STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison's Crossing Health Campus	395 8th Avenue Terre Haute, IN 47804

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on observation and record review, the facility failed to ensure a resident was treated in a dignified manner during 1 of 1 random meal service observation (Resident 8). Findings include: On 2/14/25 at 10:05 a.m., Resident 8 was observed eating a meal at the nurses' station table with several other residents who were not eating. The resident was observed spilling food over their clothing. Certified Nurse Aide (CNA) 20 was standing next to the resident and talking to him. On 2/14/25 at 10:07 a.m., during an interview, CNA 20 acknowledged the resident should have a clothing protector, but she forgot to put one on because he was in the hall. The employee did not obtain a clothing protector, and the resident continued to spill food over himself. On 2/14/25 at 10:10 a.m., during an interview, CNA 13, indicated the resident did need a clothing protector. She obtained a washcloth and cleaned the resident's clothing and applied a clothing protector. The resident repeatedly told the employee he was sorry he had spilled his food. The employee reassured him it was okay, and the resident thanked her. On 2/14/25 at 10:30 a.m., the medical record of Resident 8 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) without dyskinesia (uncontrolled, involuntary muscle movements ranging from shakes, tics and tremors to full-body movements), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), and dysphagia (difficulty swallowing). A quarterly Minimum Data Set (MDS) assessment, dated 12/6/24, indicated the resident required assistance of one person for eating and was not cognitively intact. A care plan, dated 8/15/19, indicated the resident had diagnosis of Parkinson's disease requiring assist with activities of daily living (ADL) care. Interventions included, but were not limited to, provide assistance during ADL care to include but not limited to eating, toileting, bed mobility, transfers, wheelchair mobility, ambulation. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/2025 at 11:32 a.m., the Clinical Nurse Consultant provided a document, titled, Resident Rights, dated 12/17/24, and indicated it was the policy currently being used by the facility. The policy indicated, . Purpose .To ensure resident rights are respected and protected and provide an environment in which they can be exercised .2. Our residents have the right to .a. Be treated with dignity and respect 3.1-3(v)(1)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 35317 Based on interview and record review, the facility failed to ensure a resident was provided showers as preferred for 1 of 26 residents reviewed for choices (Resident 2). Findings include: During an interview, on 2/10/25 at 11:34 a.m., Resident 2 indicated it had been almost 2 weeks since she last had a shower. She was scheduled to receive 3 showers a week, on Monday, Wednesday, and Friday. She further indicated the shower in her room was too cold and she was waiting for it to be fixed by the maintenance worker. Resident 2's record was reviewed on 2/12/25 at 11:52 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/22/24, indicated the resident was cognitively intact and required two-person physical assist with transfers. A care plan, dated 4/19/22, indicated profile care guide. Interventions included, but were not limited to, perform transfers 2 assist with gait belt and showers on Monday, Wednesday, and Friday on the evening shift. Review of point of care documentation, dated January 13 through February 12, 2025, indicated Resident 2 did not receive a shower on 1/29/25, 1/31/25, 2/3/25, 2/5/25, 2/7/25, 2/10/25. Review of shower sheets, dated 2/5/25, indicated Resident 2 had refused her shower because the water in her room was still too cold. The shower sheet lacked documentation that staff had offered the resident an alternative shower to use. Review of shower sheet, dated 2/7/25, indicated Resident 2 had refused her shower because it was too cold. The shower sheet lacked documentation that staff had offered the resident an alternative shower to use. During an interview, on 2/12/25 at 11:24 a.m., Resident 2 indicated the shower was now fixed and was hoping to get back on her regular schedule of shower days, she indicated the staff never offered her an alternative shower to use when the water in her room was too cold. During an interview, on 2/12/25 at 2:18 p.m., the Clinical Support Nurse indicated the resident should have been offered an alternative shower if hers was too cold. During an interview, on 2/12/25 at 2:20 p.m., the Director of Health Services (DHS) indicated they had a spa area where the resident could have used a shower or in an unoccupied room. During an interview, on 2/13/25 at 9:30 a.m., the Administrator indicated the facility did have a spa that residents could use for showers, but the room was cold, and most residents did not like to use it. Staff should have offered the resident an alternative shower to use. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 11:43 a.m., the Clinical Support Nurse provided a document, with a revised date of 5/11/17, titled, Resident Rights Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To ensure resident rights are respected and protected and provide an environment in which they can be exercised .2. Our residents have a right to: a. Be treated with dignity and respect 3.1-3(u)(3)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226 Based on record review and interview, the facility failed to notify the physician of significant weight loss for 1 of 6 residents reviewed (Resident 15). Findings include: On 2/12/25 at 10:19 a.m., the medical record of Resident 15 was reviewed. The resident was admitted to the facility on [DATE]. Admission diagnosis included, but was not limited to, fracture of the right femur (fracture of the long thigh bone of the leg), cardiomyopathy (a disease of heart muscle. It causes the heart to have a harder time pumping blood to the rest of the body), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), Lymphedema (swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system), edema (swelling caused by too much fluid trapped in the body's tissues). An admission Minimum Data Set Assessment (MDS) dated [DATE], indicated the resident was administered a diuretic (medication to reduce extra fluid in the body) and was short of breath during the assessment period. A care plan, dated 1/23/25, indicated the resident was receiving high risk medications, received diuretic medication. Intervention included, but were not limited to, observe and report effectiveness as needed. A physician order, dated 1/25/25, indicated to adminster Lasix 40 mg (milligrams) one tablet by mouth two times per day. A review of the resident's weight record indicated the resident had 19.5 % weight loss, 37.5 pounds in less than 30 days. Admission weight on 1/24/25 was recorded as 192.3 pounds. On 2/4/25 recorded weight was 163 pounds. On 2/12/25 recorded weight was 154.8 pounds. A physician order, dated 2/6/25, indicated to adminster Lasix 40 mg, one tablet by mouth one time per day for diagnosis of edema. On 2/11/25 a nutrition progress note indicated the root cause of weight loss was due to decreased swelling of bilateral lower extremities with diuretic treatment and compression wraps. A nurse progress note, on 12/6/25, indicated the resident was seen by the Nurse Practitioner (NP). Lasix was decreased to 40 mg daily from 40 mg twice daily. Compression wraps were ordered on 2/3/25. The record lacked documentation of physician notification of the increased and continual weight loss. NP visit notes did not indicate a plan of treatment had been in place for reduction of edema, a review of current weight loss status or continuation of weight loss plan. The NP note lacked notification to the attending physician of the weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 2:10 p.m., during an interview with the residents physician and the Director of Health Services (DHS) the physician indicated the weight loss was due to administration of Lasix to decrease massive abdominal edema. He acknowledged he had not reviewed the residents weight loss until 2/14/25. The physician acknowledged the medical record lacked documentation of notification of the weight loss, though the NP had seen the resident on 2/6/25 and decreased the Lasix to 40 mg daily. The physician acknowledged the record lacked notification of significant weight loss or of continual plan to reduce edema. On 2/18/2025 at 1:37 p.m., the Clinical Nurse Consultant provided a document titled, Physician Provider Notification Guidelines, dated12/17/24, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose .ensure the resident's physician or practitioner (may include NP, PA or clinical nurse specialist) is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care .11. Attempts to notify the physician/provider and their response should be documented in the resident electronic health record 3.1-5(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. 34525 Based on observation, record review, and interview, the facility failed to ensure a resident's urostomy (a surgical opening in the belly that re-directs urine away from a bladder that's diseased, had been injured, or isn't working as it should) catheter bag (a bag that collects urine) was kept from coming in contact with the floor for 1 of 2 residents reviewed for catheters (Resident 4). Findings include: During a meal service observation, on 2/10/25 at 11:51 a.m., Resident 4's urinary catheter bag was observed to be in contact with the floor. During a random observation, on 2/10/25 at 12:49 p.m., Resident 4 was propelling herself in her wheelchair out of the dining room. Her urinary catheter bag was in contact with the floor and dragging underneath her wheelchair. During a random observation, on 2/11/25 at 9:29 a.m., Resident 4 was in the therapy room. Her urinary catheter bag was in contact with the floor. During a random observation, on 2/11/25 at 10:46 a.m., Resident 4 was being assisted in her wheelchair by a staff person down the hallway to participate in an activity. The resident's urinary catheter bag was dragging on the floor under her wheelchair. Resident 4's record was reviewed on 2/12/24 at 2:28 p.m. The profile indicated the resident's diagnoses included, but were not limited to, personal history of urinary tract infections (UTI-an infection in any part of the urinary system), and disorder of the kidney and ureter (a blockage where the ureter and kidney meet which may cause the kidney to swell and eventually stop working). An admission Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident had no cognitive deficit and had a urostomy. A care plan, dated 12/27/24, indicated the resident had an ostomy to divert her urine. The care plan lacked documentation to maintain the catheter bag and/or tubing from coming contact with the floor. An event document, dated 1/13/25, indicated the resident had developed a UTI that was not present upon admission. During an interview, on 2/13/25 at 10:06 a.m., Certified Resident Care Assistant (CRCA) 9 indicated urinary catheter bag and/or tubing should not come into contact with the floor. During an interview, on 2/13/25 at 11:44 a.m., the Clinical Support nurse indicated the resident's urinary catheter bag should not have been in contact with the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 10:01 a.m., the Executive Director (ED) provided a document, with a review date of 12/16/24, titled, Preserving Dignity with Indwelling Catheter, and indicated it was the policy currently being used by the facility. The policy indicated, .SOP (Standards of Practice) Details: 1 .e. Urinary drainage bags and catheter tubing should be kept from touching the floor surface 3.1-41(a)(2)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on record review and interview, the facility failed to ensure proper administration of scheduled medication by nursing staff and failed to ensure competent nursing staff removed a PICC line (a thin, flexible tube that's inserted into a vein in the arm and ends in a large vein near the heart) for 2 of 5 residents reviewed for unnecessary medications (Resident 14 and 20). Findings include: 1. Resident 14's record was reviewed on 2/11/25 at 2:00 p.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). A quarterly Minimum Data Set (MDS) assessment, dated 1/31/25, indicated the resident had moderate cognitive impairment and was on an anti-anxiety medication. A care plan, dated 5/3/22, indicated the resident has a diagnosis of anxiety disorder. Interventions included, but were not limited to, medications per order and psych services as needed. A physician order, dated 12/30/24, indicated to administer alprazolam (anti-anxiety medication) 0.5mg (milligrams) by mouth four times a day. Administration hours were 7 to 9:00 a.m., 1 to 1:30 p.m., 4 to 5 p.m., and 8 to 10 p.m. Review of December 2024 Medication Administration Record (MAR) indicated the following: a. On 12/6/24, Licensed Practical Nurse (LPN) 21 documented that he administered Resident 14's alprazolam medication at 6:35 p.m. and the medication was not due until 8 to 10:00 p.m. b. On 12/12/24, LPN 21 documented that he administered the resident's alprazolam mediation at 6:35 p.m. and the medication was not due until 8 to 10:00 p.m. Review of January 2025 MAR indicated the following: a. On 1/4/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:56 p.m. and the medication was not due until 8 to 10:00 p.m. b. On 1/17/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:25 p.m. and the medication was not due until 8 to 10:00 p.m. c. On 1/24/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:28 p.m. and the medication was not due until 8 to 10:00 p.m. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 1/31/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:44 p.m. and the medication was not due until 8 to 10:00 p.m. Review of February 2025 MAR indicated the following: a. On 2/1/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:30 p.m. and the medication was not due until 8 to 10:00 p.m. b. On 2/6/25 LPN 21 documented that he administered the resident's alprazolam mediation at 6:32 p.m. and the medication was not due until 8 to 10:00 p.m. Resident 14's record lacked documentation that the physician was ever notified that the resident was requesting her medication to be administered early. During an interview, on 2/11/25 at 3:01 p.m., Registered Nurse (RN) 4 indicated she wasn't sure if they could administer medication outside of the timeframe, she would have to check the policy. During an interview, on 2/11/25 at 3:02 p.m., LPN 5 indicated nursing staff may administer medication an hour before or after the medication administration time. During an interview, on 2/12/25 at 9:46 a.m., the Clinical Support Nurse indicated nursing staff may administer medication an hour before or after the medication administration times. Staff should notify the doctor if residents were requesting the medication earlier. Medications should be administered as ordered by physicians. The facility was not aware that the LPN was administering medications outside of the hour window. On 2/12/25 at 10:19 a.m., the Clinical Support Nurse provided a document, dated 12/1/21, titled, Medication Administration Times Procedural Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, . To ensure mediation is administered in resident centered fashion and documented in medical record .f. The nurse shall give the resident options of administration to ensure appropriate spacing of administration 48226 2. On 2/11/25 at 1:59 p.m., the record of Resident 20 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, Surgical amputation right foot toes, (removal of the toes on the right foot due to disease), (MRSA) methicillin resistant staphylococcus aureus infection (a bacterial infection that is resistant to some antibiotic treatments), osteomyelitis (inflammation or swelling that occurs in the bone from an infection somewhere else in the body that has spread to the bone), gangrene the death of body tissue due to a lack of blood flow or a serious bacterial infection) of the foot, proteus mirabilis (bacteria causing serious infection in the body) as the cause of diseases classified elsewhere, pseudomonas (bacterial causing serious infection in the body) as the cause of diseases. On 2/3/25 an admission Minimum Data Set Assessment (MDS) assessment indicated the resident was cognitively intact. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, dated 1/31/25, indicated the resident required IV medication related to infection/osteomyelitis, cellulitis (a deep infection of the skin caused by bacteria), and MRSA. Interventions included but were not limited to: administer IV as ordered, IV site care as ordered. Upon admission to the facility a peripherally inserted central venous catheter PICC/Central Line (a thin, flexible tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart called the superior vena cava) was inserted into the residents arm. The IV (intravenous) was used to administer antibiotic medication to treat bacterial infections. A physician order, dated 1/31/25, administer piperacillin-tazobactam reconstituted (mixed with sterile water solution) administer 4.5 gram in100 mL (milliliters) over 30 minutes through intravenous administration (medications administered into a vein) every 6 hours for diagnosis of MRSA. A physician order, dated 1/31/25, indicated to administer vancomycin reconstituted solution 1,000 mg (milligrams) administer 1 gram in 250 mL (sterile water solution) over 1 hour through intravenous administration every 12 hours to be administered at 10:30 a.m., and 10:30 p.m. for diagnosis of MRSA. A physician order, dated 1/31/25, with a designated implementation date of 3/5/25, indicated dressing covering PICC/CL IV was to be changed every 5 days and to measure external IV catheter (the length of the IV catheter outside of the body), and enter the measurement into the medication note. The Treatment Administration Record (TAR) indicated the dressing was changed on 2/4/25 when a new PICC/CL IV was placed and changed again on 2/6/25. Review of the TAR lacked documentation indicating the PICC/CL IV had been measured since admission as ordered by the physician. Nurse progress note, dated 2/6/2025 at 10:14 a.m., entered by Licensed Practical Nurse (LPN) 14 indicated the following: resident showered this shift. When resident was getting out of shower he took the PICC line drsg (dressing) off, when he removed drsg it pulled PICC out and inch and was visibly bleeding when i arrived in resident room. PICC was removed access RN was called promptly to replace line . bleeding was stopped . no c/o [complaints of] from patient at this time. On 2/10/25 at 2:20 p.m. an entry was made in the medical record by LPN 23. The documentation indicated LPN 23 drew blood from the PICC/CL for lab testing. The medical record lacked documentation of physician order to draw blood from the PICC/CL IV or documentation that a licensed Registered Nurse (RN) completed the blood draw. The medical record lacked documentation of an assessment by an RN prior to and after blood draw from the PICC/CL line. On 2/13/25 at 9:31 a.m., observed PICC/CL dressing. The dressing was soiled and edges starting to roll. The dressing was dated 2/6/25. On 2/13/25 at 9:50 a.m., during an interview with the Director of Health Services (DHS) she indicated the implementation date was a data entry error, and the dressing should have been changed on 2/11/25. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 10:10a.m., during an interview Licensed Practical Nurse (LPN) 14 indicated on 2/6/25 Resident 20 was in the shower and the resident attempted to remove the dressing over the PICC/CL IV and pulled on the IV. She indicated the PICC/CL IV was pulled out approximately one inch from the arm and was bleeding slightly. The LPN applied pressure to the arm for a minute to ensure it was no longer bleeding. She notified the DHS of the incident. She returned to the resident's room with another LPN and removed the PICC/CL from the residents arm and notified the Registered Nurse (RN) who would replace the PICC/CL IV. The LPN acknowledged she did not notify the physician of the incident and did not obtain an order to remove the PICC/CL IV. The employee indicated the DHS was in the facility and the DHS had notified the physician and obtained an order to remove the IV. The medical record lacked documentation of physician notification and order to remove the PICC/CL IV. The medical record lacked documentation of the length of the PICC/CL IV after removal, of pressure being applied to the area for a specific amount of time after removal, or an assessment of the IV site by a licensed RN before and after removal of the IV. On 2/14/25 at 10:40 a.m., during interview with the Registered Nurse Clinical Consultant (RNCC) and Director of Health Services (DHS), the DHS failed to verify she notified the physician for an order to remove the IV or of an assessment being completed by an RN before or after removal. The RNCC indicated an LPN was not licensed or permitted to remove a PICC/CL or draw blood from a PICC/CL IV. The RNCC acknowledged a central line IV catheter must be assessed by an licensed RN and only removed by a qualified licensed RN trained specifically in PICC/CL IV insertion and removal. On 2/14/2025 at 11:32 p.m., the RNCC provided a document titled, Catheter Insertion and Care , dated 12/15, and indicated it was the policy currently being used by the facility. The policy indicated, .General Guidelines .1, A prescriber must write an order for a CVAD or midline to be removed .7. The nurse or practitioner removing the catheter must have proven competency in this procedure Procedure .1. The procedure for removing CVAD and midlines is different for each catheter. 2. This procedure must be performed by a person who is certified in the removal procedure and demonstrates clinical competency in removing catheter .D. Peripherally Inserted Central Catheter (PICC) .4. Catheter can be placed or removed at the bedside or in the hospital setting by a Certified Specialty Nurse (Verify with the State Nurse Practice Act) .6. Catheter length is measured for baseline comparison upon removal. Catheter measurements are compared to baseline to verify that all of catheter has been removed .11. No blood pressure or phlebotomy should be done on arm that contains PICC 3.1-14(i)

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	155830	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison's Crossing Health Campus	395 8th Avenue Terre Haute, IN 47804

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 35317 Based on record review and interview, the facility failed to ensure justification for the long-term use of antibiotics for 1 of 26 residents reviewed for antibiotic use (Resident 1). Findings include: Resident 1's record was reviewed, on 2/12/25 at 2:44 p.m. The profile indicated that the resident's diagnoses included, but were not limited to, urinary tract infection (UTI - an illness in any part of the urinary tract the system of organs that make urine) and chronic kidney disease stage 3 (a person has moderate damage to their kidneys, with a noticeable decline in kidney function). A quarterly Minimum Data Set (MDS) assessment, dated 11/15/24, indicated the resident had moderate cognitive impairment and was always incontinent with bowel and urine. A physician order, dated 6/12/23 with no discontinue date, indicated to administer doxycycline hyclate (antibiotic) 100 mg (milligrams) by mouth once daily for UTI prophylaxis (tending to prevent or ward off, preventive). Review of Resident 1's notes indicated the last documented UTI was on 12/20/24 per a nursing progress note. During an interview, on 2/14/25 at 9:29 a.m., the Clinical Support Nurse indicated the Medical Director had prescribed the prophylactic antibiotic back in 2023 for the resident and was no longer Resident 1's primary care doctor. She was unable to provide documentation that the physician had documented a justification for the long-term antibiotic use. During an interview, on 2/14/25 at 2:10 p.m., the Medical Director indicated that he had not been informed of the best practice regarding antibiotic stewardship and the use of prophylactic antibiotic treatment. Review of a typed statement, dated 2/14/25, indicated the Medical Director had prescribed the antibiotic for UTI prophylaxis due to the resident being prone to UTI's. The resident had since changed doctors, and the new physician continued with the medication. During an interview, on 2/17/25 at 8:55 a.m., the Clinical Support Nurse indicated they had not been able to get a hold of Resident 1's primary care doctor regarding prophylactic antibiotic use, and to obtain a justification for the use of it. On 2/11/25 at 3:00 p.m., the Administrator provided a document, dated 11/10/17, titled, Antibiotic Stewardship Guideline, and indicated it was the current policy being used by the facility. The policy indicated, .Purpose: Optimize the treatment of infections by ensuring the residents who require an antibiotic, are prescribed the appropriate antibiotic. Reduce the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use .6. Pharmacy provider will assist in review of all antibiotic usage for appropriateness. 7. Antibiotic use will be calculated on monthly basis for QAPI purposes (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-48(a)(2) 3.1-48(a)(4)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34525 Based on record review and interview, the facility failed to ensure abnormal involuntary movement scale (AIMS) assessments (a 12-item clinician-rated scale to assess severity of involuntary movements of the mouth, face, extremities, and trunk in residents taking neuroleptic [psychiatric drugs that treat mental health symptoms] medications) were conducted for 3 of 5 residents reviewed for unnecessary medications (Residents 31, 5, and 15). Findings include: 1. Resident 31's record was reviewed on 2/11/23 at 2:03 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance (a condition where a person with dementia [a group of brain conditions that cause memory loss, thinking problems, and difficulty doing daily tasks] experiences a range of behavioral changes. A quarterly Minimum Data Set (MDS) assessment, dated 1/17/25, indicated the resident had severe cognitive deficit and received antipsychotic medication (drugs used to treat symptoms of psychosis [hallucinations: sights, sounds, smells, tastes, or touches that a person believes to be real but are not real, delusions: false beliefs], and dementia) on a routine basis. A care plan, dated 7/17/24, indicated the resident had been admitted on an antipsychotic medication. Interventions included, but were not limited to, monitor for side effects of the medication. A physician's order, dated 7/12/24, indicated to administer a 100 milligram (mg) tablet of quetiapine (antipsychotic medication) two times a day. A pharmacy recommendation, dated July 2024, recommended to complete an AIMS assessment on the resident. The record lacked documentation that an AIMS assessment had been completed. During an interview, on 2/11/25 at 3:40 p.m., the Clinical Support nurse indicated the facility was unable to produce AIMS assessments for the resident. The AIMS assessment had not been completed. 2. Resident 5's record was reviewed on 2/11/25 at 3:22 p.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance (a condition where a person with dementia [a group of brain conditions that cause memory loss, thinking problems, and difficulty doing daily tasks] experiences a range of behavioral changes). An admission Minimum Data Set (MDS) assessment, dated 1/21/25, indicated the resident had severe cognitive deficit and received antipsychotic medication (drugs used to treat symptoms of psychosis [hallucinations: sights, sounds, smells, tastes, or touches that a person believes to be real but are not real, delusions: false beliefs], and dementia) on a routine basis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, dated 1/20/25, indicated the resident had a diagnosis of dementia with behaviors and was treated with antipsychotic medication. Intervention included, but were not limited to, observe for adverse side effects of medication. A physician order, dated 1/18/25, indicated to administer a 50 milligram (mg) tablet of Seroquel XR (extended-release antipsychotic medication) one time a day for diagnosis of unspecified dementia with other behavioral disturbance. The record lacked documentation that an AIMS assessment had been completed. During an interview, on 2/11/25 at 3:40 p.m., the Clinical Support nurse indicated the facility was unable to produce AIMS assessments for the resident. The AIMS assessment had not been completed. 3. Resident 15's record was reviewed on 2/11/25 at 3:27 p.m. The profile indicated the resident's diagnoses included, but were not limited to, dementia with agitation (a resident with the loss of cognitive functioning who becomes restless and worried and experienced the inability to settle down) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). An admission Minimum Data Set (MDS) assessment, dated 1/27/25, indicated the resident had no cognitive deficit and received antipsychotic medication (drugs used to treat symptoms of psychosis [hallucinations: sights, sounds, smells, tastes, or touches that a person believes to be real but are not real, delusions: false beliefs], and dementia) on a routine basis. A care plan, dated 1/27/25, indicated the resident had come from the hospital with an antipsychotic medication due to post operative (after surgery) hallucinations. Interventions included, but were not limited to, observe for adverse side effects of the medication. A physician's order, dated 2/6/25, indicated to administer a 25 milligram (mg) tablet of Seroquel (antipsychotic medication) with Special Instructions: To be given with a 50 mg tablet, for a total of 75 mg, two times a day. A physician's order, dated 2/6/25, indicated to administer a 50 mg tablet of Seroquel with Special Instructions: To be given with a 25 mg tablet, for a total of 75 mg, two times a day. The record lacked documentation that an AIMS assessment had been completed. During an interview, on 2/11/25 at 3:40 p.m., the Clinical Support nurse indicated the facility was unable to produce AIMS assessments for the resident. The AIMS assessment had not been completed. On 2/12/25 at 10:21 a.m., the Clinical Support nurse provided a document, with a review date of 12/17/24, titled, Guidelines for: Abnormal Involuntary Movement Scale (AIMS), and indicated it was the policy currently being used by the facility. The policy indicated, .Procedures: 1. A licensed nurse will complete an AIMS scale assessment on all residents on antipsychotic medications .3. The AIMS assessment will be repeated for residents taking antipsychotic medications every six (6) months or as needed for displaying symptoms 3.1-48(a)(3) (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-48(a)(5)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48226 Based on observation and interview, the facility failed to ensure employees were sanitizing hands while providing meal service during 1 of 2 dining observations, and the facility failed to ensure sanitary measures were maintained while obtaining temperature readings of prepared food with a food temperature measuring device during 1of 2 dietary food service observations. Findings include: 1. On 2/10/25 at 12:06 p.m. observed Dietary Assistant 18 assist a resident by repositioning her wheelchair and moving the chair closer to the table. The employee then obtained food for another resident and failed to sanitize his hands between residents. Observed several employees entering kitchen by touching the door handle and did not sanitize their hands before serving residents their meal. Observed Certified Nurse Aide (CNA) 19, serve food to residents and did not sanitize hands between residents. Observed CNA 19 entering the kitchen multiple times pushing on the door handle and did not sanitize hands before serving food to residents. Hand sanitizer was available in the dining area. Hand washing sink was available inside of the kitchen service area for employees to use. On 2/11/25 at 11:30 a.m., during interview the Clinical Nurse Consultant acknowledged the employs did not need to touch the kitchen door to open it as it had a push bar on the door and employees should sanitize between residents while serving food. On 2/13/2025 at 11:43 a.m., the Clinical Nurse Consultant provided a document titled, Guideline for Handwashing/Hand Hygiene, dated 2/9/17, and indicated it was the policy currently being used by the facility. The policy indicated, .1. All healthcare workers shall utilize hand hygiene frequently and appropriately .b. Before/after preparing/serving meals, drinks 2. On 2/18/25 at 11:36 a.m., during observation of food temperature testing with Dietary [NAME] (22), the employee tested the temperature of the meat and then tested the temperature of the other food items on the steam table and the cold food with a food temperature measuring device then wiped the device on a napkin. The employee failed to disinfect the temperature device between each food item. On 2/18/25 at 11:45 a.m., during interview employee 22, acknowledged she had not sanitized the temperature device between each food item. She acknowledged she should have sanitized the device and indicated she did not have any wipes available. On 2/18/25 at 11:47 a.m. during interview the Dietary Manager acknowledged the cook should have wiped the food temperature measuring device between each food item and wipes were available in the main kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/2025 at 1:29 p.m., the Clinical Nurse Consultant provided an undated document, titled, guidelines, and indicated it was the policy currently being used by the facility. The document indicated, .Equipment food-contact surfaces and utensils shall be cleaned as follows .3. Between uses with raw fruits and vegetables and with potentially hazardous food. 4. Before using or storing a food temperature measuring device 3.1-21(i)(1) 3.1-21(i)(3)