STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38767 Based on observation, interview, and record review, the facility failed to ensure resident preference assessments were completed and residents received showers twice a week for 2 of 3 residents reviewed for bathing preferences (Residents C and B). Findings include: 1. Resident C's record was reviewed on 7/20/21 at 9:15 a.m. Diagnoses on Resident C's profile included, but were not limited to, hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction affecting right dominant side, aphasia (loss of ability to understand or express speech), type 2 diabetes mellitus, and need for assistance with personal care. A Care Plan for Resident C, dated 5/10/21, indicated the resident had a self-care performance deficit and required assistance with ADLs related to cardiovascular accident and hemiplegia. The goal was for the resident to demonstrate increased independence with ADL completion. Interventions included the resident required 1 staff assistance with bed mobility, eating, toileting, transfers. Place call light within reach. Remind resident to call for assistance if cognitively intact. PT/OT evaluation and treat per medial provider orders. A Resident Preferences Evaluation for Resident C, dated 5/17/21, indicated it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The resident preferred a shower. A Care Plan Conference note for Resident C, dated 5/20/21 at 10:21 a.m., indicated resident preferences were discussed and updated. The resident and her daughter attended the meeting. A Shower Assignments form, undated, indicated Resident C showered Wednesday and Saturday evenings. Licensed Practical Nurse (LPN) 20 indicated, nursing staff filled out shower/bathing sheets daily after completion of resident care. Staff knew what day the resident was supposed to have a shower per the shower assignments in the binder on the desk. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bathing Sheets for Resident C, dated June and July 2021, indicated the resident was documented as having only received a bed bath on 7/7/21. Documentation also indicated the resident had an open area, no location or description provided. LPN 20 and an aide indicated, there was no other documentation for the resident, and no shower sheets besides those in the binder to indicate the resident had documentation of a bed bath or shower. The quarterly MDS (Minimum Data Set) assessment, completed on 6/4/21, assessed Resident C as rarely/never made herself understood, usually understood others. Cognitive skills for daily decision making severely impaired. Resident C required extensive assistance of 2 or more persons physical assist for bed mobility, and dressing. Total dependence of 2 or more persons physical assistance for transfers. She did not walk in the room or corridor or have locomotion off the unit. Locomotion of the unit only occurred once or twice during the assessment period with 1 person physical assistance. Extensive assistance of 1 person physical assist for eating, toileting, and personal hygiene. Total dependence of 1 person for bathing. Mobility devices included a wheelchair. Always incontinent of bowel and bladder. Resident at risk for developing a pressure ulcer/injury, no current pressure ulcers, or skin problems. On 7/21/21 at 7:24 a.m., Certified Nursing Assistant (CNA) 18 indicated, Resident C was supposed to have been washed up daily, and her shower days were Wednesday and Saturday evenings. If there was no shower sheet, documentation could possibly also be found in the electronic documentation system. On 7/22/21 at 10:01 a.m., Registered Nurse (RN) 6 and LPN 15 indicated, shower sheets were only kept in the binder on the counter of the nurse's station, they are not stored in other areas of the hallway. Every few months someone would come and thin out the binder and file them away. On 7/22/21 at 5:01 p.m., the DNS indicated, Resident C's bathing/shower sheet were not kept on the unit, she kept them in her office. Upon review the resident had only 1 shower documented since admission. Staff had indicated, the resident was too had to transfer. The resident possibly needed a bigger bed. 2. On 7/19/21 at 12:14 p.m., Resident B's spouse indicted, when she had visited the resident, he looked like he'd not had a bath for several days. The spouse asked for towels and was told by staff the resident had not requested help for a bath, so they didn't do it. Resident B's record was reviewed on 7/19/21 at 1:02 p.m. Diagnoses on Resident B's profile included, but were not limited to, open wound on right lower leg, peripheral vascular disease, diabetes mellitus, acquired absence of right leg below knee, and need assistance with personal care. Shower Sheets for Resident B, dated June 2021, indicated, documentation of only 1 bath sheet, dated 6/10/21. The bath sheet indicated the resident received a bed bath. On 7/23/21 at 11:12 a.m., observation of Resident B's medical record with the Director of Nursing Services (DNS). The residents medical record lacked documentation that a Preferences Assessment had been completed per nursing. The assessment for daily and activity preferences was not completed in the Admission MDS. On 7/23/21 at 11:23 a.m., the DNS provided 5 bathing sheets for Resident B that had not been found in the bathing/shower binder. A bathing sheet, dated 6/21 21, indicated the resident had a shower. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/21 at 11:23 a.m., the DNS provided a handwritten copy of a Resident Preference Evaluation for Resident B, dated 6/4/21. The preference sheet indicated, it was not very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath. Documentation indicated the resident preferred a shower but not every day. An Admission MDS assessment, completed on 6/10/21, indicated Resident B had the ability to make himself understood and to understand others. A brief interview for mental status (BIMS) score of 15 indicated cognitively intact. The resident required extensive assistance of 1 person for bed mobility transfers, dressing, and toilet use. He did not walk in room or corridor. Supervision and 1 person physical assist for locomotion on and off unit. Supervision and set up help only for eating and bathing. Limited assistance and 1 person physical assist for personal hygiene. Supervision and set up help only for bathing. Mobility devices included a wheelchair. The assessment for daily and activity preferences not completed, to include bathing and preferences. The resident was occasionally incontinent of bladder, frequently incontinent of bowel. A Care Plan for Resident B, dated 6/7/21, indicated he had an ADL self-care performance deficit and required assistance with ADL's related to a right below the knee amputation shortness of breath, weakness, and pain. His goal was to demonstrate increased independence with ADL completion. Interventions included, the resident required 1 staff assistance with eating, toileting, bed mobility, and transfers. Place call light within reach. Remind resident to call for assistance if cognitively intact, PT/OT evaluation and treat per medical provider orders. On 7/23/21 at 11:30 a.m., DNS indicated, resident showers were to be provided two times weekly unless the resident had a different preference. Aides documented showers on bathing sheets or in the EMR under tasks. She could not answer as to why documentation of Resident B's preferences was not completed, or showers given. On 7/22/21 at 1:02 p.m., the DNS provided a Personal Bathing and Shower policy, dated 5/30/21, and indicated the policy was the one currently being used by the facility. The policy indicated, Residents 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 types of activities for bathing that may include a shower, a bed-bath or tub bath, or a combination and on different days . Bathing preferences should be care planned including type and schedule .Procedure .a. Determine resident preferences for shower or bathing at bedside. b. Determine resident preference for AM or PM personal bathing care. c. Determine resident preference for number of showers during week. d. Care plan resident preferences and communicate to staff providing personal care This Federal tag relates to Complaints IN00357020 and IN00357478. 3.1-3(t) 3.1-3(v)(1)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38767 Based on observation, interview, and record review, the facility failed to prevent pressure ulcers on a dependent resident, complete follow-up assessments, track wound progression, implement interventions, or follow interventions recommended by the wound nurse practitioner (NP), resulting in harm when preventive interventions were not implemented and a pressure ulcers on the resident's heel developed into an unstageable ulcer (full thickness tissue loss where the wound bed is covered by slough) and then a stage III (full thickness tissue loss with subcutaneous fat exposed, but bone, tendon, or muscle are not visible) pressure ulcer for 1 of 3 residents reviewed for pressure (Resident C). Findings include: On 7/20/21 at 10:51 a.m., Resident C was observed lying on her back in bed on a regular mattress, head elevated, both feet propped on a pillow, and left foot in a specialty boot. On 7/20/21 at 12:20 p.m., Resident C observed lying on her back in bed on a regular mattress with the head of bed elevated. On 7/21/21 at 6:50 a.m., Resident C was observed lying on her back in bed on a regular mattress with the head of bed elevated. Licensed Practical Nurse (LPN) 23 indicated she was the night nurse and not sure if the resident got out of bed. She was also not sure what nursing measures were being used to prevent skin breakdown for the resident. Resident C was dressed and changed by day shift. Resident C's physician's orders included changing the dressing every other day on her sacrum, and staff used some type of silver nitrate and gauze to the g-tube site. There was a heel treatment, and orders for the NP to see the resident. On 7/21/21 at 8:49 a.m., Resident C was observed lying on her back in bed on a regular mattress, head elevated, and specialty foam boots on both feet. On 7/21/21 at 2:22 p.m., Resident C was observed lying on her back in bed on a regular mattress with the head elevated. Specialty foam boots were on bilateral feet with the left bootie twisted sideways with the straps tight across the lower leg. On 7/22/21 at 9:45 a.m., staff were observed getting Resident C out of bed into a Broda chair (tilt in space positioning chair) at bedside. Once up and staff left room, resident was observed to have her head suspended approximately 3 inches off chair back, no head support, facial grimacing, and resident observed every few minutes with head hyperextended to lay a few minutes on the back of the chair. Left foot with pressure ulcer observed to be braced flat against left foot pedal creating pressure on bottom of foot, toes curled over top of the pedal. Right foot off the foot pedal and turned to the right. Director of Nursing Services (DNS) was summoned to observe resident and placed a pillow behind the head. She indicated she would get a pillow to cushion the bottom of the resident's feet. On 7/22/21 at 2:32 p.m., Resident C was observed still sitting in a Broda chair at bedside. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/22/21 at 3:11 p.m., Resident C was observed still sitting in a Broda chair at bedside. The medical record lacked documentation to indicate the resident had her brief changed or weight distribution since gotten up in the am. Resident was observed to be out of bed approximately 6 hours, exceeding therapy recommendations and education to nursing staff of 3-4 hours During a continuous observation on 7/22/21 from 3:25 p.m. to 4:30 p.m., CNA 24, CNA 25 and LPN 26 were observed to bring a mechanical lift into Resident C's room to transfer her back to bed, but after discussion staff indicated they had never transferred the resident with the lift before and did not know how to get her into bed. At 3:40 p.m., CNA 25 and CNA 27 transferred and placed Resident C on a newly placed low air loss mattress on top of 2 folded flat sheets. Resident C's brief observed to be saturated with urine, soiled with bowel movement (bm), and the hydrocolloid dressing observed with LPN 26 to be displaced off stage 2 (wound extending into the deeper layers of skin, usually tender and painful) sacral wound, with wound and dressing soiled. Stage 2 wound site was circular shaped with small amount bloody drainage. The sacral wound was left open to air, aides were not observed to put protective cream onto bottom with brief change. Heels were lying on the bed. At 4:08 p.m., the left heel wound was observed with nurse LPN 28. The wound dressing was loose around the edges, and the sheet was wet below the heel. Dressing, dated 7/20/21, were heavily soiled with dark blackish drainage. Resident C's record was reviewed on 7/20/21 at 9:15 a.m. Diagnoses on Resident C's profile included, but were not limited to, hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction affecting right dominant side, aphasia (loss of ability to understand or express speech), type 2 diabetes mellitus, and need for assistance with personal care. The quarterly MDS (Minimum Data Set) assessment, completed on 6/4/21, assessed Resident C as rarely/never made herself understood, usually understood others. Cognitive skills for daily decision making severely impaired. Resident C required extensive assistance of 2+ persons physical assist for bed mobility, and dressing. Total dependence of 2+ persons physical assistance for transfers. She did not walk in the room or corridor or have locomotion off the unit. Locomotion of the unit only occurred once or twice during the assessment period with 1 person physical assistance. Extensive assistance of 1 person physical assist for eating, toileting, and personal hygiene. Total dependence of 1 person for bathing. Mobility devices included a wheelchair. Always incontinent of bowel and bladder. Resident at risk for developing a pressure ulcer/injury, no current pressure ulcers, or skin problems. A Care Plan for Resident C, dated 5/10/21, indicated the resident had a self-care performance deficit and required assistance with ADLs related to cardiovascular accident and hemiplegia. The goal was for the resident to demonstrate increased independence with ADL completion. Interventions included the resident required 1 staff assistance with bed mobility, eating, toileting, transfers. Place call light within reach. Remind resident to call for assistance if cognitively intact. PT/OT evaluation and treat per medial provider orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Care Plan for Resident C, dated 5/10/21, indicated the resident was at risk for impaired skin integrity. The goal was for the resident's skin to remain intact. Interventions included, keep skin clean and well lubricated, provide skin care per facility guidelines and as needed, and utilize pressure relieving devices on appropriate surfaces. Documentation indicated the focus was revised on 7/7/21 to indicate, risk for impaired skin integrity pressure ulcer unstageable (full thickness tissue loss where the wound bed is covered by slough) to left heel, stage 2 (partial thickness loss of the dermis) on the sacrum. The record lacked documentation the care plan interventions were revised. A physician order, dated 5/10/21, indicated a weekly skin evaluation by licensed nurse on Monday. A physician order, dated 5/10/21, indicated calmoseptine (moisture barrier skin protectant) to bilateral buttock every shift for preventative. A physician order, dated 5/25/21, indicated hoyer lift for transfers with assistance of two staff members. Weekly Skin Assessments in the electronic medical record (EMR), dated 5/11/21 - 7/21/21, indicated documentation of weekly assessments were completed only on 6/28/21. A Weekly Skin Assessment for Resident C, dated 6/28/21, indicated resident had a new skin condition since the last review. Left heel mushy dark area measured 4.5 centimeters (cm) by (x) 3.5 cm. Prevalon (cushioned boots used to float heels off the surface of the mattress) on. A Skin/Wound Note by the Wound NP for Resident C, dated 7/7/21 at 9:02 p.m., indicated chief complaint was wounds. A left heel unstageable pressure ulcer due to eschar, and a sacral stage 2 pressure ulcer. Patient had a pressure injury. Pressure reduction and turning precautions discussed with staff at time of visit recommended, including heel protection and pressure reduction to bony prominences. Staff educated on all aspects of care. Factors affecting healing, patient had frequent incontinence which could decrease healing rate of wound. Recommend providing incontinence care as needed. Increased moisture at wound site could promote poor prognosis of wound healing. Please keep wound site covered and avoid contamination with feces at all times. Wound rounds completed and reconciled with wound nurse (LPN 12) today. All questions and concerns answered for staff and patient as applicable. Staff made aware that wound rounds were completed and of any changes in treatment plan. A physician order, dated 7/7/21, indicated Betadine Solution 5 % (Povidone-Iodine) apply to left heel topically two times a day for wound management. A physician order, dated 7/7/21, indicated cleanse area to sacrum with normal saline, pat dry and apply hydrocolloid and secure, change every Tuesday and Friday for wound care. A physician order, dated 7/12/21, indicated wound NP to evaluate and treat open area on left heel and hyper granulation tissue around g-tube. A Tissue Analytics report, dated 7/13/21, indicated unstageable left heel wound measuring 3.67 cm x 4.75 cm x 0.0 cm. Scant serosanguinous drainage. Pressure reduction/offloading: ensure compliance with turning protocol, wedge/foam cushion for offloading, wheelchair cushion, and specialty bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Tissue Analytics report, dated 7/13/21, indicated Stage 2 pressure wound on sacrum wound measuring 0. 93 cm x 2.39 cm x 0.1 cm. Scant serosanguinous drainage. Pressure reduction/offloading: ensure compliance with turning protocol, wedge/foam cushion for offloading, wheelchair cushion, and specialty bed. A Progress Note for Resident C, dated 7/13/21 at 1:31 p.m., indicated the resident was seen by the wound team today, no new orders given at this time. Nurse left messages for both daughters to call for an update. Will continue to monitor. A Progress Note for Resident C, dated 7/13/21 at 2:51 p.m., indicated chief complaint, comprehensive skin and wound evaluation for sacrum, left heel, and g-tube site. Orders, Aspercreme Lotion 10 % topically 10 % Trolamine Salicylate, Eucerin Cream topically skin Protectants, and Lac-Hydrin Lotion 12 % topically 12 % Ammonium Lactate. A Progress Note for Resident C, dated 7/13/21 at 1:31 p.m., indicated the resident was seen by the wound team today, no new orders given at this time. Nurse left messages for both daughters to call for an update. Will continue to monitor. A Progress Note for Resident C, dated 7/13/21 at 2:51 p.m., indicated chief complaint, comprehensive skin and wound evaluation for sacrum, left heel, and g-tube site. Orders, Aspercreme Lotion 10 % topically 10 % Trolamine Salicylate, Eucerin Cream topically skin Protectants, and Lac-Hydrin Lotion 12 % topically 12 % Ammonium Lactate. A Tissue Analytics report, dated 7/20/21, indicated previously unstageable wound improving to Stage III (full thickness tissue loss with subcutaneous fat exposed, but bone, tendon, or muscle are not visible) on left heel wound measuring 1.5 cm x 2.11 cm x 0.2 cm. Scant amount serosanguinous drainage. Pressure reduction/offloading: ensure compliance with turning protocol, wedge/foam cushion for offloading, wheelchair cushion, and specialty bed. A Tissue Analytics report, dated 7/20/21, indicated Stage 2 pressure wound on sacrum wound measuring 1. 41 cm x 0.34 cm x 0.1 cm. Scant amount serosanguinous drainage. Pressure reduction/offloading: ensure compliance with turning protocol, wedge/foam cushion for offloading, wheelchair cushion, and specialty bed. A physician order, dated 7/20/21, indicated cleanse area to sacrum with normal saline, pat dry, and apply silver alginate and cover with bordered gauze, change every other day and as needed. Resident C's medical record lacked documentation to indicate the resident had an order for specialty boots or low air loss mattress. On 7/21/21 at 3:19 p.m., the DON provided additional Weekly Skin Check sheets had been located and been put into the electronic medical record (EMR). The forms lacked nurse signature and dates of completion. The forms indicated: a. Effective 6/7 21 resident had no skin conditions. b. Effective 6/14/21 resident had not skin conditions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	d. Effective 6/21/21 resident had no skin conditions. d. Effective 7/5/21 resident had a change in skin condition. Left heel wound measuring 4.0 cm x 4.5 cm x 0 cm. Sacrum wound measuring 1.0 cm x 2.5 cm x 0.1 cm. Abdomen wound measuring 2.0 cm x 1.0 cm x 0.1 cm. e. Effective 7/12/21 resident had skin conditions that were not new since the last assessment on abdomen, left heel and sacrum. Documentation lacked measurements or description of the wounds. During an interview on 7/19/21 at 12:29 p.m., Resident C's daughter indicated she had filled out 3 blue complaint forms and nobody from management had called her back since she submitted her concerns starting in June 2021. The resident had a heel that was actively bleeding, and the facility did not get the wound NP to see her until 7/13/21. Daughter thought the bandage on her left foot had been changed but did not think nursing staff were using the ordered medications to her heel wound. Aides had been instructed to put cream on the resident's bottom with each brief change, and that was not happening. During an interview on 7/20/21 at 11:38 a.m., LPN 8 indicated she was the nurse treating Resident C. The resident had an order for betadine to an open area on the left heel and it was to be left open to air. The sacrum wound order included, normal saline and a hydrocolloid dressing to be used on Tuesdays and Fridays during dressing changes by the wound team, and staff were responsible for changing the dressing as needed on the other days. During an observation with NP 31, on 7/20/21 at 11:22 a.m., Resident C was laying on her back on a regular mattress, head of bed elevated and left heel in a specialty boot. NP 31 indicated the wound team saw the resident that morning and they may have written new orders. The last time she saw the daughter she had wanted the special boot, but NP 31 was not sure if there had been an order for the boots. NP 31 indicated she was unsure why the staff had not put a pressure relieving mattress on the bed. Staff had told her the resident was not compliant with turning and being propped, she was told by staff the resident preferred to be on her back. She had never seen the resident out of bed and was unsure why she did not get out of bed. During an interview on 7/20/21 at 11:48 a.m., the Wound NP and Wound Nurse LPN 12 indicated they had seen Resident C that morning during wound rounds and her heel pressure wound had improved from a Stage IV (Full thickness tissue loss with bone, tendon, or muscle exposed) to a Stage III (full thickness tissue loss with subcutaneous fat exposed, but bone, tendon, or muscle are not visible). Wound Nurse LPN 12 indicated the open area on Resident C's bottom and heel were most likely due to pressure, but he was not sure as she was not his resident and he only saw after being informed she had a wound. He could not answer as to preventative measures or why the resident was not gotten out of bed. On 7/21/21 at 6:50 a.m., LPN 17 indicated, she was the night nurse and usually worked another unit. She was not sure if Resident C was gotten out of bed, and she was not sure what preventative skin measures were used for the resident. LPN 17 indicated the resident was changed by the day shift. There were orders for a dressing change every other day to the sacrum, silver nitrate, and cover with gauze. Heel treatment order only includes NP to see. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/21/21 at 6:56 a.m., LPN 20 indicated, the facility had a wound team that came in the mornings, she herself was not sure what preventative nursing measures were being used to treat the resident's skin breakdown. Certified Nursing Assistant's (CNA's) would mark on the bathing sheet if there were skin concerns, they informed the nurse, and then the information went into the Medical Binder and the NP or physician would see when they come into the building. On 7/21/21 at 7:00 a.m., CNA 19 indicated, she had worked in the facility approximately 2 years. She was not sure if Resident C was ever gotten out of bed, possibly the day shift would get her up. The resident usually laid on her back, when pillows were placed under her to prop, she would just move back. Calmoseptine ointment (protectant) was used on the resident's buttocks with brief changes, and they would prop her heels on a pillow except when specialty foam boots were put on her. On 7/21/21 at 7:00 a.m., CNA 20 indicated, she had worked in the facility approximately 2 years, but she worked night shift. She was not sure if the resident was ever gotten out of bed, possibly the day shift wound got her up. Most times she observed Resident C she was laying on her back, when pillows were placed, she would just try to move back. Calmoseptine ointment was used on buttocks with brief change, float heels on pillow except when provolone boots on. During an interview on 7/21/21 at 9:10 a.m., Resident C's daughter indicated she was the one who found the open area on the resident's heel on Friday 7/9/21. She was not aware the resident had an open area on her bottom. She had asked the aides to put cream on the resident's bottom to help prevent open areas. The daughter indicated Resident C was not gotten out of bed and she was not sure why. During a care plan meeting in June the daughter had asked therapy to get the resident an appropriate chair and a Broda chair was obtained. The resident had been seen up in her chair per family one time and she was positioned wrong causing her to cry. The resident had not been up since to her knowledge. To her knowledge the resident had only booties to use on her feet, although she had to take them home to wash them due finding them soiled with blood. The resident was not propped on her side, she was always positioned on her back in the bed. Resident C had been seen with booties on her right foot frequently twisted to the side and positioned wrong, and she knew this as there would be an imprint on the leg from the straps. On 7/21/21 at 7:24 a.m., CNA 18 indicated she worked the assignment to include Resident C. Indicated the resident was washed up daily, shower days were Wednesday and Saturday evenings. The resident would occasionally get out of bed with staff using the hoyer lift. Calmoseptine ointment was used on her bottom with brief changes. As aides they made sure Resident C was dry all the time to help prevent skin breakdown. They had tried in the past to prop the resident onto her side, but she did not stay. CNA 18 indicated, she supposed the staff should have asked therapy to get a special wedge or some kind of cushion to keep her off her back. On 7/21/21 at 11:57 a.m., the DNS indicated, the facility had just started using a new wound company on 7/6/21. The wound company had done a wound sweep of the entire resident population to identify skin concerns and provided documentation. The wound company came every Tuesday and Friday and saw residents along with LPN 12 who was the facility wound nurse. The DNS looked at residents upon admission for special needs, and to make sure the room was set up for the resident. A care plan was initiated by the admitting nurse to open it, then the MDS nurse finished the care plan and kept it updated as needed. The DNS indicated, she would have to look for documentation on how Resident C acquired her wounds and preventative measures that were being used before (continued on next page)

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Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/22/21 at 10:18 a.m., the Occupational Therapist (OT) indicated, Resident C had been assessed by Physical Therapy (PT) on 5/11/21 and OT on 5/13/21. Resident C had remained on case load and received treatment for 3 weeks. PT assessed Resident C for positioning in a Broda chair and provided range of motion (ROM) to the upper body. Education was provided to staff on proper positioning techniques and having the resident up in a Broda chair to build tolerance at least 3 times weekly. OT indicated she had not observed the resident up in her Broda chair 3 times weekly as recommended. On 7/22/21 at 11:19 a.m., Resident C was observed with the daughter. The resident was sleeping in her Broda chair at bedside, the daughter indicated this was only the 2nd time she had seen the resident out of bed since admission in May. On 7/22/21 at 2:39 p.m., Wound Nurse LPN 12 indicated, Resident C had multiple comorbidities that would put her at risk for skin breakdown, the root cause of her sacrum and heel wounds were documented by the Wound NP as pressure, and thought the wounds were documented as unavoidable but would need to check. The wound team rounded weekly and made recommendations for nursing interventions, then he would put the orders into the computer and the orders should show on the resident orders for nursing to follow and document. The MDS nurse updated most of resident care plans, but he tried to update wound care plans. Turning and repositioning every 2 hours should be standard for all dependent residents. After it had been established Resident C had wounds, she should have had a specialty low air loss mattress placed on her bed. The wound NP gave orders and he put them into the resident chart. In the past 3 weeks they had a new wound company and rounding program. Residents with wounds were seen on Tuesday with the wound NP. Then she would return and the team saw all new resident admissions on Thursday or Friday, or newly identified residents with wounds. On 7/22/21 at 3:30 p.m., the MDS Coordinator indicated, any one of the administrative nurses could update care plans with a change in condition. The MDS nurse might find out about a new wound when reviewing the chart, or in the morning meeting. A new wound group came weekly and put in progress notes, then the clinical team provided a list of residents with wounds or issues to the MDS nurses. The MDS Coordinator indicated, she was not aware Resident C had wounds. If she had known she would have updated her care plan. On 7/22/21 at 5:01 p.m., the DNS indicated Resident C's bathing/shower sheet were not kept on the unit, she kept them in her office. Upon review the resident had only 1 shower documented since admission. Staff had indicated, the resident was too hard to transfer. The resident possibly needed a bigger bed. DNS indicated the wound sheets had not been observed in Resident C's EMR as they were kept in a different section under documents. Some of the wound assessments had measurements and some did not. The resident's skin/wound care plan had not been updated to include preventative measures specific to the resident. Nurses should have read and followed the care plans physician's orders were not needed for following care plans. The wound care team recommendations and therapy recommendations for compliance with turning protocol, wedge/foam cushion for offloading, wheelchair cushion, or specialty bed, were just recommendations. That did not mean the recommendations were orders or staff had to follow them. She thought the Wound NP had documented Resident C's wounds as unavoidable, but if staff had not been following care plan interventions, or using any preventative measures, the wounds could not be considered unavoidable. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 7/21 21 at 3:45 p.m., the DNS provided a Skin Care & Wound Management policy, dated 5/30/19, and indicated the policy was the one currently being used by the facility. The policy indicated, .The staff strives to prevent resident/patient skin impairment and to promote healing of existing wounds .Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition .4. Develop a care plan with individualized interventions to address risk factors .6. Evaluate for consistent implementation of interventions and effectiveness at clinical meeting. 7. Modify and document goals and interventions as needed On 7/21/21 at 3:45 p.m., the DON provided a Wound Care policy, dated 5/30/19, and indicated the policy was the one currently being used by the facility. The policy indicated, Residents/patients admitted with or develop skin integrity issues will receive treatment as indicated based on location, stage, and drainage This Federal tag relates to Complaint IN00357478. 3.1-40(a)(1) 3.1-40(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37981 Based on observations, interviews, and record review, the facility failed to ensure medications were not left in resident's rooms, residents with medications left at bedside had self-administration assessments and physician's orders to self-administer medications for 8 of 12 residents reviewed for medications in their rooms (Resident F, G, H, K, M, P, AT, and AU). Findings include: 1. On 7/19/21 at 10:18 a.m., 3 tubes of barrier ointment (used as a topical skin protectant), a box of gauze sponges, an unidentified container of white ointment, tape, and various wound supplies were observed on the windowsill, and dresser of Resident F's room. An unlabeled tube of diclofenac Sodium Topical gel (pain reliever) was on the bedside table and an unidentified white tablet in a medication cup was on over the bed table. The resident indicated he thought it was a pain pill. Registered Nurse (RN) 6 indicated, did not know what the pill was on the bedside table, it was there when she got there this morning. She indicated the nursing staff should not have left pills for residents to take later. She told the resident he should take his medication but did not know what the pill was. On 7/20/21 at 11:06 a.m., a second observation of a plastic container on Resident F's windowsill with the unidentified ointment, and an opened and unlabeled tube of diclofenac sodium topical gel was still on the bedside table. On 7/23/21 at 11:31 a.m., the RNC indicated Resident F had no self-administration assessment. He should not have had loose pills in his room waiting for him to take later. The only pain medication he had a physician's order for was scheduled and PRN (as needed) Tylenol. 2. On 7/19/21 at 10:27 a.m., wound supplies were observed in Resident G's room. On the over the bed table was Nystatin powder 100,000 U/gm (unit per gram) (used to treat fungal infections), and Aloe Vista skin protectant (used to protect the skin). Three packs of wipes were observed on windowsill. A bottle of peroxide (topical antiseptic), box of skin preps (protective film to reduce friction), and two containers of Miconazole/Triamcinolone/Lidocaine 1:1:1 ointment (mixture of 2 antifungal medications and a pain reliever) was on the chest of drawers. On 7/23/21 at 11:39 a.m., the RNC indicated Resident G's nystatin powder and wound care items should have been in the treatment cart. He had no self-administration assessment of medications. He did not do own wound care. 3. On 7/19/21 at 10:49 a.m., an opened bottle of Aleve (pain reliever), with no pharmacy label, was observed on Resident H's on bedside table. On 7/20/21 at 11:02 a.m., an opened bottle of Aleve, without a pharmacy label, was observed again on Resident H's on bedside table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident H's record was reviewed. It indicated there was no physician's order for Aleve, no self-administration assessment, and no care plan. Resident H indicated she took 2 tablets whenever she needed them. On 7/21/21 at 6:58 a.m., an opened bottle of Aleve, without a pharmacy label, was observed for the third time on Resident H's on bedside table. On 7/21/21 at 7:34 a.m., Qualified Medical Aide (QMA) 16 indicated he believed residents could self-administer medications if they had a physician's order and a self-administration assessment. He thought the Nurse Practitioner (NP) and Director of Nursing Services (DNS) would make sure there was a self-administration assessment. On 7/21/21 at 10:22 a.m., Resident H's record was reviewed, there was no physician's order for Advil and no self-administration assessment. On 7/21 21 at 3:50 p.m., an opened bottle of Aleve, without a pharmacy label, was observed for a fourth time on Resident H's on bedside table. On 7/23/21 at 11:24 a.m., the Regional Nurse Consultant (RNC) indicated Resident H's had a self-administration assessment, it was specific is for benalin (used to reduced allergies), not Aleve (pain reliever). The medication should have been kept in the medication lock box in the resident's room. 4. On 7/19/21 at 11:09 a.m., visible from the hallway, 4 pharmacy labeled bottles of eye drops were observed on the over the bed table in Resident K room. She indicated she gave herself her own eye drops: Latanoprost 0.005% (used to treat glaucoma), Timolol Maleate 0.5% (used to reduce pressure in the eye), and Brimonidine 0.2% (used to reduce pressure in the eyes). These eye drops had no open dates or expiration dates. She also administered Dorzolamide 2% (used to reduce pressure in the eye), it was open dated 3/17/21, with no expiration date. Once the bottles were empty, she would have a nurse re-order her eye drops. On 7/20/21 at 3:30 p.m., the DNS provided Resident K physician's orders, they indicated may keep eye drops at bedside. On 7/23/21 at 11:26 the RNC indicated Resident K's eye drops were not secured properly. The eye drops should have been in a medication lock box. 5. On 7/19/21 at 11:28 a.m., an opened and half empty bottle of Pepto-Bismol (used to treat upset stomach) was observed on Resident M the over the bed table. She indicated she took a teaspoon or so when she had an upset stomach. On 7/20/21 at 3:30 p.m., the DNS provided Resident M physician's orders, there was no order or self-administration assessment for Pepto-bismal. On 7/23/21 at 11:28 the RNC indicated Resident M had self-administration assessment, but it was not specific for Pepto-bismal. The Pepto-bismal should have been in a medication lock box (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 7/19/21 at 11:38 a.m., visible from the hallway, a bag of 15 albuterol 0.083% (used to treat shortness of breath) vials was observed on Resident P's dresser. The expiration dates on the vials were 10/11/18. On 7/21/21 at 11:19 a.m., the Assistant Director of Nursing Services provided Resident P's Medication Administration Record (MAR), dated July 2021. The MAR indicated he did not have an order for albuterol nebulizer treatments. On 7/19/21 at 11:34 a.m., Resident N was observed ambulating independently in his room. On 7/23/21 at 11:35 the RNC indicated Resident P did not have a self-administration assessment for nebulizer treatments. On 7/23/21 at 12:23 p.m., the Administrator in Training (AIT) provided documentation of ambulatory residents with Brief Interview of Mental Status (BIMS) of moderate or severe cognitive impairment. Residents N, P, AY, AZ, BA, and BB were ambulatory and had severe cognitive impairment. Residents Z, AV, AL, AK, R, AW, and AX were ambulatory and had moderate cognitive impairment. 7. On 7/23/21 at 9:35 a.m., Vapo-rub (topical analgesic) was observed on the dresser of Resident AU. On 7/23/21 at 11:43 a.m., the RNC indicated Resident AU had no self-administration assessment. There was no physician's order or care plan for vapo-rub. The vapo-rub should not have been in the Resident's room. 8. On 7/23/21 at 9:45 a.m., a tube of clotrimazole (antifungal) and betamethasone (used to treat skin inflammation) 1/0.5% was observed on the bedside table of Resident AT room. On 7/23/21 at 11:45 the RNC indicated Resident AT had a self-administration assessment. There was no current order for clotrimazole and betamethasone 1/0.5%. She indicated the physician's discontinued the order on 6/17/21 and the medication should have been removed from the Resident's room. On 7/23/21 at 10:15 a.m., the RNC indicated there were a limited number of residents who were ambulatory and wandered (nursing diagnosis meaning a resident who meanders aimlessly that exposes the resident to potential harm). A current policy, titled, Resident Self-Administration of Medications, dated 5/29/19, was provided by the ADNS, on 7/21/21 at 11:30 a.m. A review of the policy indicated, .Resident may not self-administer medication until the assessment is completed by the IDT (inter-disciplinary team) team and determined to be safe to do so .Physician/Provider order is required from residents to self-administer medication .if only some of the medications will be self-administered clearly indicated which drug(s) including time and route, by physician order .Assessments will include addressing the following and documenting in the care plan: a. storage of the medication b. Responsible party for storage of medication (resident or nursing staff) c. Documenting the administration of drugs d. Location of where the drug will be administered This Federal tag relates to Complaint IN00357020. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-45(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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37982 Based on observation, interview, and record review, the facility failed to follow standards of practice to obtain supplies needed to administer, maintain, and care for a gastric (through the stomach) feeding tube for a resident, which included the correct ordered diabetic formula to control blood sugars, weight gain, prevent tube clogging, and care of the insertion site to prevent it from sustaining an erosion wound (Resident C) for 1 of 3 residents reviewed for tube feedings. Findings include: On 7/19/21 at 12:29 p.m., during an interview with Resident C's daughter, she indicated on 7/7/21 the resident's g-tube was bleeding. The area around the g-tube insertion site was raw, and drainage like stomach acid and liquid had been observed on Resident C's gown. When nurse came in and cleaned it, she had seen blood around g-tube. No one told her the g-tube had been changed the week before. All skin around g-tube looked like raw skin, the Nurse Practitioner (NP) told her it was normal to have blood from g-tube. They said she was to be seen by wound care team by that Friday, for her g-tube and her foot that was actively bleeding. She was not seen by the wound care team until 7/13/21. She had spoken with NP on 7/12/21 and had been told she (NP) got orders for wound care. Resident C had been seen by the wound care team on 7/14/21. When she visited the resident's sheets not been changed. She was told the G-tube kept getting clogged, the resident's daughters didn't think they were crushing the medications correctly. Resident C's g-tube was just changed at the hospital in April. Family visited Resident C at the facility 2-3 times a week and the g-tube was frequently clogged. On 7/20/21 at 10:51 a.m., Resident C was observed lying on her back in bed with the head of the bed elevated, both feet were propped on a pillow, on the left foot she wore a specialty boot. A Glucerna (brand name of type of formula for tube feed) bottle was hanging on a feeding pump, attached to a rolling pole, at the bedside. The feeding was infusing to the resident's g-tube (a tube inserted into the stomach for administration of liquid formula and medication) per pump at 45 ml/hr (rate of administration). The feeding bottle label was, dated 7/17/21 at 5 a.m., and indicated, keep bottle, add new formula. The administration tubing was not dated. A syringe was bagged and hanging on the pump. The syringe was dated 7/18/21 at 5 a.m. A sign on wall behind feeding pump, dated 6/24/21, indicated, Please put residents name and date on new feeding bottle. Feeding is only good for 24! Thank you! On 7/20/21 at 11:22 a.m., during an observation with the Nurse Practitioner, in Resident C's room, she indicated the feeding tube bottle, dated 7/17/21 at 5 a.m., should have been changed she would inform the nurse. On 7/20/21 at 12:20 p.m., during an observation, Resident C remained on her back with the head of the bed elevated. The tube feeding bottle was still dated 7/17/21 at 5 a.m. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/20/21 at 12:31 p.m., during an interview, the Director of Nursing Services (DNS) indicated the facility had ran out of the ordered formula, in bottles, for the resident. They had found some cans. Until the ordered bottles of formula arrived, staff were supposed to be rinsing the current bottle and putting cans of formula into that (disposable) bottle and reusing it. She had no idea why staff were not dating and labeling the current (reused, disposable) bottle when they added formula to it (from a can). She would ask the Dietician if they could use Diabetic Source until the current ordered formula arrived. On 7/20/21 at 9:15a.m., Resident C's medical record was reviewed. The diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (paralysis) following cerebral infarction (stroke), affecting the right dominant side, aphasia (difficulty speaking), and dysphasia (difficulty swallowing). A Care Plan, dated 5/21/21, with a target date of 8/19/21 indicated Resident C required a tube feeding related to dysphasia. The goal indicated she would remain free of complications through the review date. The interventions included: Administer flushes per medical provider's order. Administer medications via tube, per orders. Check placement and residuals per policy. Head of bed elevated 30 degrees or higher. Nutritional consult on admission, quarterly, and PRN (as needed). Provide insertion site care, per orders. Provide tube feeding per medical provider orders. ST (speech therapy)/OT 9occupational therapy) eval and treat, as needed. A Care Plan dated 5/13/21, with a target date of 8/19/21 indicated Resident C had a potential nutrition problem related to dysphasia status post (s/p) stroke, hypertension (elevated blood pressure), type 2 diabetes, hyperlipidemia (elevated cholesterol), and NPO (nothing by mouth) dependent on enteral nutrition (tube feeding). The goal indicated Resident C would tolerate enteral regimen, would be without weight loss, and maintain adequate nutritional status through the review date. The interventions included administer regimen as ordered and administer water flushes as ordered. A Quarterly MDS (Minimum Data Set) assessment, dated 6/4/21, indicated .rarely/never made herself understood, usually understood others. Unable to complete assessment for BIMS [brief interview mental status] score. Cognitive skills for daily decision making severely impaired. No signs or symptoms of delirium, behaviors, or rejection of care. Extensive assistance of 2+ persons physical assist for bed mobility, and dressing. Total dependence of 2+ persons physical assistance for transfers. Did not walk in the room or corridor or have locomotion off the unit. Locomotion of the unit only occurred once or twice during the assessment period with 1-person physical assistance. Extensive assistance of 1-person physical assist for eating, toileting, and personal hygiene . Weight gain of 5% in a month or 10% in the last 6 months, not on a physician prescribed weight-gain regimen On 6/18/21 at 1:38 p.m., a Physician Progress Note indicated, GT drainage staff requesting increased water flush. Staff report drainage around G-tube this morning. Staff report of foul odor noted. The patient is NPO due to dysphagia. She is on enteral feedings. Staff report she was started on Glucerna last evening. Her G-tube was clogged this morning. Staff requesting to increase water flushes . is NPO feedings switched to Glucerna last evening. Staff concerned with GT clogging, requesting increased water flushes, current order Glucerna 1.5 at 55ml/hr with 20ml of water hourly and 30ml of water before and after meds (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/22/21 at 1:39 p.m., a Physician Progress Note indicated, .f/u [follow up] recent elevated blood sugars. Subjective: Patient seen today to evaluate blood sugars. The patient's feeding was recently changed from Osmolite to Glucerna. Since the change in the feeding her blood sugars have improved. Staff were having difficulty with G-tube clogging easily on the Osmolite feeding. Evaluated CMP [complete metabolic panel, blood test] results today GT [gastric tube] present with drainage near site with foul odor noted . Staff have had difficulty with GT [g-tube] clogging easily. daughter planning on caring for her mother at home. Plans to discharge at the end of next month . has 30 ml water flush before and after med pass and 20ml water flush hourly with continuous feeding -will increase water flushes to 30 ml/hour . Slightly elevated BUN [blood urea nitrogen, blood test result] creatinine [kidney function test] above baseline GFR>100 on Losartan [blood pressure medication] BMP [basic metabolic panel, blood test]monthly -should improve with increased water flushes. A physician order, dated 6/25/21, with an end date of 7/13/21, indicated Glucerna 1.5 at 55 ml/hr with 30ml water flush every hour, every shift, may use Osmolitie 1.2 when out of Glucerna. An order, dated 7/12/21, indicated Wound NP (Nurse Practitioner) to evaluate and treat the hypergranulation (overgrowth) tissue around GT (g-tube, insertion site). A physician order, dated 7/13/21, with an end date of 7/13/21, indicated Glucerna 1.5 at 45 ml/hr with 35ml water flush/hr q (every) 24 hours this provides 1080 ml TV (total volume), 1620 cccu (caloric/unit) and 89 grams of protein, every shift, may use Osmolitie 1.2 when out of Glucerna. A Skin/Wound Progress Note, dated 7/13/2021 at 2:51 p.m., indicated Resident C had a new area to her g-tube site. Hypergranulated Area cauterized (surgically burned) today. Consider referral to GI (gastric) surgeon if site continues to leak gastric fluid. See Tissue Analytics Documentation for full wound description and recommended nursing plan of care. A Tissue Analytics report, dated 7/13/21, indicated surgical wound complicated by gastric drainage on abdominal gastric tube site measuring 1.56 cm x 1.07 cm x 0.1 cm. Moderate amount of drainage. Continue to facility protocol for changing gastric tube site. On 7/13/21 at 10:52 a.m., a Dietary Progress Note indicated, .Res NPO [nothing by mouth] dependent on enteral nutrition. Current order: Glucerna 1.5 at 55 mL/hr with 30 mL/hr flush x 24 hours. TF [tube feeding] running at 65 mL/hr with no water flush at visit - this exceeds energy needs and does not meet hydration needs. Change order to Glucerna 1.5 at 45 mL/hr + 35 mL/hr flush x 24 hours continuous via G tube. This provides 1080 mL total volume, 1620 kcal, 89 g protein. Receiving Prostat [supplement] 30 mL BID for wounds to heel and buttocks. BG [blood glucose] typically under 180 mg/dL, which is ideal for wound healing. Will continue to monitor intakes, weights, labs/BG, and wound healing. A Tissue Analytics report, dated 7/20/21, indicated surgical wound complicated by gastric drainage on abdominal gastric tube site measuring 1.72 cm x 1.82 cm x 0.1 cm. Moderate amount of drainage. Check into using large g-tube. The physician's orders, dated 7/20/21, with no end date, indicated DiabeticSource at 56 ml/hr plus 25ml/hr water flush times 24 hrs continuous via g-tube, providing 1334 ml total volume 1613 kcal (kilo calories, caloric measurement), every shift. (continued on next page)

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	155826	A. Building B. Wing	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional order, dated 7/22/21, was provided by the DNS on 7/23/21 at 12:40 p.m. This order indicated cleanse g-tube with normal saline, apply Calcium Alginate (absorbs wound fluid and forms gel that can provide environment for healing) with silver and cover with T-drain sponge (cut gauze) or like product and secure twice a day and as needed for wound management every day and night shift. The previous treatment order, dated 6/18/21, indicated cleanse g-tube site with normal saline. Apply bacitracin (antibiotic ointment) and cover with clean dry dressing, one time a day, for dressing change, as discontinued. On 7/21/21 at 6:50 a.m., Resident C was observed lying on her back in bed, with the head of the bed elevated. A bag of DiabeticSource (brand name of formula type) feeding solution was infusing to the resident's g-tube, per feeding pump at 55ml/hr. The bag was dated 7/20/21. During an interview, at that time, Licensed Practical Nurse (LPN) 23 indicated, she was the night nurse. She was not familiar with Resident C's routine. She didn't know if she got out of bed. Resident C was dressed and changed by day shift. On 7/21/21 at 6:56 a.m., during an interview, LPN 20 indicated she was familiar with Resident C's tube feeding orders. There was a different tube feed formula hanging, from what had been hanging over the past few days. She was not sure when the current formula had been administered. She had not been part of the process. Resident C had some redness around her g-tube, they had applied some cream and replaced the dressing that morning. When daily care was provided (bathing) the Certified Nursing Assistants (CNAs) would mark on the bathing sheet if there were skin concerns, they informed the nurse, and then the information went into the Medical Binder and the NP (Nurse Practitioner) or physician would see the notation when they come into the building. On 7/22/21 at 11:19 a.m. during an interview with Resident C's daughter, and the Regional Consultant, at the bedside, Resident C was observed as she slept in a Broda (specialized reclining chair) chair. The resident's g-tube was dressed in a 4x4 gauze covering the site around tube, a large amount of dark colored sticky drainage was present on the gauze. Resident C's daughter questioned if meds were not being done correctly. The NP was asked to the room to join conversation. The NP indicated the g-tube she recently placed may have been smaller than the prior tube the resident had in place and could have caused an increase in drainage at the site, and ultimately resulted in the skin breakdown. The dark substance observed was most likely caused by recent cauterization of site on 7/20/21 and the daily treatment of silver alginate dressings. On 7/22/21 at 5:04 p.m., during an interview, the DNS indicated Resident C's tube feeding bottle had not been changed, according to policy. It was not labeled with the date and time it was hung. She had no way of knowing if the bottle had been washed out before refilling it, to decrease risk for contamination and infection. The staff should have reached out to the Unit Manager or the DNS. They should have still changed the tubing and dated it. They should have let management know there was a problem obtaining the formula bottles so the proper supplies could have been provided. Whomever initialed the use of canned formula should have let management know there was a problem following the physician order and/or policy, so they could intervein and obtain the correct supplies needed to perform the task. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/21 at 3:45 p.m., the DNS provided a current policy, titled General Enteral Feeding Guidelines. This policy indicated It is the policy of this facility to provide resident centered care by providing enteral feeding and hydration for residents unable to tolerate oral feedings or oral medication delivery and those who have a stable (not new) enteral tube in place .Medications should be reviewed for residents with G-tubes to determine the appropriate delivery method to reduce the risk for blockage/obstruction of the tube .Change syringes, tubing or bottles used for feeding daily. Physician order is required for enteral feeding changes including but not limited to: Water flushes including amount and interval. Dressing changes for insertion site. Nutritional feeding including type of formula, strength of formula, amount to be given, and rate. This Federal tag relates to Complaint IN00357478. 3.1-44(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 Based on observation, interview, and record review, the facility failed to ensure topical medications were kept separate from oral and inhalant medications, loose pills were not in the medication cart, and all medications had open dates and expiration dates for 4 of 4 observations of 3 of 4 medication carts (Resident AE, AF, AG, AH, AI, AJ, AK, AL, AN. AO, and AS). Findings include: On [DATE] at 8:20 a.m., 2 unlabeled tubes of Calmoseptine (topical cream used to treat and prevent skin irritations) were observed with Registered Nurses (RN) 6 in the top drawer of the Medication Cart 1 on the Health Unit with the oral medications. One unlabeled tube of Calmoseptine and one tube of ketoconazole cream (used to treat fungal infection) 2% was in the medication cart drawer with oral and inhalant medication. Two unidentified white tablets were in the top drawer among the alcohol wipes and lancets. RN 6 indicated she did not know who the creams or white tablets belonged to. During an interview, on [DATE] at 11:10 a.m., Registered Nurse (RN) 21 indicated all resident eye drops were stored at room temperature and after opened were disposed of after 6 weeks. For the nasal sprays, the expiration date was the same as the manufacturer's date. On [DATE] at 11:12 a.m., during an observation of the [NAME] East Medication Cart with RN 21, the findings were as follows: a. Resident AE had Artificial Tears (eye lubricant) opened on [DATE] with no expiration date written on the bottle. She indicated they were good until the manufacturer's expiration date of ,d+[DATE]. b. Resident AF had Prednisolone 1% (used to treat eye inflammation) opened on [DATE] with no expiration date written on the bottle. She indicated they were good until the manufacturer's expiration date of , d+[DATE]. c. Resident AG had Dorzolamide Timolol (used to reduce pressure inside the eye) 22XXX,d+[DATE].8 mg opened on [DATE] with no expiration date written on the bottle. d. Resident AH had Artificial Tears (eye lubricant) opened on [DATE] with no expiration date written on the bottle. e. Resident AI had Systane 0.4% (eye lubricant) opened on [DATE] with no expiration date written on the bottle. f. Resident AJ had an open Brimonidine 0.2% (used to reduced pressure in the eye) opened on [DATE] with no expiration date written on the bottle. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Resident AH had an open fluticasone 50 mcg (used to relieve allergies) with no open or expiration date on the bottle. RN 21 was observed as she added [DATE] to the box. h. Resident AF had an open fluticasone 50 mcg with no open or expiration date on the bottle. RN 21 was observed as she added [DATE] to the box. i. Resident AJ had Wixela ,d+[DATE] with a date on the box of [DATE]. RN 21 was observed as she added information to the inhaler: Pouch opened [DATE], then marked through it and changed it to [DATE], use by [DATE]. j. Resident AH had Wixela ,d+[DATE] with a date on the box of [DATE]. RN 21 was observed as she added information to the inhaler: Pouch opened [DATE], expired [DATE]. k. Resident AK had Symbicort with a date on the box of [DATE]. The pharmacy date indicated to discard after 3 months. There was no open or expiration dates on the inhaler. l. Resident AL had Albuterol sulfate with a date on the box of [DATE]. No specified expiration date on the pharmacy label. No open or expiration date on the inhaler. On [DATE] at 12:04 p.m., Licensed Practical Nurse (LPN) 22 indicated eye drops were good for 90 days after opening unless the bottle indicated otherwise. Once fluticasone was opened, she did not know how long it was good for. She indicated she tried not to keep it for more than 90 days. On [DATE] at 12:05 p.m., during an observation of the [NAME] 1 Medication Cart with LPN 22, the findings were as follows: a. Resident AS had Clear Eyes (eye lubricant) opened on [DATE] with no expiration date. b. Resident AN had Fluticasone with an open date of [DATE] with no expiration date. c. Resident AO had Pulmicort with an open date of [DATE] with no expiration date. During an interview, on [DATE] at 2:40 p.m., the Director of Nursing indications the pharmacy put stickers on the medication boxes. The actual medication bottles should have had open and expirations dates on them. The eye drops expired 30 days after opened, nasal sprays expired 60 days after opened, and inhalers expired 30 days after opened. The pharmacy provided medication expiration charts in all the narcotic tracking binders on all the medication carts. Medications used for treatments should not have been stored in the medication cart because they should not be mixed in the oral medications because of infection control issues due to cross contamination. On [DATE] at 2:57 p.m., the Director of Nursing Services (DNS) indicated her expectation was for the nurse to check the pharmacy expiration chart in the narcotic tracking binder and date medication accordingly. If nursing staff opened a medication, the open date and expiration date should have been placed at opening. No there was no open or expiration date, the expectation for the nurses was to verify with the DNS or Assistant Director of Nursing (ADNS) before labelling. The facility nursing staff needed education on proper medication storage and dating. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on [DATE] at 3:04 p.m., the DNS indicated she requested open and expiration stickers from pharmacy so stickers that could be added to the inhalant medications for open and expiration dates. The expectation was for the facility to have the stickers, and once the inhalant medications were opened, an open date and expiration date would be added with the sticker. During an interview, on [DATE] at 3:21 p.m., Qualified Nursing Aide (QMA) 28 indicated the Heritage 1 Medication Cart did not have a pharmacy expiration chart in the narcotic tracking binder but did find a laminated inhaler expiration page. During an interview, on [DATE] at 3:23 p.m., QMA 30 indicated the Heritage 2 Medication Cart did not have a pharmacy expiration chart in the narcotic tracking binder. She also checked for a pharmacy expiration chart at the nurse's station and did not find it there either. On [DATE] at 3:31 p.m., RN 21 indicated she found four loose pills in drawer 2 of the [NAME] East Medication Cart. The pills were identified by the imprint, color, and shape of the pills. After they were identified, she put them in the red needle box in the side of the medication cart. The findings were as follows: a. An oval, white pill was imprinted with F and 91. It was identified as Ondansetron (anti-nauseous medication) b. A round, white pill was imprinted with C and 128. It was identified as Amlodipine Besylate (used to relax blood vessels). c. An additional ,d+[DATE] pill, RN 21 identified as Baclophen (muscle relaxant). d. An oval gel pill with liquid inside, RN 21 identified as Vitamin D (supplement) During an interview, on [DATE] at 4:14 p.m., the Regional Nurse Consultant (RNC) indicated the nurses were educated regarding open and expiration dates through facility in-services. She was not aware of pharmacy expiration charts in the narcotic tracking binders on the medication carts. Liquid medications were good until the manufacturer's guidelines and insulin was good for 28 days. During an interview, on [DATE] at 11:52 a.m., the RNC indicated the staff could have written the open and expiration dates on the inhalers with a sharpie pen. Staff should have thrown away and reorder medication bottles with no open and expiration dates on them, even if a date was written on the box, and the nursing staff should not have added a delivery date on the outside of a medication box. It was not appropriate. During an interview, on [DATE] 2:52 p.m., the Regional Nursing Consultant indicated all opened all eye drops expired in 30 days. The facility went by the pharmacy expiration dates and not the manufacturer's expiration dates. Whoever opened the bottle, should have open dated it and put the correct expiration date on it based on the information from the pharmacy. She was not aware of a pharmacy expiration chart in the narcotic tracking binder. The pharmacy prescription label indicated the pharmacy dispense date; an expiration date could have been presumed from the dispense date from the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current policy, titled, (Name of pharmacy) Medication Storage Guidance, dated [DATE], was provided by the Administer in Training (AIT) on [DATE] at 4:38 p.m. A review of the policy indicated for, .ophthalmic (for the eye) products date when opened and discard unused portion after 28 days .Symbicort Inhalation .Date after opening the foil pouch. Discard after 3 months .Wixela .Date when removed from the foil pouch and discard 1 month after removal from foil pouch A current policy, titled, Storage of Medications, with no date, was provided by the RNC on [DATE] at 3:30 p. m. A review of the policy, indicated, .Orally administered medications are kept separate for externally used medication and treatments such as suppositories, ointment, creams .Outdated, contaminated, or deteriorated medications .are immediately removed from inventory .ophthalmics .once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency .When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated .The nurse shall place a date opened sticker on the medication and enter the date opened .All expired medication will be removed from the active supply and destroyed in the facility This Federal tag relates to Complaint IN00357020. 3XXX,d+[DATE](j)