STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Place Health Campus	2320 N Montgomery Road Greensburg, IN 47240

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38769 Based on interview and record review, the facility failed to report an allegation of abuse in a timely manner for 1 of 15 residents reviewed for reporting of alleged violations. (Resident 20) Findings include: During an interview, on 05/06/25 at 1:16 P.M., Resident 20 indicated a few weeks ago she had gone to the bathroom and her wet wipes were gone. Certified Nurse Aide (CNA) 11 was assisting her roommate. The resident asked the CNA to get her some wipes because someone had taken hers out of the bathroom. The CNA gave her about five wipes and the resident told her that wouldn't be enough, and she wanted a full pack. The CNA had brought her a full pack of wipes and stood in the doorway to the bathroom and tossed the full package of wipes at her. The wipes hit the back of her wheelchair and landed in the seat. She believed the CNA was angry when she tossed the wipes into the bathroom. She reported to other staff member, but didn't think it had been taken care of. She felt safe in the building but thought it was unacceptable that the CNA tossed the wipes towards her. During an interview, on 05/12/25 at 1:26 P.M., CNA 11 indicated a few weeks ago she was assisting Resident 20's roommate when Resident 20 was in the bathroom asking for wet wipes. She handed the resident a few wipes, but the resident told her it wasn't enough and threw the wipes down on the ground. She went and got the resident a pack of wipes and went back into the bathroom. The resident was sitting on the toilet with the wheelchair in front of her. She went to give the resident the wipes and they hit the back of the wheelchair and landed in the seat. She never threw the wipes at her. She asked the resident if she needed anything else and she told her no. The nurse working that night had her go into the resident's room because the resident wanted to make a complaint and the nurse wanted both of them in the room. They all went into the room and the resident said she wasn't going to talk with the CNA in the room. She left the room and made sure another staff member has cared for that resident since that night. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 05/12/25 at 9:24 A.M., the Director of Nursing (DON) indicated she had gotten called to the business office on a Friday related to an accusation that CNA 11 had thrown a package of wet wipes at the resident a few days prior. The CNA was working that day and had gone and talked with her. She was removed from taking care of that resident. The resident made Qualified Medication Aide (13) aware that CNA 11 had thrown wipes at her the night that it happened. Licensed Practical Nurse (LPN) 12 had taken the CNA to the resident's room that night to resolve the issue, but the resident wouldn't speak to her about it. She investigated and did not believe the CNA threw the wipes at the resident. The facility investigation was provided by the DON on 05/13/25 at 11:23 A.M. The investigation included, but was not limited to the following: - A typed statement from Resident 20, dated 05/02/25 , that indicated the incident occurred on 04/28/25. The resident had indicated that CNA 11 had thrown a package of wipes at her. - A written statement from LPN 12, that indicated she had entered the resident's room to answer the call light, and the resident had appeared upset. She had asked her if she was ok and she said no that she was upset. The resident told her that she needed to file a complaint. The LPN explained that she would need to get a complaint form and left the room to get one. She walked to the nurse's station to get the form and asked CNA 11 about the resident because the resident was upset. The CNA explained that the resident had wanted wipes but she was busy so she gave her a handful until she could get her a pack, but she was upset. LPN 12 has asked CNA 11 to go to the room with her to get both sides of the story. When they entered the room, the resident asked why she had brought the CNA with her. The resident had said she wouldn't talk to the LPN, and she would talk to someone later. - A written statement from QMA 13 indicated on 04/30/25 Resident 20 had called her into the room to tell her about an incident with CNA 11. Resident 20 had told her that the CNA had thrown wipes at her. - A written statement from CNA 11 indicated on 04/29/25 she was assisting Resident 20's roommate when Resident 20 was in the bathroom asking for wet wipes. She handed the resident a few wipes, but the resident didn't like that and wanted a new pack. She told her she would get her some when she was done. She had gone and gotten a pack of wipes and put them in the resident's wheelchair. The nurse had wanted her to go into the resident's room and the resident didn't like that and that she would just talk to the higher ups. She had tried to keep herself away from the resident's room. During an interview, on 05/12/25 at 2:13 P.M., CNA 14 indicated if a resident reported any type of abuse to her, she would report it to the Administrator immediately anytime of the day. During an interview, on 05/13/25 at 10:35 P.M., the DON indicated staff should report allegations of abuse immediately to her or the Administrator. She would immediately remove the staff from the situation and report it to the state. The staff should have reported this incident sooner. The clinical record for Resident 20 was reviewed on 05/08/25 at 10:15 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/13/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, diabetes, malnutrition, depression, and bipolar. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 05/13/25 at 2:45 P.M., the Administrator indicated they did not have a policy for reporting, and they would follow the state guidelines. 3.1-28(b)(2)(c)

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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. 38769 Based on record review and interview, the facility failed to follow a physician's order related to blood pressure monitoring for 1 of 15 residents reviewed for quality of care. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 05/08/25 at 10:35 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, acute respiratory failure with hypoxia, hypertension, non-Alzheimer dementia, malnutrition, anxiety, depression, and psychotic disorder. A physician's order, dated 01/30/25 through 02/24/25, indicated the staff were to check the resident's blood pressure daily. The resident's clinical record lacked document blood pressures for the following dates: - 02/02/25 through 02/04/25, - 02/08/25, - 02/09/25, - 02/11/25 through 02/13/25, - 02/17/25, - 02/19/25, - 02/20/25, - 02/22/25, and - 02/23/25. During an interview, on 05/12/25 at 9:18 A.M., RN 15 indicated if a physician ordered for a resident's vital signs to be monitored then they would be documented the in Electronic Medication Administration Record. During an interview, on 05/13/25 at 3:27 P.M., Corporate Clinical Support Nurse indicated they did not have a policy for following physician orders, it was just standards of practice. 3.1-37(a)

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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. 38769 Based on interview and record review, the facility failed to ensure residents with a urinary tract infection received antibiotic treatment in a timely manner for 2 of 15 residents reviewed for laboratory services. (Resident 26 and 31) Findings include: 1. The clinical record for Resident 26 was reviewed on 05/08/25 at 10:35 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, acute respiratory failure with hypoxia, hypertension, non-Alzheimer dementia, malnutrition, anxiety, depression, and psychotic disorder. A Progress Note, dated 04/15/25 at 1:51 P.M., indicated the resident's urine was obtained for a Urinalysis Culture and Sensitivity (UA C&S). A Progress Note, dated 04/17/25 at 2:47 P.M., indicated the resident's urine culture was pending at that time. A Progress Note, dated 04/21/25 at 3:07 P.M., indicated the resident's urine culture result showed a Urinary Tract Infection (UTI) and a new order was obtained for Macrobid (an antibiotic) 100 milligrams, twice a day for 10 days. A Laboratory Report document indicated the resident's urine was collected on 04/14/25 at 2:15 P.M., received at the laboratory (lab) on 04/16/25 at 12:10 P.M., and the culture results were reported on 04/18/25 at 10:54 P.M. 2. The clinical record for Resident 31 was reviewed on 05/07/25 at 2:56 P.M. An Annual MDS assessment, dated 02/04/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, metabolic encephalopathy, anemia, heart failure, hypertension, neurogenic bladder, diabetes, paraplegia, malnutrition, anxiety, depression, and respiratory failure. A Progress Note, dated 03/11/25 at 4:52 P.M., indicated the resident's urine was obtained and was in the refrigerator waiting for the lab to pick it up. A Physician Progress Note, dated 03/14/25 at 6:14 A.M., indicated the resident had their urinary catheter replaced on 03/11/25 due to leaking and a UA was obtained and was pending at time of visit. A Progress Note, dated 03/17/25 at 11:55 P.M., indicated the Nurse Practitioner was in for rounds and a new order was received to start the resident on Linezolid 600 milligrams, twice a day for 10 days, for a UTI. A Laboratory Report, indicated the resident's urine was collected on 03/11/25 at 4:15 P.M., received at the lab on 03/12/25 at 1:51 P.M., and the culture results were reported on 03/14/25 at 7:17 A.M. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 03/17/25 through 03/27/25, indicated the resident was to receive linezolid 600 milligrams, twice a day, for 10 days. The March 2025 Electronic Medication Administration Record indicated the resident had not received the first dose of the antibiotic until 03/18/25 from 6:00 P.M. to 10:00 P.M. due to the medication being unavailable. During an interview, on 05/12/25 at 9:18 A.M., RN 15 indicated when they received orders for a UA C&S, they would obtain the urine and have it ready for the lab to pick it up. The lab techs came nightly. They would have the preliminary results by the afternoon. If the urine needed to be cultured, it would take 48 to 72 hours to get those results back. Once they had the results they would send them to the physician. The resident should start on an antibiotic as soon as possible when the results were back. There was always a physician available to call once they got the results of the culture back to get orders. During an interview, on 05/13/25 at 10:08 A.M., the Infection Preventionist indicated when a resident had an order for a UA C&S, the nursing staff would get the urine, and the lab would pick it up in the evening. The preliminary results usually came back within 24 hours, and the final culture came back after 72 hours. If the staff were not seeing the culture results after 72 hours, then they should be calling the lab to obtain those results. Residents should start on an antibiotic within 72-84 hours after obtaining the urine. The lab came to the facility every day except Saturdays and staff could always call the lab and get results. There were some nurses that had access to view the labs online. During an interview, on 05/12/25 at 3:15 P.M., Corporate Clinical Support Nurse indicated the facility did not have a policy on timeliness of labs. 3.1-49(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 33613 Based on record review and interview, the facility failed to monitor daily weights, administer an ordered medication related to fluid retention, and monitor meal consumptions for 2 of 3 residents reviewed for nutrition. (Resident 27 and 26) Findings include: 1. The clinical record for Resident 27 was reviewed on 05/09/25 at 9:16 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/27/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited, heart disease, hypertension, and diabetes. An open-ended physician's order, with a start date of 10/28/24, indicated the resident was to be weighed daily. An open-ended physician's order, with a start date of 10/28/24, indicated a PRN (as needed) dose of Lasix was to be administered if the resident gained two pounds in one day or five pounds in a week. The resident's clinical record lacked a document weight for the following dates: - 03/05/25, - 03/07/25, - 03/08/25, - 03/13/25, - 03/28/25, - 03/30/25, - 03/31/25, - 04/01/25, - 04/02/25. - 04/03/25, - 04/06/25, - 04/10/25, - 04/16/25, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 04/24/25, - 04/29/25, and - 05/01/25. The Resident's weight gain was two pounds or greater on the following days and a PRN dose of Lasix was not administered: - 03/19/25 weight was 218 pounds, - 03/20/25 weight was 221 pounds, - 04/11/25 weight was 203 pounds, - 04/12/25 weight was 205 pounds, - 04/19/25 weight was 205 pounds, - 04/20/25 weight was 208.3 pounds, - 04/26/25 weight was 206.6 pounds, - 04/27/25 weight was 209.1 pounds, - 05/04/25 weight was 205.2 pounds, and - 05/05/25 weight was 209 pounds. During an interview on 05/12/25 at 2:54 P.M., Qualified Medication Aide (QMA) 16 indicated she would obtain the resident's weight upon rising or between 6:00 A.M. and 10:00 A.M. The mechanical lift had a scale to obtain the resident's weight, so even if the resident didn't want to get up their weight could still be measured. She would notify the nurse of the weight, and the nurse would give permission for the PRN dose of Lasix to be given. Resident 26 was usually agreeable to being weighed. During an interview on 05/13/25 at 1:06 P.M., RN 15 indicated the CNA would obtain the resident's weight first thing of a morning and report it to her. She would look at the previous day's weight and administer the medication if there was a weight gain greater than two pounds. During an interview on 05/13/25 at 3:27 P.M., Corporate Clinical Support Nurse indicated they did not have a policy for following physician orders, it was just standards of practice. 38769 2. The clinical record for Resident 26 was reviewed on 05/08/25 at 10:35 A.M. A Quarterly Minimum Data Set assessment, dated 04/18/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, acute respiratory failure with hypoxia, hypertension, non-Alzheimer dementia, malnutrition, anxiety, depression, and psychotic disorder. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's clinical record lacked documented meals for the following dates and times for a resident with a diagnosis of malnutrition: - 03/01/25 at dinner, - 03/02/25 at breakfast, lunch, and dinner, - 03/03/25 at breakfast and lunch, - 03/05/25 at breakfast and lunch, - 03/12/25 at dinner, - 03/15/25 at breakfast and lunch, - 03/17/25 at breakfast and lunch, - 03/26/25 at breakfast and lunch, - 03/30/25 at breakfast and lunch, - 04/17/25 at breakfast and lunch, - 04/18/25 at breakfast and lunch, - 04/22/25 at breakfast and lunch, - 05/10/25 at breakfast and lunch, and - 05/11/25 at dinner. During an interview, on 05/13/25 at 11:12 A.M., Certified Nurse Aide 14 indicated resident meals were documented in the resident's clinical record. The current facility policy titled; Guidelines for Meal Service was provided by the Director of Nursing on 05/13/25 at 1:23 P.M. The policy indicated, .Meal intake should be recorded in the electronic health record . 3.1-46(a)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38769 Based on record review and interview, the facility failed to ensure medications were available for 1 of 15 residents reviewed for pharmacy services. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 05/08/25 at 10:35 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 04/18/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, acute respiratory failure with hypoxia, hypertension, non-Alzheimer dementia, malnutrition, anxiety, depression, and psychotic disorder. A physician's order, dated 11/24/24 through 02/25/25, indicated the resident was to receive tramadol (a pain medication) 50 milligrams, twice a day from 6:00 A.M. to 10:00 A.M. and 6:00 P.M. to 10:00 P.M. The January 2025 Electronic Medication Administration Record indicated the resident had not received the medication on the following dates and times: - On 01/22/25 from 6:00 P.M. to 10:00 P.M., the resident's medication was not administered due to the medication being unavailable. - On 01/24/25 from 6:00 A.M. to 10:00 A.M., the resident's medication was not administered due to the medication being unavailable and the resident needed a new prescription. - On 01/25/25 from 6:00 A.M. to 10:00 A.M., the resident's medication was not administered due to the medication being unavailable. - On 01/26/25 from 6:00 A.M. to 10:00 A.M., the resident's medication was not administered due to the medication being unavailable. - On 01/28/25 from 6:00 P.M. to 10:00 P.M., the resident's medication was not administered due to the medication being unavailable. - On 01/29/25 from 6:00 A.M. to 10:00 A.M., the resident's medication was not administered due to the medication being unavailable. A Physician Progress Note, dated 01/21/25, indicated the resident was seen by the Nurse Practitioner with no indication a new prescription was needed for the tramadol. The resident was being seen for having recurring abdominal discomfort and a gallbladder ultrasound order. A Progress Note, dated 01/25/25 at 7:45 P.M., indicated the resident was out of Tramadol and needed a new prescription. The writer went to the nurse to request to the provider for a 3-day supply. The request was placed in the provider book at the 200 Hall nurse's station. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Progress Note, dated 01/27/25 at 6:11 A.M., indicated the resident was seen by the Nurse Practitioner. The note lacked any indication that the resident needed a new prescription for tramadol. A Progress Note, dated 01/29/25 at 8:10 A.M., indicated a message was sent to the Nurse Practitioner requesting a hard script for tramadol. During an interview, on 05/12/25 at 9:18 A.M., RN 15 indicated when a resident was out of a medication that required a prescription they could pull one emergency dose from the emergency drug kit. They would need to call the physician to get a prescription sent to the pharmacy. They should have a new prescription within 24 hours. If nursing staff communicated with the physician related to medications being unavailable, it should be documented in a progress note. The current facility policy titled, Guidelines for Medication Orders, with a review date of 12/17/24 was provided by the Director of Nursing on 05/12/25 at 3:01 P.M. The policy indicated, .The purpose of the policy it to establish uniform guidelines in the receiving and recording of medication orders . The current facility policy titled, Medication Ordering and Receiving from Pharmacy, with a revised date of 11/18, was provided by the Director of Nursing on 05/12/25 at 3:01 P.M. The policy indicated, .Reorder medication several days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand . 3.1-25(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 38239 Based on observation, interview, and record review, the facility failed to ensure medications were administered appropriately to prevent significant medication errors for 1 of 3 residents reviewed for significant medication errors. (Resident 23) Findings include: QMA 9 was observed preparing medications for Resident 23 on 05/12/25 at 8:48 A.M. QMA 9 sanitized her hands and opened the plastic packages that contained the resident's various medications and placed the medications in a cup. The medications included, but were not limited to, a 20 milliequivalent (mEq) Extended Release (ER) Potassium Chloride tablet. QMA 9 indicated the resident took her medications crushed. She removed a soft gel vitamin supplement tablet from the medication cup and indicated the gel tablet couldn't be crushed. She poured the remaining medications into a clear packet and crushed them with the pill crusher on the medication cart. She poured the crushed medications back into the cup, added pudding and the gel tablet to the cup, and preceded to administer the medications to the resident. During an interview, on 05/12/25 at 9:09 A.M., QMA 9 indicated there were several medications that were not allowed to be crushed because of the coating on the medications. There was a do not crush list on the medication cart. She reviewed the list and indicated the potassium chloride table she administered to the resident was on the do not crush list. She was not aware that it was not to be crushed. She learned something new. The resident's clinical record was reviewed on 05/13/25 at 3:50 P.M. A Quarterly Minimum Data Set assessment, dated 03/11/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, coronary artery disease, hypertension, and malnutrition. The resident's most recent laboratory values were reviewed, and her potassium level was within normal limits. The Medications Not To Be Crushed list, with a revision date of 12/22, was provided by the Corporate Clinical Support Nurse on 05/13/25 at 3:30 P.M. The list indicated the Potassium Chloride tablet was not to be crushed because it was an extended-release medication. 3.1-48(c)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155797	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Place Health Campus	2320 N Montgomery Road Greensburg, IN 47240

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 38239 Based on observation and interview, the facility failed to appropriately store medications for 1 of 3 medication carts reviewed (100 Hall Medication Cart). Findings include: On 05/13/25 at 1:13 P.M., the 100 Hall Medication Cart was observed with RN 10 and contained the following: - A Basaglar insulin pen for Resident 30. The pen was 1/2 full and was not labeled with an opened on date, and - A 198-milliliter bottle of liquid fish oil for Resident 30. The bottle was two-thirds full and was not labeled with an opened-on date. During an interview, on 05/13/25 at 1:18 P.M., RN 10 indicated the resident received 32 units of the insulin twice a day and received 2.5 ml of the fish oil daily. Both medications should have been labeled with opened on dates. The Basaglar insulin pen package insert indicated, .Throw away all insulin .in use after 28 days, even if there is insulin left . The current facility policy, titled MEDICATION STORAGE IN THE FACILITY, with a revision date of 11/18, was provided by the Corporate Clinical Support Nurse on 05/13/25 at 3:15 P.M. The policy indicated, .When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated .a date opened sticker shall be placed on the medication . 3.1-25(o)

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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. 38769 Based on record review, interview, and observation, the facility failed to follow infection control guidelines related to infection tracking and trending, and Enhanced Barrier Precautions (EBP) related to infection control. (Residents 10 and 40) Findings include: 1. During a review of the Infection Control Tracking and Trending documentation on 05/13/25 at 10:08 A.M., The facility lacked documented tracking of antibiotic use for February and March 2025. During an interview on 05/13/25 at 3:35 P.M., the Infection Preventionist indicated she came to this facility in April and infections and antibiotic usage was not tracked in February and March. The current facility policy titled, Infection Prevention and Control Program with a review date of 12/17/24, was provided by the Administrator on 05/06/25. The policy indicated .The purpose of this policy is to: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .The campus has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases .The campus shall designate a member of the clinical team to monitor the campus .program to perform surveillance to identify, investigate, control, and prevent the spread of infection and reporting . 33613 2. The clinical record for Resident 10 was reviewed on 05/08/25 at 1:33 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 03/09/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), hypertension, heart failure, dementia. The resident had an unhealed pressure ulcer on her right buttocks. An open-ended physician's order, with a start date of 12/13/24, indicated staff were to use Enhanced Barrier Precautions (EBP), wearing a gown and gloves at minimum during high contact care activities. During an observation, on 05/12/25 2:09 P.M., the resident's door had a sign on it that indicated staff were to STOP and that the resident was in ENHANCED BARRIER PRECAUTIONS. Everyone must wear gloves and a gown for High-Contact Resident Care Activities, including wound care. RN 7 entered the resident's room and provided direct care as she removed and then reattached the wound dressing to visualize the wound without donning a gown. During an interview, on 05/12/25 at 2:12 P.M., RN 7 indicated nursing staff should wear gloves and a gown when providing direct care for residents who are in EBP. She should have worn a gown when she was touching the wound dressing for Resident 10. 38239 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 40's clinical record was reviewed on 05/07/25 at 3:09 P.M. A Significant Change MDS assessment, dated 03/17/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, non-Alzheimer's dementia, and peripheral vascular disease. The resident had pressure ulcers and venous ulcers that were present on admission. The resident's current physician's orders included, but were not limited to, an open-ended order, with a start date of 04/29/25, that indicated the resident was in EBP and staff were to wear a gown and gloves at minimum during high-contact care activities. During an observation, on 05/12/25 at 1:21 P.M., the resident's door had a sign on it that indicated staff were to STOP and that the resident was in ENHANCED BARRIER PRECAUTIONS. Everyone must wear gloves and a gown for High-Contact Resident Care Activities, including wound care. RN 7 and RN 8 entered the resident's room and proceeded to cleanse and administer wound care treatments to the resident's multiple wounds without donning gowns. During an interview, on 05/12/25 at 2:12 P.M., RN 7 indicated nursing staff should wear gloves and a gown when providing direct care for residents who are in EBP. She should have worn a gown during the wound dressing changes for Resident 40. The current facility policy, titled Enhanced Barrier Precautions (EBP) Standard Operating Procedure, dated 04/01/24, was provided by the DON on 05/12/25 at 3:01 P.M. The policy indicated, .EBP will be in place during high-contact care activities for residents with the following conditions .All Residents with chronic wounds, including but not limited to, pressure ulcers .at minimum, staff shall wear gloves and gowns during high-contact care activities . 3.1-18(b)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 33613 Based on record review and interview, the facility failed to ensure the staff had the required six hours of dementia training within six months of hire and three hours annually for 3 of 10 employee records reviewed. (CNA 2, CNA 3, and CNA 5) Findings include: The employee records were provided by the Employee Experience Manager on 05/08/25. The following staff members, working on the skilled unit failed to have the required number of hours of dementia training prior to working with residents that had a diagnosis of dementia: - Certified Nurse Aide (CNA) 2 was hired on 06/19/24 and had 1.5 hours of dementia training, - CNA 3 was hired on 12/20/24 and had 1 hour of dementia training, and - CNA 5 was hired on 10/16/24 and had 1.5 hours of dementia training. During an interview, on 05/09/25 at 11:13 A.M., the Employee Experience Manager indicated she had provided all the documented dementia training in the employee files. Reports were sent to the staff through email, and it was their responsibility to complete the training. The department managers received a report indicating which staff members still had training to complete. The department managers were to follow up with their staff. She believed new staff members were to have six hours of dementia training and was unsure of older employees. During an interview, on 05/09/25 at 11:28 A.M., Corporate Clinical Support Nurse indicated the facility did not have a policy related to dementia training they would follow State and Federal regulations. 3.1-14(u)