STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Syracuse Skilled Nursing Facility, The	500 E Pickwick Dr Syracuse, IN 46567

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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 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. Based on observation, record review and interview, the facility failed to provide a dignity cover for a urinary indwelling catheter for 1 of 1 residents reviewed for urinary indwelling catheters. (Resident 34) Finding includes: During an observation, on 1/7/2025 at 1:46 P.M., Resident 34 was lying in her recliner. The urinary drainage tubing was observed over her left thigh and the drainage bag had a white side and a clear side. The urinary collection bag was observed from outside the room, hanging on the wheelchair next to the recliner, without a dignity cover and urine was able to be viewed through the clear side of the bag and was also leaking on the floor. During an observation, on 1/8/2025 at 9:11 A.M., the urinary collection bag was observed hanging from the bed frame without a dignity bag. Urine was visible in the collection bag. During an observation, on 1/8/2025 at 11:24 A.M., Resident 34 was transported via a wheelchair to the therapy room with the urinary drainage bag attached under the resident's wheelchair without a dignity bag. Urine was visible in the collection bag. During an observation, on 1/9/2025 at 11:26 A.M., Resident 34 was observed in the therapy room with the urinary drainage bag hanging from the wheelchair armrest without a dignity bag. Urine was visible in the collection bag. A record review for Resident 34 was completed on 1/8/2025 at 10:04 A.M. Diagnoses included, but were not limited to: neuromuscular dysfunction of the bladder, kidney failure and history of urinary tract infections. An admission Minimum Data Set (MDS) assessment, dated 12/9/2025, indicated Resident 34 was cognitively intact and had an indwelling urinary catheter. A Physician's Order, dated 12/3/2024, indicated catheter care was to be provided every shift and staff were to ensure the catheter drainage bag was below the resident's waist height and covered. A Care Plan, dated 10/2/2024 and revised on 10/3/2024, indicated Resident 34 was at risk for complications related to the use of a Foley (urinary) catheter due to a neurogenic bladder. During an interview, on 1/9/2025 at 11:46 A.M., CNA 7 indicated the Foley catheter drainage bags (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	should be covered. A policy was provided, on 1/10/2025 at 8:37 A.M., by the Executive Director. The policy titled, Catheters, did not indicate the need for dignity covers for indwelling urinary catheters. 3.1-3(t)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to ensure a SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Form was provided following the end of Medicare skilled services for 2 of 3 residents who discharged from Medicare services and remained in the facility. (Resident 9 & 14) Finding includes: On 1/8/2025 at 9:07 A.M., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed. 1. The form indicated Resident 9 was not issued an SNF-ABN form. Resident 9 was provided with a Notice of Medicare Non-Coverage (NOMNC) Form which indicated Resident 9's Medicare coverage would end on 8/28/2024. An Advanced Beneficiary Notice (ABN) was not provided to Resident 9. During an interview, on 1/9/2025 at 9:52 A.M., the Business Office Manager (BOM) indicated Resident 9 had 34 Medicare A days remaining to use and was provided with a NOMNC which indicated Resident 9 would be discharged from Medicare A services on 8/28/2024. 2. The form indicated Resident G was not issued an SNF-ABN form. Resident G was provided with a Notice of Medicare Non-Coverage (NOMNC) Form which indicated Resident G's Medicare coverage would end on 6/6/2024. An Advanced Beneficiary Notice (ABN) was not provided to Resident G. During an interview, on 1/9/2025 at 9:56 A.M., the BOM indicated Resident G had 57 Medicare A days remaining to use and was provided a NOMNC which indicated Resident G would be discharged from Medicare A services on 6/6/2024. She indicated anyone who received a NOMNC will receive an ABN after they are no longer covered by Medicare A services. She indicated she did not keep a copy of the ABN's provided. A policy for ABN administration was requested. On 1/10/2025 at 1:37 P.M., the Executive Director indicated a policy was not available for ABN notices/documentation. 3.1-4(f)(2)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure a PASARR (Pre-admission Screening and Resident Review) was completed timely for 1 of 1 residents reviewed. (Resident B) Finding includes: The record for Resident B was reviewed on 1/7/2025 at 11:34 A.M. Diagnoses included, but were not limited to fractured ribs, cancer, end stage renal disease, bipolar, and malnutrition. A PASARR Level 1 for Resident B was completed on 6/16/2024. The Level 1 determined Resident B had a serious mental illness and/or intellectual disability and was placed in the Convalescence category - 60 Day Convalescence Care Approval. A 60 day or less stay in the NF (nursing facility) was authorized. The form indicated Re-screening must occur by or before the 60th day if the individual is expected to remain in the NF beyond the authorization timeframe On 1/8/2025 at 1:13 P.M., the Social Service consultant provided a Notice of Level 1 screen outcome. The level 1 screening form indicated it was valid for 60 days with an end date of September 14, 2024. The record for Resident B lacked the documentation to show a new level 1 screen had been completed before 9/14/2024. During an interview, on 1/8/2025 at 2:18 P.M., the Social Service consultant indicated there should have been another Level of Care (LOC) PASARR form completed in September. She indicated she had instructed the Business office manager (BOM) to initiate the process. On 1/9/2025 at 12:03 P.M. the Corporate MDS consultant provided a policy, titled Ascend-PAS and LOC, undated, and indicated the policy was the one currently used by the facility. The policy indicated . 5. Short term LOC a. 7- 14 days prior to expiration date, nursing facility (BOM) to initiate a new level 1 and LOC . 8. Update LOC audit tool with resident names, date of admission, date path tracker was completed, date level 1 was completed, if level 2 was needed, date LOC was completed, short term/long term status of LOC, and date if any of LOC ending date (BOM) 3.1-16(d)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure base line care plans were initiated for a resident with falls and receiving dialysis, and a resident at high risk for falls for 2 of 5 residents reviewed for base line care plans. (Resident B & 247) Findings include: 1. The record for Resident B was reviewed on 1/7/2025 at 11:34 A.M. Diagnoses included but were not limited to: fractured ribs, cancer, end stage renal disease, bipolar, repeated falls and malnutrition. An admission Minimum Data Set (MDS) assessment, dated 7/30/2024 indicated Resident B was receiving dialysis. A Base Line Care Plan form, dated 7/30/2024, indicated the resident required dialysis and had previous falls with injury. The form lacked goals, interventions and any special needs to properly care for the resident. During an interview, on 1/8/2025 at 10:59 A.M., the MDS coordinator indicated the care plan summary should have had goals and interventions. 2. The record for Resident 247 was reviewed on 1/8/2025 at 9:40 A.M. Resident 247 was admitted on [DATE]. Diagnosis included, but were not limited to subarachnoid hemorrhage, cardiomegaly, falls, insomnia, and polyneuropathy. A Nursing Progress Note, dated 12/14/2024 at 4:59 P.M., indicated Resident 247 was alert and oriented, transferred with 1 assist and was at high risk for falls. A fall risk review, dated 12/14/2024, indicated Resident 247 was at high risk for falls. A baseline care plan, dated 12/16/2024, indicated Resident 247 had a history of falls. The care plan lacked goals and/or interventions for falls. During an interview, on 1/09/2025 at 2:29 P.M., the MDS nurse indicated the baseline care plan did not have goals or interventions. The comprehensive care plan for falls was not completed until 12/27/2024 while Resident 247 was at the hospital. The current facility policy, titled Baseline Care Plan Assessment/Comprehensive Care Plans, dated 3/23/2021, was provided by the Regional MDS Consultant on 1/9/2025 at 1:50 P.M., and indicated the policy was the one currently used by the facility. The policy indicated . the admitting nurse will initiate the Baseline Care Plan Assessment to establish an initial plan of care to identify potential problems and to initiate appropriate goals and interventions 3.1-30(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview, the facility failed to complete a comprehensive care plan for 3 of 13 residents reviewed for comprehensive care plans. (Residents 18, 20 and 32) Findings include: 1. During an observation on 1/6/2024 at 9:53 A.M., Resident 18 had facial hair stubble. He indicated this was the longest his facial hair had been in a while and the CNA (Certified Nursing Assistant) was to assist him to shave. A record review for Resident 18 was completed on 1/8/2025 at 1:20 P.M. Diagnoses included, but were not limited to: cerebral infarction (stroke), spinal stenosis and chronic obstructive pulmonary disease (COPD). A Quarterly Minimum Data Set (MDS) assessment, dated 12/16/2024, indicated Resident 18 was cognitively intact, required partial/moderate assistance for bed mobility and substantial/maximal assistance for transfers and personal hygiene. A Care Plan for activities of daily living (ADLs) could not be located in the medical record. During an interview, on 1/9/2024 at 10:05 A.M., the MDS (Minimum Data Set) Coordinator indicated a care plan for ADLs was initiated on 12/8/2024 and resolved on 12/15/2024. The care plan for ADLS was no longer active. He indicated Resident 18 should have had a care plan for ADL care needs. 2. During an interview, on 1/6/2025 at 2:01 P.M., Resident 20 indicated he had a Foley catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body). A record review for Resident 20 was completed on 1/7/2025 at 1:05 P.M. Diagnoses included, but were not limited to: chronic kidney disease stage 4, obstructive and reflux uropathy and congestive heart failure. A Significant Change Minimum Data Set (MDS) assessment, dated 10/31/2024, indicated Resident 20 have moderate cognitive impairment and had an indwelling catheter. A Physician's Order, dated 12/19/2024, indicated a 16 French (5.3 millimeters) urinary catheter with a 10 milliliter balloon to be changed as needed and catheter care every shift during routine CNA (certified nursing assistant) care. A Care Plan for Foley (urinary) catheter care could not be located in the medical record. During an interview, on 1/9/2025 at 12:00 P.M., the MDS Coordinator indicated the care plan was created on 7/9/2024 and resolved on 7/22/2024. The care plan for the Foley catheter was no longer active. He indicated Resident 20 should have had a care plan for Foley (urinary) catheter care. 3. A record review for Resident 32 was completed on 1/7/2025 at 11:18 A.M. Diagnoses included, but were not limited to: underweight, disorientation and osteoarthritis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly Minimum Data Set (MDS) assessment, dated 11/18/2024, indicated Resident 32 had moderate cognitive impairment. Hypothyroidism was not a diagnosis listed for active diagnoses. A Physician's Order, dated 11/25/2024, indicated levothyroxine sodium 75 mcg (micrograms) medication daily for high thyroid stimulating hormone. A Care Plan for hypothyroidism could not be located in the medical record. During an interview, on 1/9/2025 at 10:10 A.M., the MDS Coordinator indicated a care plan for hypothyroidism was not available and Resident 32 should have had a care plan for hypothyroidism. A policy was provided by the Director of Nursing, on 1/10/2025 at 11:28 A.M. The policy titled, Baseline Plan Assessment/Comprehensive Care Plan, indicated, .The Comprehensive Care Plan will further expand on the resident's risk, goals and interventions using the Person-Centered Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs. These needs will be defined from observations, interviews, clinical record review and through assessment and CAAs [care area assessments]. The facility Interdisciplinary team in conjunction with the resident, resident's family, surrogate or representative as appropriate along with a hands on caregiver, such as a Certified Nursing Assistant will discuss and develop quantifiable objections along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable for the resident .3. The Comprehensive Care Plan will be finalized within 7 days of completion of the Full Comprehensive MDS assessments and corresponding CAAs. The Comprehensive Care plan will include participation from IDT [interdisciplinary team] members as well as CNA[s] who deliver hands on care by the way of interview, some member of the food/nutritional service staff, restorative nursing team as applicable, as well as a Social Service Worker .9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. During an interview on 1/6/2025 at 10:35 A.M., Resident 30 indicated he had never been to a care plan conference. On 1/7/2025 at 11:23 A.M., a record review was completed for Resident 30 and indicated the resident was admitted to the facility on [DATE]. A record review indicated Resident 30 had a care plan conference on 10/2/2023, 11/17/2023 and 12/4/2024. The record lacked documentation that a care plan conference was held between 11/17/2023 and 12/4/2024. During an interview on 1/9/2025 at 8:48 A.M., the Administrator indicated care plan conferences were located in the resident's progress notes or documents. He indicated he would try and find the residents care plan conferences that were missing between 11/17/2023 and 12/4/2024. During an interview on 1/9/2025 at 10:09 A.M., the Regional MDS Consultant indicated the resident did not have any care conferences between 11/17/2023 and 12/4/2024 and should have. 3.1-35 Based on record review and interview, the facility failed to ensure care plan meetings were held timely for 3 of 25 residents whose care plans were reviewed. (Residents 27, 30 and 38) Findings include: 1. The record for Resident 27 was reviewed on 01/07/2025 at 2:48 P.M. Diagnosis included, but were not limited to arthritis, hypertension, obstructive and reflux uropathy and glaucoma. A Care Plan meeting progress note, dated 4/4/2024, indicated Resident 27's POA (Power of Attorney) was present at the meeting. The record lacked documentation of any care plan meetings having been held after 4/4/2024. During an interview, on 1/8/2025 at 1:23 P.M., the Corporate Social Service Director (SSD) indicated a meeting was held in April and Resident 27 should have had two additional meetings since then, but no meetings have been held since April. 2. During an interview, on 1/6/2025 at 11:02 A.M., Resident 38's Power of Attorney (POA) indicated he had not had any care plan meetings since the initial admission meeting but he was just informed the meetings should have been held quarterly. The record for Resident 38 was reviewed on 1/8/2025 at 1:24 P.M. Diagnosis included, but were not limited to fracture of Rt. femur, hemiplegia and hemiparesis, contracture of muscle to right hand, calorie malnutrition, hx history of stroke, depression and dysphagia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan meeting progress note, dated 7/10/2024, indicated Resident 38's POA was present at the meeting and Resident 38 had declined to attend the meeting. The record lacked the documentation of any care plan meetings having been held after 7/11/2024. During an interview, on 1/8/2025 at 1:23 P.M., the Corporate Social Service Director (SSD) indicated a meeting was held in July and Resident 38 should have had one in October.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to develop and implement interventions to reduce the risk of falls for 2 of 4 residents reviewed for accidents, (Resident 27 and 247). This deficient practice resulted in a fall requiring hospitalization for 1 of 4 residents reviewed for accidents. (Resident 247). Findings Include: 1. The record for Resident 247 was completed on 01/08/2025 at 9:40 A.M. Resident 247 was admitted on [DATE]. Diagnosis included, but were not limited to subarachnoid hemorrhage, cardiomegaly, falls, insomnia and polyneuropathy. The admission Minimum Data Set (MDS) assessment, completed on 12/18/2024 indicated Resident 247 was moderately cognitively impaired, required moderate/partial assistance for personal hygiene, toileting and transfers and substantial assistance for ambulation more than 10 feet. The resident was marked as having falls in the past 1 - 6 months prior to her admission. A Fall Risk review (assessment), dated 12/14/2024, indicated Resident 247 was at high risk for falls. A baseline Care Plan, dated 12/16/2024, indicated the resident had a history of falls and required two person physical assist for transfers. There were no goals or interventions on the care plan. A Nursing Progress Note, dated 12/14/2024 at 4:59 P.M., indicated Resident 247 was at high risk for falls but there were no interventions implemented to prevent falls. Daily Skilled Progress Notes, dated 12/21/2024, 12/22/2024 and 12/24/2024, all indicated resident 247 had unsteady balance, weakness and needed reminders to use a call light before transferring but there were no interventions implemented to prevent falls. A Nursing Progress Note, dated 12/24/2024 at 9:59 A.M., indicated the resident informed staff she was walking around the bed and tripped on her bed covers and hit her head on the wall. A small amount of bleeding was noted around the staples in the resident's head, which were in place prior to her admission due to a head injury from a fall prior to her admission. The staples were noted to be intact and the resident denied any pain. A Nursing Progress Note, 12/24/2024 at 2:04 P.M., indicated the staff spoke with Residents' son to inform him they had initially sent the resident out to a local hospital and then she was transferred to a level two trauma hospital in a nearby city and was treated in the Intensive Care Unit (ICU) for a brain hemorrhage. A facility IDT general note, dated 12/25/2024 at 9:15 A.M., indicated the resident had an unwitnessed fall on 12/24/2024 at 09:37 A.M. with an injury to the back of her head. The Resident's head was bleeding and due to the resident's recent history of brain bleed, she was sent to the local hospital emergency room and then transferred to a level two trauma hospital ICU unit due another brain hemorrhage in same area as her previous brain hemorrhage. An intervention was to be initiated, a sign (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	placed in her room as a visual cue to use call light for help prior to getting out of bed or getting up to walk, when the resident returned from the hospital. A hospital history and physical assessment, dated 12/24/2024, indicated Patient was seen earlier this month for a fall with a head bleed. Diagnostic imaging today reveals a broad left subdural hematoma with two millimeters (MM) of left to right midline shift. There were no care plan interventions to prevent falls in place for Resident 247 to prevent this fall resulting in a subdural hematoma and subsequent hospitalization. A current Care Plan, initiated on 12/27/2024 after the resident had fallen and while the resident was hospitalized , indicated the resident was at risk for falls related to a closed head injury on admission. Interventions included, but were not limited to: Observe for side effects from medications that increase risk of falling such as dizziness and unusual drowsiness and notify the physician if observed, keep call light in reach when in room, encourage resident to use call light to seek assistance, refer to therapies as needed, and evaluate possible causes of falls and address issues to the extent possible. There were no interventions to increase supervision and/or providing any assistive devices to prevent falls. A Daily Skilled Nursing Note, dated 1/3/2024 at 11:04 P.M., indicated Resident 247 was alert and oriented with confusion, unsteady with weakness, tried to get up and walk without help and had to be reminded many times to ask for help before standing. There were no additional interventions implemented to prevent falls. A Daily Skilled Nursing Note, dated 1/4/2025 at 12:23 P.M., indicated Resident 247 was alert but very confused, kept walking around outside of her room, was unsteady with weakness and was reminded many times to ask for help before standing. There were no additional interventions implemented to prevent falls. A Daily Skilled Nursing Note, dated 1/8/2025 at 8:41 A.M., indicated Resident 247 was unsteady with weakness and had to be re-educated many times to ask for help before standing. There were no new interventions implemented to prevent falls. During a random observation, on 1/6/2025 at 10:20 A.M., Resident 247 was observed walking in her room unassisted, without an assistive device and there was no sign posted to remind the resident to use the call light. During a random observation, on 1/7/2025 at 9:56 A.M., Resident 247 was observed walking in her room unassisted, without an assistive device and there was no sign posted to remind the resident to use the call light. During a random observation, on 1/8/2025 at 1:15 P.M., Resident 247 was observed walking in her room unassisted, without an assistive device and there was no sign posted to remind the resident to use the call light. During an interview, on 1/8/2025 at 1:26 P.M., CNA 3 indicated she did not know what intervention had been implemented after Resident 247 fell and she would have to ask. During an observation, on 1/8/2025 at 1:36 P.M., CNA 3 handed Resident 247 a paper and educated the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	resident on using her call light. During an interview, on 1/8/2025 at 1:38 P.M., CNA 3 indicated the resident should have a reminder to use call light in room. During an observation, on 1/8/2025 at 1:40 P.M., Resident 247 was observed walking to her restroom unassisted without an assistive device. During an interview, on 1/9/2025 at 10:46 A.M., CNA 4 indicated staff were notified of changes through the electronic record, but sometimes she had to ask the charge nurse about changes. During an interview, on 1/9/2025 at 11:25 A.M., the DON indicated she did not believe a new intervention had been put in place after Resident 247's fall as the resident was in the hospital and would be treated as a new admission when she returned. She indicated staff were notified of new interventions by putting the new interventions in the electronic record and also telling staff at the shift change huddle. During an interview, on 01/09/2025 at 2:29 P.M., the MDS nurse indicated the baseline care plan did not have goals or interventions and that the comprehensive care plan for falls had not been completed until 12/27/24 while Resident 247 was at the hospital. 2. The record for Resident 27 was completed on 01/07/2025 at 2:48 P.M. Diagnosis included, but were not limited to arthritis, hypertension, obstructive and reflux uropathy, and glaucoma. A Quarterly Minimum Data Set assessment, completed on 11/15/2024 indicated Resident 27 was severely cognitively impaired, required substantial/extensive staff assistance for transferring, walking, personal hygiene, bed mobility and wheelchair mobility. The resident was marked as not having any falls since admission to the facility. The current Care Plan, initiated on 12/28/2022 and revised on 11/26/2024, indicated the resident was at risk for falls due to her condition, risk factors, decreased strength/endurance, general weakness, and osteoarthritis. Interventions included but were not limited to, bed in lowest position with fall mat next to bed, initiated on 12/31/2024, place call light in reach and encourage me to use and nursing staff to complete a fall risk assessment per facility protocol. An Interact Assessment, dated 12/28/2024 at 11:50 P.M., indicated Resident 27 had an unwitnessed fall and the physician was notified. The Nursing Progress Note related to the fall on 12/28/2024 at 11:50 A.M., completed on 12/29/2024 at 12:45 A.M., indicated Resident 27 was observed lying face down beside her bed and was assessed to have a bump to the left side of her head. An Interdisciplinary Team (IDT) note, dated 12/30/2024 at 9:00 A.M., indicated the root cause of the fall, on 12/28/2024 at 11:50 P.M., was rolling out of bed. A new intervention was for the bed to be placed in the lowest position with fall mat beside the bed. There were no new interventions implemented as a result of Resident 27's fall from bed on 12/28/2025. During a random observation, on 1/7/2025 at 2:18 P.M., Resident 27 was lying in bed with no mat beside her bed and the bed was not in lowest position. During a random observation, on 1/8/2025 at 1:13 P.M., Resident 27 was lying in bed with no mat (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	beside her bed and the bed was not in lowest position. During an interview, on 1/8/2025 at 1:19 P.M., CNA 3 indicated she was not aware of any fall interventions for Resident 27 and would have to ask the nurse. On 01/08/25 at 01:25 P.M. CNA 3 was observed placing a fall mat in Resident 27's room. During an interview, on 01/08/25 at 01:27 P.M., CNA 3 indicated the resident is to have her bed in lowest position and a mat on floor next to the bed. During an interview, on 01/09/25 at 10:46 A.M., CNA 4 indicated they are notified of interventions by DON putting a message in PCC (computer) to let us know, but sometimes we have to ask the charge nurse. During an interview, on 01/09/25 at 11:25 A.M., the DON indicated new interventions should be on the care plan for staff and the DON talked to staff about them at the shift change huddle. She indicated she did not know why the new intervention for Resident 27 had not been observed to be in place on 1/7/2025 and 1/8/2025 while the resident was in bed. , The current facility policy, titled Guidelines for Incidents/Accidents/Falls, dated 6/30/2023, was provided by the Regional MDS Consultant on 1/9/2025 at 1:50 P.M., and indicated the policy was the one currently used by the facility. The policy indicated . 11. All falls will have a site investigation by appropriate staff in an effort to define the root cause of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Note: each fall needs a new care plan intervention. Residents are assessed for fall risk upon admission, re-admission, quarterly and when there is a change of condition to include a fall. 15. The resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place. 3.1-45(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** Based on observation, record review and interview, the facility failed to ensure an incontinent resident remained free from an indwelling urinary catheter for 1 of 1 residents reviewed for urinary catheters. Finding includes: During an observation, on 1/7/2025 at 1:46 P.M., Resident 34 was lying in her recliner. The urinary drainage tubing was observed over her left thigh and the urinary drainage bag was hung on the wheelchair next to the recliner. A record review for Resident 34 was completed on 1/8/2025 at 10:04 A.M. Diagnoses included, but were not limited to: neuromuscular dysfunction of the bladder, kidney failure and history of urinary tract infections. Resident 34 was admitted to the facility on [DATE]. She was discharged on 10/19/2024 and readmitted on [DATE]. An admission Minimum Data Set (MDS) assessment, dated 10/1/2024, indicated Resident 34 was cognitively intact and was frequently incontinent of bladder. An admission Minimum Data Set (MDS) assessment, dated 12/9/2025, indicated Resident 34 was cognitively intact and had an indwelling urinary catheter. A Bowel and Bladder Incontinence Screener assessment, dated 9/24/2024, indicated Resident 34 voided appropriately without incontinence always, was incontinent of bowel and was sometimes mentally aware of the need to use the toilet. The assessment indicated to proceed with a Bowel and Bladder Incontinence History Review for further evaluation to determine eligibility for a structured toileting program. A Bowel and Bladder Incontinence History Review was not completed. A Nursing Progress Note, dated 10/2/2024 at 1:25 P.M., indicated a Foley (urinary) catheter was anchored in the bladder. A Care Plan, dated 10/2/2024 and revised 12/17/2024, indicated Resident 34 was at risk for complications related to the use of a Foley catheter due to a neurogenic bladder. A Hospital History and Physical, dated 11/25/2024, indicated Resident 34 had a chronic Foley catheter placed in October 2024. The Foley (urinary) catheter was placed due to Resident 34 leaking urine constantly and no records suggested or supported a neurogenic bladder diagnosis. A Bowel and Bladder Incontinence Screener assessment, dated 12/2/2024, indicated Resident 34 voided appropriately without incontinence not always, but at least daily, was incontinent of stool 1-3 times per week and was usually aware of the need to use the toilet. The assessment indicated Resident 34 had a urinary/bowel collection device, remained continent at the time and do not proceed with Bowel and Bladder Incontinence History Review was marked. A Urinary Catheter Review assessment, dated 12/2/2024, indicated Resident 34 did not have a (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis for an unavoidable catheterization. A Urinary Catheter Review assessment, dated 12/3/2024, indicated Resident 34 had a post void residual of 200 milliliters or more, an inability to manage the retention/incontinence with intermittent catheterizations and persistent overflow incontinence, systemic infections and/or renal dysfunction. However, a post void residual or orders for intermittent catheterizations could not be located in the medical record. A Physician's Order, dated 12/3/2024, indicated a Foley urinary catheter 16 French 10 milliliter balloon and catheter care every shift. During an interview, on 1/10/2025 at 10:37 A.M., the Nurse Practitioner indicated Resident 34 may have some retention. During an interview, on 1/10/2025 at 12:08 P.M., Resident 34 indicated she was peeing all over herself and requested a urinary catheter to be placed. During an interview, on 1/10/2025 at 12:33 P.M., the Nurse Practitioner indicated Resident 34 had a neurogenic bladder. She indicated her thought process was Resident 34 had moisture associated skin dermatitis on her buttock and was unable to control her urine. Resident 34 would stand up and urine would flow, so a Foley (urinary) catheter was placed. The Nurse Practitioner indicated she did not try to implement a medication, complete a bladder scan or a toileting program prior to placement of the Foley (urinary) catheter. During an interview, on 1/10/2025 at 12:41 P.M., the Director of Nursing indicated a 3-day bowel and bladder assessment was completed upon admission and Resident 34 had a full medical examination for neurogenic bladder prior to admission. However, documents supporting the evaluation of neurogenic bladder were not available for review. A policy was provided, on 1/10/2025 at 8:37 A.M. by the Executive Director. The policy titled, Catheters, indicated, .It is the policy of the facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. Further that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible 3.1-41(a)(1)

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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. 2. The record for Resident 27 was reviewed on 01/07/2025 at 2:48 P.M. Diagnosis included, but were not limited to arthritis, hypertension, obstructive and reflux uropathy and glaucoma. A current Care Plan revised on 8/22/2024, indicated the resident was at nutritional risk due to: diagnoses of hypertension, gastroesophageal reflux disease and hyperlipidemia. Receives diuretic treatment with anticipated weight fluctuations related to fluid shifts. Interventions include but were not limited to; diet served as ordered, offer replacement for foods/beverages not consumed or if consumes 50% or less of meal, monitor weights and intakes, and requires adaptive feeding devices of built-up handled silverware. The care plan does not mention any interventions for significant weight loss. A nutrition at risk review, dated 12/11/2024, indicated Resident 27 was on a regular diet, and weighed 135.2 pounds (lbs) on 11/27/2024 and 122.2 on 12/11/2024, indicating a loss of 9.6% in two weeks. The resident intakes were less than 50 percent of meals. The recommendations included, but were not limited to, house shakes three times a day (TID). A Nurse Practitioner Progress note, dated 12/11/2024, and signed electronically on 1/9/2025 indicated Resident 27 was being seen for a 10 percent weight loss and had poor oral intake. The recommendations related to abnormal weight loss included house shakes TID. A nutrition at risk review, dated 12/19/2024, indicated that Resident 27 was on a regular diet and had a weight of 120.8 lbs on 12/18/2024, indicating a loss of 10.1% in one month. The resident intake were less than 25 percent of meals. The recommendation included house shakes TID. A Physician's Order, dated 12/20/2024, indicated house shake TID, one container/serving, and record percent consumed. A Physician's Order, dated 12/23/2024 and revised on 1/9/2025, indicated house shake with meals. The order did not indicate record consumption or serving amount until 1/9/2025. A nutrition at risk review, dated 12/27/2024, indicated Resident 27 was on a regular diet with house shake at meals and had a weight of 120.8 lbs on 12/18/2024, indicating a loss of 10.1% in one month. The resident intake was less than 25 percent of meals and no new recommendations were made. A nutrition at risk review, dated 1/8/2025, indicated Resident 27 was on a regular diet with house shake at meals, continued to have weight loss, and weight on 1/5/2025 was 117 lbs, indicating a loss of 13.1 percent in 1 month. There were no new recommendations. During an interview, on 1/9/2025 at 11:25 A.M., the Director of Nursing (DON) indicated the Dietician would email her recommendations, and she would put the order in the computer. She indicated she did not know why the recommendation on 12/11/2024 was not implemented until 12/20/2024. The DON indicated she was not sure why the order was changed to not include documentation of amount consumed because the dietician would not know how effective the supplement was. The DON indicated when a resident had a significant weight loss, the resident would be added to the Skin-Weight-Assessment-Team program (SWAT). The DON indicated the resident was not currently followed by SWAT. On 1/10/2025 at 12:04 P.M., the Director of Nursing provided the policy titled,Guidelines for (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Orders- Following Physician Orders, dated 6/18/2023, and indicated the policy was the one currently used by the facility. The policy indicated . 4. All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received The current facility policy, titled Dietician Referrals and Recommendations, dated 4/2017, was provided by the Regional Nurse Consultant on 1/10/2025 at 12:04 P.M., and indicated the policy was the one currently used by the facility. The policy indicated . the dietician will communicate recommendations to be carried out by the DON or nursing designee The current facility policy, titled S-W-A-T Program, was provided by the Regional Nurse Consultant on 1/10/2025 at 12:04 P.M., and indicated the policy was the one currently used by the facility. The policy indicated . 5 percent or more (undesirable) weight change in 30 days . and SWAT meets weekly to discuss residents who meet criteria as stated. as stated. A policy was provided, on 1/10/2025 at 12:41 P.M. by the Dietary Manager. The policy titled, Liberalized Diets, indicated, .Resident swill receive the least restrictive diet to maximize meal intake, improve quality of life, and increase Resident satisfaction .2. Each resident shall receive the least restrictive diet per physician order .4. Diet orders and diet spreadsheets shall match the facility approved terminology 3.1-46(a)(2) 3. During an interview, on 1/6/2025 at 2:02 P.M., Resident 20 indicated he had just returned from his dialysis treatment. A record review for Resident 20 was completed on 1/7/2025 at 1:05 P.M. Diagnoses included, but were not limited to: chronic kidney disease stage 4, mild protein-calorie malnutrition, diabetes mellitus type 2 and gastroparesis. A Significant Change Minimum Data Set (MDS) assessment, dated 10/31/2024, indicated Resident 20 had moderate cognitive impairment and had no significant weight loss or gain. A Physician Order, dated 12/14/2024, indicated a consistent carbohydrate dialysis diet. A Physician's Order, dated 12/19/2024, indicated a gastroparesis diet with no lentils, seeds or nuts; no dried, raw or uncooked fruits and vegetables with skins; no fruits or vegetables with seeds; no fatty foods; no citrus drinks; and no highly sweetened foods. A Care Plan indicated Resident 20 was at risk for a nutritional deficit related to protein calorie malnutrition, chronic kidney disease with dialysis and diabetes mellitus type 2. Interventions included, but were not limited to: prepare and serve diet as ordered. During an observation, on 1/9/2025 at 11:53 A.M., Resident 20 had a meal tray served to his room. The food on the plate included mashed potatoes with gravy on top of a slice of bread and turkey, carrots and peach cobbler. However, according to the Menu Extension for special diets, Resident 20 should have been served fluffy rice in place of the mashed potatoes due to his need for a renal diet, and a half serving of 2 (continued on next page)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

ounces for peach cobbler instead of 4 ounces due to the consistent carbohydrate diet requirements.

During an interview, on 1/9/2025 at 12:12 P.M., Resident 20 indicated he had the choice of the main meal served or alternatives if he did not want the main meal. He indicated he likes rice, and should not have potatoes as they are high in potassium. Resident 20 indicated he had a list of foods to avoid that were high in potassium. This list was observed hanging on his closet door.

During an observation, on 1/10/2025 at 12:16 P.M., Resident 20 had a meal tray delivered to his room. The meal tray included chicken cornbread bake, broccoli and chocolate cream pie. A meal ticket indicated no dairy products, no deli meats or hot dogs, no ground beet, no uncooked fruits or vegetables and no whole grain breads or cereal. The meal ticket indicated he had ordered the main meal.

However, according to the Menu Extension for special diets, Resident 20 should have been served 5 ounces of baked chicken and rice pilaf in place of the chicken cornbread bake and sugar cookies in place of the chocolate cream pie due to his renal diet.

During an interview, on 1/10/2025 at 12:21 P.M., the Dietary Manger indicated staff asked the residents for their meal preferences and Resident 20 had requested the main meal. He indicated Resident 20 should have been served baked chicken, rice pilaf and sugar cookies. He indicated he did not realize the main menu diet was different for the renal diet.

Based on record review, observation and interview, the facility failed to ensure nutritional supplements % (percentage) were documented for a resident with weight loss; failed to initiate RD recommendations for supplements for a resident with weight loss and failed to serve the appropriate diet to a resident receiving dialysis for 3 of 4 residents reviewed for nutrition. (Residents 1, 27 and E)

Findings include:

1. During an interview, on 1/6/2025 at 10:17 A.M., Resident 1 indicated she had lost maybe another 25 pounds.

The record for Resident 1 was reviewed on 1/9/2025 at 8:59 A.M. Diagnoses included, but were not limited to:

diabetes, anxiety, kidney failure, and polyneuropathy.

Current Physician Order, dated 12/23/2024, included the following: House shake with meals for Supplement- give 1 container/serving by mouth. Record % consumed.

A Care Plan, initiated on 9/16/2024, indicated Resident 1 was at risk for nutritional deficit related to diagnoses of heart disease, diabetes, hypertension and gastro esophageal reflux disease. Weight loss. Interventions included but were not limited to: Diet is served as ordered. Snacks are available to me between meals upon request. Offer replacement for foods/beverages not consumed or if consumes 50% or less of meal. Monitor weights and intakes. Notify physician and resident & responsible party of significant weight changes.

The December Medication Administration Record (MAR) indicated the percentage for the House Shakes was only documented three times.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The January MAR dated 1/1 through 1/9/2025 lacked the documentation of the percentage consumed of the Health Shake. During an interview, on 1/9/2025 at 3:13 P.M., the Director of Nursing indicated she completed the order and did not put it in the electronic charting system correction. She indicated the percentages should have been documented.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview, the facility failed to properly store oxygen therapy equipment and C-PAP (continuous positive airway pressure) equipment for 2 of 2 residents reviewed for oxygen therapy. (Resident 18 and 20) Findings include: 1. During an observation, on 1/6/2025 at 9:53 P.M. and 1/7/2025 at 10:37 A.M., Resident 18's C-Pap mask was observed on top of his personal refrigerator, unbagged. During an observation, on 1/8/2025 at 1:14 P.M., Resident 18's C-Pap mask was observed on the floor. During an observation, on 1/9/2025 at 11:27 A.M., a CNA came out of the Resident 18's room. The C-Pap mask was observed on top of the personal refrigerator, unbagged. At 1:30 P.M., the C-Pap mask was still on top of the resident's personal refrigerator. A record review for Resident 18 was completed on 1/8/2025 at 1:20 P.M. Diagnoses included, but were not limited to: cerebral infarction (stroke), congestive heart failure, obstructive sleep apnea and chronic obstructive pulmonary disease (COPD). A Quarterly Minimum Data Set (MDS) assessment, dated 12/16/2024, indicated Resident 18 was cognitively intact. The assessment did not indicate he received C-Pap therapy. A Physician's Order, dated 2/9/2024, indicated Resident 18 to wear the C-Pap at bedtime and for naps every shift. A Care Plan, dated 11/6/20924 and revised on 11/15/2024, indicated Resident 18 presented with altered sleeping and breathing functions secondary to obstructive sleep apnea. Interventions included, but were not limited to: utilization of the sleep apnea machine per doctor's orders and to set up the machine according to manufacturer's guidelines. During an interview, on 1/9/2025 at 1:31 P.M., CNA 9 indicated the C-Pap mask should be stored in the bedside table drawer, and should not be on the over the bed table. She indicated she has not seen a respiratory bag in use for storage of C-Pap masks. During an interview, on 1/9/2025 at 1:37 P.M., QMA 8 indicated C-Pap masks should be stored in a respiratory bag when not in use. 2. During an observation, on 1/6/2025 at 9:49 A.M., Resident 20's nasal cannula tubing was attached to the hydration chamber of the concentrator tank and on the floor. During an observation, on 1/6/2025 at 11:04 A.M., Resident 20's nasal cannula tubing was attached to the hydration chamber of the concentrator tank. The respiratory storage bag was intertwined in the nasal cannula on the floor. During an observation, on 1/6/2025 at 1:51 P.M., the nasal cannula was draped over the over the bed table at the end of the bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 1/9/2025 at 11:38 A.M., the respiratory storage bag was observed intertwined with the nasal cannula on the floor. Resident 20 was wearing his nasal cannula. A record review for Resident 20 was completed on 1/7/2025 at 1:05 P.M. Diagnoses included, but were not limited to: congestive heart failure, anemia and cardiomyopathy. A Significant Change Minimum Data Set (MDS) assessment, dated 10/31/2024, indicated Resident 20 have moderate cognitive impairment. The assessment did not indicate he received oxygen therapy. A Physician's Order, dated 12/14/2024, indicated Resident 20 to wear oxygen at 4 liters per minute via nasal cannula continuously. A Care Plan, dated 2/8/2024, indicated Resident 20 had complications with gas exchange related to shortness of breath and oxygen saturations less than 90 percent. During an interview, on 1/9/2025 at 1:31 P.M., CNA 9 indicated oxygen tubing should be stored in a respiratory bag when not in use. She indicated the oxygen tubing should not drag on the floor. During an interview, on 1/9/2025 at 1:37 P.M., QMA 8 indicated nasal cannulas should be stored in a respiratory bag when not in use. A policy was requested for oxygen therapy and C-Pap guidelines. A policy was provided, on 1/10/2025 at 10:58 A.M., titled, Bi-Level Therapy. The employee indicated that oxygen and C-Pap storage was not included in the policy. 3.1-47(a)(6)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interview, the facility failed to ensure pain medications were being monitored for effectiveness for 1 of 2 residents reviewed for pain management. (Resident 1) Finding includes: During an interview, on 1/06/2025 at 10:18 A.M., Resident 1 indicated If I move, I get pain, I get Tramadol. The record for Resident 1 was reviewed on 1/9/2025 at 8:59 A.M. Diagnoses included, but were not limited to diabetes, anxiety, kidney failure and polyneuropathy. A Quarterly Minimum Data Set (MDS) assessment, dated 12/15/2024, indicated Resident 1 had pain occasionally at a score of 6 (moderate) level and received routine and PRN (as needed) pain medications. A current Care Plan, initiated on 4/19/2023, indicated Resident 1 had the potential for pain/discomfort related to their diagnosis, reduced mobility, diabetes and right shoulder pain. Interventions included, but were not limited to: monitor the effectiveness of pain medications and administer pain medication as per MD orders and note the effectiveness. Current physician orders included, but were not limited to: Tramadol (narcotic) 50 mg (milligrams) every 6 hours for pain. The November Medication Administration Record (MAR) lacked the documentation to show the effectiveness of the Tramadol medication had been monitored. The effec (effectiveness) box on the MAR was x' d out from the 1st through the 30th. The December MAR lacked the documentation to show the effectiveness of the Tramadol medication had been monitored. The effec (effectiveness) box on the MAR was x' d out from the 1st through the 31st. The January MAR lacked the documentation to show the effectiveness of the Tramadol medication was being monitored. The effec (effectiveness) box on the MAR was x' d out from the 1st through the 8th. During an interview, on 1/9/2025 at 1:39 P.M., RN 6 indicated the effectiveness of the pain medication should have been documented. On 1/9/2025 at 12:19 P.M., the ADON provided the policy titled, Guidelines for Pain Management, dated 9/1/2023, and indicated the policy was the one currently used by the facility. The policy indicated . Methods to Achieve Goals of Pain Management . 6. Monitor the effectiveness of any medication being used for pain management/control . 10. Pain Monitoring- The effectiveness of administered pain medication will be documented 1-2 hours post administration of the medication 3.1-37(a)

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NAME OF PROVIDER OR SUPPLIER Waters of Syracuse Skilled Nursing Facility, The		STREET ADDRESS, CITY, STATE, ZIP CODE 500 E Pickwick Dr Syracuse, IN 46567	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to ensure pre/post dialysis assessments were completed for 1 of 1 resident reviewed for dialysis services. (Resident 20) Finding includes: During an interview, on 1/6/2025 at 2:02 P.M., Resident 20 indicated he had just returned from dialysis. A record review was completed for Resident 20, on 1/7/2025 at 1:05 P.M. Diagnoses included, but were not limited to: chronic kidney disease stage 4, anemia in chronic kidney disease and acute kidney failure. A Significant Change Minimum Data Set (MDS) assessment, dated 10/31/2024, indicated Resident 20 had moderate cognitive impairment and received dialysis services. A Physician's Order, dated 12/19/2024, indicated Resident 20 to go to the [company name] dialysis unit on Mondays, Wednesdays and Fridays. A Care Plan indicated Resident 20 was at risk for fluid volume deficit related to rapid fluid removal following dialysis treatment. Interventions included, but were not limited to: observation for hypotension (low blood pressure), hypovolemia (low extracellular fluid in the blood), tachycardia (high heart rate) and flat neck veins. The Care Plan also indicated the resident was at risk for fluid volume excess related to fluid accumulation since last dialysis (treatments). Interventions included, but were not limited to: observation for hypertension (high blood pressure), tachycardia (high pulse rate), jugular vein distention, crackling breath sounds, postural (related to positioning) edema and weight gain A review of the pre/post assessments for dialysis treatment indicated the following: -No pre/post assessment completed on 11/20/2024,11/25/2024,12/4/2024, 12/6/2024 and 12/11/2024 -No post follow up 11/1/2024, 11/4/2024, 11/27/2024, 11/29/2024, 12/9/2024 and 12/16/2024. -No pre assessment on 12/22/2024. During an interview, on 1/9/2025 at 1:48 P.M., RN 6 indicated the pre/post assessments go back and forth between the facility and the dialysis center for communication purposes She indicated the pre/post dialysis assessment was to be completed for every dialysis session. A policy was provided, on 1/10/2025 at 8:37 A.M., by the Executive Director. The policy titled, Guidelines for Post Hemodialysis Care, indicated, .When should the physician be notified? -Fever -There is no buzzing or humming [thrill and bruit] when the fistula or graft is gently palpated -Chills and/or fever -Coughing -Weakness -Pain -Skin is itchy or there is a rash .What would be considered an emergency situation related to a dialysis patient? -Patient is breathing rapidly with an elevated pulse. Patient may be confused, dizzy and/or light-headed. Patient has sudden chest pain and/or labored breathing. -There is little or no urine being passed by the patient. -Sudden chest pain or trouble breathing-all of a sudden. -The skin around the fistula or graft becomes painful or seems hot to (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	touch or appears red/swollen. -The dressing is soaked with blood. -Patient's fingers under the fistula or graft look blue or pale and are cold to the touch. -Inability to eat/drink-vomiting .The disease that caused the renal failure must be constantly and continually managed. Signs/symptoms as stated above cannot be ignored 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs.

Based on record review and interview, the facility failed to adjust medication related to laboratory results to ensure the dose was not excessive for 1 of 5 residents reviewed for unnecessary medications. (Resident 32)

Finding includes:

A record review for Resident 32 was completed on 1/7/2025 at 11:18 A.M. Diagnoses included, but were not limited to: underweight, disorientation, muscle weakness and osteoarthritis.

A Quarterly Minimum Data Set (MDS) assessment, dated 11/18/2024, indicated Resident 32 had moderate cognitive impairment.

A Physician's Order, dated 4/19/2024, indicated cholecalciferol 10,000 units daily for vitamin D deficiency.

A 25-hydroxyvitamin D laboratory test was obtained on 8/13/2024. The test indicated a vitamin D level greater than 120 ng/mL (nanograms per milliliter). The normal range specified on the test result was 30-100 ng/mL.

Nurse Practitioner Progress Notes, dated 8/16/2024, 8/26/24 and 8/30/24, indicated Resident 32 was seen by the nurse practitioner. The notes did not address the elevated 25-hydroxyvitamin D laboratory test results.

During an interview, on 1/10/2025 at 10:32 A.M., the Nurse Practitioner indicated she liked to see vitamin D level between 30-80 ng/mL. She indicated if the level was over 100, she would decrease the vitamin D medication. She indicated it was not harmful to have a high Vitamin D level.

A professional reference from the National Institutes of Health, https://ods.od.nih.gov>facesheets>VitaminD-Consumer.gov, indicated too much vitamin D can be harmful. The source indicated very high levels of vitamin D in your blood (greater than 150 ng/mL) can cause nausea, vomiting, muscle weakness, confusion, pain, loss of appetite, dehydration, excessive urination and thirst, and kidney stones.

A policy was provided, on 1/10/2025 at 12:09 P.M., by the Assistant Director of Nursing. The policy titled, Guidelines for Lab Scheduling/Tracking, indicated, .6. The Charge Nurse will monitor the scheduled labs daily to check to ensure that any collected lab results are received timely as well as to confirm that received results are reported to the physician as well as the resident's representative and that any order received related to the lab results are carried out

3.1-48(a)(2)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on record review and interview, the facility failed to limit the use of an as needed psychotropic medication to 14 days for 1 of 5 residents reviewed for unnecessary medications. (Resident 20) Finding includes: A record review was completed for Resident 20 on 1/7/2025 at 1:05 P.M. Diagnoses included, but were not limited to: major depressive disorder and adjustment disorder with depressed mood. A Significant Change Minimum Data Set (MDS) assessment, dated 10/31/2024, indicated Resident 20 had moderate cognitive impairment and took an antidepressant. A Physician's Order, dated 12/14/2024, indicated Xanax (antianxiety medication) 0.5 milligrams every 12 hours as needed for anxiety. The Medication Administration Record, dated 12/2024, indicated Resident 20 received Xanax beyond the 14-days on 12/28/2024, 12/29/2024 and 12/31/2024. The Medication Administration Record, dated 1/2025, indicated Resident 20 received Xanax beyond the 14-days on 1/7/2025. A Care Plan, dated 1/3/2025, indicated Resident 20 was at risk for increased anxiousness with the need for anxiolytic medication. Interventions included, but were not limited to: gradual dose reduction per guidelines. During an interview, on 1/9/2025 at 2:05 P.M., RN 6 indicated she was not aware of the time limits for an anxiolytic medication and would need to find out about the limitations. She then indicated the facility completed drug reviews to determine if a gradual dose reduction could be completed. She indicated the reviews were completed every 6 months for as needed and routine psychotropic medications. During an interview with the Nurse Practitioner and Director of Nursing, on 1/10/2025 at 12:27 P.M., they indicated Resident 20 had been to the emergency room multiple times in a row for complaints of shortness of breath. They indicated the emergency room physician prescribed Xanax, due to Resident 20's complaints of shortness of breath. They indicated a progress note was not completed to determine the use of the as needed Xanax beyond the 14-days allotment. A policy was provided, on 1/10/2025 at 1:50 P.M., by the Executive Director. The policy titled, Guidelines For Psychotropic Medication, indicated, .PRN [as needed] Orders for Psychotropic Medications: PRN orders for psychotropic drugs will be limited to 14 days, unless the physician identifies and documents rationale to extend the medication beyond the 14 days. PRN antipsychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication 3.1-48(b)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure nutritive value and flavor was maintained for puree diets for 2 of 2 residents who received a puree diet. Finding includes: During an observation of food preparation for pureed foods, on 1/6/2025 from 11:14 A.M. to 11:36 A.M., the following was observed: The Dietary Manager obtained a bowl of cooked carrots, indicating he was preparing 2 servings. He placed the carrots in the blender and started the blender. He added 1/2 cup of water and resumed blending the carrots and water. He then placed the pureed carrots in a small metal pan and placed it on the steamer table for service. The Dietary Manager indicated he followed the (instruction) sheet that was taped to the inside of a cabinet door. The untitled paper listed the number of servings under the heading portion:#12 scoop for pureed vegetables. The left side of the paper indicated cooked vegetables, 4 oz. spoodle (green beans, wax beans, carrots, etc.); Chicken Base: teaspoon; Hot water, cups; Thick and Easy Thickener, Tablespoons. For 2 servings of pureed vegetables- the paper indicated to use: 1/4 teaspoon of chicken base, 1/4 cup of hot water, and 2 tablespoons of the thickener. During an interview, on 1/6/2025 at 11:36 A.M., the Dietary Manager indicated he should have added the base to the carrots. On 1/9/2025 at 12:13 P.M., the Dietary Manager provided the policy titled,Characteristics & Procedures for Consistency Modified Foods, undated, and indicated the policy was the one currently used by the facility. The policy indicated .Prepare recipe as given unless otherwise stated 1.3-21(a)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to ensure food was stored, prepared and served under sanitary conditions related to unsealed and undated items in the freezer/cooler,expired foods in use, and dirty cooking utensils and appliances in the main kitchen. This deficient practice had the potential to affect 44 of 44 residents who received meals out of the kitchen. Findings include: 1. During the initial tour of the kitchen, on 1/6/2025 at 9:25 A.M., with the Dietary Manager the following was observed: - the reach in freezer had dirty seals along the bottom of the freezer and the freezer floor had food debris - the walk-in freezer had a box of sausage links that was not sealed properly - an entire bag of Salisbury steak not sealed. - a bag of biscuits was opened and not sealed - the kitchen floor had stains and food debris. - the walk-in cooler had 2 water containers belonging to staff - there was an opened and undated jar of dill pickles in the walk in cooler. - an opened and undated bag of chicken gravy in the dry storage area. - 4 bags of navy beans with an expiration date of 3/15 /2024 were noted in the dry storage area - an opened and unsealed bag of sugar was in the dry storage area. - an opened and unsealed box of graham crackers was in the dry storage area - an opened and unsealed bag of thickener was in the dry storage area During an interview, on 1/6/2025 at 9:32 A.M., the Dietary Manager indicated the foods should be sealed and the floor should have been swept. During an interview, on 1/6/2025 at 9:40 A.M., the Dietary Manager indicated the personal items should not have been in the cooler and the other food items should have been dated and sealed. 2. During a second visit to the main kitchen, on 1/6/2025 at 11:41 A.M., a metal spoon was observed under the food prep counter and a dish rag was seen underneath and between a second refrigerator. 3. During lunch service on 1/6/2025 at 12:29 P.M., the cook was observed resting the plates against his uniform during the plating of the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a revisit to the main kitchen on 1/8/2025 at 9:40 A.M., the following things were observed: - the plate in the microwave was dirty with yellow debris. - the drinking glasses white powdery stains on the bottoms of the glasses. - an opened and undated jar of peanut butter - 1 metal pan had a greasy substance on it and was stored as clean - a rubber spatula with burnt areas to the end was stored as clean - a small, medium and large sized skillet with the Teflon coating scrapped and/or peeling off the cooking area During an interview, on 1/8/2025 at 9:47 A.M., the Dietary Manager indicated the microwave plate should have been cleaned, the spatula should have been thrown away and the skillets should not be used. During an interview, on 1/8/2025 at 10:04 A.M., [NAME] 12 indicated she had not added any sanitizing solution to the cleaning bucket. She indicated It's only water. The cook indicated she should have added the sanitizing solution. On 1/9/2025 at 12:31 P.M., the Dietary manager provided the policy tilted, Storage of Refrigerated Foods, dated 8/19/2023, and indicated the policy was the one used by the facility. The policy indicated . 13. Refrigerated items must have a label showing the name of the food and the dated it should be consumed or discarded . 14 . Monitor daily for expiration dates or 'used by' dates and discard all outdated items immediately . 16. Medications, employee lunches . shall not be stored in dietary refrigerators On 1/9/2425 at 12:31 P.M., the Dietary Manager provided the policy titled, Labeling and Dating, dated 8/12/2023, and indicated the policy was the one currently used by the facility. The policy indicated . Leftovers and opened foods shall be clearly labeled with date food item is to be discarded On 1/9/2025 at 12:31 P.M., the Dietary Manager provided the policy titled, Storage of Frozen Foods, undated, and indicated the policy was the one currently used by the facility. The policy indicated . 11. Food stored in the freezer shell be covered, labeled and dated On 1/9/2025 at 12:31 P.M., the Dietary Manager provided the policy titled, Equipment Cleaning and Sanitizing, undated, and indicated the policy was the one currently used by the facility. The policy indicated .3. Wash, rinse, and sanitize all food contact surfaces of the equipment that are stationary On 1/9/2025 at 12:31 P.M., the Dietary Manager provided the policy titled, Sanitation Bucket/Wiping Cloths food contact surfaces & equipment too large to rinse in the sink, undated, and indicated the policy is the one currently used by the facility. The policy indicated .Wiping cloths kept in a sanitation (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bucket containing a solution of water and chemical sanitizer are used to sanitize food contact surfaces . In the red sanitation bucket mix the water and the chemical sanitizer . The sanitation buckets are changed as often as necessary to maintain the correct concentration of sanitizing solution 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control practices were carried out appropriately for residents on enhanced barrier precautions (EBP) for 3 of 3 residents reviewed for infection control (Residents 30, 247 & 27). Findings include: 1. During an observation of medication administration on 1/9/2025 at 9:41 A.M., Resident 30 had an Enhanced Barrier Precautions sign on their room door and an isolation cart inside their room. RN 6 entered Resident 30's room wearing a pair of gloves. The RN did not have on a gown. RN 6 proceeded to administer medications to the resident via their feeding tube. On 1/7/2025 at 11:23 A.M., a record review was completed for Resident 30. Diagnoses included, but were not limited to: dysphagia, malnutrition and cerebral infarction. A review of Resident 30's Physician's Orders indicated Enhanced Barrier Precautions due to internal peg tube device. A Care Plan, initiated on 1/16/2024 indicated Resident 30 was on Enhanced Barrier Precautions due to a newly inserted PEG tube. Interventions included, but were not limited to: follow EBP Guidelines when providing care and coming into direct contact with potentially infected material or devices. During an interview on 1/9/2025 at 11:00 A.M., RN 6 indicated a gown and gloves were required for residents on EBP. She indicated she did not have on a gown when she administered Resident 30's medications and she should have been wearing one. 2. During an observation, on 01/06/2025 at 9:40 A.M., CNA 3 entered Resident 247's room without applying PPE (Personal Protective Equipment -gloves, gown and mask) and provided morning activity of daily living (ADL) care for the resident. A sign indicating Enhanced Barrier Precautions was located on the door of the resident's room. The sign provided instructions on when to use the gloves, gown, face mask and face shield depending on the types of care being provided During an observation, on 01/07/25 10:15 A.M., CNA 2 entered resident 27's room without PPE. CNA 2 applied gloves and applied lip balm to Resident 27's lips. CNA 2 then handled the resident's urinary catheter drainage bag without changing gloves or putting on additional PPE. The urinary catheter drainage bag was visibly leaking. During an observation, on 1/7/2025 at 10:35 A.M., CNA 3 assisted Resident 27 into bed using a hoyer lift. CNA 3 was observed handling the leaking urinary catheter drainage bag only wearing gloves. During an interview, on 01/07/2025 at 11:32 A.M., CNA 2 indicated for residents on enhanced barrier precautions, staff should be wearing gloves, gown, mask and if needed eye protection when providing care. CNA 2 indicated she should have been wearing additional PPE when handling the catheter drainage bag. During an interview, on 1/8/2025 at 1:19 P.M., CNA 3 indicated Residents 247 and 27 were on enhanced barrier precautions and staff should be wearing gloves, gowns, mask and if needed eye protection when providing care. CNA 3 indicated she should have been wearing PPE for resident 247 and should (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have had additional PPE on besides gloves when handling the leaking catheter drainage bag for Resident 27. On 1/9/2025 at 11:40 A.M., the Regional MDS Consultant provided the policy titled, Guidelines for Enhanced Barrier Precautions: An extension of Personal Protective Equipment, dated 12/2022 and indicated it was the policy currently being used by the facility. The policy indicated Policy: It is the policy of the facility to ensure that additional and appropriate PPE (Personal Protective Equipment) is utilized, when indicated, to prevent the spread of Multi-drug resistant Organisms also known as MDRO's. Examples of High Contact resident care activities at which time EBP is to be practiced are: g) Device Care or Use of to include: Feeding tubes (any type). Procedure: 1) When engaging in any of the aforementioned High Contact Resident Care Activities with a resident who has a known MDRO, or a colonized MDRO, or who would be at a high risk to contract a MDRO - use gloves and gowns (EBP) .