STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155834	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Willow Springs Care Center	2002 West 86th Street Indianapolis, IN 46260

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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. Based on observation, interview and record review, the facility failed to ensure the call system was within reach for 1 of 8 residents reviewed for accommodation of needs. Findings include: During an interview, on 4/30/25 at 10:43 a.m., Resident 8 indicated she was left wet and was not changed as often as she needed. During an observation, on 5/5/25 at 2:13 p.m., Resident 8 was sitting in her wheelchair in her room. She was alert and able to voice her needs. Resident 8 indicated she was wet and did not have the call light. The call light was not in view or reach of the resident. The resident indicated she was aware of when she needed to use the restroom. During an observation and interview, on 5/5/25 at 2:15 p.m., CNA 10 found the call light behind the resident and out of reach. CNA 10 indicated the call light was supposed to be left where the resident could reach it. The clinical record for Resident 8 was reviewed on 5/7/25 at 8:46 a.m. The diagnoses included, but were not limited to, hypertension, weakness, and hemiplegia and hemiparesis (weakness and paralysis on the left side) following cerebral infarction (stroke). A care plan, dated 3/26/25, indicated the resident had a communication problem and to leave the call light in reach of the resident. A care plan, dated 3/26/25, indicated Resident 8 had bladder incontinence related to a need for assistance with toileting due to impaired mobility. The care plan did not address leaving the call light in reach. A current facility policy, titled Call Lights: Accessibility and Timely Response, dated 2024 and received from the Executive Director on 5/6/25 at 12:14 p.m., indicated .Staff will ensure the call light is within reach of resident and secured, as needed This citation relates to Complaints IN00451279 and IN00451331. 3.1-3(v)(1)

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the ombudsman was notified after a discharge and there was documentation the bed hold policy was provided to a resident for 3 of 5 residents reviewed for hospitalization. (Resident 19, 173 and 27) Findings include: 1. The clinical record for Resident 19 was reviewed on 5/5/25 at 9:31 a.m. The diagnoses included, but were not limited to, cognitive communication deficit, muscle weakness, and vitamin D deficiency. A nursing progress note, dated 1/14/25, indicate the resident had jerking movements with coffee ground secretions in her mouth. The physician was notified, and the resident was sent to the hospital. There was no documentation the bed hold information was provided to the resident. A transfer form, dated 1/14/25, indicated the resident was transferred to the hospital due to jerking movements and coffee ground emesis. There was no documentation the bed hold information was provided to Resident 19 in the record. 2. The clinical record for Resident 173 was reviewed on 5/5/25 at 9:09 a.m. The diagnoses included, but were not limited to, respiratory failure with hypoxia, dysphagia, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). A nursing progress note, dated 4/20/25, indicated the residents' respiratory status was declining and Resident 173 was transferred to the hospital. There was no documentation the bed hold information was provided to the resident. A completed transfer form was not located in the resident's record. There was no documentation the bed hold information was provided to the resident in the record.3. The clinical record for Resident 27 was reviewed on 5/2/25 at 11:01 a.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, end stage renal disease, and major depressive disorder. a. Resident 27 was discharged from the facility on 10/30/24 and returned on 11/7/24. A document, titled Ombudsman Notice of Resident Discharges, for the month of October 2024, did not indicate the Ombudsman was not notified of Resident 27's discharge, as the resident was not identified on the notice. b. Resident 27 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. The electronic health record did not indicate the bed hold policy had been given to Resident 27 at the time of the transfer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/5/25 at 10:24 a.m., Clinical Support 2 indicated transfer forms and bed hold policies were filled out and sent to the hospital with the residents. Staff did not document in the electronic health record the forms were given to the residents at the time of transfer. During an interview, on 5/5/25 at 10:22 a.m., the Director of Nursing (DON) indicated she was not sure if the ombudsman was notified. During an interview, on 5/5/25 at 10:24 a.m., Clinical Support 2 indicated Resident 27 was not on the ombudsman notification list for the month of October 2024. A document, titled Family of Social Service Administration, last updated October 2024, indicated .Dear Nursing Home Administrator: As you know, CMS requires nursing facilities to notify the Long-Term Care (LTC) Ombudsman of the majority of residents' transfers and discharges .When a resident is transferred on an emergency basis to an acute care facility and expected to return, the SLTCO must be notified. Information from facilities regarding emergency transfers should be provided in a monthly list to the SLTCO, which should include residents' names, dates of transfer, facilities to which residents were transferred, and reasons for the transfers A current facility policy, titled Bed Hold Notice, dated as last revised 2025 and received from the Executive Director (ED) on 5/6/25 at 12:14 p.m., indicated .It is the policy of this facility to provide written information to the resident and/or the resident representative regarding the bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave .The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative A current facility policy, titled Transfer and Discharge, dated as last revised 2025 and received from the ED on 5/6/25 at 12:14 p.m., indicated .The facility will maintain evidence that the notice was sent to the Ombudsman .Provide notice of transfer and the facility's bed hold notice policy to the resident and representative as indicated .The Social Service Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman .such as in a list of residents on a monthly basis 3.1-12(a)(6)(A)(iv) 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was correctly coded for 3 of 3 residents reviewed for resident assessments. (Resident 38, 4 and 222) Findings include: 1. The clinical record for Resident 38 was reviewed on 5/2/25 at 11:45 a.m. The diagnoses included, but were not limited to, hypertension, end stage renal disease, and hyperlipidemia. An MDS assessment, dated 4/16/25, indicated Resident 38 did not receive dialysis. A nursing progress note, dated 5/2/25 at 11:45 a.m., indicated the resident did receive dialysis. During an interview, on 5/2/25 at 11:45 a.m., the MDS Coordinator indicated the resident did receive dialysis and the resident should have been marked as receiving dialysis on the MDS assessment. 2. During an observation and interview, on 4/30/25 at 3:05 p.m., Resident 4 was lying in her bed with bilateral bed rails in the raised position. Resident 4 indicated she used the bed rails to assist with bed mobility and for support when getting out of bed. The clinical record for Resident 4 was reviewed on 5/6/25 at 10:00 a.m. The diagnoses included, but were not limited to, morbid obesity, muscle weakness, and abnormalities of gait and mobility. An admission MDS assessment, dated 11/27/24, did not indicate bed rails were in use. A quarterly MDS assessment, dated 4/24/25, did not indicate bed rails were in use. Resident 4's care plans did not include interventions related to the use of bed rails. 3. During an observation, on 4/30/25 at 11:33 a.m., Resident 222 was lying in bed with bilateral bed rails in the raised position. The clinical record for Resident 222 was reviewed on 5/5/25 at 10:08 a.m. The diagnoses included, but were not limited to, insomnia, major depressive disorder, and anemia. An admission MDS assessment, dated 4/28/25, did not indicate bed rails were in use. Resident 222's care plans did not include interventions related to the use of bed rails. During an interview, on 5/6/25 at 9:20 a.m., the Director of Nursing (DON) indicated the residents' care plans would indicate the use of bed rails. A document, titled Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1. 20.1, indicated .nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-31(c)(1)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a new pre-admission screening and resident review (PASARR) was completed after the number of approved days expired for 1 of 1 resident reviewed for PASARR. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on [DATE] at 10:47 a.m. The diagnoses included, but were not limited to, bipolar disorder, post-traumatic stress disorder (PTSD), and autistic disorder. A notice of PASARR level I screen outcome, dated [DATE], indicated the PASARR level I determination was a temporary approval of 60 days. If you or your care provider thinks you need to stay longer than the number of approved days listed on the PASARR level I screen outcome which came with this letter, a nursing facility staff member must submit a new level I screen to Maximus. This must be completed by or before the last approved day. A new level 1 PASARR was not resubmitted after 60 days. During an interview, on [DATE] at 10:14 a.m., the Social Services Director (SSD) indicated a new PASARR was not completed. During an interview, on [DATE] at 10:16 a.m., the Minimum Data Set (MDS) Coordinator indicated the PASARR level I was completed but only approved for 60 days. The facility should have submitted another one. During an interview, on [DATE] at 12:02 p.m., a PASARR help desk staff member indicated a level of care determination would not trump the most recent level I PASARR. A PASARR level I with an approval period of 60 days must be followed up on and was no longer valid after 60 days. A new PASARR screening would need to be resubmitted. A current facility policy, titled Resident assessment - Coordination with PASARR Program, dated 2024 and received from Clinical Support 2, indicated .All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for a resident with a diagnosis of epilepsy who received medications for seizure control for 1 of 2 residents reviewed for comprehensive care plans. (Resident 23) Findings include: The clinical record for Resident 23 was reviewed on 5/2/25 at 10:47 a.m. The diagnoses included, but were not limited to, epilepsy with status epilepticus (seizures which are not well controlled and complicated by prolonged seizure events), aphasia following cerebral infarction (a language disorder following a stroke) and hemiplegia and hemiparesis following cerebral infarction (weakness and paralysis on one side of the body following a stroke). A quarterly Minimum Data Set (MDS) assessment, dated 3/27/25, indicated the resident had a diagnosis of seizure disorder or epilepsy. A physician's order, dated 4/17/25, indicated to give Depakote Sprinkles (a medication for seizures) 125 milligrams (mg) once a day for epilepsy. A physician's order, dated 4/17/25, indicated to give lacosamide (a medication for seizures) 200 mg twice a day for epilepsy. A physician's order, dated 4/17/25, indicated to give levetiracetam (a medication for seizures) 750 mg twice a day for epilepsy. A seizure care plan was not located in the resident's record. During an interview, on 5/6/25 at 2:34 p.m., the Director of Nursing indicated the resident previously had a seizure care plan in the facility's old system. A current facility policy titled, Comprehensive Care Plans dated 2025 and received from Corporate Support Nurse on 05/07/25 at 9:50 a.m., indicated, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan .that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality 3.1-35(a) 3.1-35(b)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to complete an elopement assessment accurately to ensure hazard risks were evaluated, analyzed, and interventions were implemented for 1 of 4 residents reviewed for accidents hazards. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on 5/2/25 at 10:47 a.m. The diagnoses included, but were not limited to bipolar disorder, post-traumatic stress disorder (PTSD), and autistic disorder. A hospital discharge report, dated 12/24/24, indicated the resident presented to the hospital with burns on her bottom. The resident's caregiver indicated the resident eloped from home frequently and had been gone for several days. A facility elopement assessment, dated 1/15/25, indicated the resident had no history of elopement or an attempted elopement while at home. A progress note, dated 1/16/25, indicated the resident's caregiver stated the resident eloped from home frequently and had been missing from home for several days. The resident came back home with burns on her bottom. During an interview, on 5/6/25 at 2:36 p.m., the Social Services Director (SSD) indicated the resident was not in the elopement book. The nurse completed the elopement assessment incorrectly and it should have indicated the resident did have a history of eloping at home. She was not aware the resident had eloped prior to coming to the facility. Moving forward, the facility needed to monitor Resident 35. A current facility policy, titled Elopements and Wandering Residents, dated 2024 and received from the Clinical Support Nurse 2 indicated .Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team 3.1-45(a)(1) 3.1-45(a)(2)

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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. Based on observation, interview and record review, the facility failed to ensure staff followed facility policy and procedure for reconciliation of controlled substances for 2 of 6 medication carts reviewed for controlled medications. (South and Southwest) Findings include: 1. During an observation of medication storage, on 5/5/25 at 1:33 p.m., the South medication cart had the following: a. A document, titled CONTROLLED SUBSTANCE SHIFT CHANGE COUNT RECORD, for February 2025, indicated: On 2/1/25, the form was missing the signature for the off-going nurse from 6:30 a.m. to 6:30 p.m. On 2/6/25, the form was missing the signature for the on-coming nurse from 6:30 a.m. to 6:30 p.m., and the off-going nurse from 6:30 a.m. to 6:30 p.m. On 2/9/25, the form was missing the signature for the on-coming nurse from 6:30 p.m. to 6:30 a.m. On 2/10/25, the form was missing the signature for the off-going nurse from 6:30 p.m. to 6:30 a.m., the on-coming nurse from 6:30 a.m. to 6:30 p.m., and the off-going nurse from 6:30 a.m. to 6:30 p.m. On 2/11/25, the form was missing the signature for the off-going nurse from 6:30 p.m. to 6:30 a.m. On 2/14/25, the form was missing the signature for the on-coming nurse from 6:30 p.m. to 6:30 a.m. On 2/15/25, the form was missing the signature for the off-going nurse from 6:30 p.m. to 6:30 a.m. There were an additional 5 missing signatures for the on-coming and/or off-going nurses from 2/22/25 to 2/28/25. b. A document, titled CONTROLLED SUBSTANCE SHIFT CHANGE COUNT RECORD, for April 2025, indicated: On 4/1/25, the form was missing the signature for the off-going nurse from 6:30 p.m. to 6:30 a.m., and the on-coming shift from 6:30 p.m. to 6:30 a.m. On 4/2/25, the form was missing the signature for the off-going nurse from 6:30 p.m. to 6:30 a.m. On 4/3/25, the form was missing the signature for the on-coming nurse from 6:30 p.m. to 6:30 a.m. On 4/4/25, the form was missing the signature for the off-going nurse from 6:30 p.m. to 6:30 a.m. On 4/18/25, the form was missing the signature for the off-going nurse from 6:30 a.m. to 6:30 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. A document, titled CONTROLLED SUBSTANCE SHIFT CHANGE COUNT RECORD, for May 2025, indicated: On 5/1/25, the form was missing the signatures for the off-going nurse from 6:30 p.m. to 6:30 a.m., the on-coming nurse from 6:30 a.m. to 6:30 p.m., and the off-going nurse from 6:30 a.m. to 6:30 p.m. On 5/2/25, the form was missing the signature for the on-coming nurse from 6:30 p.m. to 6:30 a.m. On 5/3/25, the form was missing the signature for the off-going nurse from 6:30 p.m. to 6:30 a.m. 2. During an observation of medication storage, on 5/5/25, the Southwest medication cart had the following: a. A document, titled CONTROLLED SUBSTANCE SHIFT CHANGE COUNT RECORD, for May 2025, indicated: On 5/2/25, the form was missing the signature for the on-coming nurse from 6:30 p.m. to 6:30 a.m. On 5/3/25, the form was missing the signature for the off-going nurse from 6:30 p.m. to 6:30 a.m. During an interview, on 5/5/25 at 1:51 p.m., LPN 6 indicated staff were supposed to count the narcotics with the other nurse and sign the narcotic log before they left their shift and when they came on shift. A current facility document, titled CONTROLLED SUBSTANCE SHIFT CHANGE COUNT RECORD, undated and received from the Corporate Support Nurse 2 on 5/5/25 at 1:50 p.m., indicated .Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication is in agreement with the quantity stated on the Controlled Substance Shift Change Count Records A current facility policy, titled Controlled Substance Administration & Accountability, dated 2025 and received from the Executive Director on 5/6/25 at 12:14 p.m., indicated .two licensed nurses account for all controlled substances and access keys at the end of each shift 3.1-25(e)(2) 3.1-25(e)(3)

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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. Based on interview and record review, the facility failed to ensure baseline Abnormal Involuntary Movement Scale (AIMS) assessments were completed for evaluation of adverse reactions related to antipsychotic medication use for 2 of 5 residents reviewed for unnecessary medications. (Resident 4 and 222) Findings include: 1. The clinical record for Resident 4 was reviewed on 5/6/25 at 10:00 a.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia and major depressive disorder. A physician's order, dated 11/14/24, indicated Resident 4 was prescribed Latuda (an antipsychotic medication) 60 milligrams (mg) daily at bedtime. A care plan, dated 11/15/24, indicated Resident 4 used psychotropic medications with an intervention to monitor adverse reactions including, but not limited to, tardive dyskinesia (repetitive involuntary movements). Resident 4's assessments from 11/13/24 to 4/30/25 did not include a baseline AIMS assessment. 2. The clinical record for Resident 222 was reviewed on 5/5/25 at 10:08 a.m. The diagnoses included, but were not limited to, insomnia and major depressive disorder. A physician's order, dated 4/24/25, indicated Resident 222 was prescribed Aripiprazole (an antipsychotic medication) 10 mg daily. A physician's order, dated 4/30/25, indicated to monitor for side effects of antipsychotic medications, including but not limited to, EPS (extrapyramidal symptoms), which could include involuntary movements. A care plan, dated 4/24/25, indicated Resident 222 was on antipsychotic therapy related to major depressive disorder with an intervention to monitor side effects of the medication. Resident 222's assessments from 4/23/25 to 5/5/25 did not include a baseline AIMS assessment. During an interview, on 5/5/25 at 3:30 p.m., the Director of Nursing indicated an AIMS assessment was not completed upon admission for Resident 4 or Resident 222. A current facility policy, titled Use of Psychotropic Medication(s), dated as last revised 2025 and received from the Executive Director on 5/6/25 at 12:14 p.m., indicated .Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement scale (AIMS) test performed when indicated .The effects of the psychotropic medications on a resident's physical, mental and psychosocial well-being will be evaluated on an ongoing basis, such as .Upon physician evaluation (routine and as needed) .During MDS review .In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice (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)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155834	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Willow Springs Care Center	2002 West 86th Street Indianapolis, IN 46260

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were stored in their original packaging, open dates were placed on medications, and discontinued medications were removed from the cart for 2 of 3 medication carts reviewed for medication storage. (200-unit and 300-unit) Findings include: 1. During an observation, on [DATE] at 1:19 p.m., with RN 8, the 200-unit medication cart had the following: a. one bottle of latanoprost 0.005% eye drops without an open date. b. one bottle of liquid protein 30 ounces opened without a resident's name. c. 19 pills not in a package loose in the drawers. During an interview, on [DATE] at 1:26 p.m., RN 8 indicated the eye drops should have had an opened date, and the liquid protein was for a resident who had discharged . She was supposed to give the liquid protein to the resident at discharge, or it should have been discarded. During an interview, on [DATE] at 1:45 p.m., the Corporate Support Nurse 2 indicated there should not be free (unpackaged) pills in the cart. 2. During an observation, on [DATE] at 1:59 p.m., with LPN 6, the 300-unit north cart had the following: a. one bottle of latanoprost 0.005% eye drops without an open date. b. one bottle of olopatadine 0.1% eye drops without an open date. c. one bottle of carboxymethylcellulose eye drops without an open date. At that time, LPN 6 indicated the resident had discharged from the facility and the medication should have been removed from the cart. d. one bottle of moxifloxacin 0.5% eye drops without an open date. The medication had a discontinued date of [DATE]. LPN 6 indicated the medication had been discontinued. e. one container of potassium chloride 10% solution without an open date. f. one container of lactulose without an open date. g. 16 pills not in a package loose in the drawers. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] at 2:07 p.m., LPN 6 indicated staff were supposed to place open dates on the medications when they were opened. A current facility policy, titled Medication Administration, dated 2025 and received from Corporate Support Nurse 2 on [DATE] at 1:25 p.m., indicated .All unused, contaminated, or expired prescription drugs shall be disposed of A current facility policy, titled Labeling of Medications and Biologicals, dated 2025 and received from the Executive Director on [DATE] at 12:14 p.m., indicated .All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications 3.1-25(j) 3.1-25(o) 3.1-25(p) 3.1-25(r)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure enhanced barrier precautions (EBP) signs were posted, Personal Protective Equipment (PPE) was available and worn, and medications were prepared in a sanitary manner for 3 of 3 residents reviewed for infection control. (Resident 47, 6 and 10) Findings include: 1. During an observation, on 5/2/25 at 10:35 a.m., LPN 6 was observed to provide wound care to the pressure wound on the back of Resident 47's left upper thigh. LPN 6 was observed to clean the wound, starting in the center of the wound bed and moving outward. She was observed to move back into the wound bed using the same gauze dressing to finish cleaning the wound. She was not observed to discard the dressing and use a new gauze dressing when she returned to the wound bed to clean it. After cleaning the wound, LPN 6 was observed to use a towel, which was on the bedside table, to pat dry the wound. She completed the wound care and secured a dressing to the area. LPN 6 was not observed to wear a gown at any time during wound care. The clinical record for Resident 47 was reviewed on 5/1/25 at 11:01 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), back pain, and obesity. A physician's order, dated 5/1/25, indicated .Enhanced Barrier Precautions: Sign outside resident's room. Gown and Gloves for high contact resident care activities. Used for residents with known MDRO or have an increased risk of MDRO acquisition (Residents with wounds or indwelling medical devices). Face shield should be used for any tasks that have a high potential of splash or spray The care plans for Resident 47 did not address the use of enhanced barrier precautions. During an interview, on 5/2/25 at 11:08 a.m., LPN 6 indicated the wound was supposed to be cleaned from the inside to the outside. A EBP sign was not posted, and she was not aware of the PPE which should be used for enhanced barrier precautions. During an interview, on 5/2/25 at 11:09 a.m., the Director of Nursing indicated there was not a sign posted, related to Resident 47's enhanced barrier precautions, a sign was there. The nurse was not aware of the enhanced barrier precautions in place. The Director of Nursing indicated she would replace the sign. 2. During an observation, on 5/6/25 at 8:26 a.m., RN 8 was observed preparing medications for Resident 6. During the preparation of the medications the nurse was observed dropping one tablet onto her medication cart. She picked up the medication with her fingers and put the pill into the medication cup. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/6/25 at 8:31 a.m., RN 8 indicated she picked up the pill with her fingers after it had fallen on the medication cart surface. It was not the correct infection control procedure, and she should have replaced the medication.3. During an observation and interview, on 4/30/25 at 10:29 a.m., Resident 10 was in her room, lying in bed. Wound supplies, which consisted of Betadine, Sure prep wipes, sterile water, and absorbent dressings were sitting on top of the dresser. Resident 10 indicated she had wounds on her vagina and butt. She indicated the staff did treatments on the wounds. When asked if the nurses wore gowns and gloves while performing treatments on her wounds, Resident 10 replied no, they only wear gloves. No EBP sign was observed on the resident's door or in her room and PPE was not observed outside of the resident's room. The clinical record for Resident 10 was reviewed on 5/2/25 at 1:31 p.m. The diagnoses included, but were not limited to, type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting the right side, and lack of coordination. A physician's order, dated 4/29/25, indicated wound care was to be completed every day. A physician's order, dated 5/1/25, indicated Resident 10 was placed on EBP. The order indicated a sign needed to be outside the resident's room and a gown and gloves were to be worn for high contact resident care activities. The order for wound care to be completed daily was started three days before the order for EBP. Resident 10's care plans did not include EBP at the time the care plan for her pressure ulcer was initiated on 3/31/25. The discontinued orders, for Resident 10, indicated EBP had not been ordered, at any time, prior to 5/1/25. During an interview, on 5/5/25 at 11:07 a.m., Clinical Support 3 indicated EBP orders would be initiated when a wound had started and the order for EBP should have been initiated before 5/1/25. During an interview, on 5/7/25, the Infection Preventionist (IP) indicated a resident would need EBP if they had wounds. A sign would be posted on the resident's door and an EBP cart for PPE supplies would be outside of the resident's room. A current facility document, titled Validation Checklist Wound Care, indicated .Reviewed physician's order . donned appropriate personal protective equipment .Cleanse wound thoroughly .taking care not to contaminate other skin surfaces or other surfaces of the wound A current facility policy, titled Destruction of Unused Drugs, dated 2025 and received from Corporate Support Nurse 2 on 5/7/25 at 1:25 p.m., indicated .taking care not to touch medication with bare hands (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Enhanced Barrier Precautions, dated as last revised 2025 and received from Clinical Support 2 on 5/7/25 at 3:32 p.m., indicated .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .[Enhanced barrier precautions] (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .An order for enhanced barrier precautions will be obtained for residents with any of the following . Wounds .Enhanced barrier precautions should be used .until resolution of the wound A current facility policy, titled Personal Protective Equipment, dated as last revised May 2024 and received from the ED on 5/6/25 at 12:14 p.m., indicated .All staff who have contact with residents and/or their environments must wear person protective equipment as appropriate during resident care activities and at other times which exposure to blood, body fluids .is likely .Gloves .Wear gloves when direct contact with blood, body fluid .non-intact skin .is anticipated .Gowns .Wear gowns to protect arms, exposed body areas, and clothing from contamination with blood, body fluids A current facility policy, titled Infection Prevention and Control Program, undated and received from the ED upon entrance, indicated .All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE 3.1-18(b)(1)(A) 3.1-18(b)(2)