STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. Building B. Wing	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allison Pointe Healthcare Center	5226 E 82nd Street Indianapolis, IN 46250

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41129 Based on observation and interview, the facility failed to maintain a clean, sanitary, homelike environment by having a shower room on the Cambridge unit with dirty towels on the floor, handrails and sink; and shower curtains hanging down and not properly hung by hooks; and a shower room on the [NAME] unit with a pile of hair on the floor with the potential to affect 123 residents residing at the facility. Findings include: A complaint was received by the Indiana Department of Health on 5/16/22. It indicated; the shower rooms were very dirty. An observation was made of the two shower rooms on the [NAME] unit on 5/24/22 at 10:38 a.m. One of the shower rooms had a large pile of dry brown hair on the floor. It appeared as if someone had used clippers to give themselves a haircut and left the pile of brown hair on the floor. The sink in this shower room was also covered with bits of hair clippings. An observation was made of the two shower rooms on the Cambridge unit on 5/26/22 at 8:42 a.m. One shower room appeared to be used for storage and the other had dirty, used towels and washcloths on the floor, a clear plastic bag with used towels sitting in the sink, a stack of wipes not in a container sitting on a shower chair and some on the floor, a used washcloth was on hanging on the grab bar, and two shower curtains not securely hung from all hooks. An interview with Resident D was conducted on 5/17/22 at 10:42 a.m. They indicated, about a month ago there was feces on the floor for 3 days in the shower room on [NAME]. An interview with CNA (Certified Nursing Assistant) 42, who worked on the Cambridge unit, was conducted on 5/26/22 at 8:47 a.m. She indicated, she cleans the shower rooms before and after a resident uses it but hadn't given anyone a shower yet that day. An interview with CNA 43 was conducted on 5/26/22 at 8:51 a.m. indicated, it is the responsibility of the aides to clean the shower rooms after a resident has used it. She also stated, she had not given any showers yet that day. This Federal tag relates to complaint IN00380287. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-19(f)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on observation, interview, and record review, the facility failed to provide bathing, as scheduled, dressing, as needed, and nail care for a dependent resident for 3 of 9 residents reviewed for ADL (activities of daily living) care and 1 of 4 residents reviewed for choices. (Residents G, F, 5, and 33) Findings include: 1. The clinical record for Resident 33 was reviewed on 5/18/22 at 11:00 a.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and hemiplegia. The ADL (activities of daily living) care plan, revised 2/28/22, indicated she had an ADL self-care performance deficit related to her COPD and hemiplegia. An intervention was to offer her a shower twice a week per her choice. The unit shower schedule was located in a binder at the nurse's station. Resident 33's shower schedule was during day shift, twice weekly on Tuesday and Friday. An interview was conducted with Resident 33 on 5/18/22 at 11:25 a.m. She indicated her shower day was yesterday, but staff didn't offer or give her a shower. She hadn't had a shower in a month. Staff would give her a washcloth to wash up, but she wanted a shower and did not refuse them. The last 30 days of bathing documentation from the tasks section of the EHR (electronic health record) indicated bathing was provided on the following days: a bed bath on 5/3/22 at 7:37 a.m., a bed bath on 5/6/22 at 2:29 p.m., and a bed bath on 5/20/22 at 2:29 p.m. There were no refusals indicated. An interview was conducted with UM (Unit Manager) 22 on 5/24/22 at 10:50 a.m. She indicated any bathing documented on the shower sheets should also be documented in the tasks section of the electronic health record. Shower sheets for the last 30 days were provided by the DON (Director of Nursing) on 5/24/22 at 2:03 p.m. They indicated showers were provided on the following dates: 4/25/22, 4/30/22, 5/2/22, 5/6/22, 5/10/22, 5/17/22, 5/20/22, 5/21/22, and 5/23/22. An interview was conducted with Resident 33 on 5/24/22 at 9:48 a.m. She indicated the shower sheets for the last 30 days were not accurate, but the 3 documented in the tasks section of the EHR sounded more accurate, if that. 40287 2. The clinical record for Resident G was reviewed 5/16/22 at 3:05 p.m. The Resident's diagnosis included, but were not limited to, tracheostomy and acute respiratory failure. An Admission Initial Evaluation, dated 5/3/22, indicated she was dependent on personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/16/22 3:05 p.m., she was observed laying in her bed. She had a splint on her right hand. Her nails were long with chipped purple nail polish on them. On 5/19/22 at 10:46 a.m., she was observed lying in bed. She had a hand splint on her right hand. Her nails continued to be long, and the index fingernail was broken off. They continued to have chipped purple nail polish on them. On 5/24/22 at 11:30 a.m., she was observed laying in her bed. Her nails continued to be chipped and long. LPN (Licensed Practical Nurse) 13 indicated that her fingernails needed to be cut. On 5/25/22 at 10:34 a.m., the DON (Director of Nursing) provided the Nail and Hair Hygiene Services Policy, last reviewed on 2/15/22, which read .This facility will provide routine care for the resident for hygienic purposes and for the psychosocial well-being of the resident including .nail hygiene services including routine trimming, cleaning, and filing. Routine Nail Hygiene .may be performed in conjunction with bathing or performed separately . 41129 3. The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder. Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. Resident 5's annual MDS dated [DATE] indicated, it was very important for her to choose the clothes she wears. An interview with Resident 5 was conducted on 5/17/22 at 1:47 p.m. Resident 5 was wearing a hospital gown at the time and indicated, she prefers to be dressed in her own clothes rather than the hospital gown. An observation of Resident 5 was made on 5/18/22 at 10:42 a.m. Resident 5 was in her room, lying in her bed and wearing a hospital gown. An observation of Resident 5 was made on 5/19/22 at 12:51 p.m. Resident 5 was in the main dining room sitting in a high back wheelchair. She was wearing a hospital gown and had a sheet over her lap. An observation of Resident 5 was made on 05/20/22 at 9:47 a.m. Resident 5 was in her room, lying in bed and wearing a hospital gown. An observation of Resident 5 was made on 5/20/22 at 1:32 p.m. Resident 5 was in her room, lying in bed and wearing a hospital gown. An observation of Resident 5 was made on 5/23/22 at 10:45 a.m. and 2:27 p.m. During both observations, Resident 5 was wearing a hospital gown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident 5 was conducted on 5/20/22 at 9:47 a.m. She indicated, prefers to wear clothing rather than a hospital gown. She stated, my dignity is being taken away from me and I'm trying to save what dignity I have left in reference to being in the dining room the previous day while wearing a hospital gown. An interview with Resident 5 was conducted on 5/23/22 at 2:37 p.m. Resident 5 was wearing a hospital gown and stated no one had asked her if she wanted to get dressed today, but she had requested to get dressed because someone was coming to visit her later. 4. The clinical record for Resident F was reviewed on 5/19/22 at 3:44 p.m. Resident F's diagnoses included, but not limited to, end stage renal disease, cerebral infarction, and chronic obstruction pulmonary disease. Resident F's annual MDS (Minimum Data Set) dated 3/9/22 indicated, Resident F was cognitively intact. It also indicated, the choice between a bed bath or shower was very important to them. An interview with Resident F was conducted on 5/17/22 at 9:41 a.m. They indicated, they had to fight to get a shower. They stated, they were supposed to get a shower last weekend on Saturday, 5/14/22, but it didn't happen, and no one even asked them if they wanted a shower. They indicated, they don't like to use the sink in their room because the sink was used to clean up their roommate after an incontinent episode and the staff didn't clean the sink afterward. They further stated, they prefer showers and only need someone to prep the room and help them into the shower room since they were in a wheelchair. An interview with Resident F was conducted on 5/19/22 at 3:01 p.m. They indicated, they had received a shower today but, had not received one in a week prior to this one. A copy of Resident F's Documentation Survey Report was received on 5/20/22 at 9:17 a.m. from NC (Nurse Consultant) 2. Under the section listed as Bathing per residents choice, it indicated Resident F received bed baths/showers on the following days: 3/1/22 bed bath 3/8/22 bed bath 3/17/22 bed bath 3/22/22 bed bath 3/26/22 bed bath 3/29/22 bed bath 4/14/22 bed bath 4/19/22 bed bath 4/26/22 bed bath (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/28/22 shower 4/30/22 bed bath 5/3/22 bed bath 5/5/22 shower 5/7/22 bed bath 5/10/22 NA code- code legend does not contain a code NA 5/12/22 shower 5/14/22 bed bath 5/17/22 bed bath 5/19/22 shower The DON (Director of Nursing) provided Resident F's shower sheets on 5/19/22 at 1:11 p.m. The shower/bed bath sheets for 5/14/22 nor the 5/17/22 bed baths were not located. The [NAME] unit's shower sheet binder was observed on 5/19/22 at 10:11 a.m. The only shower sheets found for Resident F were for the following dates: 4/28, 5/3, 5/5, and 5/12/22 An interview with Resident F was conducted on 5/19/22 at 3:17 p.m. Resident F indicated, they did not receive a bed bath or shower on 5/17/22 nor does she ever take bed baths. They again stated, they had not received a shower for a week. A Routine Resident Care policy was received from DON (Director of Nursing) on 5/23/22 at 9:54 a.m. The policy indicated, It is the policy of this facility to promote resident centered care by attending to the physical, emotional, social, and spiritual needs and honor resident lifestyle preferences while in the care of this facility . Unlicensed staff .Routine care by nursing assistant includes but is not limited to the following: Assisting or provides for personal care .dressing . A Personal Bathing and Shower policy was received on 5/23/22 at 9:54 a.m. from DON. The policy indicated, Resident have the right to choose their schedules, consistent with their interests, assessments, and care plans including choice for personal hygiene. This includes, but is not limited to, choices about the schedules and type of activities for bathing that may include a shower, a bed-bath or tub bath, or a combination and on different days .Bathing preference should be care planned including type and schedule. This Federal tag relates to complaints IN00379801 and IN00379484. 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-38(a)(3)(E) 3.1-38(b)(2)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on interview and record review, the facility failed to administer residents' medications as ordered, timely address skin conditions, provide wound care as ordered, and administer treatments as ordered, resulting in debridement and delayed surgery for wound closure; for 3 of 3 residents reviewed for skin conditions, 1 of 3 residents reviewed for hospitalization , and 3 of 8 residents reviewed for unnecessary medications. (Residents B, F, 37, 82, 103, 229, and 233) Findings include: 1. The clinical record for Resident B was reviewed on 5/20/22 at 10:00 a.m. The diagnoses included, but were not limited to, neurogenic bladder. He was admitted to the facility from the hospital on 3/10/22. He discharged from the facility on 4/27/22 for a planned surgery for wound closure. The 3/10/22 hospital discharge summary read, Condition on Discharge/Disposition: Stable condition will require extensive wound care and working with PT [Physical Therapy] and OT [Occupational Therapy.] The 3/10/22, 5:54 p.m. nurse's note indicated his wound vac was removed before being transported to the facility and had instructions to leave the wound vac off until Monday 3/14/22, as it would be put back on after his visit to the hospital wound clinic at 7:45am. He was currently using a wet to dry dressing. The 3/11/22, 5:11 p.m. Skin/Wound Note, written by the facility Wound Nurse, indicated Resident B had a surgical incision wound\line separation that went from his buttocks, perineum and left thigh region. The Wound Nurse was notified by the hospital emergency room nurse and EMT (emergency medical technicians) and family at bedside that resident's wound vac (vacuum) would be off until his 3/14/22, 7:45 a.m. hospital wound clinic appointment. The physician's orders indicated to cleanse buttock/perineum/incision/wound with normal saline, pat dry, apply wet-to-moist dressing/border gauze daily and as needed every day shift for surgical incision/line separation wound, effective 3/11/22. The March 2022 TAR (treatment administration record indicated this was not done on 3/12/22, 3/13/22, or 3/14/22. An interview was conducted with the Wound Nurse in the presence of the DON on 5/23 at 3:57 p.m. She indicated Resident B was supposed to admit to the facility with a wound vac, but didn't, so they got an order for the wet to dry dressing daily. She was unsure why it wasn't completed his first couple days in the facility. If they were completed, they should have been signed off on the TAR. There were no 3/14/22 hospital wound clinic notes. An interview was conducted with the facility Wound Nurse on 5/20/22 at 11:21 a.m. She indicated she was the wound nurse in March 2022 when Resident B admitted to the facility. They had issues with transportation getting him to his weekly wound appointments. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 3/16/22 hospital wound clinic note indicated it was his initial evaluation and treatment of sacral and perineal wound. The note indicated Resident B was accompanied by his parents for the visit. Resident B and his parents were very concerned about the wound healing prognosis and had multiple questions. The wound assessment was described as a chronic full thickness necrotizing fasciitis. The measurements were 32 cm X 40 cm X 9 Cm, with an area of 1280 sq cm and a volume of 11520 cubic cm. There was a moderate amount of sero-sanguineous drainage noted. The wound pain level was 4/10. The wound margin was not attached to wound base. The wound bed had 11-20% slough and 81-90% granulation. The periwound skin color was normal, and the periwound skin exhibited maceration. The wound clinic attempted to call the facility and left a voicemail for the DON (Director of Nursing) at the time to discuss the patient's plan of care and scheduling, detailed instructions for the wound vac application, and activity limitations. They were going to fax this note to the facility. It read, Will see pt [patient] weekly in collaboration with SNF [skilled nursing facility] for wound care, next appointment Monday 3/21/22 at 10:30 a.m. Pt was given appointment card to give to the facility to arrange for transportation. The plan was for his NPWT (negative pressure wound therapy) to be changed twice a week or when soiled, once at the wound clinic on Mondays and once at the facility on Thursdays. An interview was conducted with the DON on 5/24/22 at 2:02 p.m. She indicated Resident B did not go to his wound clinic appointment on 3/21/22, due to transportation. The scheduled transportation canceled. The March 2022 TAR indicated the above order for his wound vac was completed every Thursday beginning 3/17/22, but it also indicated the previous order of wet to moist dressing continued to be done daily. An interview was conducted with the Wound Nurse in the presence of the DON on 5/23/22 at 3:57 p.m. She indicated she knew they were doing the wound vac treatments on Thursdays, as ordered, and was unsure why the daily wet to dry dressings continued to be signed off on the TAR. There was no 3/29/22 weekly wound clinic note. The 4/5/22 hospital wound clinic note indicated his wound was ready for combination of excision and complex closure as well as skin grafting. He could have his wound vac reapplied. They recommended a nonstick contact layer such as Adaptic or silver layer such as a product called UrgoTul which was like Adaptic with silver impregnated. They were going to place his order for surgery. In the meantime, they recommended continuing the wound vac dressing. The April 2022 TAR did not indicate the addition of a nonstick contact layer as recommended on 4/5/22, rather it indicated a continuing of the previous order of normal saline, pat dry, wet to moist dressing and border gauze from his admission. There was no 4/12/22 weekly wound clinic note. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 4/19/22 weekly wound clinic note indicated Resident B had not been getting regular dressing changes and the facility took him off the wound vac because there was bone present in the wound and the facility claimed bone in the wound was contraindicated to a vac. Resident B educated facility that is was not a contraindication; however the size of the wound with the location made it difficult on a non-hospital vac which was a more likely reason for doing the wet to dry dressings. Resident B's mother informed the dressings hadn't been changed for some time, then were changed at 12:30 a.m. and the dressings had thick yellow/green drainage. The note indicated there was no change noted in the wound progression. Surgery for wound closure was scheduled for 4/27/22. It read, Patient is in a facility; however, will be at [name of hospital] for urology appointment so would like to keep wound appointment next week prior to surgery. Pt sated that would be fine. Patient and family nervous about anything messing up surgery. The 4/25/22 weekly wound clinic note indicated he was 2 days in advance of his anticipated procedure for complex closure of his wound. On presentation, he had strikethrough green drainage from his wound. Acetic acid was started. Instructions were issued to parent to bring to facility, and they would be faxed there. It stated, Do not anticipate further treatment is indicated at this time given plan for closure with [name of surgeon] on Wednesday. The plan read, Dressings: . Please change dressing twice per day at a minimum. Dressing was changed at 11:00 on 4/25, please change again in the evening. Apply acetic acid moistened gauze (acetic acid issued to patient) to wound and cover with ABD pads, secure with medipore tape. Again, change twice per day at a minimum, and more often if needed with strikethrough drainage. The 4/25/22 wound clinic orders for twice daily dressing changes were not added to the facility physician's orders until 4/27/22, after discharging from the facility. The April 2022 TAR indicated a second dressing change was not completed the evening of 4/25/22, nor was it completed twice daily on 4/26/22, as instructed in the 4/25/22 wound clinic note. The 4/26/22, 4:00 p.m., nurses note, written as a late entry on 5/6/22, read, Res father presented writer with wound dressing concerns, writer then went in and completed res wound [sic] dressing, wound shows no s/s [signs/symptoms] of bleeding or foul odor, no drainage. Res given clean linen, placed in comfortable position. Denies pain/discomfort. Father at bedside, thanked and appreciated writer. The 4/27/22, 5:00 a.m. nurse's note, written as a late entry on 5/9/22, read, writer and CNA [Certified Nursing Assistant] entered room together to meet patients needs before his scheduled transfer out. nurse offered drsg [dressing] change and pt declined, drsg still present and intact. offered colostomy bag empty/change, pt declined d/t [due to] not needed at the time. CNA emptied f/c [foley catheter] bag and pt did allow nurse to irrigate the cath [catheter.] CNA and nurse offered to change linens on bed, pt declined , pt was on clean linens with a lift sheet on it from shoulders to feet so that he could be transferred to cot. pt took his AM med with sips of water. pt declined getting a bed bath or washed up before he went. 4/27/22, 6:25 a.m. nurses note read, pt sent out per ambulance, stretcher, for scheduled surgery. mother and father at bedside. An interview was conducted with Family Member 33, Resident B's mother, on 5/23/22 at 2:50 p.m. She indicated (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident B's wound was so infected when he discharged the facility on 4/27/22 that he couldn't get the surgery for wound closure. The surgeon said he could not close the wound. He needed it debrided. It was delayed 2 days. It was infected. It had green drainage. She was concerned it was infected prior to leaving. They went to wound care on Monday, 4/25/22, and it was green then and they said that wasn't good. They were going to get it all cleaned up for surgery. By Wednesday, 4/27/22, it was all green again. The wound care center said they wanted the dressing changed twice daily, but the facility said no, they were only going to do it once daily. The nurse at the facility said he was the only nurse there and couldn't do it twice. It was truly, truly horrible. The 4/27/22-5/17/22 hospital notes indicated the planned procedure was debridement and skin graft plus complex closure on 4/27/22. The notes read, A tissue biopsy was obtained 4/25/2022 that was polymicrobial w/Acinetobacter baumannii, Group A strep, Pseudomonas aeruginosa, Corynebacterium, and 1 colony of Staph aureus. He was admitted [DATE] for planned surgery which ended up being a debridement only as his mother states his wound was not taken care of at [name of facility] and he presented with purulence. Following his debridement yesterday [4/27/22,] he has remained on IV Cefepime CT scan also revealed a concern for osteomyelitis of the ischium. There are plans for him to return to the OR [operating room] tomorrow for possible wound coverage .Surgical History Internal 04/29/2022 [name and title of surgeon] Skin Graft Split Thickness. 02/27/2022 [name and title of surgeon] Wound Debridement. 2. The clinical record for Resident 229 was reviewed on 5/17/22 at 9:45 a.m. The diagnoses included, but were not limited to: hyperlipidemia, edema, ventricular arrhythmias, heart failure, and hypertension. He was admitted to the facility from the hospital on 5/12/22. An interview was conducted with Resident 229 on 5/17/22 at 9:52 a.m. He indicated he did not receive any his medication for the first 2 days after admission. The 5/12/22 hospital discharge medication list indicated to start taking one 150 mg capsule of mexiletine every 8 hours, and the last dose was given on 5/11/22 at 12:40 p.m.; one 75mg tablet of clopidogrel daily, and the last dose was given on 5/11/22 at 10:03 a.m.; one 81mg tablet of aspirin daily, and the last dose given was on 5/11/22 at 10:01 a.m.; one 10 mg tablet of ezetimibe daily, and the last time it was given was 5/11/22 at 10:02 a.m.; one 21 mg nicotine patch to be applied daily, and the last time it was applied was 5/11/22 at 10:08 a.m.; one multivitamin tablet daily; one 60 mg tablet of torsemide daily; and one 400 mg tablet of amiodarone twice daily. The May, 2022 MAR (medication administration record) indicated the mexiletine was given only twice on 5/13/22 and twice on 5/14/22; the clopidogrel was not given at the facility for the first time until 5/14/22; the aspirin was not given at the facility for the first time until 5/14/22; the ezetimibe was not given for the first time until 5/14/22; the nicotine patch was not applied for the first time at the facility until 5/15/22; the multivitamin tablet was not administered for the first time at the facility until 5/14/22; the torsemide was not given at the facility for the first time until 5/14/22; and the amiodarone was given at the facility only once on 5/13/22. The 5/13/22 physician note read, Patient is being admitted following a COPD [chronic obstructive pulmonary disease] exacerbation and bronchitis. Patient is being admitted for continued medical care and therapy. Patient has some peripheral edema. Patient has not gotten his torsemide 20mg PO daily. Patient denies any other complaints or concerns (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with UM (Unit Manager) 22 on 5/18/22 at 3:40 p.m. She indicated upon admission, the medication orders are faxed to the nurse practitioner on call, who enters the orders into the computer, which went straight to the pharmacy. Normally, Resident 229's medications would have been delivered to the facility the morning of 5/13/22, around 6:00 or 7:00 a.m. Some of the Resident 229's admission medications were in the emergency drug kit, like the Aspirin, but he should have received all of his medications on 5/13/22. The Medication Administration policy was provided by the DON (Director of Nursing) on 5/19/22 at 9:05 a.m. It read, Medication will be administered as prescribed. 3. The clinical record for Resident 233 was reviewed on 5/17/22 at 1:30 p.m. The diagnoses included, but were not limited to, sciatica and osteomyelitis of vertebra. He was admitted to the facility on [DATE]. The skin integrity care plan, revised 5/18/22, indicated he was at risk for altered skin integrity related to his disease process with an intervention to complete weekly skin checks. An interview was conducted with Resident 233 on 5/17/22 at 2:01 p.m. He indicated he found a knot on his stomach, on the lower left side. It was hard and knotty. He informed one of the NPs (nurse practitioners,) and was told he needed to tell his physician. He also had red, splotchy skin and red spots that were popping up on his chest since admission. On 5/17/22 at 2:01 p.m., an observation of Resident 233's upper chest was made when he pulled down the neck of his shirt. There were small, scattered, red, raised bumps. The physician's orders indicated to complete weekly skin assessments on day shift on Thursdays for skin assessments of skin health, starting 5/5/22. The May 2022 TAR (treatment administration record) indicated skin assessments were completed on 5/5/22, 5/11/22, and 5/19/22. There were no corresponding skin assessments in the EHR (electronic health record.) An interview was conducted with Resident 233 on 5/25/22 at 2:51 p.m. He indicated no one had addressed the knot on his stomach or the small red dots on his chest, nor had any nursing staff ever performed a skin assessment on him. An interview was conducted with UM (Unit Manager) 2 on 5/25/22 at 3:10 p.m. She indicated nurses are to physically do a head-to-toe skin assessment during a weekly skin assessment. She reviewed Resident 233's electronic clinical record and indicated no skin assessments triggered. Upon admission, the EHR is supposed to trigger a skin assessment to be completed and documented under the assessments section of the EHR. An interview was conducted with UM 2 on 5/26/22 at 10:53 a.m. She indicated she went in to see Resident 233, and he did have small pimples on his chest and an area on his stomach that was kind of hard. She informed the NP, who was going to look at him the next time they were in the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 5/25/22, 12:18 p.m. nurse's note, recorded as a late entry on 5/26/22 at 9:22 a.m. read, .Writer also addressed res [resident] concern regarding his skin, skin assessment completed, notified in house NP. NP will follow up with res. Res complains of no pain/discomfort at this time. Family made aware. On 5/25/22, skin assessments were created under the assessments section of the EHR by UM 2 for 5/5/22, 5/12/22, and 5/19/22. All of the assessments indicated there were no skin conditions, or changes, ulcers, or injuries. 40287 4. The clinical record for Resident 37 was reviewed on 5/16/22 at 2:31 p.m. The Resident's diagnosis included, but were not limited to, chronic kidney disease and hypothyroidism. An Admission MDS (Minimum Data Set) Assessment, completed 2/23/22, indicated she was cognitively intact. She had no skin tears and did not display behaviors such as scratching herself. A care plan, last revised on 3/7/22, indicated she was at risk for altered skin integrity due to immobility. The goal, last revised on 3/17/22, was for her to be without impaired skin integrity. The interventions, initiated 2/11/22, were for her to have skin at risk assessments quarterly and as needed, weekly skin checks were to be completed and therapy was to evaluate and treat as needed. On 5/24/22 at 10:16 a.m., NC (Nurse Consultant) 3 provided the May shower records for Resident 37. They indicated that on 5/2/22 she had redness and skin tears, 5/7/22 she had an open area, redness, and skin tear, 5/9/22 she had skin tears, 5/14/22 she had an open area, redness and bleeding, and skin tears. The comments section of the shower sheet included that she suffers from severe itching on her body and that lotion was applied and linen changed, 5/16/22 shower record had redness and skin tear recorded and the comment section included that the nurse was aware of the areas. The skin sheets were signed by the Certified Assistant that provided the shower and Unit Manager 2. On 5/16/22 at 2:31 p.m., Resident 37 was observed lying in bed. She was scratching her arms. She had multiple open areas on her arms and legs. She indicated that she had itchy skin. On 5/24/22 at 11:00 a.m., she was observed laying in her bed. She had white sleeves present on both arms, which were spotted with blood. She had open, bleeding areas on her right shoulder, left arm and both hands. She was scratching at her skin. Her nails were long and had blood on the nail beds and under the nails. During an interview on 5/24/22 at 11:05 a.m., LPN (Licensed Practical Nurse) 30 indicated she had not noticed any skin areas when she had administered her medication earlier in the morning. During an interview on 5/24/22 at 12:04 p.m., Unit Manager 2 indicated she had a picking behavior. She would pick at her arms and when she did the staff would apply geri sleeves. There was lotion that was applied for it. During an interview on 5/24/22 at 12:15 p.m. SS (Social Service) 1 indicated that she was unaware of Resident 37 having a behavior of picking at her skin. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/24/22 at 12:20 p.m., she was observed with SS 1, who indicated she had not looked like that before. She was bleeding from several open areas and had blood on her hands. She would make sure the physician was made aware of the areas. During an interview on 5/24/22 at 2:10 p.m., NP (Nurse Practitioner) 6 indicated she had not been informed of her itching previously and that she would have wanted to know about the itching and open areas. 5. The clinical record for Resident 82 was reviewed on 5/17/22 at 10:37 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease and anxiety. A physician's order, dated 12/2/21, was for a wet to dry dressing to be applied to the right calf twice daily. A care plan, last revised on 12/28/21, indicated she had impaired skin integrity due to a wound on her right lower leg. The goal, last revised on 3/17/22, was for her to have no complications to the right leg. An intervention, initiated 12/16/22, was to administer treatments as ordered by the medical provider. A Quarterly MDS Assessment, completed 3/23/22, indicated she was cognitively intact. A physician's order, dated 5/4/22, indicated to cleanse right lower leg and pat dry, apply silver alginate (wound dressing) to wound bed and then apply a border gauze. Change the dressing 3 times weekly and as needed. During an interview on 5/17/22 at 10:24 a.m., she indicated that she had a sore on her right leg that had been giving her trouble. The dressing did not always get changed. On 5/23/22 at 10:40 a.m., she was observed lying in bed in a hospital gown. She indicated the last time her dressing was changed was Saturday. She removed the sheet from her leg and there was a kerlix (gauze strip) dressing which was labeled with the date of 5/21/22. On 5/23/22 at 10:57 a.m., RN (Registered Nurse) 8 was observed changing her dressing to her right lower leg. The 5/21/22 kerlix dressing had been removed, revealing a boarder gauze dressing, dated 5/19/22. She removed the boarder gauze dressing with her gloved hands. The dressing had two 2 x 2 squares, which were stiff and covered with a dark red substance and had an oblong dark yellow area in the middle. She indicated the dressing was saturated with blood and puss. She then cleansed the area with a dry 4x4 gauze. She then changed her gloves, without performing hand hygiene, and sprayed wound cleanser on the wound. She covered the wound cleanser with silver alginate and applied a new border gauze dressing. The May 2022 TAR (Treatment Administration Record) indicated that the wet to dry dressing to right calf had been completed at least daily, except for on 5/13 and 5/14/22. The May 2022 TAR indicated the silver alginate dressing was to be changed on Tuesdays, Thursdays, and Saturdays. It had not been initialed as completed on 5/14 and 5/17/22. It had been initialed as completed on 5/21/22, however the silver alginate dressing present on her leg on 5/23/22 had been dated as completed on 5/19/22. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/24/22 at 3:47 p.m., the Wound Nurse indicated that silver alginate dressing to her right lower leg should have been completed as ordered. The order for the wet to dry dressing should have been discontinued. The area on her right calf had been healed for some time. 6. The clinical record for resident 103 was reviewed on 5/16/22 at 3:25 p.m. The Resident's diagnosis included, but were not limited to, congestive heart failure and chronic respiratory failure. A care plan, initiated 12/17/21, indicated he was at risk for impaired skin integrity related to his disease process, immobility, poor nutrition, and poor vascularity. The goal, initiated 12/17/21, was for him to be without impaired skin integrity. The interventions, initiated 12/17/21, included, but were not limited to, complete skin at risk assessments upon admission/ readmission, quarterly and as needed and to complete weekly skin checks. A progress note, dated 1/28/22 at 1:25 p.m., indicated he was readmitted to the facility and appeared to have a patch of psoriasis noted on his face. A physician's order, dated 1/28/22, indicated he was to have Elidel Cream 1% (cream used to treat dermatitis) applied to his face every day for treatment of psoriasis patches on face. The order was discontinued on 4/20/22 when he went to the hospital for acute care. A Quarterly MDS Assessment, completed 4/2/22, indicated he was cognitively intact. On 5/16/22 at 3:25 p.m., he was observed sitting on the side of his bed. He had flakey crusts of skin in his right ear and on his forehead. On 5/19/22 at 10:48 a.m., he was observed sitting in his room. Flakey crusts of skin were noted on forehead. On 5/23/22 at 10:54 a.m., he was observed laying sideways on bed. He was dressed in a black tee shirt and had been shaved. He had reddened areas on face. On 5/25/22 at 2:50 p.m., he was observed sitting in his room. He had red and scaly patches on his cheeks, chin, and forehead. He indicated he used to have some cream that the nurses put on his face. During an interview on 5/52/22 at 3:08 p.m., QMA (Qualified Medication Aide) indicated that a physician should have been informed of the red, crusty areas on his face. 41129 7. The clinical record for Resident F was reviewed on 5/19/22 at 3:44 p.m. Resident F's diagnoses included, but not limited to, end stage renal disease, cerebral infarction, and chronic obstruction pulmonary disease. Resident F's annual MDS (Minimum Data Set) dated 3/9/22 indicated, Resident F was cognitively intact. An interview with Resident F was conducted on 5/17/22 at 10:11 a.m. Resident F indicated; they do not always get their insulin. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident F's May 2022 MAR (Medication Administration Record) was reviewed on 5/24/22 at 2:05 p.m. from DON (Director of Nursing). The May Mar indicated the following: - Lantus Solo Star pen; give 13 units at bedtime - no administrations recorded for 5/12/22, 5/13/22, and 5/14/22. - Lantus solution; 14 units in morning - no administrations recorded on 5/9/22. On 5/13/22 and 5/18/22 a NC was charted. NC was determined by DON to stand for no coverage given. - Humalog solution; 7 units three times a day - no administrations recorded on 5/3/22 for p.m. dose, 5/9/22 for morning and afternoon doses, 5/12/22 p.m. dose, 5/13/22 p.m. dose. On 5/15/22, the morning dose was coded 9 for see nurses notes. On 5/18/22, the morning dose was coded as NC. The clinical record did not contain any additional information regarding the code 9 for 5/15/22 nor the NC for 5/18/22. - Humalog solution sliding scale - no administrations or blood sugar readings recorded for 5/3/22 for 6 p.m.; 5/9/22 for 8 a.m. and 1 p.m.; 5/13/22 and 5/14/22 for 6 p.m. A Medication Administration Policy was received on 5/19/22 at 9:05 a.m. from DON. The policy indicated, The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner. Procedure: I. Administration Preparedness a. Medications will be administered as prescribed .If medication is not given, indicate on MAR reason it was withheld and physician notified (if applicable) . This Federal tag relates to complaints IN00380287 and IN00379008 3.1-37(a)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40287 Based on interview and record review, the facility failed to timely treat a stage 2 pressure ulcer for 1 of 2 residents reviewed for pressure ulcers (Resident G). Findings include: The clinical record for Resident G was reviewed 5/16/22 at 3:05 p.m. The Resident's diagnosis included, but were not limited to, tracheostomy and acute respiratory failure. A care plan, initiated 5/4/22, indicated that she had a stage 2 pressure ulcer on her left planter foot (ball of foot). The goal was to have no complications from her altered skin integrity. The interventions included, but were not limited to, administer treatments as ordered, initiated 5/4/22. A Wound Evaluation, dated 5/5/22, indicated she had a blister with serous (clear) fluid on her left planter foot, which was present upon admission to the facility. The dressing to be applied was skin prep (skin protectant). The May 2022 TAR (Treatment Administration Record) indicated the left plantar food was to be cleansed and patted dry. Skin prep was to be applied daily and as need to the left planter foot. There were no initials, indicating the treatment has been completed for the following days 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/11, 5/13, and 5/14/22. During an interview on 5/24/22 3:47 p.m., the Wound Nurse indicated the skin prep should have been applied to her left planter foot daily starting on 5/5/22. This Federal tag relates to complaint IN00379801. 3.1-40(a)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on interview and record review, the facility failed to deactivate a resident's [NAME] (artificial urinary sphincter) prior to catheterizing him, provide catheter care, empty and obtain urine outputs, and administer an antibiotic for a resident with a Urinary Tract Infection (UTI,) as ordered, for 1 of 1 resident reviewed for discharge and 1 of 3 residents reviewed for hospitalization . (Residents B and 127) Findings include: 1. The clinical record for Resident B was reviewed on 5/20/22 at 10:00 a.m. The diagnoses included, but were not limited to, neurogenic bladder. He was admitted to the facility from the hospital on 3/10/22. The 3/11/22 care plan indicated he had a foley catheter related to neurogenic bladder. The 3/10/22 hospital discharge summary read, 3/10 [3/10/22] Patient discharging to [name of facility] skilled nursing facility for ongoing wound management. He is in stable condition. His [NAME] [sic] with foley catheter in place draining without any problems .Neurogenic bladder .16 French catheter anchored in [NAME] channel. Patient to catheterizing 16 French catheter going forward instead of 14 French. Patient is an at fissure [sic-has an artificial] urinary sphincter. Do not catheterize per urethra. If urethral catheter attempts need to be made in the future the sphincter must be deactivated and 8, 10, or 12 French Foley catheter she [sic] will be utilize [sic] but cannot be anchored in place longer than 24-36 hours. Please page Urology further issues with catheter drainage. Will order scheduled forward flushes of catheter with 60 cc P stump syringe. Urology to schedule outpatient follow-up appointment approximately 4 weeks. The specific orders from the hospital to not catheterize per urethra and to deactivate the artificial urinary sphincter if urethral catheter attempts were needed were nowhere on the facility's physician's orders. The 3/24/22, 9:46 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 23 read, Resident was complaining of pain on his abdomen. He was complaining about the need to void even though he has a supra pubic catheter. In his bag the out put was less than 50 ml. Upon assessment, his abdomen appears distended, and tender during palpation. He added that this had happened before while he was in the hospital, and they performed in and out catheterization on him. As he continue to complain of pain/discomfort, staff performed catheterization and got an out put of about 1700 ml. It appears that his supra pubic catheter is not functioning well and a [sic]such a referral to a urologist was advised for further assessment, evaluation and replacement. An interview was conducted with LPN 23 on 5/23/22 at 2:31 p.m. He indicated he did not remember exactly what happened prior to Resident B going to the ED on 3/25/22. He was unaware Resident B had an artificial urinary sphincter. He was unfamiliar with an [NAME] and couldn't remember ever caring for a resident that had one. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/24/22, 10:25 p.m. physician note read, Minutes spent on case: 4. Comments: Patient reported suprapubic pain. He has a suprapubic catheter that has had very little drainage today. Straight cath [catheterization] was done with 1700 mL output. Recommend follow up with urologist. Straight cath every 6-8 hours depending on symptoms for urinary retention. The 3/25/22, 6:01 a.m. nurse's note read, in and out cath for 300 ml urine. cloudy urine return at start of procedure, then cleared. On 5/26/22 at 10:55 a.m., an interview was conducted with LPN 24, who signed off on the TAR as having in and out catheterized Resident B on 3/25/22 at 6:00 a.m. prior to Resident B going to the ED. She indicated she in and out catheterized him just before he went to the ED. She went through his penis and drained his bladder that way. He kept his catheter in. The only way she could do it was to go through his penis. She reported that it didn't look good at the time, that the catheter was blocked. She was told during report that she needed to in and out catheterize him. She questioned why they were doing it, because it was unusual to have and in and out catheter order, as she was used to irrigating him. She didn't do anything differently for him, having an [NAME], then she did for someone without one. The 3/25/22, 10:02 a.m. nurse's note read, call placed to [name of urologist] urologist, [phone number of urologist.] resident has an appointment on 4/21/22, called to see if appointment can be moved up. left a message, the turnaround time is up to 24 hours. MD in house made aware, mom at bedside made aware. The 3/25/22, 1:04 p.m. nurse's note read, Resident sent to 'name of hospital' per [name and title of NP] via ambulance for decreased urine output. The 3/25/22 Hospital ED (Emergency Department) notes read, .presenting to ED with/difficulty draining urine from his suprapubic cath X [times] 1 day .has had to in and out cath twice .Assessment/Plan 1. Catheter Problem .Of note, since his urethra was catheterized without deactivating the [NAME], we had scoped the urethra with and found no evidence of erosion. We had also scoped the [NAME] channel and found no abnormalities .His parents contacted 911 to transport him to the ED today because they are worried about the quality of care he is receiving there. The parents and patient have adamantly requested that the facility not catheterize his urethra due to his [NAME], and the mother presents with documentation from his medicolegal records there that also document the urethra cannot be catheterized For the last 2 days the nursing has been catheterizing his urethra despite specific instructions not to do so Assessment/Plan: [NAME] channel catheter was due for exchange so I replaced a new catheter into the [NAME] channel, outflow of clear yellow urine confirmed .Old catheter was occluded with hardened mucous. I instructed patient and family today on how to cycle the [NAME] too allow for drainage of the bladder, if he has recurrent issue with the catheter and the nurses at his facility are not able to assist in an appropriate, timely fashion. Will have ED case manager come down and speak with patient and family. There is clearly concern for [NAME] negligence from this healthcare facility. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Family Member 33, Resident B's mother, on 5/23/22 at 2:50 p.m. She indicated Resident B had a lot of sediment in his bladder and the catheter kept clogging. Nursing was supposed to irrigate it, but several didn't know how to do it, or were doing it wrong. She saw one nurse try to go through his belly button. They were pushing fluid into the catheter, but not pulling it out. They weren't willing to change the Foley catheter or put a new one in, so they ended up in the ED. The hospital replaced the catheter. They had had been told not to catheterize through his urethra. She assumed the facility knew that, but when she talked to them, they said they did what they had to do to give him relief and were not going to apologize for that. Family Member 33 told nursing they should have deactivated the sphincter to give him relief, and nursing should have addressed the no urine output after 2 hours instead of waiting until after 6 hours. On 5/26/22 at 10:40 a.m., an interview was conducted with QMA (Qualified Medication Aide) 34, who signed off on the TAR (treatment administration record) as having in and out catheterized Resident B on 3/25/22 at 12:00 p.m. prior to going to the ED. She indicated she did not do his in and out catheter. A lot of times, she would tell nurses she needed stuff done and so she would sign off on it, because they didn't do it. She definitely did not do his in and out catheter. She had never cared for a resident with and [NAME] before and wouldn't know how to if they did have one. She would need to report it to the nurse and the nurse would have to do it. An interview was conducted with NP 6 on 5/23/22 at 3:04 p.m. She indicated she was unsure if Resident B knew how to cycle his [NAME], prior to going to the ED on 3/25/22. She met him on 3/29/22. The only time she'd seen an [NAME], nothing needed to be done to it. She was uncertain how to care for it. To her knowledge, the nursing staff wouldn't know how to deactivate an [NAME]. She didn't think the orders from the 3/10/22 hospital discharge summary made its way onto the facility's orders or MAR. Resident B told her he shouldn't be in and out catheterized, and she informed him they shouldn't be doing it then. She didn't know if she discontinued the order for the in and out catheter every 8 hours or not, but it was discontinued on 3/29/22. She doubted the on-call physician assistant who placed the order would have known about Resident B's [NAME]. They would have only known what the nurse told them. The Male Intermittent or Straight Catheterization policy was provided by the DON (Director of Nursing) on 5/24/22 at 12:23 p.m. It read, 1. Basic knowledge and skills for intermittent catheterization a. Validate physician/provider order for the specific resident. 34850 2. The clinical record for Resident 127 was reviewed on 5/26/22 at 8:30 a.m. The diagnosis included, but were not limited to, sepsis and paraplegia. The resident was admitted to the facility on [DATE] and discharged on [DATE]. A care plan dated 12/16/21 indicated .The resident has an indwelling foley catheter impaired skin integrity . Interventions: .observe/record/report to MD [medical doctor] for s/sx [signs and symptoms] UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp [temperature], urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns .provide catheter care every shift and PRN [as needed] . (continued on next page)

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	155272	A. Building B. Wing	05/26/2022

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 12/15/21 indicated Resident 127 staff was to change the resident's 16 French foley catheter monthly and as needed. A physician order dated 12/15/21 indicated the resident's foley catheter bag was to be emptied every shift. A physician order dated 12/15/21 indicated the staff was to provide catheter care to the resident every shift. A physician order dated 1/25/22 indicated the resident was to receive 1 gram of ceftriaxone antibiotic for 7 days due to a diagnosis of UTI. A lab report date collected on 1/25/22, indicated Resident 127 had an abnormal urine culture. It indicated the resident had greater than 100,000 CFU/ml [the number of colonized bacteria] of proteus mirabilis [bacteria] was found in her urine collection. The January 2022 Medication Administration Record (MAR) indicated Resident 127 had received 6 out of the 7 dosages of ceftriaxone antibiotic. It indicated the staff administered 1 gram of ceftriaxone to the resident on the following days: 1/25/22, 1/26/22, 1/27/22, 1/28/22, 1/29/22, and 1/31/22. The resident had not received the ceftriaxone on 1/30/22 with a reason documented by staff as possible side effect. The January 2022 Treatment Administration Record (TAR) indicated the following days and shifts the resident's foley catheter urine bag was not drained with recorded urine outputs, and catheter care was not provided: 1/4/22 - night shift, 1/6/22 - night shift, 1/9/22 - days shift, 1/15/22 - evening shift, 1/16/22 - evening shift, 1/21/22 - evening shift, 1/28/22 - day shift, 1/29/22- day shift, and 1/30/22 - evening shift. The February 2022 TAR indicated the following days and shifts the resident's foley catheter urine bag was not drained with recorded urine outputs, and catheter care was not provided: -Drainage of urine bag was not emptied with recorded urine outputs: 2/3/22 - day shift and night shift, 2/4/22 - evening shift, 2/8/22 - day shift, 2/15/22 - evening shift, and 2/16/22 - evening shift. -Catheter care was not provided: 2/3/22 - day shift, 2/4/22 - evening shift, 2/8/22 - day shift, 2/15/22 - evening shift and 2/16/22 - evening shift. An interview was conducted with the Sister Facility Director of Nursing on 5/26/22 at 12:03 p.m. She indicated she was unsure why the ceftriaxone was not administered for the 7 days as ordered to Resident 127. She was unable to determine why catheter care was not documented as provided nor any urine outputs recorded on those missing days on the January 2022 and February 2022 MARs/TARs as ordered. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Catheter Care policy was provided by the Sister Facility Director of Nursing on 5/26/22 at 11:55 a.m. It indicated .Policy: It is the policy of this facility to provide resident care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place. CAUTI (Catheter Associated Urinary Tract Infections) is the most common adverse event associated with indwelling urinary catheters, including those that are asymptomatic .The risk of bacteremia in residents with indwelling catheters is 3-36 times more likely than residents without an indwelling catheter. Biofilm is the most important cause of bacteriuria in residents with catheters. Reducing the biofilm by performing daily care may help prevent symptomatic infections and incorporate and incorporate antibiotic stewardship recommendations to reduce unnecessary drugs and antibiotics to reduce resistant strain of infections, as well as maintain the dignity and hygiene of the resident . This Federal tag relates to complaint IN00379008. 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. 40287 Based on observation, interview, and record review, the facility failed to use proper technique when providing tracheostomy care to 1 of 1 resident reviewed for tracheostomy care (Resident G). Findings include: The clinical record for Resident G was reviewed 5/16/22 at 3:05 p.m. The Resident's diagnosis included, but were not limited to, tracheostomy and acute respiratory failure. A physician's order, dated 5/3/22, indicated to provide tracheostomy care every day and night shift. A physician's order, dated 5/3/22, indicated the inner cannula was to be changed and/or cleaned daily and as needed. On 5/26/22 at 9:15 a.m., RT (Respiratory Therapist) 15 was observed providing tracheostomy care for her. She entered the room and donned a disposable isolation gown. She put on a pair of non-sterile disposable gloves. She opened the tracheostomy suctioning kit and then donned the sterile gloves from the suctioning kit over her non-sterile gloves. She removed the suction catheter from the kit and turned on the suction machine, using her gloved hands. She placed the suction catheter onto the suction tubing and used her right hand to move the humidity tubing and collar from the tracheostomy area. She then used her right hand to suction the tracheostomy. She removed the suction catheter from the suction tubing and removed the sterile gloves, throwing them away. She then used the non-sterile gloves, had been under the sterile gloves to open the tracheostomy care kit. She removed a bottle of sterile water from the bed side table drawer. The bottle of sterile water had been previously opened and did not have a date open on it. She poured the sterile water into the disposable container from the tracheostomy care kit. She took the brush from the kit and poured sterile water onto it. She then removed the gauze from the tracheostomy site and used the brush to clean around the tracheostomy in a scrubbing motion. She then dried the tracheostomy area with a 4x4 gauze from the kit and removed the inner cannula from the tracheostomy and threw it in the trash. She removed her non-sterile gloves and donned the sterile gloves from the tracheostomy care kit, without using hand hygiene. She then opened the new inner cannula package and took the inner cannula out of the package, placing it into the tracheostomy and placed a drainage gauze around the tracheostomy. She picked up the disposable water container from the bedside table and went to the bathroom. She dumped the water out, flushed the toilet and then removed her sterile gloves. She came back to the bedside and took a new suction kit out of the drawer. She opened the kit and donned the sterile gloves from the kit. She did not use hand hygiene prior to donning the sterile gloves. She then removed the suction catheter and turned on the suction machine with her right hand. She placed the suction catheter on the suction tubing and used her left hand to move the humidity collar from the tracheostomy site and suctioned the tracheostomy, using her left hand. During an interview on 5/26/22 at 9:40 a.m., RT 15 indicated that was how she normally performed tracheostomy care. When she suctioned her the first time, her right hand was the sterile hand. During the second time she was suctioned, her left hand was the sterile hand. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/26/22 at 10:39 a.m., the Sister Facility Director of Nursing provided the Tracheostomy Care Policy, last revised 5/30/19, which read ' .Residents with tracheostomies require care to remove thickened secretions around the cannula site to maintain an open and patent airway that is free from infection and skin integrity concerns .The purpose of this policy is to provide guidance for tracheostomy care .During the procedure, one gloved hand will be considered contaminated (non-dominant) and one gloved hand will remain sterile (dominate) during the procedure .Open packages using no-touch technique; making tube connections and prepare solutions for use in sterile tray or similar sterile container using non touch method . III. Trach care: Prepare the environment .b. perform hand hygiene .d. Don clean gloves .g. remove oxygen source, soiled dressing and suction the tracheostomy as appropriate i. Discard used equipment .i. Remove gloves and perform hand hygiene j. use sterile tracheostomy kit using no-touch method m. don sterile gloves .f. clean stoma under neck plate with circular motion using sterile water or sterile normal saline-soaked cotton tip applicators and other dried secretions of the exposed outer cannula surfaces i. Pat moist areas dry with gauze pads . This Federal tag relates to complaint IN00379801. 3.1-47(a)(4) 3.1-47(a)(6) 3.1-47(a)(5)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on interview and record review, the facility failed to ensure nursing staff were competent in catheterizing a resident with an [NAME] (artificial urinary sphincter) for 1 of 3 residents reviewed for hospitalization . (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/20/22 at 10:00 a.m. The diagnoses included, but were not limited to, neurogenic bladder. He was admitted to the facility from the hospital on 3/10/22. The 3/11/22 care plan indicated he had a foley catheter related to neurogenic bladder. The 3/10/22 hospital discharge summary read, 3/10 [3/10/22] Patient discharging to [name of facility] skilled nursing facility for ongoing wound management. He is in stable condition. His [NAME] [sic] with foley catheter in place draining without any problems .Neurogenic bladder .16 French catheter anchored in [NAME] channel. Patient to catheterizing 16 French catheter going forward instead of 14 French. Patient is an at fissure [sic-has an artificial] urinary sphincter. Do not catheterize per urethra. If urethral catheter attempts need to be made in the future the sphincter must be deactivated and 8, 10, or 12 French Foley catheter she [sic] will be utilize [sic] but cannot be anchored in place longer than 24-36 hours. Please page Urology further issues with catheter drainage. Will order scheduled forward flushes of catheter with 60 cc P stump syringe. Urology to schedule outpatient follow-up appointment approximately 4 weeks. The specific orders from the hospital to not catheterize per urethra and to deactivate the artificial urinary sphincter if urethral catheter attempts were needed were nowhere on the facility's physician's orders. The 3/24/22, 9:46 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 23 read, Resident was complaining of pain on his abdomen. He was complaining about the need to void even though he has a supra pubic catheter. In his bag the out put was less than 50 ml. Upon assessment, his abdomen appears distended, and tender during palpation. He added that this had happened before while he was in the hospital, and they performed in and out catheterization on him. As he continue to complain of pain/discomfort, staff performed catheterization and got an out put of about 1700 ml. It appears that his supra pubic catheter is not functioning well and a [sic] such a referral to a urologist was advised for further assessment, evaluation and replacement. An interview was conducted with LPN 23 on 5/23/22 at 2:31 p.m. He indicated he did not remember exactly what happened prior to Resident B going to the ED on 3/25/22. He was unaware Resident B had an artificial urinary sphincter. He was unfamiliar with an [NAME] and couldn't remember ever caring for a resident that had one. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/24/22, 10:25 p.m. physician note read, Minutes spent on case: 4. Comments: Patient reported suprapubic pain. He has a suprapubic catheter that has had very little drainage today. Straight cath [catheterization] was done with 1700 mL output. Recommend follow up with urologist. Straight cath every 6-8 hours depending on symptoms for urinary retention. The 3/25/22, 6:01 a.m. nurse's note read, in and out cath for 300 ml urine. cloudy urine return at start of procedure, then cleared. On 5/26/22 at 10:55 a.m., an interview was conducted with LPN 24, who signed off on the TAR as having in and out catheterized Resident B on 3/25/22 at 6:00 a.m. prior to Resident B going to the ED. She indicated she in and out catheterized him just before he went to the ED. She went through his penis and drained his bladder that way. He kept his catheter in. The only way she could do it was to go through his penis. She reported that it didn't look good at the time, that the catheter was blocked. She was told during report that she needed to in and out catheterize him. She questioned why they were doing it, because it was unusual to have and in and out catheter order, as she was used to irrigating him. She didn't do anything differently for him, having an [NAME], then she did for someone without one. The 3/25/22, 10:02 a.m. nurse's note read, call placed to [name of urologist] urologist, [phone number of urologist.] resident has an appointment on 4/21/22, called to see if appointment can be moved up. left a message, the turnaround time is up to 24 hours. MD in house made aware, mom at bedside made aware. The 3/25/22, 1:04 p.m. nurse's note read, Resident sent to 'name of hospital' per [name and title of NP] via ambulance for decreased urine output. The 3/25/22 Hospital ED (Emergency Department) notes read, .presenting to ED with/difficulty draining urine from his suprapubic cath X [times] 1 day .has had to in and out cath twice .Assessment/Plan 1. Catheter Problem .Of note, since his urethra was catheterized without deactivating the [NAME], we had scoped the urethra with and found no evidence of erosion. We had also scoped the [NAME] channel and found no abnormalities .His parents contacted 911 to transport him to the ED today because they are worried about the quality of care he is receiving there. The parents and patient have adamantly requested that the facility not catheterize his urethra due to his [NAME], and the mother presents with documentation from his medicolegal records there that also document the urethra cannot be catheterized For the last 2 days the nursing has been catheterizing his urethra despite specific instructions not to do so Assessment/Plan: [NAME] channel catheter was due for exchange so I replaced a new catheter into the [NAME] channel, outflow of clear yellow urine confirmed .Old catheter was occluded with hardened mucous. I instructed patient and family today on how to cycle the [NAME] too allow for drainage of the bladder, if he has recurrent issue with the catheter and the nurses at his facility are not able to assist in an appropriate, timely fashion. Will have ED case manager come down and speak with patient and family. There is clearly concern for [NAME] negligence from this healthcare facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Family Member 33, Resident B's mother, on 5/23/22 at 2:50 p.m. She indicated Resident B had a lot of sediment in his bladder and the catheter kept clogging. Nursing was supposed to irrigate it, but several didn't know how to do it, or were doing it wrong. She saw one nurse try to go through his belly button. They were pushing fluid into the catheter, but not pulling it out. They weren't willing to change the Foley catheter or put a new one in, so they ended up in the ED. The hospital replaced the catheter. They had had been told not to catheterize through his urethra. She assumed the facility knew that, but when she talked to them, they said they did what they had to do to give him relief and were not going to apologize for that. Family Member 33 told nursing they should have deactivated the sphincter to give him relief, and nursing should have addressed the no urine output after 2 hours instead of waiting until after 6 hours. On 5/26/22 at 10:40 a.m., an interview was conducted with QMA (Qualified Medication Aide) 34, who signed off on the TAR (treatment administration record) as having in and out catheterized Resident B on 3/25/22 at 12:00 p.m. prior to going to the ED. She indicated she did not do his in and out catheter. A lot of times, she would tell nurses she needed stuff done and so she would sign off on it, because they didn't do it. She definitely did not do his in and out catheter. She had never cared for a resident with and [NAME] before and wouldn't know how to if they did have one. She would need to report it to the nurse and the nurse would have to do it. An interview was conducted with NP 6 on 5/23/22 at 3:04 p.m. She indicated she was unsure if Resident B knew how to cycle his [NAME], prior to going to the ED on 3/25/22. She met him on 3/29/22. The only time she'd seen an [NAME], nothing needed to be done to it. She was uncertain how to care for it. To her knowledge, the nursing staff wouldn't know how to deactivate an [NAME]. She didn't think the orders from the 3/10/22 hospital discharge summary made its way onto the facility's orders or MAR. Resident B told her he shouldn't be in and out catheterized, and she informed him they shouldn't be doing it then. She didn't know if she discontinued the order for the in and out catheter every 8 hours or not, but it was discontinued on 3/29/22. She doubted the on-call physician assistant who placed the order would have known about Resident B's [NAME]. They would have only known what the nurse told them. The Male Intermittent or Straight Catheterization policy was provided by the DON (Director of Nursing) on 5/24/22 at 12:23 p.m. It read, 1. Basic knowledge and skills for intermittent catheterization a. Validate physician/provider order for the specific resident. This Federal tag relates to complaint IN00379008.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 30344 Based on observation, interview, and record review, the facility failed to follow through with a dental recommendation for teeth extraction and to ensure residents received routine dental care for 3 of 7 residents reviewed for dental services. (Residents 2, 5, and 49) Findings include: 1. The clinical record for Resident 49 was reviewed on 5/17/22 at 10:00 a.m. The diagnoses included, but were not limited to, hypertension. An interview was conducted with Resident 49 on 5/17/22 at 10:04 a.m. She indicated she had some broken teeth and some loose teeth. No one asked her about seeing the dentist. An observation of Resident 49's oral cavity was made on 5/17/22 at 10:04 a.m. She had some missing and broken mandibular (bottom) teeth. The dental care plan, revised 3/21/22, indicated she had missing/broken teeth and obvious dental caries related to poor oral hygiene and a history of dysphagia. The physician's orders indicated dental consult as needed, effective 8/28/17. The 2/12/21 dental note indicated she was missing 4 teeth on top and 5 teeth on bottom. She had 8 root tips on top and 2 root tips on bottom. It indicated she had natural teeth without dentures and was interested in information about dentures. She was a candidate for dentures and needed to have all upper teeth extracted by an oral and maxillofacial surgeon, before she was eligible for an upper denture. There was no information in the clinical record to indicate follow up to the 2/12/21 dental recommendation for teeth extraction. An interview was conducted with SS (Social Services) 2 on 5/19/22 at 12:30 p.m. He indicated he was going to contact an oral surgeon to schedule an appointment for teeth extraction. An interview was conducted with Resident 49 on 5/19/22 at 12:33 p.m. She indicated she still wanted dentures and was okay with going out for teeth extraction. The Dental Services policy was provided by the Nurse Consultant on 5/19/22 at 9:15 a.m. It read, The facility will assist the resident in: .c. Obtaining services to the resident to meet the needs of each resident .d. Making appointments .e. Arranging for transportation to and from the dental service location. 41129 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The clinical record for Resident 2 was reviewed on 5/19/22 at 9:27 a.m. Resident 2's diagnoses included, but not limited to, chronic obstructive pulmonary disease, heart failure, and anxiety disorder. Resident 2's quarterly MDS (minimum data set) dated 4/9/22 indicated, Resident 2 was cognitively intact. A physician's order for Podiatry, Dental, Optometry or Ophthalmology consults was renewed on 3/31/22. An interview with Resident 2 conducted on 5/18/22 at 10:07 a.m. indicated, he hadn't seen a dentist in a long time and would like for his teeth to be cleaned. An interview with SS (Social Services) 2 was conducted on 5/18/22 at 2:58 p.m. SS 1 indicated; Resident 2 had not voiced he wanted his teeth cleaned. Resident 2's dental referral was sent to the contracted company at the time of Resident 2's admission. SS 2 reviewed the tracking system he uses to document when residents are seen for vision, dental, or other contracted services. SS 2 indicated; Resident 2 had not been seen by the dentist in the last year. An interview with SS 1 was conducted on 5/19/22 at 10:50 a.m. SS 1 indicated; the contracted company for special services such as vision and dental were accountable for ensuring services for those residents who had signed up were performed. 3. The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder. Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. A physician's order for Podiatry, Dental, Optometry or Ophthalmology consults was renewed on 4/14/22. An interview with Resident 5 conducted on 5/17/22 at 2:08 p.m. indicated, she had partial dentures and had recently broke when they fell on the floor and would like them replaced. An interview with SS 2 was conducted on 5/18/22 at 2:53 p.m. SS 2 indicated; Resident 5 had not told him she needed services. When asked how he ensures residents receive contracted services at least yearly, he indicated, he keeps an excel spreadsheet to document when contracted services were provided and from time to time would audit the tracker to see if anyone had not received the services they had signed up for. Resident 5 had not had any routine dental services within the last year. (continued on next page)

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Allison Pointe Healthcare Center	5226 E 82nd Street Indianapolis, IN 46250

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Dental Services policy was received on 5/19/22 at 9:15 a.m. from NC (Nurse Consultant) 3. The policy indicated, under definitions, Routine dental services for the purpose of this policy, and according to CMS means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures .Procedure: 1. The facility will assist the resident in: a. Obtaining routine Dental Services .d. Making appointments .Charges/Ability to Pay for Services .b. For Medicaid residents: i. the facility must provide all emergency dental services and those routine dental services to the extent covered under the Medicaid state plan. This Federal tag relates to complaint IN00380287. 3.1-24(a)(1) 3.1-24(b)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30344 Based on interview and record review, the facility's QA [Quality Assurance] committee failed to identify quality deficiencies and develop action plans to address them regarding wound care and pain management. This affected 6 of 123 residents in the facility. (Residents B, 33, 68, 82, 103, 233) Findings include: 1. The clinical record for Resident 68 was reviewed on 5/18/22 at 9:48 a.m. The Resident's diagnosis included, but were not limited to, peripheral vascular disease and stage 3 pressure ulcer on right thigh. An Admission MDS (Minimum Data Set) Assessment, completed 3/16/22, indicated he was cognitively intact. He received scheduled and as needed pain medications daily and his pain made it hard for him to sleep and limited his daily activities. A care plan, revised on 4/22/22, indicated he had acute and chronic pain related to his peripheral vascular disease. The goal, revised on 4/4/22, was for him to be able to verbalize relief of pain. The interventions included, but were not limited to, notify the medical provider if the interventions were unsuccessful, initiated 3/9/22, and provide medications as ordered, initiated 3/9/22. During an interview on 5/18/22 at 9:48 a.m., Resident 68 indicated he had run out of his scheduled oxycodone (narcotic pain medication). The prescription had needed refilled for a week, and without it his pain was horrible and out of control. He had been taking his as needed hydrocodone (narcotic pain medications) which made it a little more bearable. When he ran out of his scheduled oxycodone, it would take a day or two for his pain to get back under control once started receiving it again. The May 2022 MAR (Medication Administration Record) indicated he had not received doses his oxycodone on 5/14, 5/15, 5/16, 5/17, and 5/18. The controlled drug administration record for his oxycontin (brand name for oxycodone) CR (continuous release) 10 mg (milligram) indicated twenty tablets had been received by the facility on 5/2/22. He was to receive one tablet every 12 hours for chronic pain. On 5/13/22 at 9:00 p.m., he had received the last of the twenty tablets dispensed. A physician's order, dated 5/18/22, indicated he was to receive oxycodone extended-release abuse deterrent 10 mg every 12 hours for pain. The controlled drug administration record for his oxycodone ER (extended release) 10 mg indicated fifty-eight tablets had been received by the facility on 5/18/22. He had received the first tablet on 5/18/22 at 9:00 a.m. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/24/22 at 10:35 a.m., Registered Pharmacist 9 indicated the facility had sent an electronic refill request for the oxycodone ER 10mg to the pharmacy on 5/15/22 at 8:51 p.m. The pharmacy did not have a prescription authorizing refills, so a refill request had been sent out to the physician on 5/16/22 and 5/17/22. They had received the prescription to refill the medication on 5/18/22 and then sent the medication to the facility. The medication was available in the EDS (Emergency Drug System) but there not been any pulled for him during the dates of 5/13/22 through 5/18/22. A physician's order, dated 5/23/22 with a start date of 5/24/22, indicated he was to receive one hydrocodone-acetaminophen 10-325 mg tablet every 6 hours as needed for pain. A nurses note, dated 5/24/22 at 11:19 a.m., indicated he had been given his pain medication as scheduled, but refused his wound care. The controlled drug administration record for his hydrocodone- apap (narcotic pain medication with acetaminophen) 10-325 mg indicated the facility had received thirty-six tablets on 5/14/22. He had received the last of the thirty-six tablets on 5/23/22 at 4:00 p.m. On 5/24/22, the facility received thirty more hydrocodone- apap 10-325 mg tablets. He had received the first of those tablets on 5/24/22 at 4:00 p.m. During an interview on 5/25/22 at 10:59 a.m., Resident 68 indicated he had run out of his hydrocodone (narcotic pain medication) and his pain had been off the charts. He had refused his wound dressing change because he was out of his hydrocodone medication. He could not imagine how painful his dressing change would have been without receiving his hydrocodone. During an interview on 5/25/22 at 11:10 a.m., LPN (Licensed Practical Nurse) 30 indicated when narcotic pain medication needed refilled, she called the pharmacy, if the resident was out of refills, then she would contact the physician or the nurse practitioner to send a refill prescription to the pharmacy. During an interview on 5/25/22 at 11:20 a.m., Nurse Practitioner 12 indicated she depended on the facility nurses to let her know when the residents needed their pain medications refilled. If a resident had been on narcotic pain medication for a long time, then she normally refilled it for 2 weeks at a time. She had been made aware of Resident 68 needing a refill of his hydrocodone- apap late in the afternoon on 5/23/22 and had sent a prescription to the pharmacy. The resident's receiving narcotics long term were prescribed them to manage their pain. 2a. The clinical record for Resident 82 was reviewed on 5/17/22 at 10:37 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease and anxiety. A care plan, revised on 6/14/21, indicated she had acute and chronic pain related to her impaired mobility. The goal, revised on 3/17/22, was for her to be able to verbalize relief of pain. The interventions included, but were not limited to, provide medications as ordered by the physician, initiated 6/14/21. A Quarterly MDS Assessment, completed 3/23/22, indicated she was cognitively intact and received scheduled pain medications. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/17/22 10:24 a.m., she indicated that she had an open area on leg that had been giving her trouble. I get pain medication, but it is not enough sometimes. It hurts like a toothache. The May 2022 MAR indicated she received one oxycodone ER 12-hour abuse- deterrent 10 mg every 12 hours for pain and that doses of the medication had not been given on 5/16, 5/17, and 5/18/22. During an interview on 5/24/22 at 11:16 a.m., Registered Pharmacist 9 indicated that a refill request for the oxycodone ER 12-hour abuse-deterrent 10 mg had been electronically sent by the facility on 5/16/22. There were no refills left on the prescription. The physician sent a new prescription on 5/19/22 and it was delivered to the facility on that day. During an interview on 5/25/22 at 9:24 a.m., Resident 82 indicated she received scheduled pain medication each day when she went to bed and when she woke up. She could notice a difference in her pain level when she did not receive her scheduled pain medication. 2b. A physician's order, dated 12/2/21, was for a wet to dry dressing to be applied to the right calf twice daily. A care plan, last revised on 12/28/21, indicated she had impaired skin integrity due to a wound on her right lower leg. The goal, last revised on 3/17/22, was for her to have no complications to the right leg. An intervention, initiated 12/16/22, was to administer treatments as ordered by the medical provider. A Quarterly MDS Assessment, completed 3/23/22, indicated she was cognitively intact. A physician's order, dated 5/4/22, indicated to cleanse right lower leg and pat dry, apply silver alginate (wound dressing) to wound bed and then apply a border gauze. Change the dressing 3 times weekly and as needed. During an interview on 5/17/22 at 10:24 a.m., she indicated that she had a sore on her right leg that had been giving her trouble. The dressing did not always get changed. On 5/23/22 at 10:40 a.m., she was observed lying in bed in a hospital gown. She indicated the last time her dressing was changed was Saturday. She removed the sheet from her leg and there was a kerlix (gauze strip) dressing which was labeled with the date of 5/21/22. On 5/23/22 at 10:57 a.m., RN (Registered Nurse) 8 was observed changing her dressing to her right lower leg. The 5/21/22 kerlix dressing had been removed, revealing a boarder gauze dressing, dated 5/19/22. She removed the boarder gauze dressing with her gloved hands. The dressing had two 2 x 2 squares, which were stiff and covered with a dark red substance and had an oblong dark yellow area in the middle. She indicated the dressing was saturated with blood and puss. She then cleansed the area with a dry 4x4 gauze. She then changed her gloves, without performing hand hygiene, and sprayed wound cleanser on the wound. She covered the wound cleanser with silver alginate and applied a new border gauze dressing. The May 2022 TAR (Treatment Administration Record) indicated that the wet to dry dressing to right calf had been completed at least daily, except for on 5/13 and 5/14/22. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The May 2022 TAR indicated the silver alginate dressing was to be changed on Tuesdays, Thursdays, and Saturdays. It had not been initialed as completed on 5/14 and 5/17/22. It had been initialed as completed on 5/21/22, however the silver alginate dressing present on her leg on 5/23/22 had been dated as completed on 5/19/22. During an interview on 5/24/22 at 3:47 p.m., the Wound Nurse indicated that silver alginate dressing to her right lower leg should have been completed as ordered. The order for the wet to dry dressing should have been discontinued. The area on her right calf had been healed for some time. 3. The clinical record for Resident 33 was reviewed on 5/18/22 at 11:00 a.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and hemiplegia. The pain care plan, revised 2/28/22, indicated she had chronic pain and to administer her medications as ordered. An interview was conducted with Resident 33 on 5/18/22 at 11:25 a.m. She indicated she had back pain and was getting to the point where she had a hard time walking. The physician's orders indicated for her to receive Norco (7.5-325 mg) tablet of hydrocodone-Acetaminophen 4 times a day for pain. The May 2022 MAR (medication administration record) indicated she did not receive the hydrocodone, as ordered, on the following dates and times: 5/18/22 at 9:00 p.m., 5/19/22 at 1:00 p.m., 5/19/22 at 5:00 p.m., 5/19/22 at 9:00 p.m., 5/20/22 at 1:00 p.m., and 5/20/22 at 5:00 p.m. There were 2 administrations, on 5/19/22 at 9:00 a.m. and 5/20/22 at 9:00 a.m. that indicated she received the medication as ordered. An interview was conducted with UM (Unit Manager) 22 on 5/24/22 at 10:26 a.m. She indicated she did not receive her Norco, because she was out of the medication, and didn't have a prescription for more. She was unsure why there was no prescription, or how Resident 33 would have received the 9:00 a.m. administrations on 5/19/22 and 5/20/22, when the medication was unavailable. The 5/19/22, 11:36 p.m. nurse's note read, Resident was out of her Norco- (7.5-325 MG). Called pharmacy to verify her refill status but only to be told that she needs a script. Contacted in house NP [nurse practitioner] but was directed to [name of pain physician.] After talking to [name of pain physician] about the patient and the need to send her script to pharm-script pharmacy, he does not seem to have a good recollection of the patient. Consequently, he advised me to sent him a text message regarding this request. After sending a text message to him, I later followed it up with a call, unfortunately the Dr. [doctor] couldn't be reached. Will continue to follow up with resident request. An interview was conducted with the pain physician's NP (Nurse Practitioner,) NP 12, on 5/25/22 at 11:22 a.m. She indicated she did not like to send in a whole month's prescription at a time. She sent in for 2 weeks at a time. She depended on nursing to tell her which residents needed what medications. If a resident was on the same pain medication for a long time, she would send in a prescription for 2 weeks at a time. If a resident was receiving pain medication for a long time, they needed the medication to manage their pain, and if they didn't get it, they could go thru withdrawal symptoms like nausea, vomiting, sweating, and chills, like having a bad flu for 24 to 48 hours. She received a request for a refill of Resident 33's Norco on 5/20/21, and she sent in a prescription on 5/21/21. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident 33 on 5/25/22 at 9:52 a.m. She indicated she did not receive her Norco for 3 days after her original 5/18/22, 11:25 a.m. interview. She felt horrible, when she wasn't getting the medication. She was in bed the whole day, either on 5/19/22 or 5/20/22, but couldn't remember which day. She was hurting in her middle and lower back. She felt like she couldn't stand for very long. She smoked cigarettes, and only went out to smoke once one of those days, as she normally went out to smoke 6 to 8 times a day, and she wasn't able to visit with her boyfriend, like she normally would. 4. The clinical record for Resident 233 was reviewed on 5/17/22 at 1:30 p.m. The diagnoses included, but were not limited to, osteomyelitis. The pain care plan, revised 5/18/22, indicated he had complaints of chronic pain with an intervention to provide medication peer orders. The physician's orders indicated to administer one 15 mg tablet of morphine sulfate extended release every 12 hours for pain, effective 5/13/22. The May 2022 MAR (medication administration record) indicated he was not administered the morphine on once on 5/13/22, twice on 5/14/22, once on 5/15/22, and twice on 5/16/22. The electronic MAR notes indicated the reasons for not administering the above doses were due to the medication being unavailable. An interview was conducted with Resident 233 on 5/17/22 at 1:51 p.m. He indicated he was prescribed morphine last week but did not receive his first dose until 5/17/22. He stated, It was horrible the whole last week. I couldn't sleep through the night at all. An interview was conducted with NP (Nurse Practitioner) 12 on 5/25/22 at 11:40 a.m. She indicated the first time she saw him, he said he was having a lot of pain, so she started him on the extended release. Later, the physician changed all of his medication and started him on Methadone. The Medication Administration policy was provided by the DON (Director of Nursing) on 5/19/22 at 9:05 a.m. It read, Medication will be administered as prescribed. On 5/25/22 at 10:58 a.m , the Director of Nursing provided the Pain Management and Assessment Policy, last reviewed on 1/18/2022, which read .It is the purpose of this policy is to provide guidance to the clinical staff to support the intent .that based on the comprehensive assessment of the resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. There is no objective test that can measure pain. The clinician must accept the resident's report of pain. Clinical observations clarify information from the resident. Site of discomfort may direct the nurse to specific types of pain- relief measures . 5. The clinical record for Resident B was reviewed on 5/20/22 at 10:00 a.m. The diagnoses included, but were not limited to, neurogenic bladder. He was admitted to the facility from the hospital on 3/10/22. He discharged from the facility on 4/27/22 for a planned surgery for wound closure. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/10/22 hospital discharge summary read, Condition on Discharge/Disposition: Stable condition will require extensive wound care and working with PT [Physical Therapy] and OT [Occupational Therapy.] The 3/10/22, 5:54 p.m. nurse's note indicated his wound vac was removed before being transported to the facility and had instructions to leave the wound vac off until Monday 3/14/22, as it would be put back on after his visit to the hospital wound clinic at 7:45am. He was currently using a wet to dry dressing. The 3/11/22, 5:11 p.m. Skin/Wound Note, written by the facility Wound Nurse, indicated Resident B had a surgical incision wound\line separation that went from his buttocks, perineum and left thigh region. The Wound Nurse was notified by the hospital emergency room nurse and EMT (emergency medical technicians) and family at bedside that resident's wound vac (vacuum) would be off until his 3/14/22, 7:45 a.m. hospital wound clinic appointment. The physician's orders indicated to cleanse buttock/perineum/incision/wound with normal saline, pat dry, apply wet-to-moist dressing/border gauze daily and as needed every day shift for surgical incision/line separation wound, effective 3/11/22. The March 2022 TAR (treatment administration record indicated this was not done on 3/12/22, 3/13/22, or 3/14/22. An interview was conducted with the Wound Nurse in the presence of the DON on 5/23 at 3:57 p.m. She indicated Resident B was supposed to admit to the facility with a wound vac, but didn't, so they got an order for the wet to dry dressing daily. She was unsure why it wasn't completed his first couple days in the facility. If they were completed, they should have been signed off on the TAR. There were no 3/14/22 hospital wound clinic notes. An interview was conducted with the facility Wound Nurse on 5/20/22 at 11:21 a.m. She indicated she was the wound nurse in March 2022 when Resident B admitted to the facility. They had issues with transportation getting him to his weekly wound appointments. The 3/16/22 hospital wound clinic note indicated it was his initial evaluation and treatment of sacral and perineal wound. The note indicated Resident B was accompanied by his parents for the visit. Resident B and his parents were very concerned about the wound healing prognosis and had multiple questions. The wound assessment was described as a chronic full thickness necrotizing fasciitis. The measurements were 32 cm X 40 cm X 9 Cm, with an area of 1280 sq cm and a volume of 11520 cubic cm. There was a moderate amount of sero-sanguineous drainage noted. The wound pain level was 4/10. The wound margin was not attached to wound base. The wound bed had 11-20% slough and 81-90% granulation. The periwound skin color was normal, and the periwound skin exhibited maceration. The wound clinic attempted to call the facility and left a voicemail for the DON (Director of Nursing) at the time to discuss the patient's plan of care and scheduling, detailed instructions for the wound vac application, and activity limitations. They were going to fax this note to the facility. It read, Will see pt [patient] weekly in collaboration with SNF [skilled nursing facility] for wound care, next appointment Monday 3/21/22 at 10:30 a.m. Pt was given appointment card to give to the facility to arrange for transportation. The plan was for his NPWT (negative pressure wound therapy) to be changed twice a week or when soiled, once at the wound clinic on Mondays and once at the facility on Thursdays. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the DON on 5/24/22 at 2:02 p.m. She indicated Resident B did not go to his wound clinic appointment on 3/21/22, due to transportation. The scheduled transportation canceled. The March 2022 TAR indicated the above order for his wound vac was completed every Thursday beginning 3/17/22, but it also indicated the previous order of wet to moist dressing continued to be done daily. An interview was conducted with the Wound Nurse in the presence of the DON on 5/23 at 3:57 p.m. She indicated she knew they were doing the wound vac treatments on Thursdays, as ordered, and was unsure why the daily wet to dry dressings continued to be signed off on the TAR. There was no 3/29/22 weekly wound clinic note. The 4/5/22 hospital wound clinic note indicated his wound was ready for combination of excision and complex closure as well as skin grafting. He could have his wound vac reapplied. They recommended a nonstick contact layer such as Adaptic or silver layer such as a product called UrgoTul which was like Adaptic with silver impregnated. They were going to place his order for surgery. In the meantime, they recommended continuing the wound vac dressing. The April 2022 TAR did not indicate the addition of a nonstick contact layer as recommended on 4/5/22, rather it indicated a continuing of the previous order of normal saline, pat dry, wet to moist dressing and border gauze from his admission. There was no 4/12/22 weekly wound clinic note. The 4/19/22 weekly wound clinic note indicated Resident B had not been getting regular dressing changes and the facility took him off the wound vac because there was bone present in the wound and the facility claimed bone in the wound was contraindicated to a vac. Resident B educated facility that is was not a contraindication; however the size of the wound with the location made it difficult on a non-hospital vac which was a more likely reason for doing the wet to dry dressings. Resident B's mother informed the dressings hadn't been changed for some time, then were changed at 12:30 a.m. and the dressings had thick yellow/green drainage. The note indicated there was no change noted in the wound progression. Surgery for wound closure was scheduled for 4/27/22. It read, Patient is in a facility; however, will be at [name of hospital] for urology appointment so would like to keep wound appointment next week prior to surgery. Pt sated that would be fine. Patient and family nervous about anything messing up surgery. The 4/25/22 weekly wound clinic note indicated he was 2 days in advance of his anticipated procedure for complex closure of his wound. On presentation, he had strikethrough green drainage from his wound. Acetic acid was started. Instructions were issued to parent to bring to facility, and they would be faxed there. It stated, Do not anticipate further treatment is indicated at this time given plan for closure with [name of surgeon] on Wednesday. The plan read, Dressings: . Please change dressing twice per day at a minimum. Dressing was changed at 11:00 on 4/25, please change again in the evening. Apply acetic acid moistened gauze (acetic acid issued to patient) to wound and cover with ABD pads, secure with medipore tape. Again, change twice per day at a minimum, and more often if needed with strikethrough drainage. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/25/22 wound clinic orders for twice daily dressing changes were not added to the facility physician's orders until 4/27/22, after discharging from the facility. The April 2022 TAR indicated a second dressing change was not completed the evening of 4/25/22, nor was it completed twice daily on 4/26/22, as instructed in the 4/25/22 wound clinic note. The 4/26/22, 4:00 p.m., nurses note, written as a late entry on 5/6/22, read, Res father presented writer with wound dressing concerns, writer then went in and completed res wound [sic] dressing, wound shows no s/s [signs/symptoms] of bleeding or foul odor, no drainage. Res given clean linen, placed in comfortable position. Denies pain/discomfort. Father at bedside, thanked and appreciated writer. The 4/27/22, 5:00 a.m. nurse's note, written as a late entry on 5/9/22, read, writer and CNA [Certified Nursing Assistant] entered room together to meet patients needs before his scheduled transfer out. nurse offered drsg [dressing] change and pt declined, drsg still present and intact. offered colostomy bag empty/change, pt declined d/t [due to] not needed at the time. CNA emptied f/c [foley catheter] bag and pt did allow nurse to irrigate the cath [catheter.] CNA and nurse offered to change linens on bed, pt declined , pt was on clean linens with a lift sheet on it from shoulders to feet so that he could be transferred to cot. pt took his AM med with sips of water. pt declined getting a bed bath or washed up before he went. 4/27/22, 6:25 a.m. nurses note read, pt sent out per ambulance, stretcher, for scheduled surgery. mother and father at bedside. An interview was conducted with Family Member 33, Resident B's mother, on 5/23/22 at 2:50 p.m. She indicated Resident B's wound was so infected when he discharged the facility on 4/27/22 that he couldn't get the surgery for wound closure. The surgeon said he could not close the wound. He needed it debrided. It was delayed 2 days. It was infected. It had green drainage. She was concerned it was infected prior to leaving. They went to wound care on Monday, 4/25/22, and it was green then and they said that wasn't good. They were going to get it all cleaned up for surgery. By Wednesday, 4/27/22, it was all green again. The wound care center said they wanted the dressing changed twice daily, but the facility said no, they were only going to do it once daily. The nurse at the facility said he was the only nurse there and couldn't do it twice. It was truly, truly horrible. The 4/27/22-5/17/22 hospital notes indicated the planned procedure was debridement and skin graft plus complex closure on 4/27/22. The notes read, A tissue biopsy was obtained 4/25/2022 that was polymicrobial w/Acinetobacter baumannii, Group A strep, Pseudomonas aeruginosa, Corynebacterium, and 1 colony of Staph aureus. He was admitted [DATE] for planned surgery which ended up being a debridement only as his mother states his wound was not taken care of at [name of facility] and he presented with purulence. Following his debridement yesterday [4/27/22,] he has remained on IV Cefepime CT scan also revealed a concern for osteomyelitis of the ischium. There are plans for him to return to the OR [operating room] tomorrow for possible wound coverage .Surgical History Internal 04/29/2022 [name and title of surgeon] Skin Graft Split Thickness. 02/27/2022 [name and title of surgeon] Wound Debridement. 6. The clinical record for resident 103 was reviewed on 5/16/22 at 3:25 p.m. The Resident's diagnosis included, but were not limited to, congestive heart failure and chronic respiratory failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. Building B. Wing	05/26/2022

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, initiated 12/17/21, indicated he was at risk for impaired skin integrity related to his disease process, immobility, poor nutrition, and poor vascularity. The goal, initiated 12/17/21, was for him to be without impaired skin integrity. The interventions, initiated 12/17/21, included, but were not limited to, complete skin at risk assessments upon admission/ readmission, quarterly and as needed and to complete weekly skin checks. A progress note, dated 1/28/22 at 1:25 p.m., indicated he was readmitted to the facility and appeared to have a patch of psoriasis noted on his face. A physician's order, dated 1/28/22, indicated he was to have Elidel Cream 1% (cream used to treat dermatitis) applied to his face every day for treatment of psoriasis patches on face. The order was discontinued on 4/20/22 when he went to the hospital for acute care. A Quarterly MDS Assessment, completed 4/2/22, indicated he was cognitively intact. On 5/16/22 at 3:25 p.m., he was observed sitting on the side of his bed. He had flakey crusts of skin in his right ear and on his forehead. On 5/19/22 at 10:48 a.m., he was observed sitting in his room. Flakey crusts of skin were noted on forehead. On 5/23/22 at 10:54 a.m., he was observed laying sideways on bed. He was dressed in a black tee shirt and had been shaved. He had reddened areas on face. On 5/25/22 at 2:50 p.m., he was observed sitting in his room. He had red and scaly patches on his cheeks, chin, and forehead. He indicated he used to have some cream that the nurses put on his face. During an interview on 5/52/22 at 3:08 p.m., QMA (Qualified Medication Aide) indicated that a physician should have been informed of the red, crusty areas on his face. 7. The ED (Executive Director) provided the most recent QAPI [Quality Assurance and Performance Improvement] Meeting Agenda and Minutes on 5/26/22 at 1:49 p.m. They included the 3/18/22 minutes, the 4/22/22 minutes, the 4/28/22 minutes, the 5/16/22 minutes, and the 5/20/22 minutes. None of the minutes referenced wound care or pain management. An interview was conducted with the ED, Interim DON (Director of Nursing,) and a Sister Facility DON on 5/26/22 at 1:25 p.m. The ED indicated they'd discussed that there was no Wound Care Director at meetings but did not have a specific plan in place to address wound care in the facility. It was only recently that they realized they needed to tighten up on some things in regards to wound care, but more so in morning meetings format, not during QAPI meetings. He did not recall discussing or identifying pain management as an area of concern during QAPI meetings. In terms of a trend, there was no QAPI plan in place for pain management. The QAPI Plan was provided by the ED on 5/26/22 at 3:01 p.m. It read, QAPI is data-driven. QAPI is a proactive approach to improving quality of life, care and services. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement, address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This Federal tag relates to complaint IN00379008. 3.1-52(b)(1) 3.1-52(b)(2)