STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Strategies	505 N Gavin St Muncie, IN 47303

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and interview, the facility failed to ensure licensed nursing coverage 24-hour basis for 11 days of the second (2nd) quarter of 2025 reviewed for sufficient staffing. This deficiency had the potential to affect 39 of 39 residents residing in the facility.Finding includes: A Payroll-Based Journal (PBJ) Staffing report, for the second quarter of 2025, indicated the facility failed to ensure Licensed Nursing Coverage 24/7 on the following dates: 1/6, 1/11, 1/13, 2/6, 2/7, 2/8, 2/9, 2/10, 2/17, 2/20, and 3/30.Review of the current Facility Assessment, on 8/20/25 at 9:37 a.m., updated 8/1/25, the resident acuity (the level of care and supervision) affecting licensed nurses was as follows: Respiratory treatments for 3 residents, Behavioral/Mental health for 39 residents, Medication Administration for 39 residents, Hospice Care for 1 resident, and Wound Care for 2 residents. The facility overall staffing needs indicated 2 Registered Nurses (RNs) providing direct care and 4 Licensed Practical Nurses (LPNs) providing direct care. The facility available staff were documented as 4 RNs available to provide direct care, 4 LPNs available to provide direct care, and 3 Qualified Medication Aides (QMAs).During an interview, on 8/21/25 at 10:00 a.m., the Administrator indicated he was aware the facility had issues with licensed nurse staffing in January, February, and March of 2025. He ran the clock-in/clock-out reports every Monday and sent them to the corporate office, where they were reviewed and sent in to report the licensed nurse coverage hours. He indicated the situation was resolved, as the facility had been able to hire more nursing staff. QMA 9 was responsible for scheduling in the facility. During an interview, on 8/21/25 at 1:45 p.m., QMA 9 indicated she was responsible for the scheduling of the facility and tried to ensure there was licensed nurse coverage 24 hours a day. She made multiple attempts to fill the nursing hours through the company messaging system and called sister facilities to gain access to additional staff. This situation was resolved since the facility hired more staff to cover the continuous licensed nurse hours.During an interview, on 8/22/25 at 1:57 p.m., the DON indicated she was not aware of any shift without and LPN or RN on staff. She started her role as DON on 1/1/25. The nursing staff worked either 8 or 12 hour shifts. She usually worked during the day from 9:00 a.m.- 5:00 p.m., but often worked later and covered other shifts as needed. She was usually the RN coverage contact person and available by telephone 24/7. She indicated she would not be able to verify which staff members were working on the days listed in the PBJ report as she did not have access to the clock-in/clock-out reports. A record review, on 8/22/25 at 2:38 p.m., of the clock-in/clock- out reports, provided by the Business Office Manager (BOM), indicated the following days/times lacked 24/7 licensed nurse coverage: 1/6/25: 6:00 a.m. - 9:51 a.m., 2:39 p.m.- 9:48 p.m., and 1:28 a.m.- 6:00 a.m. 1/11/25: 6:00 a.m.- 9:57 a.m., 2:51 p.m.- 10:00 p.m., and 10:00 p.m.- 6:00 a.m.1/13/25: 6:00 a.m.- 7:53 a.m. and 5:48 p.m. - 7:37 p.m. 2/6/25: 6:00 a.m.- 6:15 a.m., 6:46 p.m.- 10:00 p.m., and 10:00 p.m.- 6:00 a.m.2/7/25: 4:32 p.m.- 6:30 p.m. and 2:58 a.m. - 6:00 a.m.2/8/25: 10:02 a.m. - 6:00 p.m. and 11:51 p.m.- 6:00 a.m.2/9/25: 11:47 a.m.- 2:00 p.m., 2:00 p.m. - 6:00 p.m., and 2:55 a.m. - 6:00 a.m.2/10/25: 6:00 a.m.- 10:14 a.m. and 5:25 p.m. - 10:04 p.m.2/17/25: 6:00 a.m.- 6:25 a.m., 3:10 p.m.- 6:09 p.m., and 11:57 p.m.- 6:00 a.m.2/20/25: 6:00 p.m.- 6:30 p.m. and 10:27 p.m.- 6:00 a.m.3/30/25: 6:00 p.m.- 7:01 p.m. and 12:10 a.m.- 6:00 a.m. A facility policy, revised 8/06, titled, Department Duty Hours, Nursing Services, (continued on next page)

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	provided by the DON on 8/22/25 at 12:47 p.m., indicated the following: 1. Nursing service is provided twenty-four (24) hours per day, seven days a week. The requirements for long term care facilities require that a skilled nursing facility provided 24-hour licensed nursing services . 3.1-17(a)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 interview and record review, the facility failed to ensure a Registered Nurse was present in the facility for 8 hours during a 24-hour period for 25 days of the 2nd Quarter of 2025 reviewed for sufficient staffing. This deficiency had the potential to affect 39 of 39 residents residing in the facility.Findings include: A Payroll-Based Journal (PBJ) Staffing report, for the second quarter of 2025, indicated the facility failed to have Registered Nurse coverage for 1/3, 1/6, 1/9, 1/10, 1/11, 1/12, 1/17, 1/20, 1/23, 1/24, 1/25, 1/26, 1/27, 1/31, 2/3, 2/6, 2/7, 2/8, 2/9, 3/8, 3/9, 3/23, 3/29, and 3/30. During an interview, on 8/21/25 at 10:00 a.m., the Administrator indicated he was aware the facility had issues with staffing RNs in January, February, and March of 2025. He ran the clock-in/clock-out reports every Monday and sent them to the corporate office where they were reviewed and sent in to report the RN hours. He indicated the situation was resolved as the facility now had multiple RNs on staff to ensure the 8 hours of RN coverage. QMA 9 was responsible for scheduling in the facility. During an interview, on 8/21/25 at 1:30 p.m., the DON indicated she utilized the clock-in/clock-out process for her scheduled shifts. She usually worked during the day from 9:00 a.m.- 5:00 p.m., but often worked later and covered other shifts as needed. She was usually the RN coverage contact person and available by telephone at all times. QMA 9 was responsible for the scheduling of the facility staff. The situation was resolved as there are more RNs on staff now to cover the RN hours needed. During an interview, on 8/21/25 at 1:45 p.m., QMA 9 indicated she was responsible for the scheduling of the facility and tried to ensure there was 8 hours of RN coverage daily. She made multiple attempts to fill the RN hours through the company messaging system and calling the sister facilities to gain access to additional RNs. This situation was resolved since the facility hired more staff to cover the daily RN hours. A record review, on 8/22/25 at 10:26 a.m. of the facility clock-in/clock-out reports indicated there was no RN coverage for 1/3, 1/6, 1/9, 1/10, 1/11, 1/12, 1/17, 1/20, 1/23, 1/24, 1/25, 1/26, 1/27, 1/31, 2/3, 2/6, 2/7, 2/8, 2/9, 3/8, 3/9, 3/23, 3/29, and 3/30. A facility policy, revised 8/06, titled, Department Duty Hours, Nursing Services, provided by the DON on 8/22/25 at 12:47 p.m., indicated the following: 1. Nursing service is provided twenty-four (24) hours per day, seven days a week. The requirements for long term care facilities require that a skilled nursing facility provided 24- hours licensed nursing services, and RN for 8 consecutive hours per day, 7 days a week . 3.1-17(b)(3)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to ensure residents, for whom the facility managed funds, or their representatives, received quarterly funds statements for 2 of 3 residents reviewed for quarterly statements. (Residents F and H)Findings include:A current 8/19/25, facility Trail Balance resident funds statement indicated the facility managed personal funds for 32 residents. Residents E, F and H names were listed on the account list.Quarterly statements were requested of facility management for review for Residents E, F, and H. Residents F and H did not have quarterly statements for review. During an interview on 8/20/25 at 1:36 p.m., the Administrator and Business Office Manager both indicated that quarterly statements had not been given to residents who did not have a responsible party to receive them. This had been an error and residents should have received the statements themselves.A current, 2017, facility policy titled, Deposit of Resident Funds, provided by the Business Office Manager on 8/20/21 at 1:38 p.m., indicated The resident is provided a confidential quarterly statement on funds on deposit with the facility.This citation relates to Complaint 2588630. 3.1-6(g)

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to provide a surety bond in sufficient amount to safeguard all resident funds. This deficient practice had the potential to impact 32 of 32 residents for whom the facility managed funds. Findings include: Review of a current 8/19/25, facility Trail Balance resident funds statement indicated the facility managed resident funds for 32 residents.Review of the facility's current, April 1, 2022, surety bond agreement indicated the resident funds were covered in liability surety for the amount of $30,000.00 (thirty thousand dollars).A review of bank statements for July 2025 (7/1/25 to 7/31/25), June 2025 (5/31/25 to 6/30/25) and May 2025 (5/1/25 to 5/30/25) indicated 23 days had a daily ledger balance greater than $30,000.00 as follows: 7/3/25 $41,381.03, 7/7/25 $41,422.03, 7/9/25 $43,429.03, 7/13/25 $42,740.03, 7/16/25 $43,099.03, 7/21/25 $31,950.82, 7/22/25 $32,192.32, 7/23/25 $31,869.32, 7/25/25 $31,773.27, 7/28/25 $30,109.89, 6/3/25 $42,544.15, 6/4/25 $48,374.65, 6/5/25 $39,050.65, 6/6/25 $37,644.65, 6/9/25 $38,670.65, 6/11/25 $38,802.65, 5/2/25 $42,023.85, 5/7/25 $42,188.85, 5/8/25 $42,658.85, 5/9/25 $47,217.85, 5/12/25 $46,917.85, 5/14/25 $46,096.55, and 5/21/25 $30,107.55.During an interview on 8/20/25 at 9:30 a.m., the Business Office Manager indicated the facility did not complete the reviews to ensure the surety bond was sufficient for the coverage of the balance of resident funds. It was completed through the home office.A current, 2017, facility policy titled, Management of Residents' Personal Funds, provided by the Business Office Manager on 8/20/21 at 1:38 p.m., indicated .Should the facility manage the resident's funds, the facility will act as a fiduciary of the resident funds and hold, safeguard manage, and account for the personal funds of the resident. This citation relates to Complaint 2588630. 3.1-6(i)

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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. Based on interview and record review, the facility failed to notify a resident's representative regarding change in condition for 1 of 3 residents reviewed for change in condition. (Resident C)Finding includes: Resident C's record was reviewed on 8/19/25 at 12:31 p.m. Medical diagnoses included paranoid schizophrenia, hypertension, and gastro-esophageal reflux disease (acid reflux).A 5/27/25, quarterly, quarterly Minimum Data Set (MDS) indicated the resident was mildly cognitively impaired.A nurse's note, dated 7/22/25 at 12:39 p.m. indicated the resident was found cool, clammy, tachycardic (high heart rate), and hypertensive (high blood pressure). The resident was encouraged to take her blood pressure medication and drink fluids, but verbally refused and swatted at a cup containing the medication. The note lacked notification of family or the resident representative.A progress note dated 7/22/25 at 2:57 p.m. indicated the resident was excessively sweating, tachycardic, hypertensive, and tachypneic (high respiratory rate) and continued to refuse medications and fluids. The nurse practitioner (NP) was contacted and an order received to send the resident to the emergency room (ER). The resident's representative was informed of the transfer.During an interview with the Infection Preventionist (IP) on 8/20/25 at 1:56 p.m., she indicated Resident C was a very private person, but would often say hello to her during the day. On the morning of 7/22/25, the resident did not say hello to her and was not acting at her baseline. The IP noted the resident was cold, restless, and sweaty. The IP informed the DON, who attempted to get the resident to drink fluids and take her medication. The resident adamantly refused. Around approximately 2 p.m., a CNA approached the IP and indicated the resident remained altered, tachycardic, and more restless than previously. The IP called the NP, who told her to send the resident to the ER.During an interview with the DON, on 8/21/25 at 9:18 a.m., she indicated Resident C was a very private person and frequently refused her medications. On 7/22/25, the DON was approached by staff who indicated the resident was altered and had an elevated blood pressure. The DON attempted to give the resident her blood pressure medication, but the resident verbally refused and swatted at the medicine cup. The DON indicated later on that day, she was approached by the IP, who indicated the resident remained altered and was being sent to the hospital.During an interview with LPN 7 on 8/21/25 at 10:33 a.m., she indicated when a change of condition occurred, the resident would be assessed first, then depending on the condition of the resident, the provider and family would be contacted.During an interview with the DON on 8/21/25 at 10:40 a.m. she indicated when she worked with Resident C on 7/22/25, she was not acting at her baseline. When a change of condition was identified, staff were supposed to fill out an electronic interaction (e-Interact) form, which included notification of family or the resident representative.During an interview with the DON on 8/22/25 at 10:59 a.m., she indicated nursing staff were expected to contact family and resident representatives when a change of condition was identified and this would be charted in a progress note.A current facility policy, titled Change in a Resident's Condition or Status, and provided by the DON on 8/22/25 at 11:05 a.m. indicated the following, .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., change in level of care, billing/payments, resident rights, etc.) .4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: .b. There is a significant change in the resident's physical, mental, or psychosocial status; .e. It is necessary to transfer the resident to a hospital/treatment center This citation relates to Complaint 2588630.3.1-5(a)(2)3.1-5(a)(3)

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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 obtain physician orders for oxygen services for 1 of 1 residents reviewed for oxygen use. (Resident 5)Finding includes:During an interview with Resident 5 on 8/19/25 at 10:05 a.m., he indicated he used oxygen at 3 liters per minute (lpm) via nasal cannula all the time, except when smoking. During the interview, the resident's oxygen concentrator was observed to be on 4 lpm of oxygen. The resident indicated he had not adjusted the flow rate. During an interview with Resident 5 on 8/20/25 at 8:42 a.m., he indicated his oxygen flow had not been adjusted. The oxygen concentrator remained on 4 lpm.Resident 5's record was reviewed on 8/20/25 at 10:35 a.m. Diagnoses included acute and chronic respiratory failure, atrial fibrillation (abnormal heart rhythm), and generalized anxiety disorder.Current physician orders included change nebulizer tubing weekly on Sunday night shift every Sunday, nebulizer machine for as needed (PRN) albuterol (respiratory medication) nebulization (changing a liquid medication into a gas).The record lacked orders regarding oxygen administration and flow rate.A 7/17/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. Specialized services included continuous oxygen therapy.A current care plan initiated on 3/6/25 indicated the resident had acute and chronic respiratory failure. Interventions included oxygen per physician orders.An advanced practice registered nurse (APRN) note dated 4/4/25 at 9:35 p.m. indicated the resident's oxygen was set on 3 lpm.An APRN note dated 5/9/25 at 11:56 p.m. indicated the resident ?s oxygen was set on 4.5 lpm.On 8/21/25 at 9:04 a.m., Resident 5's oxygen concentrator was set on 4 lpm.During an interview with LPN 7 on 8/21/25 at 10:33 a.m., she indicated Resident 5 was normally on 2 lpm of oxygen.During an interview with Resident 5 on 8/22/25 at 8:43 a.m., he indicated his oxygen had not been adjusted. His oxygen concentrator was on at 4 lpm.During an interview with the DON on 8/22/25 at 11:01 a.m., she indicated Resident 5 used continuous oxygen and was on 2 lpm per physician order. During an interview with the DON on 8/22/25 at 12:29 p.m., she indicated Resident 5 did not have a current order for oxygen, but should have had an order.A current facility policy titled, Oxygen Administration and provided by the IP on 8/22/25 at 11:05 a.m. indicated the following, .Procedure: 1. Heck physician's order for O2, liter flow, and method of administration.7. At regular intervals, check liter flow of oxygen, fluid level in humidifier, and assess resident's respiration to determine effectiveness of oxygen therapy.3.1-47(a)(6)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure complete and accurate daily nurse staffing information was posted and readily available for residents and resident representatives. This deficiency had the potential to affect 39 of 39 residents residing in the facility. Finding includes:During an observation, on 8/18/25 at 7:34 a.m., the 'Daily Staffing Posting without Units' information sheet was dated Thursday, 8/14/25. This was posted on the wall behind the nurse's station. On 8/18/25 at 9:30 a.m., the Daily Staffing Posting without Units was dated Monday, 8/18/25 and indicated there were no Registered Nurses (RN) or Licensed Practical Nurses (LPN) scheduled for the evening and night shifts, and there were no Certified Nursing Assistants (CNA) scheduled for the night shift. On 8/20/25 at 9:32 a.m., the 'Daily Staffing Posting without Units' indicated there were no RNs or LPNs on the evening shift. During an interview, on 8/21/25 at 1:45 p.m., QMA 9 indicated she was responsible for updating the nurse staffing post everyday. She arrived at work between 8:30 and 9:00 a.m. and printed the document from the online system. The online system populated the information from the schedule she completed. She indicated when there were open shifts in the schedule she filled them as quickly as possible and updated both the schedule and daily nurse staff posting. She printed the weekend nurse staff postings on Friday and the floor staff were responsible for changing the posting on Saturday and Sunday. A review of the facility staffing clock-in/clock- out sheets, on 8/21/25 at 2:14 p.m., indicated on 8/18/25 there was an RN present on the evening and night shifts, and an LPN present for the evening shift. There were 2 CNAs present. On 8/20/25 there was one LPN present on the evening shift. During an interview, on 8/21/25 at 2:34 p.m., the Administrator indicated QMA 9 was responsible for completing the daily staff posting. This task was to be completed every morning. A facility policy, revised 7/16 and titled, Posting Direct Care Daily Staffing Numbers, provided by the Administrator on 8/21/25 at 10:15 a.m., indicated the following: .Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RN, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format .When computing hours of direct care working split shifts, count only the total numbers of hours the individual is actually scheduled to work for the shift information being posted

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on observation, interview, and record review the facility failed to provide social services regarding financial management regarding the management of cash savings and spending down of resources to remain eligible for Medicaid for 2 of 3 residents reviewed for assistance to manage finances. (Resident C and D)Findings include:1.During an interview, Resident C's representative indicated the resident's funds had not been managed correctly. The resident had cash funds stored in the Social Service office, not the business office. There was no method to account for what funds had been spent. At the time of discharge, the representative was given cash in the amount of $700 dollars, and the family thought their loved one should have more money. The facility staff informed them the resident purchased lots of snacks, when they questioned the amount of money returned to them.During an interview on 8/21/25 at 1:00 p.m., the Administrator indicated he had not known Resident C had cash in the Social Service office until he witnessed it being given to the family at the resident's discharge.During an interview on 8/21/25 at 1:08 p.m., the Social Services Director (SSD) indicated the following:She had stored Resident C's personal money in a locked file cabinet in the Social Service office. She had received $900.00 in cash from the resident shortly after the resident's admission. The resident had a fear of banks. The SSD had not had the resident sign any form or paperwork indicating her money was stored in the SSD's office. The SSD had not kept a record of money the resident had received, nor had she had the resident sign any receipt for said money. The SSD had not talked to the resident's family member about the money being locked in the SSD office. She had not considered if the money would be covered by the surety bond or facility insurance. She had not developed any type of care plan for the resident regarding the safety and use of her money, which was stored in the SSD office. She had made purchases for the resident using said money. She had given the resident every receipt. The resident mostly purchased snacks. She was unsure if the Administrator was aware of said money being in the SSD office. She had given Resident C's family member $700 dollars at the time of the resident's discharge.Resident C's clinical record was reviewed on 8/19/25 at 12:31 p.m. Diagnoses included paranoid schizophrenia and hypertension.A 5/27/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident C was moderately cognitively impaired and required assistance with decision making.2. A current, facility, 8/19/25, Trail Balance resident funds statement indicated Resident D had a current balance of $20,619.36. A resident specific quarterly statement indicated Resident D received a deposit of $22,466.00 in March 19, 2025. The facility was the resident's representative payee.Four letters addressed to Resident D, titled Resident Funds Balance Notification, dated April 30, 2025, May 30, 2025, June 30, 2025, and July 31, 2025 indicated the following: This letter is to notify you that your current Resident Funds Balance is within $200.00 or exceeding what is allowed under Medical Assistance. Please contact your Social Worker within the next 7 days to discuss ways to assure continuance of Medicaid benefits. None of the 4 letters indicated the information had been verbally shared with the resident, nor did it indicated assistance had been offered.During an interview on 8/21/25 at 10:00 a.m., Resident D indicated he didn't believe he had any extra money to spend. If he had extra money, he'd really like to look into a different place to live. Additionally, if he had to stay at the facility, he'd spend his money on clothes and room decorations such as posters. During an observation at this time, the resident's room lacked any room decorations.Resident D's record was reviewed on 8/19/25 at 2:29 p.m. Current diagnoses included hypertension, diabetes, major depressive disorder, and unspecified dementia. The resident received Medicaid benefits.A 7/11/25, significant change, MDS assessment indicated the resident was moderately cognitively impaired and required assistance with decision making.A current 8/19/25 care plan indicated the resident had impaired decision making. The care plan originated 11/2024.A current 12/10/24 care plan indicated the resident had an alteration in mental functioning due to mental health diagnoses. The clinical record lacked documentation or plan of care regarding the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Strategies	505 N Gavin St Muncie, IN 47303

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's need to spend his money in order to remain eligible for Medicaid.During an interview on 8/21/2025 at 11:38 a.m., the Business Office Manager indicated the facility had no documentation of action taken to assist Resident D in spending his resources. The Corporate Director of Business Office Operation had told her because the resident had nine months to spend down his resources, the facility had not needed to assist the resident yet. The cooperate consultant hadn't assisted him yet and planned to come and start Monday, 8/25/25. This citation relates to Complaint 2588630. 3.1-34(a)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies. Findings include:Review of the Summary Statement of Deficiencies, for the facility's last annual Recertification and State Licensure Survey completed on 9/26/24, indicated the facility failed to ensure nurse staffing information readily available in a readable format to residents and visitors daily. The plan of correction indicated, A new updated form was completed and placed in accessible area to resident and visitors, all staff that complete the daily nurse staffing information forms have been provided a revised form and provided education on the completion and accessibility to resident and visitors. Each morning, upon arrival to the facility the Administrator and/or Designee will ensure the current day's nurse staffing information was completed. Repeat concerns regarding complete and accurate daily nurse staffing posting were cited during the August 18, 2025, survey as follows: Based on observation and interview, the facility failed to ensure complete and accurate daily nurse staffing information was posted and readily available for residents and resident representatives. This deficiency had the potential to affect 39 of 39 residents residing in the facility.During and interview, on 8/22/25 at 1:07 p.m., the Administrator indicated the facility completed the Plan of Correction for last year's citation on 1/17/25. The audits tools utilized indicated there were no concerns and the daily staffing was posted appropriately. A previous citation's plan of correction was usually completed within six months and if there were no concerns it would be considered completed. This issue was not reviewed in QAPI after this date. A facility policy, dated 4/19, titled, Quality Assurance & Performance Improvement (QAPI) Program Process, provided by the DON on 8/22/25 at 11:05 a.m., indicated the following: Goal: To provide consistent, comprehensive and ongoing quality resident care .3. To identify areas in need of improvement .5. To implement action for resolution of known problem areas at the time ., 6. To provide audit tools whereby immediate implementation of corrective action is taken at the point of care delivery .Cross reference F732.3.1-52(b)(2)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to provide education for and to offer administration of influenza and/or pneumococcal vaccinations to residents for 3 of 5 residents reviewed for vaccinations. (Residents K, 5, and 7)Finding includes: 1.Resident 7's clinical record was reviewed on 8/19/25 at 1:25 p.m. Diagnoses included heart failure, asthma, and anxiety disorder. An 8/7/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The record lacked influenza and pneumococcal vaccine education or administration records. During an interview with the DON on 8/22/25 at 11:34 a.m., she indicated she was unable to locate information regarding resident 7's influenza or pneumococcal vaccination status. 2.Resident 5's record was reviewed on 8/20/25 at 10:35 a.m. Medical diagnoses included acute and chronic respiratory failure, hypertension, and anxiety disorder. A 7/17/25, quarterly, MDS assessment indicated the resident was cognitively intact. The clinical record indicated the resident received an unspecified pneumococcal vaccine in 2013, prior to admission to the facility. During an interview with the DON on 8/22/25 at 11:01 a.m. she indicated Resident 5's clinical record showed a pneumococcal vaccine in 2013, but the facility was unable to verify what type of vaccine was received and could not verify the resident was offered additional pneumococcal vaccination on admission. 3. Resident K's clinical record was reviewed on 8/19/25 at 2:02 p.m. Diagnoses included coronary artery disease, malignant neoplasm of the prostate, hypertension, and hyperlipidemia. A 4/15/25, annual, MDS assessment indicated the resident had severe cognitive impairment. The resident signed a consent form for the Pneumovax 23 on 12/12/24. The clinical record lacked documentation indicating the vaccination was provided. During an interview, on 8/22/25 at 11:06 a.m., the DON indicated she was unable to locate documentation indicating Resident K received the Pneumovax 23 vaccination. The consents and/or declinations were to be utilized for all vaccinations and kept in the resident's record. Once the consent were signed, the resident should have received the vaccination as soon as possible. A current facility policy titled, Influenza, Prevention, and Control of Seasonal, provided by the IP on 8/22/25 at 9:33 a.m. included the following, .Vaccination 1. The Infection Preventionist will promote and administer seasonal influenza vaccine. 2. Unless contraindicated, all residents and staff will be offered the vaccine. A current facility policy titled, Immunization Program Policy, provided by the DON on 8/22/25 at 11:05 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m. indicated the following: Policy: To ensure all residents residing in the facility are offered annual influenza vaccines and at least one pneumococcal vaccine after obtaining informed consent and a physician's order, unless the vaccine is determined to be medically contraindicated.4. The facility will administer immunizations in accordance with recommendations established by the Centers for Disease Control and Prevention in effect at the time the immunization is administered. 3.1-18(b)(5)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to educate on offer the COVID-19 vaccination to employees for 1 of 1 employees reviewed for COVID-19 vaccination. (CNA 8)Finding includes:During an interview with CNA 8 on 8/22/25 at 8:45 a.m., she indicated she had worked at the facility for approximately two years. During her time at the facility, she had not been educated on or offered the COVID-19 vaccination.During an interview with the IP on 8/22/25 at 8:57 a.m., she indicated the facility had no documentation of vaccination education or offerings from 2024.A current facility policy titled, COVID-19 Vaccination Policy provided by the DON on 8/22/25 at 11:05 a.m. indicated the following, .7 The infection prevention and control measures that are implemented to address the SARS-CoV-2 are incorporated into the facility infection prevention and control plan. These measures include: a. encouraging staff, residents and visitors to remain up-to-date with all COVID-19 vaccine doses; b. providing resources and counseling about the importance of receiving the COVID-19 vaccine.