STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155836	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Trace Health & Living Community	1925 Reeves Road Plainfield, IN 46168

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement an advanced directive (code status) order for 1of 1 residents reviewed for advanced directives. Findings include: On [DATE] at 9:30 a.m., Resident 205's record was reviewed. He had the following diagnoses which included but were not limited to heart failure, weakness, type 2 diabetes mellitus, and Alzheimer's disease. Resident 205's record lacked an order for an advance directive. His profile indicated he desired to have cardiopulmonary resuscitation (CPR). His care plan dated [DATE] indicated he desired to have CPR. During an interview with the Director of Nursing on [DATE] at 10:53 a.m., he indicated this was an order they missed and they would be doing a Quality Assurance Performance Improvement (QAPI) plan for missed advanced directive orders. A policy was provided by the DON on [DATE] at 1:30 p.m. It indicated, The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. 3.1-4(d) 3.1-4(e) 3.1-4(f) 3.1-4(l)(4)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observations, interviews, and record review, the facility failed to accurately assess 2 of 29 residents (Residents 53 and 15) reviewed for accurate Minimum Data Set (MDS) assessments. Findings include: 1. Resident 53's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to, Alzheimer's disease, dementia, unsteadiness on feet and difficulty walking. Resident 53 had an active order, dated 2/17/23, that indicated her activity level was up as tolerated. A progress note, dated 11/10/24, indicated Resident 53 was found sitting on the floor in her bathroom. The note indicated the resident did not have any injuries or skin tears at that time. A progress note, dated 1/05/25, indicated Resident 53 was found sitting on the floor in her bedroom. The note indicated the resident complained of right foot pain. An Interdisciplinary Team (IDT) note, dated 1/6/25, indicated no injuries were noted at the time of the fall on 1/5/25. A progress note, dated 1/6/25, indicated Resident 53 complained of right pinky toe pain. A progress note, dated 1/8/25, indicated Resident 53 had no new wounds or injuries. In Resident 53's most current MDS assessment, dated 3/2/25, the section titled, Number of falls since admission/entry or reentry or prior assessment whichever is more recent, indicated the Resident had no falls without injury and one fall with injury. 2. On 5/19/25 at 1:50 p.m., Resident 15 indicated she was continent of bowel and bladder, but sometimes it took a long time for the staff to help her use the bathroom because she needed to use the stand up lift which required two staff members. Resident 15 indicated sometimes she had an accident because she had to wait so long. Resident 15's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to, muscle weakness, tremors, difficulty walking and Urinary Tract Infections (UTI). A progress note dated 12/19/24 indicated Resident 15 was continent of bowel and bladder. A progress note dated 1/30/25 indicated Resident 15 was continent of bowel and bladder. A progress note dated 3/10/25 indicated Resident 15 was occasionally incontinent of bowel and bladder. A progress note dated 3/11/25 indicated Resident 15 was continent of bowel and bladder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 3/23/25 indicated Resident 15 was continent of bowel and bladder. During an interview on 5/21/25 at 10:33 a.m., Qualified Medication Aide (QMA) 6 indicated Resident 15 was usually continent and will tell them when she needed to go to the bathroom. Occasionally she would be incontinent of bowl if she had diarrhea or she may have a small amount of urinary incomitance in the morning but most of the time she would tell them and was continent. In Resident 15's most current MDS assessment, dated 4/15/25, the section titled, Bladder and Bowel, indicated she was frequently incontinent of bladder, and frequently incontinent of bowel. On 5/20/25 the Director of Nursing (DON) indicated the facility did not had a specific policy for MDS assessments. They followed the Resident Assessment Instrument (RAI) manual.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On [DATE] at 10:19a.m., a record review was completed for Resident 216. He had the following diagnoses which included but were not limited to sleep apnea, heart failure, hypertension, and high cholesterol. He had a physician's order for cardiopulmonary resuscitation (CPR) dated [DATE]. His profile indicated he desired CPR. His record lacked a care plan indicating he desired CPR. On [DATE] at 10:53 a.m., during an interview with the Director of Nursing (DON), he indicated his care plan was missing and the facility would be doing a quality assurance performance plan. A guide titled, Care Planning Guide related to Minimum Data Set (MDS) Assessments was provided by the Executive Director (ED) on [DATE] at 2:11 p.m. It indicated, Initiate care comprehensive care plan. 3.1-35(a) Based on observation, interview, and record review, the facility failed to implement a care plan for history of Urinary Tract Infections (UTI) for a Resident (Resident 22) and for advanced directives for a resident (Resident 216) for 2 of 29 residents reviewed for care plan implementation. Findings include: 1. On [DATE] at 1:43 p.m., Resident 22's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to, type 2 diabetes, and pneumonia. A progress note dated [DATE], indicated Resident 22 was tearful, agitated, and complaining of pain and burning with urination and abdominal pain. A urine dip test (a test to see if a Resident has a UTI or not) was done and was negative. A progress note, dated [DATE] at 8:41 a.m., indicated Resident 22 was complaining of lower abdominal pain that radiated to her lower back A progress note, dated [DATE] at 12:58 p.m., indicated Resident 22 was still complaining of lower back pain. At this time there was a new order to collect a urine specimen. A progress note, dated [DATE] at 9:15 a.m., indicated Resident 22 was tearful and complaining of pain and needing more assistance than usual. The Resident indicated she wanted to go to the emergency room. The Nurse Practitioner (NP) was notified and immediately came to the resident's room to preform a urine dip test. The test was positive and indicated the resident did have a UTI. A progress note, dated [DATE] at 3:10 p.m., indicated Resident 22 was sent to the emergency room for uncontrolled pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital records indicated Resident 22 was diagnosed with Cystitis (a type of UTI affecting the bladder, bladder infection) and Pyelonephritis (a type of UTI affecting the kidneys, kidney infection). Resident 22's record lacked documentation of a care plan related to UTIs or a history of UTIs. On [DATE] at 1:00 p.m., the DON provided a copy of a discontinued care plan. The care plans problem was Resident has history of urinary tract infection. With a start date of [DATE] and a last reviewed or revised date of [DATE]. There was no discontinue date noted on the copy the DON provided.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy for wound management to ensure a resident, (Resident C) received effective and appropriate treatments to prevent a non-pressure wound from becoming infected which resulted in actual harm when Resident C's wound became infected and required a hospital re-admission with a hip replacement exchange of the femoral head and liner [the plastic or metal part that sits inside the socket] for 1 of 1 residents reviewed for non-pressure wounds. Findings include: During a confidential interview, it was indicated Resident C had a total right hip replacement, but while she was home recovering, she fell and sustained a second right hip fracture and several fractures in her left foot and ankle. The new hip fracture and left foot fractures were non-operable, and she was sent to the facility for rehabilitation. The wound on her right hip from her surgery was still healing with steri-strips in place and she had not experienced any complications with the incision site. At the hospital, Resident C used a bedside commode or the staff helped her with an extra-large bed pan and would elevate the head of her bed upright so it felt more like sitting on a toilet. The hospital also used a PureWick (non-invasive, external female catheter that [NAME] urine away from the patient and into a designated collection canister) to help keep any urine away from her incision. Resident C became concerned when she got to the nursing facility because the nursing facility put her in adult diapers and the surgical incision was left uncovered. Staff would not get Resident C up to go to the toilet, and she was left in soiled briefs for long periods of time. Resident C expressed her concern to the staff that she did not want the wound to get infected, but they still put her in briefs, and did not clean her well. Resident C told the staff she did not want to wear the adult diapers and that she would prefer to go to the toilet to keep her incision site clean. However, since staff had to use a Hoyer lift to transfer the resident, staff put her in a brief and she was left in a soiled brief for long periods of time while she waited for staff to help get her up. On 5/21/25 at 11:47 a.m., Resident C's medical record was reviewed. She was admitted to the facility on [DATE] for nursing care and rehabilitation with diagnoses which included, but were not limited to, post-surgical total right hip replacement, secondary non-operable right trochanter fracture, and several non-operative fractures in her left foot and ankle. A hospital discharge packet, dated 7/29/24, indicated Resident C had a periprosthetic (a medical term refers to something located or occurring near an artificial implant, specifically a prosthesis) fracture involving the right greater trochanter, after her total right hip arthroplasty (replacement). She was alert and oriented times four (oriented to person, time, place, and situation). Due to her recent hip replacement (which had been completed on 7/11/24), and the new fractures of the right trochanter and left foot, she was unable to walk, was totally dependent for bed mobility, and required physical therapy follow up for strengthening and endurance. During her hospital stay, she utilized a bedside commode and/or a bedpan for bowel elimination, and while in bed, utilized a PureWick. At the time of discharge on [DATE] Resident C's right hip surgical incision site, continues to appear to be healing well without erythema, [redness] swelling, tenderness, drainage or bleeding. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Hospital Discharge packet included a Clinical Liaison (CL) Assessment from the facility completed on 7/24/24 at 12:50 p.m. The Assessment noted Resident C was dependent with assist of 2 people for bed mobility due to her non-weight bearing status, had a healing hip incision from a total hip replacement with steri-strips intact and was at high risk for infection. A nursing admission assessment, dated 7/29/24 at 9:07 p.m., indicated Resident C had altered skin integrity related to her surgical incision from, right hip fracture repair. The assessment indicated she required surgical wound care. An admission nursing progress note, dated 7/29/24 at 9:37 p.m., indicated Resident C was alert and oriented times four. Her diagnoses included but were not limited to, .fractured right hip repair and a fracture of the left ankle. The left ankle fracture is reported to be non-repairable. Right hip dressing is clean, dry and intact. The record lacked initial and/or ongoing assessments and descriptions of the incision site. The record lacked documentation that a treatment order had been clarified with the doctor. The record lacked initial and/or ongoing wound care orders or notes. Resident C had a physician's order, initiated on 7/29/24, for Weekly head to toe skin inspection to be completed per licensed nurse. If any new areas are noted complete a Skin Integrity Event. Skin assessments were signed off with no new areas of concern on 7/30/24, 8/6/24, and 8/13/24. A nursing progress note, dated 7/30/24 at 10:24 p.m., indicated Resident C was alert and oriented, cooperative with caregivers, and able to use her call light to summon nursing assistance. The dressing to her right hip surgical incision was clean and dry. A comprehensive care plan, initiated on 7/30/24, indicated, Resident has surgical incision to Right Hip, potential for complications, with interventions which included, but were not limited to, provide treatment per MD order, and to report complications such as drainage, or signs of infection. The record lacked documentation of treatment orders for the surgical incision. An initial Physician Visit and Progress Note was dated 7/30/24 at 2:47 p.m. Resident C was seen for an initial assessment. The progress note lacked documentation or orders to address the resident's incision site. The note indicated, Skin: Visible skin is warm, dry, and intact. Additional details r/t [related to] the resident's skin condition to be noted in facility documentation. The record lacked documentation of related skin integrity conditions, specifically to her surgical incision. A comprehensive care plan, dated 7/30/24, indicated Resident C had specific needs related to their care, which was a part of the Certified Nursing Aide (CNA) assignment sheet. The CNA assignments/interventions for this plan of care included, but was not limited to, Resident is incontinent and continent of bladder and bowel .Resident is mechanical lift two person assist with transfers .Resident prefers a shower/bath on Tues/Fri day-shifts .Resident wears briefs/pull ups XXXL was non-weight bearing on her left side and only toe-touch weight bearing on her right side. The care plan lacked specifications or precautions related to the resident's surgical incision. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An occupational therapist (OT) daily noted, dated 7/30/24 at 10:24 a.m., indicated Resident C was totally dependent for putting on and removing her brief and peri-care. A nursing progress note, dated 7/31/24 at 10:01 p.m., indicated Resident C remained cooperative with care and therapies and the steri-strips to her right hip remained intact. A comprehensive care plan, dated 8/1/24, indicated, Resident is unable to independently perform late loss ADLs [activities of daily living] r/t [related to] right total hip arthroplasty and requires assistance/encouragement for bed mobility, transfers, toileting and eating. Interventions for this plan of care included, but were not limited to, providing assistive devices as needed. The care plan lacked description of the assistive devices needed such as bedpan, bedside commode, or other toileting options as had been her preference in the hospital. On 8/5/24 Resident C had a follow up appointment with her Orthopedic doctor where her lateral hip wound was noted to be healing nicely with no signs of infection. A nursing progress note, dated 8/11/24 at 7:33 p.m., indicated, Resident has drainage from her left hip incision [incision was on the right hip] with intact steri-strips, drainage has no foul odor and no noted redness or increased pain. The record lacked documentation of physician notification of the change of condition related to the drainage of her incision site. The record lacked documentation of a new Skin Integrity Event. The record lacked documentation of putting a treatment over the draining wound. A nursing progress note, dated 8/13/24 at 1:45 p.m., indicated Resident C's wound was noted to have yellowish drainage and slough at the incision site. The Nurse called and left a message with the Resident's Ortho Dr. A nursing progress noted, dated 8/13/24 at 2:01 p.m., indicated Resident C's Ortho office nurse called back and her next follow up appointment was moved up to 8/19/24 and a new order for an antibiotic was started. A nursing progress note, dated 8/13/24 at 8:41 p.m., indicated Resident C's infection did meet the McGreer Criteria with a wound infection of purulent draining, slough and pain. The outside MD office treatment for antibiotics was started. A nursing progress note, dated 8/14/24 at 11:16 a.m., indicated Resident C was seen by Pain Management Nurse Practitioner (NP) due to her increased pain in the right hip. An occupational Therapy (OT) daily note, dated 8/14/24 at 2:00 p.m., indicated upon the OT's arrival, Resident C had a soiled brief and required maximum assistance for hygiene and doffing/donning (removing and putting on) a new brief. Resident C told the OT her incision was infected. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 8/15/24 at 2:39 p.m., indicated, Resident continues to take antibiotic for right hip surgical wound. There is no noted odor or redness noted at incision site. Steri-strips are intact with noted dark blood drainage on them. Resident August Medication Administration (MAR) and Treatment Administration (TAR) records were reviewed and lacked documentation of a as needed (PRN) dressing change for the infected incision site. A late entry Pain Management NP progress note, created on 8/19/24 at 2:30 p.m., effective for a visit on 8/16/24 at 10:30 p.m., indicated, Resident C continued to have drainage from her right hip incision, but lacked additional description and or notification to her Ortho Dr. A Physical Therapy (PT) daily note dated 8/17/24 at 12:21 p.m., indicated Resident C's dressing on her right hip was soiled and needed to be changed. A nursing progress note, dated 8/17/24 at 2:08 p.m., indicated Resident C's left hip incision (incision was on the right) with drainage and foul odor. Antibiotics were used. The noted lacked documentation of a wound description and/or if the wound was improving or declining. The note lacked documentation that the MD or [NAME] Dr. were notified of the foul odor. A nursing progress note, dated 8/17/24 at 3:09 p.m., indicated Resident C's right hip continued to drain with a foul odor. The noted lacked documentation of a wound description and/or if the wound was improving or declining. The note lacked documentation that the MD or [NAME] Dr. were notified of the foul odor. A nursing progress note, dated 8/18/24 at 11:07 a.m., indicated Resident C's right hip continued to drain with a foul odor. The noted lacked documentation of a wound description and/or if the wound was improving or declining. The note lacked documentation that the MD or [NAME] Dr. were notified of the foul odor. A nursing progress note, dated 8/19/24 at 12:57 p.m., indicated Resident C went out for her Ortho follow up appointment but was sent to the emergency room and admitted for in hospital wound care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/23/25 at 11:28 a.m., Resident C's Ortho Dr. indicated Resident C had a total hip replacement that was done by him and his team, there were no complication pre or post op. She was cleared to go home for recovery but unfortunately fell and came back to the hospital where it was determined she sustained a new non-operative fracture on the trochanter hip bone, on top of where her new joint had been replaced. She also sustained several foot and ankle fractures on her left foot, which basically made her unable to move from the waist down. The Ortho Dr. indicated if an incision site looked good, steri-strip were clean/dry, and there was not drainage, patients were told to leave the wound open to air. In Resident C's condition however, due to her inability to easily get to the toilet on her own, and having to use a brief, it would be best practice and advisable to put a dry dressing on top of the wound to help protect it from urine or bowel contamination. Especially if the wound started to show new signs and symptoms of an infection, the Ortho office would expect the nursing staff to follow best practice of putting a cover on the draining wound, and to keep his office notified or new or worsening symptoms. Resident C's appointment was moved up to 8/19/24, but his office would have to rely on the facility's nursing judgement to call for worsening symptoms and the Ortho office could schedule a more urgent earlier appointment. When Resident C was seen again on the 8/19/24, the Ortho Dr. indicated her wound was clearly infected, and he recommended her to go back to the hospital for wound care and management. On 5/22/25 at 12:36 p.m., the Ortho Dr. provided a copy of his progress note from 8/19/24 which indicated, . she comes back today for a wound check . she notes that her dressings are not routinely changed, frequently been left sitting in her own feces and urine at her rehab facility . patient now has foul-smelling drainage from her right hip wound. We discussed the seriousness of this problem and recommended admission to the hospital where we will get wound care involved and likely proceed on Wednesday with an irrigation and debridement of her right hip incision. It is very concerning this may track all the way down to the implant During an interview on 5/23/25 at 12:41 p.m., the Pain Management NP indicated nursing staff should have ensured the wound was covered if it was draining and should have had some monitoring orders to watch for worsening signs/symptoms especially if the resident was incontinent because it was important to keep the wound as clean as possible. The NP indicated she remembered Resident C; she was alert, oriented, and cooperative with her care. A Hospital Summary Record, dated 8/19/24, indicated, . has foul smelling wound on her right hip with Steri-Strips in place. These were removed today. The central portion of the wound has a small volume of drainage and surrounding erythema and tenderness .Wound Site Assessment: Brown, tan, yellow, fragile. Peri-wound Assessment: Clean, dry, edema, blanchable erythema, pink. Wound Length (centimeters [cm]): 0. 7 cm. Wound Width: 14.5 cm. Wound Depth: 0.6 cm. Non-staged Wound Thickness: full thickness. Drainage amount: small. Drainage description: tan. Slough %: 100%. Signs and symptoms of infection present, mild odor On 8/21/24 Resident C underwent a second surgery for head and linear exchange, (this procedure describes a revision total hip arthroplasty where the femoral head and liner [the plastic or metal part that sits inside the socket] are exchanged). Cultures of the wound were taken three bacterial infections were noted: 1. Enterobacter cloacae complex, (ECC) (a group of closely related Enterobacterales species that are significant hospital-acquired pathogens) 2. Klebsiella Pneumoniae (a gram-negative bacteria that typically cause nosocomial infections and shows a great deal of antibiotic resistance) 3. Porphyromonas somerae (a is a Gram-negative and anaerobic bacterium). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/22/24 at 12:15 p.m., the Director of Nursing (DON) provided a copy of current facility policy titled, Wound Management, dated 2/1/19. The policy indicated, [NAME] and Associates, Inc. is committed to providing quality of care to our residents by implementing clinical guidance and best practice for management of wounds and other skin conditions throughout a resident's stay in our [NAME] communities . The skin conditions that the Wound Team should evaluate include, but are not limited to . new admission with any skin conditions documented on admission such as; post-operative sites, amputations, sutures, staples, etc . any other skin condition that had the potential to worsen without adequate management . the Interdisciplinary team (IDT) will document the wound assessment weekly in the medical record. Additional documentation can be inserted into the medical record using the progress notes. Each week a skin condition will be documented as: (1) improved, (2) unchanged; or (3) worsened . Skin conditions worsened: notify MD, family and staff . determine if the physician ordered treatment has been evaluated for effectiveness, modified, or changed as appropriate and/or needed On 5/22/25 at 1:05 p.m., the DON provided a copy of current facility policy titled, Change in a Resident's Condition or Status, revised October 2010. The policy indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition . except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status . On 5/22/25 the DON provided a copy of current facility policy titled, Enhanced barrier precaution Policy & Procedure, revised 4/1/24. The policy indicated, . Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). EBP employs targeted gown and glove use during high-contact resident activities . indication for Enhanced Barrier Precautions: Use of EBP is indicated for resident with . any skin opening requiring a dressing such as for chronic wounds* (e.g. pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) This deficiency relates to Complaint IN00459740. 3.1-37(a)

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	155836	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Trace Health & Living Community	1925 Reeves Road Plainfield, IN 46168

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. A. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents for a resident (Resident 60) who had a history of falls with injury, by ensuring appropriate interventions were in place after she moved to a new room which resulted in actual harm, after she rolled out of bed and sustained an arm fracture for 1 of 9 residents reviewed for accidents; and failed to implement new interventions to prevent the potential for accidents for 2 of 9 residents reviewed for accidents (Residents 30 and 64). B. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when medications were found at bedside for residents without orders or assessments to self-administer their medications for 4 of 9 residents reviewed for accidents (Residents 41, 49, 22 and 2). Findings include: A1. On 5/21/25 at 9:26 a.m., Resident 60 was observed in her room. She was seated in her wheelchair, and a bandage was noted above her left eye which was bruised and had dried blood crusted around the edge of the bandage. She guarded her left arm, with it tucked close to her chest and held her left elbow with her right hand across her stomach. Resident 60 made grimaces and demonstrated a painful facial expression as she indicated she rolled out of her bed again. She did not know how or why, but she had a tendency to roll out of bed. This time she hit her head on the corner of her bedside table and hurt her left arm real bad. Resident 60's bed was observed. There were no side rails, or other bed-boundary devices in place. On 5/21/25 at 9:30 a.m., a contracted mobile x-ray technician came to Resident 60's room for a set of x-rays. The x-ray tech was able to obtain two views of her left shoulder. On 5/21/25 at 9:46 a.m., the x-ray technician spoke to the Unit Manager and indicated she was unable to obtain x-rays of Resident 60's forearm as she was unable to tolerate the movement and repositioning for the image. The x-ray technician informed the nurse there was evidence to suspect a humeral head fracture, but the radiologist would call as soon as possible to confirm. On 5/21/25 at 10:56 a.m., the Nurse Practitioner (NP) was in to evaluate Resident 60. The NP indicated the x-ray results were confirmed and Resident 60 had sustained a humerus head fracture and the NP was trying to determine if she wanted to send the resident to the emergency room, or straight into an orthopedic clinic. During an interview on 5/22/24 12:00 p.m., the Unit Manager indicated Resident 60 was sent to Ortho for evaluation and potential surgical repair. On 5/21/25 at 11:37 a.m., Resident 60's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, unspecified dementia, history of fall with fracture, anxiety and weakness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note, dated 3/26/25 at 12:00 p.m., indicated Resident 60 self-reported a fall to one of her peers who then notified the nursing staff. The nurse interviewed the resident regarding the fall but she stated she couldn't remember what happened, all she could remember was she was in lying in bed and the next thing she knew she was on the ground. Resident 60 complained of back pain and on skin assessment two bruises were found to her outer right thigh. An Interdisciplinary Team (IDT) note, dated 3/27/25 at 2:39 p.m., indicated the root cause of Resident 60's fall was that she rolled out of bed so the IDT team agreed to install side rails for assistance. Resident 60 had a comprehensive care plan, dated 4/16/2020, which indicated she was at risk for falls. Interventions for this plan of care included, but were not limited to, bilateral side rails on her bed. A nursing progress note, dated 5/21/25 at 8:36 a.m., indicated Resident 60 was found on the floor in her room with a laceration above her left eyebrow and complained of pain in her left arm. She was cradling her arm due to pain and reported her pain level was 10/10. During an interview on 5/21/25 at 10:58 a.m., Unit Manager indicated Resident 60 had been in another hall and was moved into memory care prior to the Unit Manager's arrival as manager. If she had side rails on her bed in her previous room, then side rails should have been installed on the bed in her new room, or another intervention should have been considered if side rails were no longer appropriate. During an interview on 5/22/25 at 11:03 a.m., the Executive Director (ED) indicated Resident 60's side rails should have followed her over to her new unit until it was determined if she still needed them or another intervention should replace it. A2. On 5/20/25 at 12:14 p.m., Resident 30's medical record was reviewed. She was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, unspecified dementia, weakness, and repeated falls. A nursing progress note, dated 2/19/25 at 6:07 a.m., indicated Resident 30 had a fall in the hallway when she went to look for assistance due to incontinence. The fall was unwitnessed and she was found in the hall by the storage room screaming out, and laying on her left side. Resident 30 winced at pain in her right wrist and hip. An x-ray was ordered for her right hip and wrist. The x-ray results were received and confirmed a right hip fracture. Resident 60 was sent to the emergency room for evaluation and treatment. An IDT progress note dated 2/19/25 at 9:52 a.m., indicated the root cause of the fall determined Resident 30 lost her balance self-ambulating. The immediate intervention had been to obtain an x-ray, but the note lacked documentation of a new intervention to be put in place related to the root cause of the fall upon her return from the hospital. Resident 30 had a comprehensive care plan, dated 5/3/22, which indicated she was at risk for falls and fall related injuries. An intervention created 9/8/22 indicated, staff is to walk with resident. The care plan lacked revision of a new intervention after her fall on 2/19. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A3. On 5/20/25 at 10:05 a.m., Resident 64's record was reviewed. He was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, vascular dementia, repeated falls with a history of fall with fracture. A nursing progress note, dated 1/19/25 at 7:51 p.m., indicated Resident 64 had been found on the floor lying on his right side next to the toilet in his bathroom. He had been put to bed earlier, but sometimes got up and tried to ambulate around the room. Resident 64 complained that he hurt all over. He was assisted back to bed and the MD was notified. A nursing progress note, dated 1/20/25 at 9:20 a.m., indicated Resident 64 had increased pain, was unable to bear weight on his right hip, and had decreased range of motion. The NP was notified and a STAT x-ray was ordered. A re-admission NP progress note, dated 1/27/25 at 4:23 p.m., indicated Resident 64 was being seen for follow up after he sustained a fall on 1/19/25 which resulted in an acute right femoral neck fracture. Ortho was consulted and the Resident underwent right femur fracture repair before he was discharged back to the facility. Upon his re-admission, the record lacked documentation of IDT fall follow up and any new interventions to prevent the potential for similar falls in the future. During an interview on 5/21/25 at 11:15 a.m., the DON indicated he could not find IDT follow up or new root-cause interventions which should have been put in place after Resident 30 and 64's falls. On 5/21/25 at 11:30 a.m., the DON provided a copy of current facility policy titled, Fall Prevention Policy and Procedure, dated 5/2016. The policy indicated, .strategies to prevent falls are unique for each community. Each fall risk factor is unique for every resident . A narrative IDT note will include a root cause explanation with new intervention strategy to prevent reoccurrence B1. On 5/16/25 at 10:10a.m., silva, 2% miconazole nitrate (mico) 025% triamcinolone (triam) cream (treats skin conditions involving fungal infection and inflammation) was observed on Resident 41's nightstand. On 5/20/25 at 11:42 a.m., silva 2% mico 025% triam cream was observed on Resident 41's nightstand. On 5/21/25 at 11:00 a.m., a record review was completed for Resident 41. He had the following diagnoses of pressure ulcer stage 3 (full thickness skin loos with fat visible) on the buttock, history of diabetic foot ulcer, chronic kidney disease, and hypertension. Resident 41 had an order for silva 2% mico 025% triam cream, dated 4/28/25, to apply to bilateral (both) buttocks, scrotum, peri area three times daily. B2. On 5/16/25 at 10:15 a.m. trelegy (an inhaler) and AZO (a medication to help relieve symptoms of a urinary tract infection (UTI)) were observed sitting on Resident 49's bedside. On 5/21/25 at 11:12 a.m., observed trelegy and AZO on Resident 49's bedside. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/21/25 at 11:30 a.m., a record review was completed for Resident 41. She had the following diagnoses which included but were not limited to anxiety, fracture of the right fibula, vitamin deficiency, chronic respiratory failure, and depression. She had an order for Trelegy Ellipta (fluticasone umeclidin-vilanter) blister with device, 100-62.5-25mcg (micrograms) 1 puff (inhalation) once a day. She did not have orders for AZO. B3. On 5/16/25 at 10:35 a.m. Resident 22 was observed as she lay in her bed resting with her eyes closed. She was in and out of sleep, hard to understand, slightly confused and groggy. There was a medication cup with multiple unidentified pills in it sitting on her bedside table. She did not answer appropriately when asked if she forgot to take the medications or when they were given to her. Qualified Medication Aide (QMA) 2 indicated that the resident had just got back from the hospital not too long ago. She indicated she normally sat there and waited for the resident to take her medications, but today she left them because the resident took a few pills and then said she would do the rest herself. QMA 2 tried to wake the resident up and ask her if she wanted her pills crushed or whole. Resident 22 stated she wanted to take them whole, but then fell back asleep. QMA 2 went to get a spoon to help the Resident take the medications. QMA 2 gave Resident 22 her medications one by one with a spoon without complication, but the resident had trouble staying awake to take her medications. Resident 22's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to, type 2 diabetes, and pneumonia. The medical record indicated Resident 22 had a Brief Interview for Mental Status (BIMS) score of 11 indicating she had moderate cognitive impairment. Resident 22's assessments were reviewed. The record lacked documentation of an up-to-date self-administration assessment for medications for Resident 22. B4. On 5/16/25 at 11:39 a.m. Resident 2's room was observed. The resident was not in the room at this time, a medication organizer with pills in the Friday, Saturday, and Sunday slots were observed on the Residents windowsill. Resident 2's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to dementia and dysphagia. The medical record indicated Resident 2 had a BIMS score of 4 indicating she had severe cognitive impairment. Resident 2's assessments were reviewed. The record lacked documentation of a self-administration assessment for medications for Resident 2. On 5/19/25 at 3:30 p.m. the Executive Director (ED) provided a copy of a current facility policy titled, Administration of Tablets and Capsules, undated. This policy indicated .All oral medications are safely and appropriately administered by a licensed nurse, approved designee or the resident capable of self-administration ., .16. Remain with the resident to ensure that the medication is swallowed . 3.1-45(a) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3.1-45(b)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observations, interviews, and record review, the facility failed to ensure a Peripherally Inserted Central Catheter (PICC) line was dressed properly to prevent infection for 1 of 1 residents (Resident 22) reviewed for PICC line dressings. Findings include: On 5/19/25 at 1:50 p.m. Resident 22 was observed as she sat up in her wheelchair visiting with her family. Resident 22 was able to lift her arm and show where her PICC line was. The PICC line had a clean dry and intact dressing dated 5/13 and initialed. The dressing was a clear tegaderm (a clear sticky film often used to cover different intravenous (IV) lines) with a 2 by 2 spilt gauze (a 2 inch by 2 inch gauze pad that is split down the middle half way) underneath the tegaderm with the split laid on top of the catheter and insertion site. Th skin around the insertion site and the insertion site itself were completely covered and unable to be assessed because of the split gauze. On 5/20/25 at 2:25 p.m. Resident 22 was observed as she lay in bed resting. She was able to lift her arm and show where her PICC line was. The PICC line dressing had been changed and had only a clear tegaderm covering it. The insertion site and surrounding skin could easily be visualized, and the dressing was initialed and dated 5/20. On 5/19 at 2:30 p.m. the Executive Director (ED) provided a current facility procedure guide titled Changing IV PICC/Midline/Non-tunneled/Tunneled Dressing Skills Validation undated. This procedure guide indicated, . 13. Cover insertion site and connection of the needle free system completely with the transparent dressing. Label the dressing, do not cover insertion site 3.1-47(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to date and label medications for 3 of 4 medication carts reviewed and 1 of 2 medication storage rooms reviewed. Findings include: 1. On 5/19/25 at 10:22 a.m., the 500-hall medication cart 1 was observed. Resident 54 had an albuterol inhaler with just his name on it. 2. On 5/19/25 at 10:30 a.m. the 500-hall medication room was observed. There was a vial of Aplisol (tuberculosis testing serum) with no date on it. It was sent from the pharmacy on 3/4/25. 3. On 5/19/25 at 10:45 a.m., the 600-hall medication cart 2 was observed. The cart had an albuterol inhaler with a spacer with no name or date on the inhaler. Resident 38 had an inhaler, albuterol, with no date to indicate when it was opened. Resident 70 had a bottle of fluticasone spray with no date to indicate when it was opened. Resident 40 had a bottle of fluticasone spray with no date to indicate when it was opened. 4. On 5/19/25 at 10:59 a.m., the 600-hall medication cart 1 was observed. Resident 16 had an albuterol inhaler with no date to indicate when it was opened. During an interview with the Director of Nursing (DON) on 5/23/25 at 10:53 a.m., he indicated that the carts were audited and they would continue to be audited through quality assurance performance improvement. A policy titled, Drug Storage, was provided by the Executive Director (ED) on 5/19/25 at 3:30 p.m. It indicated, .Insulin and PPD (tuberculosis (TB)) vaccine and other multi-dose vials requiring refrigeration need to be dated when opened. All vials should be discarded within 28 days of the open date .