STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155855	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McGivney Health Care Center	2907 East Smoky Row Carmel, IN 46033

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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 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 interview and record review, the facility failed to ensure a physician's order for advanced directive was accurate for 1 of 1 resident reviewed for advanced directives. (Resident 30)Findings include:The clinical record for Resident 30 was reviewed on [DATE] at 2:44 p.m. The diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, bipolar disorder severe depressed without psychotic features, mood affective disorder, intermittent explosive disorder, alcohol abuse with intoxication, and chronic obstructive pulmonary disease.A physician's order, dated [DATE], indicated Resident 30 was a full code.A physician's order for scope of treatment (POST) form, dated [DATE], indicated Resident 30 did not want to be resuscitated with cardio-pulmonary resuscitation (CPR).A consent/declination to resuscitate form, signed [DATE], indicated Resident 30 did not want to be resuscitated if he had no pulse and was not breathing.A care plan, initiated [DATE] and dated as late reviewed [DATE], indicated Resident 30 was a full code, to honor the resident's code status, and to review it quarterly.The physician's order, dated [DATE], which indicated Resident 30 was a full code was not discontinued until [DATE].During an interview, on [DATE] at 11:30 a.m., the Social Services Designee (SSD) indicated Resident 30 should have had a do not resuscitate (DNR) code status since January. When the resident was admitted , the facility received the signed code status forms. A physician's order would be based off the signed forms, so staff knew how to proceed in an emergency.A current facility policy, titled Code Status, dated [DATE] and provided by the SSD on [DATE] at 10:00 a.m., indicated .the resident is full code until determined otherwise .The physician will see the resident in the first 30 days and will write order for code status.3.1-4(f)(4)(A)(ii)

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure psychotropic medications which were ordered as needed (prn) had a 14 day stop date and baseline Abnormal Involuntary Movement Scale (AIMS) assessments were completed for 2 of 5 residents reviewed for unnecessary medications. (Resident 6 and 30)Findings include:1. The clinical record for Resident 6 was reviewed on 8/20/25 at 11:23 a.m. The diagnoses included, but were not limited to, intracranial injury with loss of consciousness, chronic obstructive pulmonary disease, hemiplegia and hemiparesis affecting the left non-dominant side, dementia, traumatic brain injury, delusional disorders, and alcohol abuse. A physician's order, dated 2/14/25, indicated to give Xanax (an antianxiety medication) 0.25 milligrams (mg) every 8 hours as needed for anxiety. The order, dated 2/14/25, did not have a stop date. The physician's order for Xanax 0.25 mg every 8 hours as needed was not discontinued until 5/23/25. The as needed physician's order was current for over 90 days without review. During an interview, on 8/22/25 at 11:15 a.m., the Social Services Designee indicated the as needed Xanax required a 14-day stop date. 2. The clinical record for Resident 30 was reviewed on 8/19/25 at 2:44 p.m. The diagnoses included, but were not limited to, vascular dementia with other behavioral disturbance, bipolar disorder without psychotic features, mood affective disorder, intermittent explosive disorder, alcohol abuse with intoxication, and chronic obstructive pulmonary disease. The resident was admitted to the facility on [DATE]. A physician's order, dated 1/21/25, indicated to administer paliperidone (an atypical antipsychotic medication) 3 mg at bedtime. A physician's order, dated 1/22/25, indicated to administer Rexulti (an atypical antipsychotic medication) 0.5 mg once a day. An AIMS assessment was not completed until 3/24/25. During an interview, on 8/21/25 at 10:15 a.m., LPN 4 indicated an AIMS assessment must be completed at the start of an antipsychotic medication or on admission to the facility. The facility indicated they did not have a policy for psychoactive medications or prn medications. A current facility policy, titled Abnormal Involuntary Movement Scale (AIMS), dated 8/2017 and provided by the SSD on 8/21/25 at 10:00 a.m., indicated .The AIMS shall be completed within 14 days of initiation of psychotropic medication (baseline) 3.1-48(a)(2) 3.1-48(a)(3)

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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. Based on interview and record review, the facility failed to ensure a resident and the resident's representative was provided the written transfer and bed hold notices for 1 of 1 resident reviewed for hospitalization. (Resident 5)Findings include: The clinical record for Resident 5 was reviewed on 8/20/25 at 10:46 a.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, disorder of the brain, type 2 diabetes mellitus, conversion disorder with seizures or convulsions, asthma, congestive heart failure, dementia, pseudobulbar affect (PBA), acute necrotizing hemorrhagic encephalopathy, and localized edema. A transfer to the hospital summary, dated 6/3/25 at 7:54 p.m., indicated the resident complained of shortness of breath and difficulty breathing. Despite interventions, the resident's oxygen saturation continued to decrease to 81%. The resident was transported to the hospital by ambulance, and the resident's mother was notified. During an interview, on 8/21/25 at 10:15 a.m., LPN 3 indicated that when the resident was sent to the hospital, the transfer paperwork was sent to the hospital with the resident, and the family was called. During an interview, on 8/21/25 at 10:30 a.m., the Social Services Designee (SSD) indicated the facility had not documented the written transfer notice and bed hold notice were given directly to the resident. The notices were often sent in the hospital paperwork packet with the residents. She did not realize the notices must be sent to the family member or representative when the resident was able to sign for himself. The facility gave verbal notice that the resident was being sent to the hospital. A current facility policy, titled Transfer, dated 2/15/17 and provided by the Executive Director on 8/22/25 at 10:15 a.m., indicated .Before a facility transfers or discharges a resident, the facility must.notify the resident and the resident representative of the transfer.in writing.At the time of transfer.a nursing facility must provide the resident and the resident representative with written notice.of the bed-hold policy. A current facility policy, titled Bedhold, dated 10/2014 and provided by the SSD on 8/20/25 at 10:45 a.m., indicated .facility personnel will provide written information to the residents and a family member or legal representative that specifies the facility bed hold policy. In case of emergency transfer, every effort will be made to notify the family or legal representative at the time of transfer.Should this not occur, effort will be made to provide written notice to the family .within 24 hours of transfer. Resident's copy of the notice will be sent with other documents accompanying residents to the hospital 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)

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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. Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) was updated when new diagnoses and antipsychotic medications were added for 2 of 2 residents reviewed for PASARR. (Resident 30 and 3)Findings include:The clinical record for Resident 30 was reviewed on 8/19/25 at 2:44 p.m. The diagnoses included, but were not limited to, vascular dementia with other behavioral disturbance, bipolar disorder current episode severe depressed without psychotic features, mood affective disorder, intermittent explosive disorder, alcohol abuse with intoxication, and chronic obstructive pulmonary disease with acute exacerbation. A PASARR level II, dated 11/7/24, indicated Resident 30 had diagnoses of intermittent explosive disorder, intellectual disability, mood disorder, and schizophrenia. A psychosocial note, dated 4/23/25 at 11:28 a.m., indicated Resident 30 had diagnoses of dementia and bipolar. A PASARR level II, dated 11/7/24, did not include the diagnoses of dementia and bipolar. During an interview, on 8/21/25 at 11:35 a.m., the Social Services Designee (SSD) indicated she did not realize dementia and bipolar were not on the resident's PASARR and the facility should have submitted a new one for those diagnoses per the guidelines. 2. The clinical record for Resident 3 was reviewed on 8/20/25 at 9:21 a.m. The diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, and affective mood disorder. A PASARR level II, dated 2/17/22, indicated there were no mental health medications listed, and if there was a significant change in physical or mental health, the nursing facility must submit an updated level I screening to see if a further PASARR evaluation was needed. A physician's order, dated 4/10/25, indicated to give Risperdal (an antipsychotic medication) 0.5 milligrams (mg). The PASARR was not updated after a new antipsychotic medication was added. During an interview, on 8/21/25 at 2:24 p.m., the SSD indicated after a new psychotropic was added, the facility should have resubmitted another PASARR. During an interview, on 8/22/25 at 10:56 a.m., the Executive Director (ED) indicated the facility did not have a PASARR policy. 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 observation, interview and record review, the facility failed to ensure comprehensive care plans were developed to address the resident's medical needs for 2 of 14 residents reviewed for comprehensive care plans. (Resident 12 and 22) Findings include: 1. During an observation, on 8/19/25 at 10:53 a.m., Resident 12 had a urinary catheter and was receiving oxygen therapy.The clinical record for Resident 12 was reviewed on 8/20/25 at 10:31 a.m. The diagnoses included, but were not limited to, benign prostatic hyperplasia (prostate gland enlargement causing difficulty urinating) with lower urinary tract symptoms, prediabetes, age related physical debility, chronic obstructive pulmonary disease, and chronic respiratory failure.A physician's order, dated 8/6/25, indicated flush the urinary catheter daily with 40 milliliters (ml) of fluid.A physician's order, dated 8/14/25, indicated to check oxygen saturation every shift, and titrate the oxygen to 4L to maintain an oxygen saturation above 90%.A care plan for the use of a urinary catheter and oxygen therapy was not located in the resident's medical record.During an interview, on 8/20/25 at 2:38 p.m., the Minimum Data Set (MDS) Coordinator indicated she could not locate a care plan for a urinary catheter or oxygen therapy. Residents who have catheters and oxygen therapy should have care plans.2. The clinical record for Resident 22 was reviewed on 8/21/25 at 9:28 a.m. The diagnoses included, but were not limited to, schizoaffective disorder bipolar type, hypertension, and hyperlipidemia.Resident 22 received medications related to parkinsonism, drug induced subacute dyskinesia (a type of involuntary movement disorder which developed after taking certain medications), constipation, hypertension, and hyperlipidemia.There was no care plans located in Resident 22's medical record at the time of review related to the above listed medications.During an interview, on 8/21/25 at 1:52 p.m., the MDS Coordinator indicated nursing should have developed care plans for the medications.A current facility policy, titled Care Plans, dated as revised 6/11/21 and received from the Social Services Designee on 8/21/25 at 10:00 a.m., indicated .Collaboration of the care plan team is used to help analyze data obtained from the resident's diagnosis .and physician's orders to develop individualized care plans specific to each resident 3.1-35(a)3.1-35(b)(1)3.1-35(d)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure care plans were reviewed and updated after Minimum Data Set (MDS) assessments were completed for 2 of 14 residents reviewed for care planning. (Resident 4 and 6)Findings include: 1. The clinical record for Resident 4 was reviewed on 8/20/25 at 1:58 p.m. The diagnoses included, but were not limited to, encephalopathy, chronic obstructive pulmonary disease, epilepsy, schizophrenia, repeated falls, alcohol dependence, and congestive heart failure. A fall note, dated 1/26/25 at 11:30 a.m., indicated the resident was found on the floor with a swollen raised bump on his forehead. An incident note, dated 4/6/2025 at 11:30 a.m., indicated the resident was found walking on his knees. A Minimum Data Set (MDS) assessment was completed for Resident 4 on 6/2/25. A care plan, initiated on 7/28/24 and dated as last reviewed on 7/22/25, did not include Resident 4's falls on 1/26/25 or 4/6/25. A care plan, initiated on 3/20/24 and dated as last reviewed on 7/22/25, indicated Resident 4 was a high risk for falls related to gait and balance problems. No new interventions were noted in the resident's care plan after the multiple fall events. 2. The clinical record for Resident 6 was reviewed on 8/20/25 at 11:23 a.m. The diagnoses included, but were not limited to, intracranial injury with loss of consciousness, chronic obstructive pulmonary disease, hemiplegia and hemiparesis affecting the left non-dominant side, dementia, traumatic brain injury, delusional disorders, and alcohol abuse. A quarterly MDS assessment for Resident 6 was completed on 6/8/25. The comprehensive care plans for Resident 6 were reviewed on 3/31/25 and not again until 8/8/25. During an interview, on 8/21/25 at 11:25 a.m., the Social Services Designee (SSD) indicated she conducted the care plan meetings with the Interdisciplinary IDT team, but the MDS Coordinator was the one who reviewed the care plans. They were not reviewed with the care plan meetings. A current facility policy, titled Care Plans, dated 6/11/21 and received from the SSD on 8/21/25 at 10:00 a.m., indicated .Identify areas of concern triggered on the MDS .Evaluate the resident's .wishes, strengths, and needs .Care plans are a living document and as such may require updates following the mandated care plan completion date 3.1-35(c)(1) 3.1-35(c)(2)(A) 3.1-35(c)(2)(B) 3.1-35(c)(2)(C)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure daily weights were obtained according to the physician's order and to assess and treat a resident for constipation for 2 of 2 residents reviewed for quality of care. (Resident 31 and 22)Findings include:1. The clinical record for Resident 31 was reviewed on 8/20/25 at 12:37 p.m. The diagnoses included, but were not limited to, type 2 diabetes, edema, and acute kidney failure.A physician's order, dated 7/18/25, indicated to weigh the resident daily related to edema.The Medication Administration Record (MAR) had the following:a. On 7/18/25, no weight was recorded.b. On 7/20/25, no weight was recorded.c. On 8/1/25, no weight was recorded.d. On 8/2/25, no weight was recorded.e. On 8/6/25, no weight was recorded.During an interview, on 8/21/25 at 9:40 a.m., Licensed Practical Nurse (LPN) 3 indicated he could not locate a daily weight for those days.During an interview, on 8/21/25 at 9:43 a.m., Qualified Medication Assistant (QMA) 5 indicated he could not locate those weights in the paper charting. The weights should have been completed.During an interview, on 8/21/25 at 9:47 a.m., LPN 3 indicated he could not locate the 8/2 or 8/6 daily weights, and they were missed.2. The clinical record for Resident 22 was reviewed on 8/21/25 at 9:28 a.m. The diagnoses included, but were not limited to, schizoaffective disorder bipolar type, hypertension, and hyperlipidemia.A physician's order, dated 2/24/23, indicated to administer Sennosides-Docusate Sodium 8.6-50 milligrams by mouth two times a day for constipation.A physician's order, dated 2/24/23, indicated to administer Polyethylene Glycol 3350 powder (Miralax)17 grams by mouth every 12 hours as needed for constipation.Resident 22 did not have a documented bowel movement from 7/16/25 to 7/22/25 (7 days) and from 8/17/25 to 8/20/25 (4 days).A physician's note, dated 7/21/25, indicated the resident had been assessed with no bowel related concerns. There were no other notes or assessments found to show Resident 22 had been assessed for bowel concerns prior to 7/21/25. There was no documentation or assessment found in the record to show the resident had been assessed for bowel concerns, 8/20/25, on day four of no bowel movement for Resident 22.The resident did not have a care plan which addressed constipation at the time of the record review.The Medication Administration Record (MAR), for July 2025, indicated Resident 22 received Sennosides Docusate Sodium 16 times between 7/16/25 to 7/22/25. There was no documentation to show Miralax had been administered for constipation per the physician's order.The MAR, for August 2025, indicated Resident 22 received Sennosides Docusate Sodium 40 times between 8/1/25 to 8/20/25. There was no documentation to show Miralax had been administered for constipation per the physician's order.During an interview, on 8/22/2025 at 9:59 a.m., LPN 4 indicated the CNAs were to inform a nurse if a resident had not had a bowel movement after three days. If a resident had not had a bowel movement after three days, the nurse should have completed a bowel assessment and provided as needed medication like Miralax. If the resident did not have a bowel protocol in place, the nurse would contact the physician for orders. The nurse would document the bowel assessment and notify the physician.A current facility policy, titled Weight and Measurement, dated as effective 2019 and received from the Activities Director on 8/22/25 at 11:30 a.m., indicated .The following information should be recorded in the resident's medical record. A. Time and date the procedure was performed. B. Weight and height of resident.Weights of each individual resident are to be obtained monthly and as recommended by Physician.A current facility policy, titled Bowel Elimination, dated as effective 6/17 and received from the Executive Director on 8/25/25 at 1:32 p.m., indicated .If there is no BM in 72 hours, the day shift nurse will initiate nursing protocol for Milk of Magnesia.If no BM in 48 hours following MOM protocol, a Dulcolax suppository will be given.If no BM in 24 hours following the suppository, the physician will be contacted for a Fleets enema 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to ensure staff were aware of who was responsible to complete catheter care and to document catheter care was provided for 1 of 2 residents reviewed for urinary catheters. (Resident 12)Findings include: During an observation, on 8/19/25 at 10:53 a.m., Resident 12 had a urinary catheter.The clinical record for Resident 12 was reviewed on 8/20/25 at 10:31 a.m. The diagnoses included, but were not limited to, benign prostatic hyperplasia (prostate gland enlargement causing difficulty urinating) with lower urinary tract symptoms, prediabetes, and age-related physical debility.A physician's order, dated 8/6/25, indicated flush the urinary catheter daily with 40 milliliters (ml) of fluid.A physician's order to complete urinary catheter care on a routine basis was not located in the medical record.Cather care documentation was not located in the medical record.During an interview, on 8/20/25 at 3:03 p.m., Certified Nursing Assistant (CNA) 6 indicated the nurses completed the cleaning of the urinary catheters.During an interview, on 8/20/25 at 3:09 p.m., Licensed Practical Nurse (LPN) 4 indicated CNAs completed the cleaning of the urinary catheters.During an interview, on 8/21/25 at 11:10 a.m., the Director of Nursing (DON) indicated CNAs completed the cleaning of the urinary catheters.During an interview, on 8/21/25 at 1:36 p.m., LPN 3 indicated the nurses usually completed urinary catheter care.The staff members were unclear whose responsibility it was to complete catheter care.During an interview, on 8/21/25 at 1:42 p.m., the Minimum Data Set (MDS) Coordinator indicated catheter care should be charted in the progress notes under a health status note. She did not see where any catheter care was documented. Catheter care should be documented.A current facility policy, titled Suprapubic Catheter Care, undated and received from the Executive Director on 8/22/25 at 11:53 a.m., indicated .Review the resident's orders .Documentation: i. The following information should be recorded in the resident's medical record: a. The date and time the procedure was performed 3.1-41(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. Based on observation, interview and record review, the facility failed to ensure physician's orders were obtained for changing and dating oxygen tubing and to ensure humidified water was changed and dated for 2 of 2 residents reviewed for respiratory therapy. (Resident 1 and 12)Findings include:During an observation, on 8/19/25 at 10:45 a.m., Resident 1 was observed with a portable oxygen tank set to 2 liters per minute. The oxygen line did not have a date to show when it had last been changed. During an observation, on 8/20/25 at 11:38 a.m., LPN 4 indicated the oxygen line was supposed to be dated and it was not. During an observation, on 8/21/25 at 11:39 a.m., Resident 1's oxygen line did not have a date to show when it was last changed. During an observation, on 8/22/25 at 8:33 a.m., Resident 1's oxygen line did not have a date to show when it was last changed. The clinical record for Resident 1 was reviewed on 8/21/25 at 10:57 a.m. The diagnoses included, but were not limited to, dementia, hypertension, and a history of pneumonia. A physician's order indicated to check Resident 1's oxygen saturation every shift and to titrate the oxygen to 4 liters per minute to maintain an oxygen blood saturation above 90 percent. There was no physician's order located related to changing the oxygen line. 2. During an observation, on 8/19/25 at 10:53 a.m., Resident 12 was receiving humidified oxygen. The humidification bottle had approximately a centimeter of water left in the bottle and it was not bubbling. The oxygen tubing and the humidifier bottle did not have a date indicating when they were last changed. During an interview, on 8/19/25 at 1:52 p.m., Licensed Practical Nurse (LPN) 3 indicated Resident 12's water level in his humidifier bottle was low. There was not a date on the oxygen tubing or the humidifier bottle to show when they were last changed. The clinical record for Resident 12 was reviewed on 8/20/25 at 10:31 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, chronic obstructive pulmonary disease, and dementia. A physician's order, dated 9/23/24, indicated to change and date the nebulizer tubing every Sunday night. During an interview, on 8/20/25 at 2:38 p.m., the Director of Nursing (DON) indicated if the humidification was working, the water would be bubbling. During an interview, on 8/22/25 at 10:03 a.m., LPN 4 indicated the oxygen tubing was supposed to be changed weekly and there should be a physician's order for it. Staff were supposed to date the tube to document when it was changed. The water for humidification was supposed to be changed when it was about 1/2 to 1/4 full. If the humidification was working, the water would be bubbling. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/22/25 at 11:53 a.m., the Executive Director indicated there were a few oxygen policies, but none addressed changing, labeling, and dating the oxygen lines. 3.1-47(a)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155855	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McGivney Health Care Center	2907 East Smoky Row Carmel, IN 46033

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview and record review, the facility failed to ensure a Registered Nurse (RN) was on duty for eight (8) consecutive hours, seven (7) days a week for 1 of 14 days reviewed for RN coverage. (8/22/25)Findings include:During an observation, on 8/22/25 between 8:00 a.m. and 4:00 p.m., the facility did not have a Registered Nurse on duty.The staffing records, from 8/16/25 through 8/26/25, listed two RNs as currently employed with the facility: the Director of Nursing and the Infection Preventionist. The facility staffing records did not indicate a RN was on duty 8/22/25.The facility was unable to provide documentation to show that an RN had been on duty for the night, day, or evening shift on 8/22/25.During an interview, on 8/26/25 at 9:47 a.m., the Executive Director indicated the facility followed the state regulations.A current facility policy, titled Nursing Staffing Hours, dated 2020 and received from the Executive Director on 8/26/25 at 9:35 a.m., indicated .The requirements for long-term care facilities require a skilled nursing facility provide twenty-four (24) hour licensed nursing services, an RN .for eight (8) consecutive hours a day 3.1-17(b)(3)

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	155855	A. Building B. Wing	08/26/2025

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure spoiled food was discarded in 1 of 2 dry food storage areas reviewed for food storage. (the basement food storage area)Findings include:During an observation, on 8/19/25 at 11:12 a.m., bananas, with a received date of 8/6/25, were brown and black with a white growth substance on the stem. The bananas had spots which were oozing liquid and some bubbles forming.During an interview, on 8/21/25 at 11:40 a.m., the kitchen manager indicated the bananas needed to be thrown away as they were spoiled.A current facility policy, titled Expired Food, dated as last revised on 3/2/21 and received from the Activity Director on 8/22/25 at 11:30 a.m., indicated .DISPOSING OF SPOILED FOOD OR POSSIBLY CONTAMINATED: Place the food, i.e. expired, swollen metal cans or suspected glass jar in a heavy opaque or black garbage bag 3.1-21(i)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155855	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) were in place and followed for 2 of 2 residents reviewed for enhanced barrier precautions. (Resident 12 and 31)Findings include: 1. During an observation, on 8/19/25 at 10:53 a.m., Resident 12 had a urinary catheter.The clinical record for Resident 12 was reviewed on 8/20/25 at 10:31 a.m. The diagnoses included, but were not limited to, benign prostatic hyperplasia (prostate gland enlargement causing difficulty urinating) with lower urinary tract symptoms, prediabetes, and age-related physical debility.A physician's order, dated 8/6/25, indicated flush the urinary catheter daily with 40 milliliters (ml) of fluid.A physician's order for enhanced barrier precautions was not located in the medical record.There were no signs related to enhanced barrier precautions in the room or on Resident 12's door.During an observation, on 8/21/25 at 1:23 p.m., Licensed Practical Nurse (LPN) 3 completed catheter care for Resident 12. A gown was not worn during the procedure.During an interview, on 8/21/25 at 1:33 p.m., LPN 3 indicated he forgot to wear a gown during the procedure, and he was supposed to wear Personal Protective Equipment (PPE) during catheter care.2. During an observation, on 8/19/25 at 3:11 p.m., Resident 31 had a urinary catheter.The clinical record for Resident 31 was reviewed on 8/20/25 at 12:37 p.m. The diagnoses included, but were not limited to, acute kidney failure, neuromuscular dysfunction of the bladder, and hypertension.A physician's order for enhanced barrier precautions was not located in the medical record.There were no signs related to enhanced barrier precautions in the room or on Resident 31's door.During an interview, on 8/19/25 at 2:50 p.m., the Activity Director indicated she did not know what enhanced barrier precautions were.During an interview, on 8/19/25 at 2:55 p.m., the Director of Nursing (DON) indicated she did not know what enhanced barrier precautions were.During an interview, on 8/25/25 at 3:03 p.m., the DON indicated the facility never received any information about enhanced barrier precautions (EBP) and she did not know what it was until the survey. She understood now the staff were supposed to wear PPE during catheter care.The facility did not have a policy related to EBP.A current facility policy, titled Suprapubic Catheter Care, undated and received from the Executive Director on 8/22/25 at 11:53 a.m., indicated .Review the resident's orders .Personal Protective equipment (e.g., gowns, gloves, mask, ect., as needed) .3.1-18(b)(2)

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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft.) per resident in 1 of 18 rooms. (room [ROOM NUMBER])Findings include:During an observation, on 8/19/25 at 3:04 p.m., room [ROOM NUMBER] was found to have two beds, two nightstands, two clothing wardrobes, and one dresser. Two residents were occupying the room.During an interview, on 8/19/25 at 3:04 p.m., Resident 21 indicated he liked his room and had no concerns with the size.During an interview, on 8/19/25 at 3:07 p.m., Resident 23 indicated he liked this room and had no concerns with the size of the room.During an interview, on 8/25/25 at 11:05 a.m., the Executive Director indicated there had been no physical changes to the room which had a previous room waiver since the last survey.A bed inventory form, dated 8/25/25, indicated room [ROOM NUMBER] contained two beds.A review of the facility measurements for room [ROOM NUMBER] indicated the bedroom did not provide 80 square feet per resident. room [ROOM NUMBER] was 153.83 square feet, and according to Life Safety Code the double occupancy in room [ROOM NUMBER] measured out to 76.9 square feet per resident. A Bed Inventory form indicated room [ROOM NUMBER] was a Title 19 NF (Medicaid) room and was certified for two resident beds. Facility documentation for the room size certification indicated the following: room [ROOM NUMBER], 2 beds/NF, 153.83 Sq.Ft/76.9 Sq.Ft for each resident.During an interview, on 8/26/25 at 9:47 a.m., the Executive Director indicated the facility followed the state regulations.3.1-19(l)(2)(A)