STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Dyer LLC	1532 Calumet Avenue Dyer, IN 46311

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43293 Based on observation, record review and interview, the facility failed to ensure residents who were left to complete nebulizer treatments independently had been assessed for safe self-administration for 1 of 4 residents reviewed for respiratory services. (Resident 29) Finding includes: During a random observation on 4/21/25 at 11:40 a.m., Resident 29 was observed sitting alone in his room. A nebulizer treatment was in progress via a face mask. He removed the face mask and put it in the drawer of his nightstand. At that time, the resident indicated the staff did not stay in the room while he received the nebulizer treatments. They would initiate the treatment, and when he thought it was done, he would remove the mask and put it in his drawer. The resident's record was reviewed on 4/23/25 at 2:57 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia (low oxygen levels), and dementia. The 4/10/25 Quarterly MDS (Minimum Data Set) assessment, indicated the resident had moderate cognitive impairment, and required partial/moderate assistance with activities of daily living and transfers. The 1/27/25 Self Administration Assessment did not indicate the resident was safe to self-administer nebulizer treatments. There was no physician's order for the resident to self-administer nebulizer treatments. During an interview on 4/24/25 at 11:57 a.m., the DON (Director of Nursing) indicated the resident had not been evaluated for self-administration of nebulizers. A policy titled Self Administration of Medications and Treatments, received as current from the DON on 4/28/25 at 3:31 p.m. indicated, . Self administration of medications and treatments is determined by physician order after determining that the resident is able to self administer . 3.1-11(a)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 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. 10326 Based on record review and interview, the facility failed to ensure the physician was notified of elevated blood sugars, blood pressure medications and insulin being held, and medication refusals for 3 of 3 residents reviewed for notification of change. (Residents 52, 154, and 264) Findings include: 1. The record for Resident 52 was reviewed on 4/24/25 at 3:03 p.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage renal disease. The Admission Minimum Data Set (MDS) assessment, dated 3/2/25, indicated the resident was cognitively intact. A Physician's Order, dated 3/20/25, indicated the resident was to receive Lantus insulin, 25 units subcutaneously (injecting a medication into the fatty tissue layer beneath the skin) at bedtime. The Physician was to be notified if the resident's blood sugar level was less than 60 or greater than 400. The March 2025 Medication Administration Record (MAR) indicated the resident's blood sugar was 425 on 3/20/25 at 9:00 p.m. On 3/21/25 at 9:00 p.m., the resident's blood sugar was 433. There was no documentation indicating the physician and/or the nurse practitioner (NP) were notified of the blood sugars greater than 400. During an interview on 4/29/25 at 2:09 p.m., the Director of Nursing indicated the physician and/or the NP were not notified of the resident's blood sugars above 400 on 3/20/25 and 3/21/25. 2. The record for Resident 154 was reviewed on 4/23/25 at 11:34 a.m. Diagnoses included, but were not limited to, dementia with mood disturbance, type 2 diabetes, hypertension, and acute kidney failure. The Admission Minimum Data Set (MDS) assessment, dated 4/14/25, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 4/12/25, indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) 5 milligrams (mg) by mouth three times a day for hypotension (low blood pressure). There were no blood pressure parameters indicating when the medication should be held. The April 2025 Medication Administration Record (MAR), indicated the resident's blood pressure was 132/79 on 4/19/25 at 9:00 a.m. and 145/69 at 5:00 p.m. The Midodrine was not given at 9:00 a.m. and 5:00 p.m. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation indicating the physician and/or the nurse practitioner (NP) were notified of the medication being held. During an interview on 4/24/25 at 12:00 p.m., the Director of Nursing indicated the physician and/or the NP should have been notified that the Midodrine was held. 43293 3. Resident 264's record was reviewed on 4/23/25 at 10:58 a.m. Diagnoses included, but were not limited to, CHF (congestive heart failure) and diabetes. The 4/12/25 Admission Minimum Data Set (MDS) assessment indicated the resident had mild cognitive impairment and was dependent for activities of daily living and transfers. A Physician's Order, dated 4/6/25, indicated Insulin Lispro (a fast-acting insulin) 18 units before meals. There were no parameters for holding the insulin. The April 2025 Medication Administration Record (MAR) indicated the resident refused the morning dose of insulin on 4/14/25. The nurse held the 4/16/25 evening insulin dose when the resident's blood sugar was 70. There was no documentation indicating the physician was informed of the insulin doses not given. During an interview on 4/25/25 at 1:00 p.m., the Director of Nursing indicated the staff should have informed the physician of the refused and held doses of insulin. 3.1-5(a)(3)

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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. 32788 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to terminal prognosis and hospice care for 1 of 27 MDS assessments reviewed. (Resident 44) Finding includes: Resident 44's record was reviewed on 4/28/25 at 10:05 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and Alzheimer's disease. The Quarterly MDS assessment, dated 4/9/25, indicated the resident had not received hospice care and did not have a condition or chronic disease that may result in a life expectancy of less than six months. A Physician's Order, dated 10/4/24, indicated the resident was admitted to hospice services. A Care Plan, dated 2/21/25, indicated the resident had a terminal end stage prognosis and was receiving hospice services. The Hospice Certification, dated 2/26/25, indicated the resident was terminally ill with a life expectancy of six months or less. During an interview on 4/28/25 at 3:14 p.m., MDS Nurse 1 and MDS Nurse 2 indicated the resident was receiving hospice care and had a terminal prognosis. They would modify the MDS assessment. 3.1-31(i)

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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. 32788 Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was developed and in place for edema, compression glove use, and oxygen for 1 of 27 resident care plans reviewed. (Resident 60) Finding includes: On 4/22/25 at 9:18 a.m., Resident 60 was observed with oxygen in place via nasal cannula. The flow rate was set at 1.5 liters. Her right hand was slightly swollen and there was a compression glove on her bedside table. The resident indicated she used oxygen and it was usually at 2 liters. She wore the compression glove on her right hand, but only at night. Record review for Resident 60 was completed on 4/23/25 at 11:33 a.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 2/23/25, indicated the resident was moderately cognitively impaired and did not receive oxygen therapy. A Care Plan, dated 3/10/25, indicated the resident had renal insufficiency. The interventions included to elevate feet to help prevent dependent edema and to monitor for signs of hypervolemia (fluid overload) such as dependent edema. There was no specific care plan or interventions related to the right hand edema or the compression glove use. There was no current care plan related to oxygen use. During an interview on 4/24/25 at 1:53 p.m., the Director of Nursing was made aware of the lack of care plans. He indicated he would put in care plans for oxygen, edema, and compression glove use. 3.1-35(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 10326 Based on observation, record review, and interview, the facility failed to ensure professional standards of quality were maintained related to a CNA placing a tube feeding pump on hold for 1 of 2 residents reviewed for tube feeding. (Resident 73) Finding includes: During a random observation on 4/23/25 at 3:34 p.m., Resident 73 was observed in her room in bed. The head of the bed was elevated and the resident's tube feeding was infusing at 50 cubic centimeters (cc's). CNA 1 proceeded to enter the resident's room to perform incontinence care. Prior to lowering the head of the bed, the CNA placed the tube feeding pump on hold. After incontinence care was completed, the CNA had a nurse resume the tube feeding. The record for Resident 73 was reviewed on 4/25/25 at 2:10 p.m. Diagnoses included, but were not limited to, gastrostomy (a feeding tube placed through the abdomen and into the stomach to deliver nutrition, fluids, or medications), adult failure to thrive, and dysphagia (difficulty swallowing). The Admission Minimum Data Set (MDS) assessment, dated 2/24/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident was receiving the majority of her nutrition through a feeding tube. The Indiana State Department of Health Nurse Aide Curriculum states, . The resident with a feeding infusing should not lie flat . If the bed must be flattened, seek the nurse ' s assistance to turn off the pump prior to the procedure and turn the pump back on after the procedure During an interview on 4/23/25 at 4:08 p.m., the Nurse Consultant indicated it was not within the CNA's scope of practice to put the tube feeding pump on hold and education would be provided. 3.1-35(g)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 10326 Based on observation, record review, and interview, the facility failed to ensure bruises were assessed and monitored for 2 of 2 residents reviewed for non-pressure related skin conditions, signs and symptoms of constipation were monitored for 1 of 1 resident reviewed for constipation, edema was monitored and assessed for 1 of 3 residents reviewed for edema and medications were held per blood pressure parameters for 1 of 5 residents reviewed for unnecessary medications. (Residents 91, 255, 60, 27, and 264) Findings include: 1. During a random observation on 4/22/25 at 10:14 a.m., an area of reddish/purple discoloration was noticed on Resident 91's left forearm. The record for Resident 91 was reviewed on 4/23/25 at 12:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes, severe sepsis with septic shock, and atherosclerotic heart disease. The Admission Minimum Data Set (MDS) assessment, dated 3/28/25, indicated the resident was cognitively intact and he was receiving an anticoagulant (blood thinner). A Care Plan, dated 3/21/25, indicated the resident was receiving anticoagulant therapy. Interventions included, but were not limited to, monitor/document/report as needed (PRN) adverse reactions of anticoagulant therapy such as bruising. Physician's Orders, dated 3/21/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedtime and Aspirin 81 mg by mouth daily. A Physician's Order, dated 3/24/25, indicated the resident was receiving Enoxaparin Sodium Solution (a blood thinner) 40 mg/0.4 milliliters (ml), inject 40 mg subcutaneously one time a day to prevent blood clotting for 30 days. The Daily Skilled Nursing Evaluation, dated 4/23/25, indicated there was no documentation related to new and/or existing skin conditions. During an interview on 4/24/25 at 2:04 p.m., the Embers Unit Manager was informed of the discoloration. She indicated documentation should have been completed related to the discoloration. 2. The record for Resident 255 was reviewed on 4/23/25 at 10:21 a.m. Diagnoses included, but were not limited to, orthopedic aftercare following a surgical amputation and osteomyelitis (a bone infection) of the left ankle and foot. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 4/16/25, was in progress and indicated the resident was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated 4/16/25, indicated the resident was to receive Hydrocodone-Acetaminophen Tablet (an opioid pain medication) 5-325 milligrams (mg), give 1 tablet every 6 hours as needed for pain. The April 2025 Medication Administration Record (MAR) indicated the resident received the Hydrocodone-Acetaminophen on 4/16/25 at 5:44 p.m., 4/17/25 at 12:34 p.m., 4/19/25 at 6:03 p.m., and 4/20/25 at 3:22 a.m. The Bowel Elimination Flow Sheet located in the Task section of the electronic medical record indicated the resident did not have a bowel movement on 4/17/25, 4/18/25, and 4/19/25. There was no documentation on 4/20/25. A Nurse's Note, dated 4/20/25 at 9:07 p.m., indicated during shift report the oncoming nurse was told the resident had vomited twice. The resident vomited again right after shift change and the Nurse Practitioner (NP) was notified. An order was received for Zofran (a medication to prevent nausea and vomiting) 4 mg every 6 hours as needed. The first dose was given at 8:00 p.m. Since the first dose was given, the resident continued to vomit and the NP was notified. A Physician's Order, dated 4/20/25, indicated the resident was to have a KUB (kidney, ureter, and bladder x-ray). Physician's Orders, dated 4/21/25, indicated the resident was to receive Docusate Sodium (a stool softener) 100 mg, 1 capsule two times a day for constipation for 30 days, Lactulose (a laxative) oral solution 20 grams/30 ml, give 30 ml every 24 hours as needed for constipation for 30 days, and Glycolax Powder (a laxative) 17 gram scoop, give 17 grams as needed for constipation for 30 days, give 17 grams mixed with 8 ounces of fluid twice daily as needed. The April 2025 MAR indicated the resident received the Docusate Sodium on 4/21/25 at 5:00 p.m. and 4/22/25 at 9:00 a.m. The resident had not received the Lactulose or the Glycolax Powder. A Care Plan was initiated on 4/21/25 related to the resident receiving opioid medications. The Bowel Elimination Flow Sheet indicated the resident had a large bowel movement on 4/21/25. A Nurse's Note, dated 4/22/25 at 2:08 p.m., indicated the resident's KUB showed a mild adynamic ileus (a condition where the bowel's movement is slowed or stopped due to a lack of coordinated muscle activity) in the right mid abdomen with no bowel obstruction. The resident continued with nausea and vomiting and abdominal pain. The resident would be sent to the emergency room for evaluation. During an interview on 4/25/25 at 11:00 a.m., the Director of Nursing and the Nurse Consultant indicated they would follow up on the issue with the resident's constipation. During an interview on 4/25/25 at 11:15 a.m., the C Wing Unit Manager indicated the resident did have a bowel movement on 4/20/25 but it was not documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current facility Bowel Protocol policy was provided by the Director of Nursing on 4/29/25 at 4:25 p.m. The policy indicated the resident's drug regimen would be evaluated to identify possible constipating medications and per the bowel protocol, if the resident had no bowel movement or only small documented bowel movements for days outside of the baseline, the provider would determine if additional testing and/or medications were warranted. 32788 3. On 4/22/25 at 9:18 a.m., Resident 60's right hand was observed to be slightly swollen and there was a compression glove on her bedside table. The resident indicated she wore the compression glove on her right hand, but only at night. On 4/22/25 at 2:26 p.m., Resident 60 was observed with the compression glove in place to her right hand. Record review for Resident 60 was completed on 4/23/25 at 11:33 a.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 2/23/25, indicated the resident was moderately cognitively impaired. A Care Plan, dated 3/10/25, indicated the resident had renal insufficiency. The interventions included to elevate feet to help prevent dependent edema and to monitor for signs of hypervolemia (fluid overload) such as dependent edema. There was no specific care plan or interventions related to the right hand edema or the compression glove use. A Physician's Order, dated 3/21/25, indicated to remove the right hand glove to assess the skin every morning for skin breakdown and to document any abnormalities or skin issues. There were no directions on when to apply the compression glove or how long the resident was to wear the glove each day. The Medication Administration (MAR) and Treatment Administration (TAR) Records, dated 4/2025, indicated the compression glove had been removed daily at 9 a.m. The skin was monitored and either a + or - sign was documented. A - sign was documented on 4/1, 4/3, 4/5, 4/6, 4/7, 4/8, 4/11, 4/13, 4/14, 4/15, 4/16, 4/17, 4/19, 4/20, and 4/22/25. A + sign was documented on 4/2, 4/4, 4/9, 4/10, 4/12, 4/18, 4/21, and 4/23/25. There was no definition or key to indicate what the + or - sign meant. During an interview on 4/24/25 at 1:53 p.m., the Director of Nursing indicated he had clarified the compression glove order so it would be less confusing. 4. Resident 27's record was reviewed on 4/23/25 at 4:29 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and atrial fibrillation. The Admission Minimum Data Set (MDS) assessment, dated 2/16/25, indicated the resident was cognitively intact. A Care Plan, dated 2/11/25, indicated the resident had an altered cardiovascular status related to atrial fibrillation, coronary artery disease, heart failure, hypertension, and hyperlipidemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order, dated 2/15/25, indicated hydralazine (a medication used to lower blood pressure) 100 mg (milligrams) three times a day, hold if systolic blood pressure (top number of blood pressure reading) is less than 120. A Physician's Order, dated 2/15/25, indicated Entresto (sacubitril-valsartan, a medication used to treat heart failure that can lower blood pressure) 97-103 mg every morning and at bedtime, hold if systolic blood pressure is less than 120. The Medication Administration Record (MAR), dated 4/2025, indicated the hydralazine was not held per the Physician's Order on the following dates and times: - 4/1/25 at 2:00 p.m., blood pressure 112/63 and 10:00 p.m., blood pressure 112/69 - 4/2/25 at 2:00 p.m., blood pressure 116/63 - 4/3/25 at 6:00 a.m., blood pressure 112/68 - 4/10/25 at 2:00 p.m., blood pressure 115/64 - 4/16/25 at 2:00 p.m., blood pressure 117/63 - 4/17/25 at 2:00 p.m., blood pressure 118/72 - 4/18/25 at 2:00 p.m., blood pressure 118/58 - 4/19/25 at 2:00 p.m., blood pressure 113/65 The MAR, dated 4/2025, indicated the Entresto was not held per the Physician's Order on the following dates and times: - 4/1/25 at 8:00 a.m., blood pressure 112/61 and 8:00 p.m., blood pressure 112/69 - 4/2/25 at 8:00 a.m., blood pressure 116/63 and 8:00 p.m., blood pressure 116/63 - 4/3/25 at 8:00 a.m., blood pressure 113/61 - 4/16/25 at 8:00 a.m., blood pressure 117/63 - 4/18/25 at 8:00 a.m., blood pressure 115/62 - 4/19/25 at 8:00 a.m., blood pressure 113/65 During an interview on 4/25/25 at 12:44 p.m., the Director of Nursing indicated the medications had been given outside the blood pressure parameters. 43293 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During random observations on 4/22/25 at 9:31 a.m., 4/23/25 at 10:21 a.m., and 4/24/25 at 10:05 a.m., Resident 264 was observed resting in bed. There were purple bruises on the back of both of his hands, and on his right arm. The resident's record was reviewed on 4/23/25 at 10:58 a.m. Diagnoses included, but were not limited to, CHF (congestive heart failure) and diabetes. The 4/12/25 Admission MDS (Minimum Data Set) assessment, indicated the resident had mild cognitive impairment and was dependent in activities of daily living and transfers. A Care Plan, dated 3/24/25, indicated the resident was at risk for adverse reactions related to anticoagulant (blood thinner) therapy. Interventions included monitoring, documenting, and reporting bruising. There was no documentation of an assessment of the bruises. During an interview on 4/24/25 at 10:05 a.m., LPN 3 indicated the bruises were from lab blood draws. The left hand bruise had been present since his last hospitalization , but it was improving. She indicated the bruising should have been monitored and documented in the record. A policy titled, Bruise Identification Monitoring--Indiana, received as current from the Director of Nursing on 4/24/25 at 11:19 a.m., indicated . The staff nurse will obtain a physician order to monitor the new bruise daily until resolved. This monitoring will be recorded on the MAR [medication administration record] or TAR [treatment administration record] . 3.1-37(a)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43293 Based on record review and interview, the facility failed to assist a resident to see an eye doctor for 1 of 1 resident reviewed for vision. (Resident 29) Finding includes: During an interview on 4/21/25 at 11:33 a.m., Resident 29 indicated he could not see with the glasses he had and he had not been evaluated by an eye doctor since before his admission to the facility on [DATE]. During an interview on 4/23/25 at 2:00 p.m., the resident's daughter indicated she had asked Social Worker 1 about setting up an eye doctor appointment for the resident, and he indicated seeing the eye doctor was not part of his care at the facility and they could not make arrangements for him. The resident's record was reviewed on 4/23/25 at 2:57 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia (low oxygen levels), and dementia. The 4/10/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment, and required partial/moderate assistance with activities of daily living and transfers. There was no documentation of vision/eye care for the resident. During an interview on 4/24/25 at 11:08 a.m., the Director of Social Services indicated the resident should be able to see an eye doctor if needed and they would help make those arrangements. 3.1-39(a)(1) 3.1-39(a)(2)

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	155840	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 32788 Based on observation, record review and interview, the facility failed to ensure G-tube (gastrostomy tube, a tube inserted directly into the stomach) flushes were instilled via gravity for 1 of 6 residents observed for medication administration. (Resident 202) Finding includes: On 4/24/25 at 1:04 p.m., LPN 2 was observed preparing Resident 202's medications. She crushed each pill and placed it in a separate cup. She entered the resident's room, put the tube feeding on hold, and poured 30 cubic centimeters (cc) of water into a medication cup. She inserted the G-tube syringe into the medication cup and drew up the 30 cc of water. She opened the G-tube and placed the syringe directly into the tube and pushed the 30 cc of water down the tube using the plunger. She diluted each of the medications in 5 cc of water and administered the medications and remaining flushes by gravity. During an interview on 4/24/25 at 1:30 p.m., LPN 2 indicated she should have administered the G-tube flush by gravity. During an interview on 4/24/25 at 1:53 p.m., the Director of Nursing was made aware the G-tube flush had not been administered by gravity. The G-tube medication administration policy was requested. A current facility policy, titled Medication Administration Enteral Tubes, indicated, .9. Remove plunger from syringe and insert syringe into tubing. 10. Flush with water .b. Allow medication to flow down tube via gravity . 3.1-44(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 32788 Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and treatment related to oxygen administration for 1 of 4 residents reviewed for respiratory care. (Resident 60) Finding includes: On 4/22/25 at 9:18 a.m., Resident 60 was observed with oxygen in place via nasal cannula. The flow rate was set at 1.5 liters. The resident indicated she used oxygen and it was usually set at 2 liters. On 4/22/25 at 2:26 p.m., Resident 60 was observed with oxygen in place via nasal cannula. The flow rate was set at 1.5 liters. Record review for Resident 60 was completed on 4/23/25 at 11:33 a.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 2/23/25, indicated the resident was moderately cognitively impaired and did not receive oxygen therapy. There was no current care plan related to oxygen use. The Physician's Order Summary, dated 4/2025, lacked any orders for oxygen. During an interview on 4/24/25 at 11:58 a.m., the Director of Nursing indicated he was unable to find any current orders for oxygen. A facility policy, titled Oxygen, indicated, 1. Residents who are admitted on oxygen or isolation precautions will have orders recorded in the resident's chart. The oxygen will be administered by the route and liter flow ordered by the physician . 3.1-47(a)(6)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32788 Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 6 residents observed during medication administration. Two medication errors were observed during 26 opportunities for error in medication administration. This resulted in a medication error rate of 7.69%. (Resident 66) Finding includes: On 4/24/25 at 9:30 a.m., LPN 1 was observed preparing Resident 66's medications, which included Lantus (insulin glargine, long-acting insulin). LPN 1 removed the resident's insulin pen from the medication cart and donned a gown and gloves. She entered the room, cleaned the top of the insulin pen with an alcohol swab, and put the needle on the pen. She dialed the Lantus insulin pen to 20 units and administered the injection to the resident's left abdomen. She had not primed the insulin pen prior to administering the injection. She then removed her gown and gloves, washed her hands, and disposed of the needle in the sharps container. The record for Resident 66 was reviewed on 4/23/25 at 2:33 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The Physician's Order Summary, dated 4/2025, indicated Lantus 18 units subcutaneously in the morning. During an interview on 4/24/25 at 9:55 a.m., LPN 1 indicated she had not primed the insulin pen prior to administering the injection. The insulin pens were primed when they were new and first opened. She had administered 20 units of insulin, and the resident was supposed to receive 18 units. During an interview on 4/24/25 at 10:44 a.m., the Director of Nursing was made aware of the medication errors. The insulin administration policy was requested. A facility policy, titled Insulin Administration Procedure, indicated, .Insulin Pens: .8. Turn the dose selector to 2 units. Hold the pen with the needle pointing up, and tap the cartridge gently a few times. This moves the air bubbles to the top. 9. Press the push button all the way in until the dose selector is back to a 0. A drop of insulin should appear at the tip of the needle. This will ensure proper dosing and avoid injecting air onto the patient .12. Turn the dose selector to the number of units needed to inject. The pointer should line up with the correct dose . 3.1-48(c)(1)

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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. 32788 Based on observation and interview, the facility failed to ensure medications were kept in a locked medication cart at all times for 1 of 6 residents observed during medication administration. (Resident 66) Finding includes: On 4/24/25 at 9:30 a.m., LPN 1 was observed preparing medications for Resident 66. She placed a pill card of multivitamin medication and a pill card of ferrous sulfate medication on top of the medication cart. She placed the medication cup containing the resident's morning medications on top of the medication cart. At 9:37 a.m. she indicated she needed to go get something from the Nurse's Station and walked down the hallway away from the medication cart. The two pill cards of medications and the medication cup with the resident's morning medications remained on top of the medication cart, out of her sight. On 4/24/25 at 9:40 a.m., LPN 1 returned to the medication cart. During an interview, at that time, LPN 1 indicated she should not have left the medications unattended. During an interview on 4/24/25 at 10:44 a.m., the Director of Nursing was made aware the medications had been left on top of the medication cart. A medication storage policy was requested. No further information was provided. 3.1-25(m)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43293 Based on record review and interview, the facility failed to assist a resident to obtain dental care for 1 of 1 resident reviewed for dental services. (Resident 29) Finding includes: During an interview on 4/21/25 at 11:33 a.m., Resident 29 indicated his dentures did not fit well, making it difficult to chew, and he had not been evaluated by a dentist since before his admission to the facility on [DATE]. During an interview on 4/23/25 at 2:00 p.m., the resident's daughter indicated she asked Social Worker 1 about setting up a dentist appointment for the resident, and he indicated dental care was not part of his care at the facility and they could not make arrangements for him. The resident's record was reviewed on 4/23/25 at 2:57 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia (low oxygen levels), and dementia. The 4/10/25 Quarterly MDS (Minimum Data Set) assessment indicated the resident had moderate cognitive impairment, and required partial/moderate assistance with activities of daily living and transfers. There was no documentation of dental care for the resident. During an interview on 4/24/25 at 11:08 a.m., the Director of Social Services indicated the resident should be able to see a dentist if needed and they would help make those arrangements. 3.1-24(a)(1) 3.1-24(b)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43293 Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to food not labeled and dated for 1 of 1 kitchen. This had the potential to affect 86 residents who resided in the facility and received food from the kitchen. (The Main Kitchen) Findings include: During the Initial Kitchen Sanitation Tour on 4/21/25 at 9:17 a.m. with the Kitchen Manager, the following was observed: 1. In the dry storage room, there was a large unlabeled storage bin containing a white powder and an unlabeled container partially filled with yellow liquid. 2. In the walk-in cooler, there was a partially full, unlabeled squeeze bottle containing a red/brown substance. There was an uncovered bucket filled with cut-up potatoes and water. There were trays of desserts in a rack that were uncovered and unlabeled. 3. In the walk-in freezer, there was an open, unlabeled bag of fish patties and an open, unlabeled bag of corn. 4. In the food prep area, there was a large plastic bin and a smaller plastic container filled with a white powder. Both were unlabeled. During an interview on 4/21/25 at 9:20 a.m., the Kitchen Manager indicated all food items should have been labeled and dated when opened and the uncovered items should have had lids on them. A policy titled Labeling and Dating Foods, received as current from the Kitchen Manager on 4/24/25 at 8:28 a. m. indicated, . Packaged or containerized bulk food may be removed from the original package and stored in an ingredient bin labeled with the common name of the food, the date the item was opened and the date by which the item should be discarded or used by . A policy titled Storage of Dry Goods/Foods, received as current from the Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, . Opened products are labeled, dated with the use by date and tightly covered to protect against contamination including from insects and rodents . A policy titled Labeling and Dating Foods--Refrigerated Food, received as current from the Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, . If opened, the cold food item is labeled with the date opened and the date by which to discard or use by . 3.1-21(i)(3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43293 Based on record review and interview, the facility failed to ensure the medical record was complete and accurately documented related to medication administration documentation and medication orders for 1 of 27 records reviewed. (Resident 42) Finding includes: Resident 42's record was reviewed on 4/24/25 at 8:26 a.m. Diagnoses included, but were not limited to, diabetes and heart failure. A Physician's Order, dated 2/25/25, indicated Droxidopa (a medication to treat the symptoms of low blood pressure) every 8 hours. The boxes for documenting administration of the medication on the April 2025 Medication Administration Record (MAR) were blank for the following doses: 4/6/25 at 10:00 p.m., 4/7/25 at 6:00 a.m., and 4/12/25 at 6:00 a.m. A Physician's Order, dated 4/13/25, indicated Midodrine (a medication to treat low blood pressure)every 8 hours as needed for hypotension (low blood pressure). There were no orders for blood pressure parameters for administration. During an interview on 4/24/25 at 3:45 p.m., the Assistant Director of Nursing indicated the nurse administered the Droxidopa at the times that were blank on the MAR, but she forgot to document it. During an interview on 4/24/25 at 12:01 p.m., the Director of Nursing indicated there should be specific blood pressure parameters for administering the Midodrine, but he could not find any. 3.1-50(a)(1) 3.1-50(a)(2)