STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Pointe Health Campus	1051 Cumberland Ave West Lafayette, IN 47906

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 2. The clinical record for Resident 29 was reviewed on 6/10/25 at 3:06 p.m. The diagnoses included, but were not limited to, diabetes type 2, cardiomegaly, hypertension, obesity, and age-related physical debility. A current physician's order, dated 12/22/21, indicated Resident 29 had a full code status. A care plan, dated 12/23/21, indicated advanced directives would be reviewed quarterly and honor Resident 29's medical POA's decisions. An Indiana Physicians Orders for Scope of Treatment (POST) form, dated 4/9/24, was signed by Resident 29's power of attorney (POA) and indicated the resident's code status was DNR (do not resuscitate). It was not signed by a physician. During an interview, on 6/11/25 at 10:00 a.m., Resident 29 indicated she wanted to be a DNR. During an interview, on 6/16/25 at 11:07 a.m., the Executive Director (ED) indicated the form should have been given to the physician to complete after it was filled out by the POA and the code status should have been updated to reflect Resident 29's wishes. A current facility policy, titled Guidelines for Advanced Directives, dated 12/17/24 and received from the Director of Nursing (DON) on 6/11/25 at 2:03 p.m., indicated .The purpose of this policy is to: to ensure facility staff obtains and follows resident's advanced directives regarding end of life care .Advanced directives will be reviewed with the resident and/or resident representative by the admissions representative or designee at time of admission. A member of the IDT will review and/or update quarterly and PRN thereafter .The resident or representative will advise the admission representative/designee regarding wishes for end of life directives and code status .The SSD or designee is responsible for providing information and handling the finalized document .The nursing staff will confirm the desired code status and obtain an order form the physician .The DNR form will be completed documenting these desires ad scanned into the medical record .Designation of code status and obtainment of physician order will be part of the medical record 3.1-4(f)(5) Based on record review and interview, the facility failed to ensure a resident's code status had been updated and a physician order for scope of treatment (POST) form was signed for 2 of 2 residents reviewed for advanced directives. (Resident 101 and 29) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: 1. The clinical record for Resident 101 was reviewed on 6/11/25 at 9:59 a.m. The diagnoses included, but were not limited to, immunodeficiency, benign neoplasm of meninges (non-cancerous tumor) and osteonecrosis (the death of bone tissue due to a lack of blood supply). A physician's order, dated 6/6/25, indicated Resident 101 was a full code (resuscitate). A physician's order, dated 6/6/25 and discontinued 6/9/25, indicated Resident 101 was a DNR (do not resuscitate). There was no documentation of a POST form in the electronic health record (EHR). During an interview, on 6/11/25 at 10:43 a.m., the Assistant Director of Nursing (ADON) indicated Resident 101 had two different code statuses in the EHR. When the resident had a DNR physician's order and a full code was documented on the face sheet, the nurse would use the highest code. The resident would be considered a DNR. During an interview, on 6/11/25 at 11:51 a.m., the Corporate Support Nurse indicated the orders were different and it was changed in the EHR on 6/9/25.

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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. 2. The clinical record for Resident 29 was reviewed on 6/10/25 at 3:06 p.m. The diagnoses included, but were not limited to, diabetes type 2, cardiomegaly, hypertension, obesity, and age-related physical debility. A quarterly MDS assessment was completed on 2/22/25. There was no documentation in the clinical record, a care plan meeting for the quarterly assessment was completed. An annual MDS assessment was completed on 5/22/25. There was no documentation in the clinical record, a care plan meeting for the annual assessment was completed. During an interview, on 6/16/25 at 11:06 a.m., the DON indicated care plan meetings should be completed on admission and quarterly. There should have been two care planning meetings completed. A current facility policy, titled Resident's First Meeting Guidelines, dated 3/7/19 and received from the DON on 6/16/25 at 11:57 a.m., indicated .Subsequent meetings for non-Medicare residents should be conducted at a minimum of quarterly and with significant change .Subsequent meetings for Medicare residents should be conducted minimally quarterly and prior to discontinuing Medicare services or being discharged from facility 3.1-35(d)(2)(B) Based on interview and record review, the facility failed to ensure care plan meetings were completed quarterly to ensure the resident had the right to participate in the development, review and revision of the care plan for 2 of 2 residents reviewed for care plan conferences. (Resident 43 and 29) Findings include: 1. The clinical record for Resident 43 was reviewed on 6/11/25 at 1:45 p.m. The diagnoses included, but were not limited to, gastrostomy status, type 2 diabetes mellitus with diabetic chronic kidney disease, and diverticulosis of the large intestine. An admission Minimum Data Set (MDS) assessment was completed on 1/2/25. A care plan conference was documented as completed on 1/2/25. A quarterly MDS assessment was completed on 3/18/25 and 4/5/25. There was no documentation in the clinical record, a care plan meeting for the quarterly assessment was completed. During an interview, on 6/16/25 at 10:26 a.m., the Director of Nursing (DON) indicated a care plan meeting for Resident 43 had not been conducted since 1/2/25. The meetings should be held quarterly and should have taken place around March or April.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure a blood pressure medication was administered according to the physician's orders for 1 of 1 resident reviewed for quality of care. (Resident 19) Findings include: The clinical record for Resident 19 was reviewed on 6/8/25 at 11:07 a.m. The diagnoses included, but were not limited to, congestive heart failure, dementia, diabetes mellitus, and hypertension. A care plan, dated 4/24/25, indicated Resident 19 had a potential for cardiovascular distress related to congestive heart failure. The approaches included, but were not limited to, medications as ordered, observe and report side effects, and observe for signs and symptoms of cardiovascular distress. A physician's order, dated 5/20/25, indicated to give furosemide (a diuretic medication which could lower blood pressure) 20 milligrams (mg) daily and to hold the medication for a systolic blood pressure less than 120. The Medication Administration Record (MAR), dated 5/1/25 through 6/4/25, indicated furosemide 20 mg was given out of the physician ordered parameters when Resident 19 had the following blood pressures: a. On 5/27/25, the blood pressure was 109/68. b. On 5/28/25, the blood pressure was 118/60. c. On 5/30/25, the blood pressure was 111/62. d. On 6/1/25, the blood pressure was 106/61. e. On 6/2/25, the blood pressure was 106/62. f. On 6/4/25, the blood pressure was 116/67. During an interview, on 6/16/25 at 9:54 a.m., RN 5 indicated when a resident had standing orders, it would be added to the orders on the MAR. If the nurse did not initiate the standing orders, it would not be on the MAR. During an interview, on 6/16/25 at 2:47 p.m., the Director of Nursing (DON) indicated the nurse should have held the medication if the blood pressure was outside of the hold parameters. The medication was given multiple times when it should have been held. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Guidelines for Medication Orders, dated 12/17/24 and received from the DON on 6/11/25 at 2:03 p.m., indicated .To establish uniform guidelines in the receiving and recording of medication orders .A current list of orders will be maintained in the electronic clinical records of each resident .Standing orders .The admitting nurse shall review the standing order list with the physician when verifying admission orders .The physician shall inform the admitting nurse if any of the standing orders should be eliminated, modified and/or other standing orders added for the specific resident .Standing orders shall be in the medical record with the other physician orders 3.1-37(a)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure a resident was kept safe during care and was evaluated for assistive devices to prevent an accident for 1 of 1 resident reviewed for accidents. (Resident 19) This deficient practice resulted in a right femoral neck fracture, a left scalp laceration, and a hematoma of the frontal scalp for Resident 19. Findings include: During an interview, on 6/12/25 at 3:40 p.m., Resident 19's daughter indicated she was the resident's Power of Attorney (POA) and was never called by the facility to inform her the resident had fallen. She heard about the fall from a Home Health Aide (HHA 6) she had hired for extra help to make sure the resident received all the care he needed. Resident 19's bed was up at waist level, and the resident was on his side when he fell off the bed and was found face down. This happened on a Sunday, and the facility did not call her. She found out from HHA 6. The resident was sent to the hospital and had surgery for his broken hip. He had a busted lip, hematoma on his forehead, multiple bruises and skin tears to both knees. She had been concerned something like this would happen. Resident 19 was on track to go home with her and only had a few days left before discharge. She had asked multiple times for a bed rail to be installed, and they were never put on. The clinical record for Resident 19 was reviewed on 6/11/25 at 1:33 p.m. The diagnoses included, but were not limited to, congestive heart failure, dementia, diabetes mellitus, and hypertension. A facility admission observation and data collection form, dated 4/24/25 at 2:46 p.m., indicated the resident's mode of transfer was a wheelchair and a mechanical lift. Resident 19's ability to change and control body position was very limited. The resident could make occasional slight changes in his body or the position of his extremities but was unable to make frequent or significant changes independently. A facility functional abilities assessment form, dated 4/24/25 at 3:33 p.m., indicated the resident's mobility to roll left and right was substantial/maximal assistance. A care plan, dated 4/24/25, indicated Resident 19 was a fall risk. The approaches included, but were not limited to, the resident would remain free of falls with major injury, encourage the resident to assume a standing position slowly, keep the call light, personal items and frequently used items within reach, and assist the resident with transfers as needed. An admission Minimum Data Set (MDS) assessment, dated 4/29/25, indicated the resident's range of motion had no impairment in the upper or lower extremity and Resident 19 was cognitively intact. A facility reported incident, dated 6/9/25 at 1:01 p.m., indicated the resident had an unwitnessed fall in his room. The resident received a subcapital fracture of his right femoral neck with superior subluxation of the femoral shaft (a break at the junction of the femoral head and neck, with the upper portion of the thigh bone shifted upward and out of alignment). The resident was assessed and complained of pain in his head and was sent to the emergency room for evaluation and treatment. The resident also had a bruise, a laceration to his forehead, and bilateral skin tears to his knees. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A hospital assessment, dated 6/8/25 at 11:11 a.m., indicated the resident had a right femoral neck fracture, a left scalp laceration, and a hematoma of the frontal scalp. A facility witness statement, dated 6/9/25, indicated CNA 3 assisted the resident with incontinence care. The resident was on his left side and had his right arm out holding onto the trapeze bar. CNA 3 indicated Resident 19 was usually able to hold himself after being rolled over onto his side. Resident 19 needed extensive assistance to roll from side to side. An Interdisciplinary Team (IDT) progress note, dated 6/11/25 at 8:00 a.m., indicated the nurse was called to Resident 19's room. CNA 3 was changing the resident, and the resident fell on the floor. The resident's bed was elevated, and the trapeze was on the left side of bed. Upon entering the room, Resident 19's face was bleeding. The resident had pain in his head, had a laceration on the right side of his forehead, and bilateral skin tears to his knees. During an interview, on 6/16/25 at 10:46 a.m., CNA 3 indicated she had rolled Resident 19 onto his right side for incontinence care and the resident rolled off the bed. Resident 19 had a trapeze bar which he would use his right hand to press against the bar, he did not grab or hold the bar, he would push against the bar while receiving incontinent care. CNA 3 was changing him, and he just leaned forward and fell on the floor. RN 3 heard him fall, ran to the room, and applied pressure to his bleeding head. The resident had a large cut on the right forehead and a bump on the left side. The resident had indicated his hip and head hurt. During an interview, on 6/16/25 at 10:50 a.m., the Executive Director (ED) indicated the resident was in the facility while the daughter was preparing her house for the resident to live with her. HHA 6 was not in the room when the resident fell. HHA 6 was there for companionship only and was not allowed to help with any type of care. HHA 6 was going to be at the resident's home and was there to get to know the resident better. During an interview, on 6/16/25 at 2:10 p.m., the Director of Nursing (DON) indicated she did not complete a bed rail assessment for Resident 19. She used her nursing judgement, and the resident was not appropriate for bed rails. There were no bed rail assessments documented in the resident's clinical record. During an interview, on 6/16/25 at 2:34 p.m., RN 3 indicated CNA 3 came down the hall and indicated she needed help. RN 3 went inside the room and saw Resident 19 face down. CNA 3 applied pressure to his head and RN 3 called the physician. RN 3 indicated he called the daughter, and she did not answer. During an interview, on 6/16/25 at 3:10 p.m., the Physical Therapist Director indicated the occupational therapist had assessed the resident for the trapeze. The occupational therapist indicated Resident 19 was able to utilize the trapeze to adjust himself in bed. The trapeze was not for turning in the bed and was used for pulling and self-adjustment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 6/17/25 at 12:02 p.m., Resident 19's daughter indicated she had requested bed rails to be placed on the resident's bed three separate times. The first time was in the care plan meeting with the DON, Executive Director, Physical Therapy, and Social Services. She had requested two more times after the care plan meeting to the nurses for bed rails to be installed. The nurse had indicated the order was put in and the rails would be installed by the next day, and they were never installed. During an interview, on 6/17/25 at 6:58 p.m., Resident 19 indicated he was in a lot of pain from the fall and broken hip. CNA 3 had dropped him on the floor. He had asked from day one for bed rails. He did not want to roll off the bed and would have felt safer with bed rails. When he landed on the floor, he broke his hip and bumped his head on the metal part of the trapeze legs. CNA 3 had made HHA 6 leave the room while she provided care for him. CNA 3 pushed the resident over onto his left side hard and he was at the very edge of the bed. He dropped hard on the floor, was in a lot of pain, and was bleeding from his head. He felt CNA 3 had pushed him too hard and he was too close to the edge of the bed. He had nothing to brace himself on and he rolled right off the bed. A current facility policy, titled Fall Management Program Guidelines, dated 12/17/24 and received by the DON on 6/16/25 at 11:59 a.m., indicated .The fall risk assessment is included as part of the admission and Quarterly Nursing Observation and other Events/Observation in EHR .Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling .Care plan interventions should be implemented that address the resident's risk factors .Should the resident experience a fall the attending nurse shall complete an Occurrence note. This includes an investigation of the circumstances surrounding the fall to determine the cause of the episode, a reassessment to identify possible contributing factors A current facility policy, titled Guidelines for the Use of Bed Rails, dated 12/17/24 and received from the DON on 6/16/25 at 2:26 p.m., indicated .Guidelines for the Use of Bed Rails .the resident is assessed for the use of bed rails, which includes a review of risks including entrapment; and informed consent is obtained from the resident or if applicable, the resident's representative .After alternatives have been attempted and prior to installation, the facility must obtain informed consent from the resident or if applicable, the residents representative for the use of bed rails. The facility should maintain evidence that it has provided sufficient information so the resident or resident representative could make an informed decision. Information the facility must provide to the resident, or resident representative include, but are not limited to: What assessed medical needs would be addressed by the use of bed rails .the resident's benefits .the resident's risk .The use of bed rails as an assistive device should be addressed in the resident's care plan .Informed consent for the use of bed rails should be obtained from the resident and/or legal representative .The use of bed rails should be reviewed during the Resident First Meeting A current facility policy, titled Resident's First Meeting Guidelines, dated 12/17/24 and received from the DON 6/16/25 at 11:57 a.m., indicated .The purpose of this policy is to: To facilitate communication and participation regarding the resident's plan of care, medical condition and care needs between the resident, family, resident representative and care givers .add any input from the resident and/or representative into the narrative notes sections on the observation form .The Resident First Meeting is a time to communicate information related to care needs and medication condition and seek input from the resident or representative .If questions require research to properly answer, assign a team member to follow up and report to the resident or representative (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	This citation relates to Complaint IN00461346. 3.1-45(a)(1) 3.1-45(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to ensure physician's orders for the care and monitoring of a catheter were obtained upon admission for 1 of 1 resident reviewed for catheter. (Resident 104) Findings include: The clinical record for Resident 104 was reviewed on 6/12/25 at 1:55 p.m. The diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus, urinary tract infection, myoglobinuria, and urogenital implants. A facility admission observation and data collection form, dated 5/25/25 at 7:45 a.m., indicated the resident was admitted with an indwelling catheter. A care plan, dated 5/26/25, indicated the resident had a catheter. The approaches included, but were not limited to, record urinary output and provide care and change catheter per the physician's orders. Physician's orders related to the catheter, the catheter care, and catheter monitoring were not ordered until 5 days after the resident was admitted to the facility. During an interview, on 6/16/25 at 10:25 a.m., the Director of Nursing (DON) indicated standing orders should have been placed for the catheter. The orders were not placed when the resident was admitted . Catheter care and catheter assessments should have been completed and documented in the Medication Administration Record (MAR). During an interview, on 6/16/25 at 9:54 a.m., RN 5 indicated if the nurse did not initiate the standing orders upon admission, it would not be on the MAR. A current facility policy, titled Guidelines for Medication Orders, dated 12/17/24 and received from the DON on 6/11/25 at 2:03 p.m., indicated .To establish uniform guidelines in the receiving and recording of medication orders .A current list of orders will be maintained in the electronic clinical records of each resident .Standing orders .The admitting nurse shall review the standing order list with the physician when verifying admission orders .The physician shall inform the admitting nurse if any of the standing orders should be eliminated, modified and/or other standing orders added for the specific resident .Standing orders shall be in the medical record with the other physician orders A current facility policy, titled Guidelines for the Use of Indwelling Catheter, dated 12/16/24 and received from the DON on 6/13/25 at 10:00 a.m., indicated .A resident who enters the campus with an indwelling urinary catheter, or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that cauterization is necessary 3.1-41(a)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on interview and record review, the facility failed to ensure staff followed the physician's orders related to a gastrostomy tube (g-tube) for 1 of 1 resident reviewed for gastrostomy tubes. (Resident 43) Findings include: The clinical record for Resident 43 was reviewed on 6/11/25 at 1:45 p.m. The diagnoses included, but were not limited to, gastrostomy status, type 2 diabetes mellitus with diabetic chronic kidney disease, and diverticulosis of the large intestine. A physician's order, dated 2/13/25, indicated to flush the g-tube with 30 ml (milliliters) of water three times a day. A nursing progress note, dated 2/14/25 at 4:02 p.m., indicated Resident 43 and family were in agreement they did not want to proceed with supplementation through the g-tube. A physician's order, dated 3/20/25, indicated to administer 120 ml of the dietary supplement Med Pass 2.0 three times a day. There was no administration route indicated in the physician's order for the Med Pass. A nursing progress note, dated 6/7/25 at 8:47 p.m., written by Registered Nurse (RN) 2 indicated .Writer administered 120mL 2.0 Med pass nutrition and hydrated resident with 240mL water through g tube. Resident tolerated well The progress note did not clearly indicate if the 120 ml of Med Pass was administered orally or through the g-tube. There was no physician's order in the clinical record which indicated the resident was to be hydrated with 240 ml of water through the g-tube. During an interview, on 6/11/25 at 3:01 p.m., Qualified Medication Aide (QMA) 3 indicated Resident 43's g-tube was used for flushes only. During an interview, on 6/13/25 at 3:33 p.m., QMA 4 indicated the only thing ordered to go into the g-tube per the physician was a 30 ml water flush once a shift. A current facility policy, titled Specific Medication Administration Procedures, dated 11/18 and received from the Clinical Support Nurse on 6/12/25 at 9:47 a.m., indicated .The physician's order must specify the route of administration of any medication via feeding tube. This is either via G-tube, via PEG tube, via NJ tube, or via J-tube .Check the medication administration record (MAR) to confirm the order: note the medication, dose, route (tube), and volume of water for flushing 3.1-44(a)(2)

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based interview and record review, the facility failed to implement physician's orders based upon current professional standards of practice for the maintenance and prevention of infection of an Intravenous (IV) line for 1 of 1 resident reviewed for IV therapy. (Resident 101) Findings include: The clinical record for Resident 101 was reviewed on 6/11/25 at 9:59 a.m. The diagnoses included, but were not limited to, immunodeficiency, benign neoplasm of meninges (non-cancerous tumor) and osteonecrosis (the death of bone tissue due to a lack of blood supply). A physician's order, dated 6/6/25 and discontinued 6/10/25, indicated to give ceftriaxone (an antibiotic) reconstitute solution 2 grams via IV daily. The only physician's order related to the IV was for the antibiotic. There were no physician's orders for the care and use of the pumps, tubing, syringes, or flushes. The Electronic Health Record did not have documentation of IV site assessments, normal saline flushes, Heparin lock flushes, monitoring for side effects, or PICC dressing changes until 6/9/25. A care plan, dated 6/8/25, indicated the resident required IV medication. The approaches included, but were not limited to, assessing the IV for complications every shift and as needed, IV site care as ordered, and observe the IV site for swelling, redness, tenderness, and warmth. During an interview, on 6/11/25 at 11:42 a.m., the Assistant Director of Nursing (ADON) indicated residents with intravenous antibiotics should have orders to flush and access the IV site. There were standard orders which should have been placed when the resident was admitted . She did not know if the IV was flushed or assessed before the orders were placed. The nurse on weekend should have called the physician and obtained orders. During an interview, on 6/11/25 at 11:55 a.m., the ADON indicated the nurse should have flushed the IV with 5 milliliters of normal saline before and after the medication administration. During an interview, on 6/16/25 at 9:54 a.m., RN 5 indicated standing orders would be added on the Medication Administration Record (MAR). If the nurse did not initiate the standing orders, they would not be on the MAR. A current facility policy, titled Guidelines for Medication Orders, dated 12/17/24 and received from the DON on 6/11/25 at 2:03 p.m., indicated .To establish uniform guidelines in the receiving and recording of medication orders .A current list of orders will be maintained in the electronic clinical records of each resident .Standing orders .The admitting nurse shall review the standing order list with the physician when verifying admission orders .The physician shall inform the admitting nurse if any of the standing orders should be eliminated, modified and/or other standing orders added for the specific resident .Standing orders shall be in the medical record with the other physician orders 3.1-47(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. Building B. Wing	06/16/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to ensure a physician's order for oxygen was in place and oxygen equipment was stored properly when not in use for 1 of 3 residents reviewed for respiratory care. (Resident 1) Findings include: During an observation, on 6/9/25 at 11:09 a.m., Resident 1 was in bed with an oxygen concentrator next to the bed. The concentrator was set on 3 liters (L) and was connected to a nasal cannula. Resident 1 was not wearing the nasal cannula, and it was laying on the floor. During an observation, on 6/10/25 at 9:57 a.m., Resident 1 was lying in bed. The oxygen concentrator was set on 3L. Resident 1 was not wearing the nasal cannula, and it was laying on the floor. During an observation, on 6/11/25 at 11:34 a.m., Resident 1 was lying in bed. The resident was wearing the nasal cannula and was receiving oxygen at 3L. The clinical record for Resident 1 was reviewed on 6/9/25 at 1:05 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, acute diastolic heart failure, chronic obstructive pulmonary disorder, schizoaffective disorder, and delirium due to a known physiological condition. A care plan, dated 4/29/25, indicated the resident demonstrated non-compliance with physician's orders. The approaches included, but were not limited to, refused to wear oxygen per order. A physician's order for Resident 1 to receive oxygen via nasal cannula at 3L was not located in the clinical record. The nasal cannula was found lying on the floor and not stored in a manner to prevent contamination. During an interview, on 6/16/25 at 11:00 a.m., the Director of Nursing (DON) indicated there was not an active order for the use of oxygen in the medical record until 6/12/25. A physician's order for the use of oxygen should have been placed when the resident returned from the hospital on 3/17/25. A current facility policy, titled Guidelines for Medication Orders, dated 12/17/24 and received from the DON on 6/16/25 at 12:00 p.m., indicated .The purpose of this policy is to: To establish uniform guidelines in the receiving and recording of medication orders .A current list of orders will be maintained in the electronic clinical record of each resident .Oxygen orders .When recording oxygen orders specify .The rate of flow, route and rationale A facility document, titled Administration of Oxygen, dated 12/13/24 and received from DON on 6/16/25 at 12:00 p.m., indicated .Guidelines to properly Administering Oxygen and any Respiratory procedure .Verify physician's order for the procedure 3.1-47(a)(6)