that covered all their hair, appropriate footwear was not worn, food was not labeled, the dishwasher was not monitored daily for safe sanitation, staff did not wash hands for appropriate length of time, and scoops were left in containers. (Kitchen) Findings include: 1. On 8/26/24 at 1:00 P.M., the following was observed during a tour of the kitchen: Kitchen on main floor: No soap in the dispenser at the hand washing sink. The Dietary Manager did not have a hairnet on and was wearing Crocs (shoes with holes on the top). When she put a hairnet on, it did not cover the hair at the nape of her neck. Kitchen Staff 1's hairnet covered the crown of her head only, leaving hair out at her temples and nape of the neck. Freezer/refrigerator #8: Opened frozen pancakes, no label Opened frozen waffles, had 6/24 handwritten on them Opened frozen Hashbrowns, no date A brown liquid and light yellow pureed substance in gallon pitchers, not labeled Cart of liquids in gallon pitchers without labels next to refrigerator #8 Totes of cereal under the prepping table labeled Rice Krispies, Frosted Flakes, Raisen Bran, and Cheerios but not dated During an interview on 8/26/24 at 1:05 P.M., Kitchen Staff 1 indicated the dishwasher used chemicals but she didn't know of any strips used to test it. She indicated they know when the dishes were sanitized because they were hot when they come out. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/26/24 at 1:06 P.M., the Dietary Manager indicated she started in the kitchen in June 2024 and they were supposed to use test strips to check the dishwasher but she had not been taught how to do it. To her knowledge, the Maintenance Supervisor who used to be the kitchen manager but was transitioning to his new role checked it when he got there in the mornings but there was no log for documentation. At that time, she called the Maintenance Supervisor to ask about the dishwasher and he indicated he had never checked the chemicals in the dishwasher and was not sure what the temperature should be. The Dietary Manager ran the dishwasher through a cycle and the temperature was observed to be 102 degrees F (Fahrenheit) during the wash and 114 degrees F during the rinse cycles. The dial on the machine indicated the temperature should be 120 degrees F minimal. Downstairs: Stagnant water puddle in the doorway of the room with freezers in it First refrigerator/freezer on the left when you entered had frozen waffles, open to air and not labeled The black refrigerator had Boil in bag eggs, not dated and a broken egg with the shell in the door shelf On 8/27/24 at 9:05 A.M., the following was observed in the kitchen: Kitchen on main floor: No soap in the dispenser at the hand washing sink. Dietary Manager was wearing Crocs and her hairnet did not cover the hair at the nape of her neck. Kitchen Staff 1's hairnet covered the crown of her head, leaving hair out at her temples and nape of the neck. The container of brown sugar had an uncovered cup in it Kitchen closet by steps going downstairs: The container of powdered sugar had an uncovered cup in it During an interview on 8/27/24 at 9:12 A.M., the Contracted Supervisor indicated the dishwasher was a low temperature dishwasher and someone should be checking it at least daily to make sure it's working. He indicated the temperature stays around 113 degrees F. He stuck a test strip in the bottom of the dishwasher where water was sitting in tub but it had not been recently cycled and the strip was observed to read 10 ppm (parts per million) of chlorine. The Maintenance Supervisor indicated there was a company that came to check the dishwasher, but he wasn't sure how often or when they were here last. He indicated he did not check the dishwasher for chemicals and the Dietary Manager should know where the logs are kept. Downstairs: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ice maker was in a separate room in the basement. The ice scoop was laying on top of the dusty machine, uncovered. On 8/29/24 at 11:00 A.M., the following was observed in the kitchen: Kitchen: Dietary Manager was wearing Crocs and her hairnet did not cover the hair at the nape of her neck. Kitchen Staff 1's hairnet covered the crown of her head, leaving hair out at her temples and nape of the neck. The container of brown sugar had an uncovered cup in it. Freezer/refrigerator #8: Opened frozen pancakes, no label Opened frozen waffles, had 6/24 handwritten on them Opened frozen Hashbrowns, no date A brown liquid and light yellow pureed substance in gallon pitchers, not labeled Cart of liquids in gallon pitchers without labels next to refrigerator #8 Totes of cereal under the prepping table labeled Rice Krispies, Frosted Flakes, Raisen Bran, and Cheerios but not dated During an interview on 8/29/24 at 11:14 A.M., the Contracted Supervisor indicated he turned on the hot water heater booster attached to the dishwasher to get the temperature up to 140 degrees F, but the test strips they had were not working properly to test the chemical sanitation. At that time, he contacted the (Dishwasher Company) technician and after discussion, he indicated the technician thought the jug of sanitizer had gone bad. Downstairs: Stagnant water puddle in the doorway of the room with freezers in it First refrigerator/freezer on the left when you entered had frozen waffles, open to air and not labeled The ice maker was in a separate room in the basement. The ice scoop was laying on top of the dusty machine, uncovered. Kitchen Staff 1 fixed the trash can liner and washed her hands with a 12 second lather with soap and then put gloves on. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary Manager washed hands with a 7 second lather with soap and then slid plates around with thumbs on top of plates to be used to serve the lunch on. Kitchen Staff 1 laid a residents cup on a prep table with the straw touching the table. The Dietary Manager used a wash cloth to clean the thermometer probe off while checking the temperatures of the food, leaned on the steam table with right forearm, laid the wash cloth that wiped thermometer probe on same place where arm was, and used the wash cloth to continue wiping the thermometer probe. During an interview on 8/26/24 at 1:20 P.M., the Dietary Manager indicated there should be a label on everything indicating the date they received it, but the labels fall off. She indicated she checked the freezers and refrigerators weekly and quarterly to get rid of anything that was no longer usable. The do not keep leftovers after meals. The resident's got what they wanted and they discarded the rest. During an interview on 8/27/24 at 11:02 A.M., the Administrator indicated the dishwasher was a low temperature dishwasher and the water should be between 100-120 degrees F. The chemicals sanitized the dishes. If chemicals are in the jug then it's working; the machine makes sure it has the correct amount of chemicals . They had a company that came in periodically (last time was 2/21/24) but was on call 24/7 and he changed the chemicals. The staff did not check the amount of chemicals the machine was using. On 8/28/24 at 2:49 P.M. the Administrator provided an email from the company that serviced the dishwasher that indicated . the training we provide to our customers allows them to check their chemical levels and the operating of the machines daily when they use our chemicals . During an interview on 8/30/24 at 12:10 P.M., the (Dishwasher Company) technician was at the facility and indicated the sanitizer probe was not completely in the jug and the chlorine had evaporated. He indicated staff should be using a smaller jug or for sure sealing the jug somehow to keep that from happening and should test the sanitation at least daily first thing of a morning. After replacing the sanitizer, the chlorine was observed at 100 ppm. It needs to be between 50-100 ppm to sanitize dishes properly. During an interview on 9/3/24 at 11:32 A.M., the Administrator indicated hairnets should cover all hair while in the kitchen and Crocs were not appropriate footwear in the kitchen. She indicated they were not aware they needed to check the dishwasher chemicals and keep a log of it to ensure proper sanitation of dishes. The ice maker scoop should be covered with a bag, there should not be scoops in the containers of sugar, and all food should be labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/24 at 9:40 A.M., a current Dishwashing Machine Use Policy, dated March 2010, was provided by the Administrator and indicated . Dishwashing machine chemical sanitizer concentration .chlorine minimum concentration 50-100 ppm . A supervisor will check the dishwashing machine for proper concentrations of sanitizer solution after filling the dishwashing machine and once a week thereafter. Concentrations will be recorded in a facility log . Corrective action will be taken immediately if sanitizer concentrations are too low . the operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. The supervisor will check the calibration of the gauge weekly . if hot water temperatures or chemical sanitation concentrations do not meet requirements, cease use of dishwashing machine immediately until temperatures or PPM are adjusted . On 8/30/24 at 9:40 A.M., a current Food Receiving and Storage Policy, dated October 2017, was provided by the Administrator and indicated . Foods shall be received and stored in a manner that complies with safe food handling practices . dry foods that are stored in bins will be removed from original packaging, labeled and dated ['use by' date] . All foods stored in the refrigerator or freezer will be covered, labeled and dated ['use by' date] . On 8/30/24 at 9:40 A.M., a current Hairnet Policy, dated January 19, 2011, was provided by the Administrator and indicated any staff members who enter the kitchen area should have a hairnet in use to prevent the contamination of food or food-contact services. All hair shall be tucked completely under the hairnet at all times . On 8/30/24 at 9:40 A.M., a current non dated Thermometer Sanitation Policy was provided by the Administrator and indicated .staff members in the kitchen shall wipe down the thermometer probe using a single alcohol prep pad between readings of different food items . 3.1-21(i)(2) 3.1-21(i)(3)

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	155708	A. Building B. Wing	09/04/2024

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 38770 Based on interview and record review, the facility failed to ensure a complete and accurate facility assessment based on the resident population and identification of resources needed to provide the necessary care and services required for their residents. Finding includes: On 8/30/24 at 9:50 A.M., the Administrator provided a facility assessment form revised 1/17/24. The form listed facility personnel but lacked a staffing plan to ensure sufficient staff were in the building to meet the needs of the residents, such as number of each staff. The form lacked training topics and competencies specific to the facility, transportation information including use of a facility van, Enhanced Barrier Precautions, resident equipment, use of oxygen therapy, pharmacy information, and the facility's plan for communication related to residents and staff with communication barriers. On 9/4/24 at 10:18 A.M., the Administrator indicated she was unaware that the facility assessment could have specific detailed information about the facility. She indicated a template was used to fill out the current facility assessment, and it was updated annually. At that time, she indicated there was not a facility policy, but that regulation guidelines were followed to fill out the facility assessment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46416 Based on interview, observation, and record review, the facility failed to ensure clinical record documentation was complete and accurate for 1 of 2 residents reviewed for hospitalization s and 1 of 1 residents reviewed for general skin conditions. (Resident 15, Resident 23) Findings include: 1. On 8/28/24 at 1:40 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, depression, chronic pain syndrome, epilepsy, and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/25/24, indicated Resident 15 was cognitively intact, totally dependent on 2 staff to assist him for bed mobility, transfers, and toileting. Non dated neuro (neurological) checks were found in the resident's clinical record and indicated he was sent out to the hospital. During an interview on 8/27/24 at 4:05 P.M., the Administrator indicated Resident 15 has a history of substance abuse and that was how he ended up in his condition. She was not sure what the exact date was or why it wasn't indicated on the neurocheck form, but they were ordered because of an episode where the resident allegedly got a vape from an unknown source with THC (tetrahydrocannabinol-found in cannabis plant that produces a high when smoked) in it. The resident smoked it at the facility and staff noticed a change of condition but did not know why so the Administrator was notified and she told them to do neuro checks and contact the doctor. The resident's condition got worse and they sent him out to the hospital. She thought the toxicology report revealed THC but wasn't sure. The administrator indicated she did not document anything because she could not prove that's what had happened. The clinical record lacked documentation related to the incident. During an interview on 8/28/24 at 10:45 A.M., Resident 15 was not sure on exact date, but admitted he got a vape from the local gas station and smoked it. When staff noticed a change in his condition, they did neurochecks and then sent to him to the hospital because he went unconscious. He indicated he got drug tested which confirmed THC and came back to the facility that night. The Administrator was present for the interview and agreed with the resident's statements. At that time, all hospital records and lab results were requested. During an interview on 8/29/24 at 9:40 A.M., the Administrator indicated she was not able to get hospital records and lab results for 5/8/24 because the resident did not go to the hospital that day. She indicated when she got to looking into the clinical record, she remembered that he had a fall around the same time and the neurochecks were from the fall and he ended up being hospitalized from sepsis from 5/13/24. She provided the fall incident report and documentation related to that fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/24 at 3:49 P.M., the DON (Director of Nursing) indicated on 5/8/24, Resident 15 did not go to hospital but he indicated he Had been smoking weed. There was a vape in his room but staff didn't know for a fact that he had been using THC. She would expect staff to document accurately, but in this instance, they were not sure what happened. 46882 2. On 8/26/24 at 2:10 P.M., Resident 23 was observed sitting in a recliner in his room with multiple bruises on his hands and arm and an undated Band-Aid on his left lower arm. On 8/28/24 at 2:10 P.M., Resident 23's clinical records were reviewed. Diagnosis included, but was not limited to, chronic obstructive pulmonary disease with exacerbation, hypertension, major depressive disorder, and anxiety disorder. The most current Annual MDS (Minimum Data Set) assessment, dated 7/3/24, indicated Resident 23 had moderate cognitive impairment and had no skin issues. The physician orders lacked an order for a dressing to the left lower arm. The nursing notes lacked documentation of why Resident 23 had a Band-Aid on his left lower arm. During an interview on 8/30/24 at 12:07 P.M., QMA (Qualified Medication Aide) 3 indicated she did not know why Resident 2 had a Band-Aid on his left lower arm. She indicated he did bruise easily. During an interview on 8/30/24 at 3:39 P.M., the DON (Director of Nursing) indicated she was not aware of Resident 23 having a Band-Aid on his arm but his skin was very fragile and bruised easily. During an interview on 9/03/24 at 10:09 A.M., the DON indicated dressings should be dated. During an interview on 9/03/24 at 2:23 P.M., LPN (Licensed Practical Nurse) 13 indicated she did not know why Resident 23 had a Band-Aid on his left arm. She looked in the nurse's note and could not find out why he had the Band-Aid on his left arm. She indicated the dressing order should indicate how often the dressing should be changed, and the dressing should have date, time and initials on it. During an interview on 9/3/24 at 2:30 P.M., LPN 13 indicated she removed the Band-Aid on the left arm and there was no indication of a wound. On 9/4/24 at 12:58 P.M., the Administrator provided an undated Job Description for Staff Nurse that was used as a policy for accurate documentation which indicated .Maintains records reflecting patient's conditions, medication and treatments .Maintains accurate and complete records of nursing observations and care . 3.1-50(a)(1) 3.1-50(a)(2)

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	155708	A. Building B. Wing	09/04/2024

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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. 38770 Based on observation, record review, and interview, the facility failed to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Gloves were not changed between dirty and clean tasks, hands were not sanitized between changing gloves, a resident was not completely cleaned, and staff did not offer a resident the opportunity to wash hands after toileting for 4 of 5 resident observations of incontinence care. Staff did not cover clean clothing when transporting clean clothes to residents, and carried clean clothes against their uniform top when carrying for 2 of 2 observations of linen handling. Residents were not placed on Enhanced Barrier Precautions (EBP) when indicated for 6 of 6 residents with wounds, 2 of 2 residents with urinary catheters, and 1 of 1 residents with a stoma. (Resident 28, Resident 3, Resident 23, Resident 21, Resident 16, Resident 15, Resident 11, Resident 2, Resident 184, Resident 4) Findings include: 1. On 8/30/24 at 12:34 P.M., the Director of Nursing (DON) indicated there were no residents currently on EBP (Enhanced Barrier Precautions). At that time, she provided a list of the following residents with wounds: Resident 28 coccyx and scrotal wounds Resident 3 left inner buttock wound Resident 23 left inner buttock wound Resident 21 left upper thigh wound and right calf wound Resident 16 diabetic wound taken care of by the wound clinic Resident 15 diabetic wound taken care of by the wound clinic On 9/3/24 at 9:54 A.M., the DON indicated Resident 28 and Resident 15 had urinary catheters, and Resident 2 had a stoma. On 9/4/24 at 12:10 P.M., the Infection Preventionist (IP) indicated she did not know what EBP was. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 9/3/24 at 10:30 A.M., Certified Nurse Aide (CNA) 9 and CNA 19 were observed to provide incontinence care for Resident 11. Both CNAs put on gloves prior to touching the resident. Both CNAs assisted to undo the resident's brief, then both wiped her front peri area, leaving 2 of the wipes between her legs. The resident was then assisted to the right side. CNA 19 obtained the wipes that were used, and placed one between the sheet and the resident's back, and the other was placed between the sheet and the resident's thigh. CNA 19 then wiped the resident's backside, with a brown substance observed on the last wipe used. The resident was then assisted to the left side, where CNA 9 then continued to wipe the resident's backside. The first wipe was observed with a substantial amount of fecal matter. CNA 9 obtained a clean wipe and placed the soiled wipe inside of it and handed it to CNA 19. CNA 19 then threw the wipes away, getting some of the fecal matter on her right gloved hand. CNA 19 then touched the resident's back, smearing fecal matter on her back. CNA 9 ran out of wipes, and left the bedside to get more. When CNA 9 left, CNA 19 obtained a clean sheet with the same gloves and covered the resident, getting a small amount of fecal matter on the sheet. After the incontinence care, the same sheet used to cover the resident was left on the resident. 45933 3. During an observation of care on 8/30/24 at 12:30 P.M., Resident 4 was assisted to the communal bathroom on the front hall by CNA (Certified Nurse Aide) 7. CNA 7 handed Resident 4 white tissue after she used the bathroom then CNA 7 assisted her to stand up with the grab bar and CNA 7 pulled up Resident 4's pants. CNA 7 pushed Resident 4 out of the bathroom in her wheelchair and failed to offer Resident 4 to sanitize or wash hands. During an interview on 9/4/24 at 12:10 P.M., LPN (Licensed Practical Nurse) 13 indicated staff should offer residents to sanitize or wash hands if they use the bathroom. 46882 4. On 8/30/24 at 2:22 P.M., CNA (Certified Nurse Aide) 7 brought a wheelchair to the common area by Back Hall Nurse's Station to take Resident 2 to his room. CNA/ 7 put a gait belt around Resident 2's waist and assisted him to stand and pivot to the wheelchair. CNA 7 pushed Resident 2 to his room, removed the gait belt and put on gloves without cleaning hands. CNA 7 removed Resident 2's shirt, which was wet, and removed wet towels from the brief and placed them in a plastic bag. His pants were observed to be wet all across the front. CNA 7 wiped the urostomy stoma site with wet wipes and put them in trash can without changing gloves, put the gait belt around the resident's waist, assisted him to stand from wheelchair and pivot to the bed, removed the gait belt and assisted the resident to lie down. At that time CNA 7 indicated Resident 7 refused to wear an urostomy bag. CNA 7 removed the resident's shoes and placed them in the wheelchair, removed his pants and placed them in a plastic bag, unfastened the brief, wiped the stoma with a wipe and placed the wipe in the trash can, resident rolled to the left side, CNA 7 removed the brief, cleaned the buttocks with a wipe and put in trash can. CNA 7 placed a clean brief under Resident 2 and asked him to turn to the right side, pulled the brief through and fastened it. CNA 7 placed a hospital gown on Resident 2 and indicated he wouldn't allow the gown to be tied. CNA 7 asked Resident 2 to scoot back in bed, put the sheet and comforter over resident, pulled up the bed rail and put the call light in the resident's hand. CNA 7 removed gloves, tied bag of wet clothing, removed trash bag from trash can and put in a new trash bag. CNA 7 carried the bags to the shower room. CNA 7 did not clean hands before starting care, or after removing gloves and did not change gloves during care. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46416 5. On 8/27/24 at 10:34 A.M., Housekeeper 35 was observed in the dining room with a cart full of resident's clean clothing. The clothing was not covered. Housekeeper 35 was observed taking the clothing, one at a time, laying them out on a table and on a chair in the corner. Once all the clothes were out of the cart, Housekeeper 35 took several of the clothes by the hangers and took them down the hall into a resident room with the closest clothing items rubbing against her uniform top. Housekeeper 35 then came back to the dining room and obtained more clothing, putting her right hand up with the clothing laying against the back of her uniform top, and held the clothing from her left hand against the front of her uniform top. The clothes were then taken into resident rooms. On 8/28/24 at 2:23 P.M., staff was observed transporting clean laundry in 2 uncovered laundry baskets on a cart up the hallway from the front hall to the back hall. On 8/30/24 at 3:44 P.M., staff was observed holding clean laundry against their shirt, carrying it up the hallway from the front hall to the back hall. On 9/3/24 at 11:42 A.M., staff was observed delivering clean laundry, and a red dress was dragging on the floor going up the hallway from the front hall to the back hall. On 8/27/24 at 10:40 A.M., the Housekeeping Supervisor indicated clean clothing should be covered and carried away from the body, keeping them away from uniform tops when taking them back to resident rooms. At that time, he indicated he was unsure if there was a policy related to linen handling, but staff should not carry them close to the body. 6. During a random observation on 8/26/24 at 2:31 P.M., staff drug ice (from the ice maker downstairs) in a trash bag up the stairs, across the floor of the front dining room, dumped the ice into the cooler on a cart, and proceeded to serve ice water to residents on the front hall from that cooler. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 9/4/24 at 11:08 A.M., CNA (Certified Nurse Aide) 9 and PCA (Personal Care Attendant) 17 were observed provided incontinence care on Resident 184. CNA 9 and PCA 17 entered Resident 184's room and put on gloves. CNA 9 opened the closet door, went through the resident's clean clothing, and closed the closet door. The resident indicated The red pants don't have a string so they don't work. CNA 9 put the pants back into the resident's closet and grabbed another pair of pants. CNA 9 opened the small dresser top drawer to get out wipes and bottom one to get out clean incontinence pad. CNA 9 moved the bedside table out of the way and then removed gloves. CNA 9 put new gloves on without sanitizing hands, used the crank on the bed to raise it, and uncovered the resident. CNA 9 assisted resident to sit on the side of his bed. CNA 9 and PCA 17 removed Resident 184's shirt and jacket. CNA 9 applied deodorant on resident and then helped resident put on his clean shirt and jacket. CNA 9 grabbed resident's shoes and put them on, removed the gait belt from around her waist and put it on the resident, and both CNA 9 and PCA 17 assisted the resident to stand. Both staff pulled the resident's pants and incontinence pad down and assisted the resident to sit back down on the side of the bed. PCA 17 removed the soiled incontinence pad and tossed it into the trash can. CNA 17 took off the resident's shoes and pants, grabbed a wipe from the package on the bedside table, and then asked the resident to lean back so she could wipe his front but the resident was not able to because he said it hurt too much. Resident tried leaning to the side while CNA 9 wiped the crease between his abdomen and left leg, discarded that wipe and grabbed another one. Resident 184 indicated he needed to lay down. CNA 9 grabbed another wipe from the package, laid that wipe on top of the package, and assisted the resident to lay back down touching his clean jacket with her left gloved hand and the resident's right leg with her right gloved hand. CNA 9 took off gloves and did not sanitize her hands before putting gloves back on. She grabbed the wipe from the top of the package, wiped the crease between the resident's abdomen and right leg, folded the wipe and wiped the resident's penis and scrotum. CNA 9 removed her gloves and did not sanitize her hands before putting gloves back on. PCA 17 slid the clean incontinence pad and pants up the resident's legs and put on the resident's shoes, placing her gloved hands on the bottom of the shoes. The resident was assisted up to sit on the side of the bed and to stand with CNA 9 on the resident's right side and PCA 17 on his left. Both staff grabbed the resident's wheelchair to pull it closer and lock the brakes, pulled up the resident's incontinence pad and tried pulling his pants up. The pants did not fit. so they pulled the pants back down and sat the resident down on the side of the bed. CNA 9 took off the resident's shoes, took her gloves off, opened the resident's door and closed it, and went downstairs to look for another pair of pants. PCA 17 opened the closet door, touched the resident's clothes with gloved hands and pulled out the same red pants. The resident again indicated Those don't fit. PCA 17 put the pants back inside the closet. CNA 9 came back into the room carrying clean clothes on hangers. She handed the clothes to PCA 17 to put into the closet. CNA 9 put on gloves without sanitizing hands, put on the resident's pants and shoes, and both staff assisted the resident to stand and sit in the wheelchair. CNA 9 removed the gait belt, opened the dresser drawers looking for a comb but couldn't find one. CNA 9 took the trash bag with the soiled incontinence pad out of the trash can, gave it to PCA 17, ran her fingers through the resident's disheveled hair, opened the door, and proceeded to push Resident 184's wheelchair towards the back hall. CNA 9 washed her hands and grabbed trash from PCA 17. PCA 17 removed her gloves and washed her hands with an 8 second lather. Resident 184's buttocks were not cleaned during incontinence care. During an interview on 9/4/24 at 11:47 A.M., CNA 9 indicated they should use hand sanitizer before putting on gloves and after taking gloves off from doing resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/4/24 at 12:17 P.M., the Infection Preventionist indicated staff were expected to do hand hygiene before gloves were put on and after gloves were removed. The staff should touch items such as closet doors, dresser handles, clean clothes, the bed cranks, and then she would expect gloves to be changed and hands sanitized again before performing incontinence care which should include cleaning the resident's front and back side every time. Gloves should be changed when going from dirty to clean tasks. When staff wash their hands, a 60 second lather with soap was expected. Ice should not be carried in a bag or drug on the floor, resident's clean clothing should be covered, carried away from the staff's clothing, touched with clean hands or gloves, and not drug on the floor. On 9/4/24 at 12:48 P.M., the Administrator indicated there was no policy for EBP, but the facility was to follow CDC guidelines. On 9/4/24 at 12:24 P.M., a current Glove Use policy was provided, revised 9/2010, that indicated hands should be washed prior to putting on gloves and taking them off. On 9/4/24 at 12:22 P.M., the Administrator indicated they do not have a specific policy for offering the resident to wash their hands after going to the bathroom, but it would be their policy to do so. On 9/4/24 at 12:23 P.M., a current Hand Washing Policy, dated 1/2014, was provided by the SSD (Social Services Director), and indicated The facility will provide guidelines and approved supplies to all employees for proper and appropriate hand washing techniques that will aid in the prevention of the transmission of infections . the use of gloves does not replace hand washing . vigorously lather hands with soap and rub them together, creating friction to all surfaces for 20-30 seconds . as an adjunct to routine hand washing, Purell Instant Hand Sanitizer is provided to apply to the hands after proper hand washing and in between proper hand washing . after removing gloves . after using the toilet . On 9/4/24 at 12:27 P.M., a current Perineal (Incontinence) Care Policy, revised February 2018, was provided by the SSD and indicated The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . For a male resident: . wash and rinse urethral area using a circular motion, continue to wash the perineal area including the penis, scrotum, and inner thighs . Ask the resident to turn on his side with his upper leg slightly bent if able, wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks . On 9/4/24 at 12:35 P.M., a current Standard Precautions Policy, revised October 2018, was provided by the Activity Director and indicated . Personnel are trained in the various aspects of standard precautions to ensure appropriate decision-making in various clinical situations . Gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a 'dirty' site to a 'clean' one) . Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident, after gloves are removed . wash hands immediately to avoid transfer of microorganisms to other residents or environments. 3.1-18(b) (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-19(g)(2) 3.1-18(l)

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	155708	A. Building B. Wing	09/04/2024

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 50827 Based on interview and record review, the facility failed to ensure designation of a certified Infection Preventionist (IP). The IP had not received specialized training in infection prevention and control, and did not currently dedicate at least part time to the role of IP for 1 of 1 staff members reviewed for IP. Finding includes: On 9/4/24 at 12:10 P.M. LPN 13 indicated that she was the current IP and responsible for the infection prevention and control program in the facility. She indicated she did not have any specialized training or certification for the role, and was able to dedicate approximately 3-4 hours per week on the infection control program. On 9/4/24 at 12:34 P.M., the facility's Administrator (via the Activity Director) indicated there was no policy or job description for the Infection Preventionist, that someone was just assigned to the role.

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	155708	A. Building B. Wing	09/04/2024

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933 Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment for 1 of 1 resident communal restrooms and 3 of 3 shower rooms observed. A three-quarter inch gap was observed on 1 of 2 doors to the courtyard. A random couch was observed to have fabric peeled off of it in 1 of 2 common areas. A brown substance was observed around the bottom of toilets, doors had chips, toilet paper holders were rusted, gnats were on the floor, tile was missing in the shower, spiderwebs were on the ceiling, and grout was soiled. (Front Hall Shower Room, Middle Hall Shower Room, Back Hall Shower Room, Communal Restroom) Findings include: 1. During an observation on 8/28/24 at 10:37 A.M., the communal restroom for residents on the front hall was observed with a brown substance around the bottom of the toilet, the toilet paper holder was rusted, and the door to the restroom had chips on the bottom of it. On 8/30/24 at 11:19 A.M., the same was observed. 2. During an observation on 8/28/24 at 10:38 A.M., the shower room on the front hall was observed with paint chipped off of the sink vanity and a white peeled substance inside of the sink and 4 gnats were on the floor. On 8/30/24 at 11:18 A.M., the same was observed and toilet paper sat in the toilet bowl and was not flushed. 3. During an observation on 8/29/24 at 10:17 A.M., the shower room on the middle hall had a vanity that was bubbling and chipped, tile was cracked by the toilet, a brown substance was around the bottom of the toilet, tile was missing in the shower, the grout was brown in the back of the shower, a brown rusty substance was on the vent in the ceiling, and the hooks on the shower curtain were rusted. On 8/30/24 at 11:16 A.M., the same was observed and a yellow substance was in the toilet and not flushed. 4. During an observation on 8/29/24 at 10:23 A.M., the shower room on the back hall was observed with a scuffed door, the vanity was chipped and scuffed up, the sink had a pink and brown substance in it, a brown substance was around the bottom of the toilet, spiderwebs were throughout the ceiling, there was a rusted substance and dust caked on the vent, the hand rail had a white substance on it, the shower chair had black residue on it, missing grout was observed around the wall in the shower, grout in the shower floor was soiled, multiple pieces of debris on the floor, the soap dispenser was empty, and the sink was dripping. On 8/30/24 at 10:30 A.M., the same was observed. (continued on next page)

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	155708	A. Building B. Wing	09/04/2024

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation on 8/29/24 at 10:30 A.M., a couch in the common area on the back hall was observed with rips in the fabric. On 8/30/24 at 11:15 A.M., the same was observed. 38770 6. On 8/27/24 at 10:07 A.M., the door to the courtyard by room [ROOM NUMBER] was observed cracked. The door was measured to be open by 3/4 inch. On 8/27/24 at 11:17 A.M., the Maintenance Supervisor indicated he was unaware that the door to the courtyard by room [ROOM NUMBER] was slightly cracked open, and was not supposed to be. At that time, he attempted to close it and could not, indicating that he would need to work on getting it fixed. On 8/27/24 at 10:40 A.M., the Maintenance Supervisor indicated there was not a policy related to maintenance, but that he did a walk through of the facility daily to look for issues. He indicated he would go to the kitchen and ask residents if they needed anything, and fix issues as they arise. At that time, he indicated he was also the Housekeeping Supervisor, and indicated Housekeeping did not have a policy either related to cleaning the facility. He indicated the Housekeeping staff followed a schedule, hall to hall then room to room. Vents were supposed to be cleaned daily, and all rooms wiped down and all floors mopped daily. Furniture should be wiped down, and worn furniture replaced as needed. He indicated the shower rooms should be cleaned daily as well as all bathrooms. Once a month, the shower rooms were deep cleaned with two staff. Housekeeping tasks were not documented. This Federal tag relates to complaint allegations IN00440429, IN00438183, IN00437376. 3.1-19(e) 3.1-19(f)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 46416 Based on observation and interview, the facility failed to ensure an effective pest control program to keep the facility free of pests and rodents. (Downstairs Dry Storage Room) Finding includes: On 8/26/24 at 1:20 P.M., a sticky pad for catching insects and rodents was observed full of insects and a dead mouse in a trap was attached to it downstairs in the dry storage room behind the staff refrigerator. On 8/29/24 at 11:04 A.M., the same was observed. Also, a live mouse was stuck to the sticky pad, and flying insects, some dead and 2 flying, were observed in the other refrigerator in the dry storage room downstairs. The refrigerator door was not closed all the way and had 1 closed gallon jug of coleslaw dressing in it. On 8/28/24 at 11:05 A.M., the contract for pest control company was reviewed and indicated they were to come to the facility monthly (except January when they were to come twice a month) to monitor for spiders, mice, and german cockroaches specifically. At that time, the Administrator indicated they have had issues in the past with mice but have had no recent trouble that she was aware of. The pest control company was there about 2 weeks ago and had no concerns. They are to treat the storage rooms upstairs, on the main floor where residents live, the basement, and outside the building. The staff were to do spot checks throughout the facility as needed. On 8/29/24 at 12:08 P.M., the Administrator was notified of the mice, insects, and refrigerator being open downstairs with flying insects in it. At that time, she indicated she would remove the sticky pad with the mice and bugs on it and call the pest control company to come and inspect the facility. On 8/30/24 at 9:40 A.M., a current Pest Control Policy, dated January 2024, was provided by the Administrator and indicated, (Facility) shall maintain an effective pest control program. (Facility) maintains an on-going pest control program to ensure that the building is kept free of insects and rodents . Maintenance services assist, when appropriate and necessary, in providing pest control services . 3.1-19(f)(4)

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	155708	A. Building B. Wing	09/04/2024

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Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46416 Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff based on the needs of the resident population in the facility for 2 of 3 residents reviewed for accidents and 1 of 1 residents reviewed for having a diagnosis of PTSD (Post Traumatic Stress Disorder). (Resident 15, Resident 24) Findings include: 1. During an interview on 8/27/24 at 4:05 P.M., the Administrator indicated Resident 15 had a history of substance abuse. On 8/28/24 at 1:40 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, depression, chronic pain syndrome, and anxiety. Resident 15 was admitted on [DATE] and was [AGE] years old. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/25/24, indicated Resident 15 was cognitively intact, totally dependent on 2 staff to assist him for bed mobility, transfers, and toileting. Current Physician's Orders included, but were not limited to, the following: Norco (narcotic pain medication) 10/325 mg (milligrams), give 1 tablet by mouth every 4 hours as needed for pain, ordered 7/29/24 The resident's clinical record lacked a plan of care for a history of substance abuse and risk of overdose. A Nurse Practitioner's Behavioral Health Progress Note, dated 8/20/24, indicated Resident 15 had abused multiple substances. During an interview on 8/27/24 at 4:05 P.M., the Administrator indicated Resident 15 had a history of vaping at the facility and although it was not confirmed, there was an incident on 5/8/24 when the resident had a change of condition. It was suspected, and the resident admitted he was smoking pot. During an interview on 8/30/24 at 3:46 P.M., LPN (Licensed Practical Nurse) 13 indicated she was not sure where Narcan (medication that can treat narcotic overdose in an emergency) would be kept. LPN 13 called the pharmacy to find out if Narcan was in the EDK (Emergency Drug Kit). Seven minutes later, LPN 13 indicated the Narcan was found in the EDK. She was not sure how it was to be administered but would follow the directions on the box. At that time, she indicated staff had not been in serviced on the use of Narcan, substance abuse, or overdosing. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 8/26/24 at 2:50 P.M., Resident 24 indicated he had PTSD (Post Traumatic Stress Disorder) and he left the door of his room open so staff did not knock on it because it was a trigger for him. On 8/29/24 at 10:00 A.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia, major depressive disorder, bipolar disorder, anxiety disorder, personality disorder, and PTSD. Resident 24 was admitted on [DATE]. The most recent Quarterly MDS Assessment, dated 6/10/24, indicated Resident 24 was cognitively intact and had PTSD. A current Mental Health Care Plan, revised on 6/23/20, indicated resident has a history of angry outbursts, delusional thoughts, poor impulse control, and low frustration level. During an interview on 8/30/24 at 3:00 P.M., the DON (Director of Nursing) she was not aware of any in-services offered for staff other then the required dementia in service hours. At that time, she indicated they did have residents with a history of substance abuse and PTSD. If someone had symptoms of an overdose, they could have the physician order bloodwork, but they have Narcan in the emergency drug kit. She was not sure what route the Narcan was to be given. There was no extra training provided for PTSD, risks of overdosing, substance abuse, or administering Narcan, but common nurse knowledge should be used. During an interview on 9/4/24 at 9:34 A.M., the Administrator indicated there was not a policy for what in-services should be given to staff, but the facility would follow the regulations. 3.1-14(k)