| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366192 | A. Building<br>B. Wing | 09/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lutheran Village at Wolfcreek | 2001 Perrysburg Holland Road<br>Holland, OH 43528 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, facility policy review, the facility failed to ensure a resident code statue was documented across all medical records. This affected two (#10 and #36) of 28 residents sampled for record review. The facility census was 57.Findings include:<br><br>1. Review of the medical record for Resident #10 revealed the resident was admitted on [DATE] with diagnoses of Alzheimer's disease, noninfective gastroenteritis and colitis, type II diabetes mellitus, chronic obstructive pulmonary disease, peptic ulcer disease, diverticulosis, iron deficiency anemia, and history of multiple hospitalizations for gastrointestinal (GI) bleed.<br><br>Review of Resident #10's paper medical record on 09/02/25 at 8:28 A.M. revealed a Do Not Resuscitate Comfort Care (DNR-CC; cardiopulmonary resuscitation will not be initiated with cardiac and/or respiratory arrest) paper signed.<br><br>Review of current physician orders as of 09/02/25 in the electronic health record (EHR) for Resident #10 revealed no code status order.<br><br>Review of current physician orders in Resident #10's EHR as of 09/08/25 revealed an order for DNR-CC.<br><br>Interview on 09/08/25 at 12:01 P.M. with the Director of Nursing (DON) verified the order for Resident #10's DNR-CC code status was not placed in the EHR until 09/03/25 at 12:20 P.M.<br><br>2. Review of the medical record for Resident #36 revealed she was admitted on [DATE] with diagnoses that included dementia, hypertension, hyperlipidemia, atherosclerotic heart disease, and heart valve replacement.<br><br>Review of Resident #36's EHR revealed no orders for the resident's code status.<br><br>Interview on 09/03/25 at 12:17 P.M. with Unit Manager Licensed Practical Nurse (LPN) #656 confirmed a code status was not present in the EHR for Resident #36 and should have been.<br><br>Interview on 09/03/25 at 2:00 P.M. with the DON revealed the facility changed their EHR software on 04/03/25, and on 07/11/25 was alerted that code status information did not migrate correctly. Continued interview confirmed resident code status should have been documented for each resident in two places in the EHR - on the landing page banner and in orders.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 09/08/25 at 12:00 P.M. with the DON confirmed the code status for Resident #36 was entered on 09/03/25.<br><br>Review of facility policy dated April 2021 titled, Advance Directives, revealed physician orders for preferred code status would be documented in the medical record. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and family interview, staff interview, medical record review, and review of facility policy, the facility failed to ensure residents who were not able to speak English had a consistent means of communication for their care needs. This affected one (#1) of two residents reviewed for communication. The facility census was 57. Findings include: Review of Resident #1's medical record revealed an admission date of 07/03/25. Diagnoses included end stage renal disease, dependence on renal dialysis, colostomy status, muscle weakness, and type II diabetes. Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 indicating Resident #1 was moderately cognitively impaired. Resident #1's preferred language was Chinese. Resident #1 required moderate assistance with toilet use and personal hygiene. Resident #1 required maximal assistance with bathing, parts of dressing, and transfers. Resident #1 displayed no behaviors during the review period. Review of Resident #1's care plan revised 08/27/25 revealed supports and interventions to address risks for alteration in skin integrity, self-care deficit, and communication as Resident #1's primary language was Chinese. Interventions for communication included a picture board for basic needs, and translation needs which noted the resident's husband was available for translation. Attempted interview on 09/02/25 at 1:34 P.M. with Resident #1 found when Resident #1 was asked questions she shook her head and pointed to her husband. Interview on 09/02/25 at 1:35 P.M. with Resident #1's husband verified Resident #1 was not able to speak any English and he was only able to speak a little. Resident #1's husband reported he was there to help translate during the day and helped with her care, but he was not sure how staff communicated with her when he was not there. He stated he could not be there all the time. Interview on 09/03/25 at 10:44 A.M. with Certified Nurse Aide (CNA) #705 verified the staff were not able to communicate with Resident #1 when her husband was not there. CNA #705 reported there were no translation devices or communication tools she was aware of. CNA #705 reported Resident #1 had put her call light on that morning, but she was unable to determine what Resident #1 needed when she responded to the light. She was able to determine it had something to do with the telephone, but she could not determine what Resident #1 needed. CNA #705 reported she asked Resident #1 to write it down, but Resident #1 shook her head, No, when she was handed paper and a pen. CNA #705 reported Resident #1's husband came in later in the morning and she found out Resident #1 had been trying to communicate she needed help with using the telephone to call her husband and had not been able to get the call to go through. Review of the facility policy titled, Translation/Interpretation, revised June 2020, revealed the residents at their care communities had the right to communicate in a dignified manner when unable to communicate either related to language, hearing, or sight barrier. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, and review of a facility policy, the facility failed to ensure residents who were dependent on staff for care received adequate and timely care to maintain oral hygiene. This affected one (#6) of four residents reviewed for activities of daily living. The facility census was 57. Findings Include:Review of Resident #6's medical record revealed an admission date of 08/05/25. Diagnoses included fusion of the cervical spine, fracture of cervical vertebrae subsequent encounter, fracture of tibia subsequent encounter, pulmonary embolism, muscle wasting, and morbid obesity. Review of Resident #6's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #6 was cognitively intact. Resident #6 was dependent on staff for all activities of daily living (ADLs) including oral hygiene. Resident #6 displayed no behaviors. Review of Resident #6's care plan revised 08/20/25 revealed supports and interventions for self-care deficits. Interventions for self-care deficits included a touch pad call light to the right side of the resident's body at all times when in bed, total dependence on one staff for bathing, bedfast most of the time, dependent on one staff for eating, and Resident #6 had his own teeth and required assistance with oral care every shift. Review of Resident #6's certified nurse aide (CNA) care task documentation for oral hygiene over the last 30 days revealed Resident #6 was assisted with oral care one time each day on 08/13/25, 08/17/25, 08/19/25, 08/21/25, 08/22/25, 08/26/25, 09/01/25, 09/03/25, and 09/04/25. Resident #6 was not provided any oral care on 08/31/25 and refused care on 09/05/25. Interview on 09/02/25 at 11:17 A.M. with Resident #6 found him to be alert and aware. Resident #6 reported he was not getting his teeth brushed as often as he would want. Resident #6 reported he was not physically able to brush his teeth himself and the nurse aides were supposed to brush his teeth for him daily. Resident #6 reported there were days his teeth were not getting brushed at all. Interview on 09/03/25 at 10:54 A.M. with CNA #705 revealed it was her first time working on her assigned hall for the shift and she was not aware yet of Resident #6's care needs. Interview on 09/03/25 at 3:16 P.M. with CNA #657 revealed Resident #6 required total assistance with all ADLs including eating and brushing his teeth. CNA #657 reported all care provided was documented in the electronic medical record when it was completed. If it was not in there, it was not completed, and confirmed documentation revealed Resident #6's teeth were not brushed daily. Interview on 09/08/25 at 9:40 A.M. with CNA #606 revealed it was her first time working her assigned hall for the shift in a long time. CNA #606 verified she was providing Resident #6's care that day and stated the resident required assistance of one staff for his care and she was not aware of how often Resident #6 got his teeth brushed. Interview on 09/08/25 at 9:40 A.M. with CNA #711 revealed she had been working at the facility for about three months and verified she was working on Resident #6's hallway that day. CNA #711 stated she did not know how often Resident #6 got his teeth brushed and stated she did not work with him. Review of the facility policy titled, ADL Nursing Care and Therapy Cares, revised April 2021, revealed residents care plan was to be followed daily for residents who required such services. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and review of facility policy, the facility failed to ensure interventions for prevention of pressure ulcers were applied as ordered. This affected one (#7) of four residents reviewed for pressure ulcers. The facility census was 57. Findings Include:Review of Resident #7's medical record revealed an admission date of 02/10/25. Diagnoses included dementia, chronic obstructive pulmonary disease, Alzheimer's disease, major depressive disorder, left heel stage four pressure ulcer, unstageable pressure ulcer of her right heel, and anxiety disorder. Review of Resident #7's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 was severely cognitively impaired. Resident #7 required maximal assistance with eating, and was dependent on staff for toilet use, bathing, dressing, bed mobility, and transfers. Resident #7 had one stage four pressure ulcer (full-thickness skin and tissue loss), and one unstageable pressure ulcer (obscured full-thickness skin and tissue loss) at the time of the review. Resident #7 displayed no behaviors and received hospice services at the time of the review. Review of Resident #7's care plan revised 08/21/25 revealed supports and interventions for self-care deficits, limited physical mobility, received hospice services, impaired cognitive function, required enhanced barrier precautions related to chronic wounds, stage three pressure ulcer (full-thickness skin loss) to the right heel, right lateral stage two (partial thickness skin loss with exposed dermis) and stage four to the left heel. Pressure ulcer interventions included to administer medications and provide treatments as ordered, follow up with wound care, assistance with turning and repositioning at least every two hours, low air loss mattress, and weekly treatment documentation to include measurement of each skin breakdown's width, length, depth, and type of tissue and exudate. and terminal prognosis with hospice services. Review of Resident #7's physician orders revealed an order dated 04/24/25 for heel protector boots to be worn while in bed as resident tolerated and allowed every day and night shift. Further review of Resident #7's physician orders revealed an order dated 07/10/25 for heel boots to bilateral lower extremities at all times as resident tolerated and allowed. Staff were to monitor Resident #7's skin integrity every shift. Further review of Resident #7's current physician orders revealed treatment orders in place to address a right lateral heel wound, a right medial heel wound, and left heel wound. Review of Resident #7's wound clinic evaluations found Resident #7 had three wounds that were being followed. The wounds included a stage four pressure wound to the left heel, a stage three pressure wound to the medial heel, and a stage two pressure wound of the right lateral heel. All three wounds were noted to be improving. Observation on 09/02/25 at 3:39 P.M. of Resident #7 found her in bed with her heels flat on the mattress. No pressure relieving boots were in place. Coinciding interview with Licensed Practical Nurse (LPN) #710 revealed Resident #7's dressing had been changed on the prior shift. LPN #710 stated Resident #7 had no boots she was aware of and verified there were treatment orders in place for Resident #7's right and left heels. Observation on 09/03/25 at 10:49 A.M. of Resident #7 found her up in the common area seated in her wheelchair. Resident #7's feet were in the footrests of the wheelchair and she was wearing a plain white sock on her right foot and purple boot was in place on the left. There was no pressure relieving device on her right foot. Observation on 09/03/25 at 1:15 P.M. of Resident #7 found her in bed with one purple boot on her left foot. Resident #7's right foot was unable to be observed as it was covered by a blanket. Interview on 09/03/25 at 3:12 P.M. with Certified Nurse Aide (CNA) #657 revealed Resident #7 required total care with dressing and personal care. Resident #7 was not always cooperative with care but if they spoke nicely to her and gave her some time it would help. CNA #657 reported they would put Resident #7's heel protector boots on her sometimes and<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #6 was supposed to have two, but she had not seen two in a while. Observation on 09/03/25 at 3:14 P.M. of Resident #7 found she continued to be in bed with a purple boot on her left foot and a plain white sock on her right. Coinciding interview with CNA #657 verified Resident #7's did not have both her boots on and her heels were flat on the bed with her right foot only having a white sock. Observation on 09/04/25 at 8:33 A.M. of Resident #7 found she had white gauze wrapping her left foot and a purple foam boot on the right. Coinciding interview with LPN #672 verified Resident #7's dressing was changed last night and Resident #7 had white gauze wrapping her left foot which was lying flat on the bed and had a purple foam boot on her right foot. There was a current order for to have dressing changes completed on night shift and boots. Review of the facility policy titled, Skin Management Protocol, revised March 2021, revealed residents at high risk for pressure ulcers should have interventions implemented including protective skin devices such as heel protectors. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of the facility policy, the facility failed to ensure fall interventions were in place as ordered and care planned. This affected one (#21) of five residents reviewed for fall interventions. The facility census was 57.Findings include: Review of the medical record for Resident #21 revealed she was admitted on [DATE] with a diagnosis of congestive heart failure (CHF).Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #21 revealed she was cognitively impaired and was at risk for falls.Review of the current physician orders from September 2025 for Resident #21 revealed she had an order for shorter oxygen tubing as a fall intervention.Review of the care plan, revised 08/27/25, for Resident #21 revealed she was care planned for a fall risk with an intervention in place for shorter oxygen tubing.Observation on 09/02/25 at 11:42 A.M. of Resident #21 revealed she had green oxygen tubing extension along with the nasal cannula tubing. Further observation of the oxygen tubing revealed the oxygen concentrator was located in the farthest corner of the room from the bathroom and the oxygen tubing stretched into the bathroom, a shared bathroom, and beyond. Interview on 09/02/25 at 12:33 P.M. with Licensed Practical Nurse (LPN) # 610 verified Resident #21 had an order for shorter oxygen tubing as a fall intervention and verified Resident #21 had green extension tubing in place that was approximately 25 feet long.Interview on 09/04/25 at 9:02 A.M. with the Director of Nursing (DON) stated Resident #21 tripped over 25 feet extension oxygen tubing and the intervention put into place was a shorter extension oxygen tubing. The DON further stated the length of the tubing at the time of the fall for Resident #21 was 25 feet long and green tubing from hospice. The DON stated the facility tubing was clear and was seven feet long, and that along with the nasal cannula resulted in a ten foot tubing that allowed Resident #21 to reach the bathroom while utilizing the oxygen.Review of the facilities policy titled, Fall Policy, revised 06/20, revealed the facility strives to reduce the occurrence of fall and to minimize complications from falling. The resident will be observed to ensure the new interventions are in place. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, medical record review, and review of facility policy, the facility failed to ensure oxygen tubing was changed and labeled as required, and failed to ensure oxygen was administered at the appropriate rate as ordered. This affected four (#20, #12, #21, and #39) of six residents reviewed for oxygen therapy. The facility census was 57. Findings Include:<br><br>1. Review of Resident #20's medical record revealed an admission date of 03/21/24. Diagnoses included pulmonary embolism, chronic obstructive pulmonary disease (COPD), osteoarthritis, anxiety disorder, morbid obesity, depression, and polyneuropathy.<br><br>Review of Resident #20's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #20 was cognitively intact. Resident #20 was dependent on staff for toilet use and required maximal assistance with bathing and parts of dressing. Resident #20 displayed no behaviors during the review period. Resident #20 had oxygen therapy at the time of the review.<br><br>Review of Resident #20's care plan revised 08/21/25 revealed supports and interventions for self-care deficits, risk for falls, psychosocial wellbeing problem, chronic pain, and COPD. Resident #20's COPD supports included oxygen settings via nasal cannula at four liters.<br><br>Review of Resident #20's physician orders revealed an order dated 03/22/25 for oxygen tubing and humidifier change the first Wednesday of the month every night shift every four weeks.<br><br>Interview on 09/02/25 at 10:56 A.M. with Resident #20 found her to alert and aware. Resident #20 reported she was able to put on and take off her oxygen nasal cannula by herself, but she required staff assistance with changing the tubing. Resident #20 reported her tubing was to be changed at least monthly and she was long overdue for her tubing change. Resident #20 pointed out how stiff and discolored her tubing was. Resident #20 stated new tubing was soft and pliable and the tubing she had was so stiff and hard it made it hard to keep the piece in her nose. Coinciding observation found the tubing was stiff, had yellowing discoloration, and there was no date or label on the tubing indicating when it was last changed.<br><br>Interview on 09/02/25 at 11:29 A.M. with Licensed Practical Nurse (LPN) #616 verified the tubing was not dated or labeled and she was not able to be determined when it had last been changed.<br><br>Observation on 09/02/25 at 11:32 A.M. of LPN #616 found she applied a piece of tape to the oxygen tubing with the date 09/02/25. The oxygen tubing was not observed being changed.<br><br>Interview on 09/03/25 at 3:09 P.M. with Resident #20 found she was alert and aware. Resident #20 reported her oxygen tubing had not been changed. Resident #20 reported the sticker the nurse put on yesterday was still on the tubing and no one had actually changed the tubing as far as she was aware. Coinciding observation of Resident #20's oxygen tubing found it continued to have a piece of tape dated 09/02/25.<br><br>2. Review of Resident #12's medical record revealed an admission date of 06/06/24 diagnoses included COPD, peripheral vascular disease, type II diabetes, major depressive disorder, bipolar disorder, anxiety disorder, stroke, chronic pain, and hallucinations.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #12's MDS assessment dated [DATE] revealed a BIMS score of seven indicating Resident #12 was severely cognitively impaired. Resident #12 was dependent on staff for toilet use, bathing, dressing and transfer. Resident #12 had hallucinations at the time of the review. Resident #12 received oxygen therapy at the time of the review.<br><br>Review of Resident #12's care plan revised 07/15/25 revealed supports and interventions for self-care deficits, impaired cognitive function, chronic pain, high risk for falls, and COPD. COPD interventions included oxygen via nasal cannula at two to four liters as ordered.<br><br>Review of Resident #12's physician orders revealed an order dated 05/27/25 for oxygen at two to four liters per nasal cannula every shift. No order was found regarding changing Resident #12's oxygen tubing.<br><br>Observation on 09/02/25 at 11:42 A.M. of Resident #12 found he had oxygen running connected to a nasal cannula. The oxygen tubing was partially touching the floor, wrapped around the side rail of his bed, no label was found on the oxygen tubing indicating when it was last changed, and his nasal cannula was lying on his chest and not connected to his nose.<br><br>Interview on 09/02/25 at 11:43 A.M. with Resident #12 revealed he was not able to apply his nasal cannula and needed assistance with untangling it and putting it on.<br><br>Interview on 09/02/25 at 11:44 A.M. with LPN #616 verified Resident #12's oxygen tubing had not been labeled and she was not able to determine when it was last changed. LPN #616 assisted Resident #12 with untangling, picking the tubbing up off the floor, and reapplying his nasal cannula. LPN #616 then took a piece of tape and labeled the tubing with the date 09/02/25.<br><br>3. Review of the medical record for Resident #21 revealed she was admitted on [DATE] with diagnoses of congestive heart failure (CHF).<br><br>Review of the quarterly MDS assessment dated [DATE] for Resident #21 revealed she was cognitively impaired and required the use of oxygen therapy.<br><br>Review of the current physician orders for September 2025 for Resident #21 revealed she was ordered oxygen therapy with the oxygen tubing and humidifier (water for less drying affect of oxygen) change to be completed the first Wednesday of every month.<br><br>Observation on 09/02/25 at 11:10 A.M. of Resident #21's oxygen tubing revealed no date on the oxygen tubing.<br><br>Interview on 09/02/25 at 12:33 P.M. with LPN #610 verified the oxygen tubing for Resident #21 not dated.<br><br>4. Review of the medical record for Resident #39 revealed an admission date of 06/09/14 with diagnoses of asthma and chronic respiratory failure.<br><br>Review of the quarterly MDS assessment dated [DATE] for Resident #39 revealed she was cognitively intact and required the use of oxygen therapy.<br><br>Review of the current physician orders from September 2025 for Resident #39 revealed she had orders<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | in place for oxygen at two liters per minute and the oxygen tubing and humidifier to be changed the first Wednesday of the month, must date and initial on tape on the oxygen tubing.<br><br>Observation on 09/02/25 at 9:51 A.M. of Resident #39 revealed the oxygen rate was at 2.5 liters per minute and the oxygen tubing was not dated.<br><br>Observation and interview on 09/02/25 at 12:38 P.M. with LPN #610 verified oxygen order for Resident #39 was for oxygen to run at two liters per minute. Further interview with LPN #610 verified oxygen rate for Resident #39 was running at 2.5 liters per minute and verified oxygen tubing was not dated.<br><br>Review of the facility policy titled, Oxygen Administration, dated 07/22, revealed the facility will facilitate breathing by providing supplemental oxygen to residents. Procedure includes turn the oxygen on to the prescribed amount and change and label the oxygen tubing monthly and as needed. |

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|---|---|---|---|
| | 366192 | A. Building<br>B. Wing | 09/08/2025 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and policy review, the facility failed to ensure medications were administered per physician's order. This affected one (#41) of four reviewed for medication administration. The facility census was 57.Findings include:Review of the medical record for Resident #41 revealed the resident was admitted on [DATE] with diagnoses of malignant neoplasm of the rectum, malignant neoplasm of the prostate, chronic kidney disease, and hypertension.Review of the medical record for Resident #41 revealed the resident developed a new diagnosis of hypotension on 03/12/25 and other hypotension on 07/01/25. Review of a progress note dated 03/27/25 for Resident #41 revealed the resident had a diagnosis of hypotension with a plan to continue midodrine (a medication to increase blood pressure) for low blood pressure management.Review of the care plan for Resident #41 dated 05/07/25 revealed focus of for hypotension related to multiple co-morbidities and an intervention to give medications as ordered. Review of a physician order dated 05/25/25 revealed Resident #41 was ordered midodrine 10 milligrams (mg) by mouth three times daily with no ordered blood pressure parameters.Review of Resident #41's medication administration record for August 2025 revealed the resident's midodrine was held for administrations on 08/01/25, 08/04/25, 08/19/25, 08/20/25, 08/21/25, and 08/22/25.Review of current physician's order on 09/02/25 at 2:30 P.M. for Resident #41 revealed he was prescribed midodrine five (5) mg with directions to give two tablets by mouth three times a day. Further review of the physician's orders revealed no hold parameters for the midodrine. Observation of medication administration on 09/03/25 at 10:50 A.M. revealed Licensed Practical Nurse (LPN) #672 obtained the blood pressure for Resident #41 with a reading of 120/51 millimeters of mercury (mmhg) obtained. Further observation of LPN #672 revealed the midodrine was not administered to Resident #41.Interview on 09/03/25 at 4:01 P.M. with LPN #672 verified there were no parameters for the administration of Resident #41's midodrine and further verified the medication was not given because the resident's blood pressure was 120/51 mmhg. LPN #672 further stated he was calling the physician immediately to have hold parameters added to the order.Interview on 09/03/25 at 4:04 P.M. with the Director of Nursing (DON) stated there was an understanding that the standard of practice was to hold the midodrine if the blood pressure was above 110 or 120 mmhg. Interview with LPN #672 on 09/03/25 at 4:45 P.M. confirmed that order parameters were added to Resident #41's midodrine order on 09/03/25 at about 4:05 P.M., shortly after confirmation that the order did not have parameters. Review of the ordered parameters revealed midodrine was to be held for a systolic blood pressure (the top number; the pressure in the arteries when the heart contracts) of greater than 120 mmhg or a diastolic blood pressure (the bottom number; the pressure in the arteries when the heart is at rest) of greater than 80 mmhg. Interview with the DON on 09/08/25 at 2:45 P.M. revealed the facility was unable to produce documentation of the standard blood pressure parameters for midodrine. Further interview with the DON stated that parameters for midodrine can vary based on the resident.Review of policy titled, Medication Administration, last revised in May 2019, revealed prescribed medications are ordered and delivered in a timely fashion to residents taking into account, when possible and appropriate, the resident's wishes for medication delivery times. Further review revealed the physician shall be notified if a medication is withheld. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, review of a medication expiration list, review of a medication package insert, and review of a facility policy, the facility failed to ensure medications and biologicals were properly dated and discarded after expiration. This had the potential to affect all 57 residents in the facility. The facility census was 57.Findings include:Observation on [DATE] at 9:08 A.M. of the medication storage room with Registered Nurse (RN) #682 revealed a bottle of Geri-Lanta (an oral medication to relieve symptoms of excess stomach acid and gas) on the shelf. The bottle was opened with an expiration date of [DATE]. Further observation of the medication refrigerator revealed a bottle of Tuberculin purified protein derivative (PPD), a Tuberculosis testing solution, that was opened and undated.Interview on [DATE] at 9:10 A.M. with RN #682 verified the Geri-Lanta was opened and expired and further verified the Tuberculin PPD was opened and undated. Additional interview with RN #682 stated the Tuberculin PPD should be dated and initialed when opened.Review of an undated document titled, Medications with Shortened Expiration Dates, revealed Tuberculin PPD should be discarded 30 days after being opened.Review of a package insert for Tuberculin PPD revealed the medication must be discarded 30 days after opened. Review of facility policy titled, Medication Administration, with a revision date of [DATE], revealed staff must date all date sensitive medications upon opening. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, review of manufacture instructions, review of a facility medication guide, and review of facility policies, the facility failed to ensure staff wore appropriate personal protective equipment when providing care for residents on enhanced barrier precautions, failed to ensure medical equipment was properly sanitized between resident use, failed to ensure hand hygiene was performed during resident care, and failed to an insulin pen was sanitized prior to applying a needle for administration. This affected four (#41, #19, #23, and #1) of four residents reviewed for infection control measured during resident care. The census was 57. Findings include:<br><br>1. Review of medical record revealed Resident #1 was admitted on [DATE] with diagnoses of end stage renal disease, dependence on renal dialysis, and type two diabetes mellitus with diabetic neuropathy.<br><br>Review of current physician orders from September 2025 for Resident #1 revealed order for insulin aspart before meals per sliding scale.<br><br>Observation on 09/03/25 at 11:30 A.M. of medication administration for Resident #1 from Registered Nurse (RN) #682 revealed RN #682 checked Resident #1's blood sugar. RN #682 then checked the order and determined the correct dosage of insulin apart to be given. RN #682 removed the insulin pen for Resident #1 from the drawer on the medication cart, removed the cap, and placed the needle onto insulin pen. Continued observation of RN #682 revealed the nurse did not clean the end of the insulin pen prior to putting the needle on it. Further observation of RN #682 revealed she administered the insulin to Resident #1.<br><br>Interview with RN #682 on 09/03/25 at 11:32 A.M. verified she did not clean the end of the insulin pen prior to applying the needle and administration of the insulin. Further interview revealed RN #682 stated she should have cleaned the end of the insulin pen prior to attaching the needle and administration of the insulin.<br><br>Review of manufacturer instructions for insulin aspart pen delivery system revealed the first step when preparing an insulin pen for administration was to disinfect the rubber stopper of the pen tip with alcohol prior to attaching the needle to the pen.<br><br>Review of the undated facility document titled, Insulin and Non-Insulin Pen Quick Reference Guide, revealed important points with pen injections included disinfecting the tip of the pen with an alcohol preparation pad before each use.<br><br>2. Review of the medical record for Resident #41 revealed he was admitted on [DATE] with diagnoses of malignant neoplasm of the rectum, malignant neoplasm of prostate, and obstructive reflux uropathy.<br><br>Review of the care plan for Resident #41 dated 04/02/25 revealed the resident required enhanced barrier precautions (EBP) related to and indwelling medical device, a urinary catheter. Further review revealed Resident #41 had an indwelling urinary catheter due to obstructive and reflux uropathy.<br><br>Review of medical record for Resident #19 revealed the resident was admitted on [DATE] with a diagnoses of quadriplegia, a carrier of carbapenem resistant enterobacter, and neuromuscular dysfunction<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of the bladder.<br><br>Review of current physician orders from September 2025 for Resident #19 revealed an order for a urinary catheter with instructions to change the urinary catheter every 28 days and as needed.<br><br>Review of the care plan for Resident #19 dated 06/11/25 revealed Resident #19 has a potential for reinfection related to chronic urinary tract infections. Further review revealed Resident #19 required EBP related to chronic wounds and an indwelling urinary catheter.<br><br>Observation during medication administration on 09/03/25 at 9:34 A.M. revealed Licensed Practical Nurse (LPN) #672 went into Resident #41's room and took the resident's blood pressure with a wrist blood pressure cuff. Observation of Resident #41's door revealed the resident was identified to require staff to practice EBP. Continued observation during medication administration on 09/03/25 at 9:44 A.M. revealed LPN #672 entered into Resident #19's room and obtained a blood pressure with the same wrist blood pressure cuff used on Resident #41. Resident #19 was identified to require staff to practice EBP. Continued observation of LPN #672 revealed the nurse did not clean and disinfect the wrist blood pressure cuff between using the device on Resident #41 and Resident #19.<br><br>Interview with LPN #672 on 09/03/25 at 9:55 A.M. verified he did not clean the blood pressure cuff between using it on Resident #41 and Resident #19. Further interview with LPN #672 verified he did not know it should be cleaned or how to clean it.<br><br>Interview on 09/03/25 at 10:02 A.M. with LPN #672 stated he asked the Director of Nursing (DON) how to clean the blood pressure cuff, and stated the DON was unable to explain how to clean it to him.<br><br>Interview on 09/03/25 at 4:03 P.M. with the DON revealed blood pressure cuffs should be cleaned between residents on EBP. Additional interview revealed manufacturer's instructions for cleaning wrist blood cuffs are to clean all surfaces with alcohol and for it to remain wet for several minutes. The DON confirmed that was not done.<br><br>Review of facility policy titled, Cleaning and Disinfection of Resident-Care items and Equipment, revised May 2020, revealed if disposable devices are not available, disinfect patient care devices after usage on a patient who is in contact/universal precautions. Further review revealed patient care devices include but are not limited to blood pressure cuffs.<br><br>3. Review of Resident #19's medical record revealed the resident had an order for a urinary catheter and a current care plan which included the resident's need to be on EBP related to chronic wounds and use of an indwelling urinary catheter. Interventions for the care plan included staff to use personal protective equipment (PPE) when completing high contact activities including changing briefs or assisting with toileting, changing linens, dressing, and providing hygiene.<br><br>Observation on 09/04/25 at 9:23 A.M. of Certified Nurse Aide (CNA) #709 revealed she was in the room with Resident #19 completing morning care without wearing PPE. Observation of Resident #19's room revealed the resident was identified as requiring EBP.<br><br>Interview with CNA #709 on 09/04/25 at 9:28 A.M. revealed she completed all morning care for Resident #19. Further interview with CNA #709 stated she changed Resident #19's incontinence brief and provided peri-care, assisted with hygiene and brushing teeth, and dressed the resident. Further interview confirmed CNA #709 was not wearing PPE during any of these activities. CNA #709 stated for EBP,<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | PPE was to be used for high contact activities. Further interview with CNA #709 stated she completed high-contact care with the Resident #19 and should have used PPE.<br><br>4. Review of the medical record for Resident #23 revealed she was admitted on [DATE] with diagnoses that included Parkinson's disease, cerebral infarction, dysphagia following unspecified cerebrovascular disease, intracranial hemorrhage, and gastrostomy complication.<br><br>Review of an active order dated 03/27/25 indicated Resident #23 would be in EBP related to her gastrostomy tube (g-tube), until criteria were no longer met.<br><br>Observation on 09/04/25 at 8:20 A.M. of Resident #23's room revealed PPE was placed adjacent to the doorway, signs were on the door, and the door frame indicated the resident was in EBP.<br><br>Observation on 09/04/25 at 8:20 A.M. of RN #708 providing gastrostomy tube care for Resident #23 revealed RN #708 donned (put on) gloves without performing hand hygiene, did not don an isolation gown, then disconnected the nocturnal tube feeding and flushed the g-tube with water. RN #708 changed her gloves, did not perform hand hygiene, then returned to Resident #23 to remove the existing drain sponge. RN #708 changed her gloves again, did not perform hand hygiene, then returned to Resident #23 to apply a new drain sponge to the g-tube site. RN #708 removed her gloves and did not perform hand hygiene prior to exiting the room.<br><br>Interview on 09/04/25 at 8:28 A.M. with RN #708 confirmed the above observation. RN #708 indicated she should have donned an isolation gown, and washed hands before resident care, between glove changes, and after resident care.<br><br>Review of facility policy dated 04/01/25 titled, Enhanced Barrier Precautions, revealed staff would utilize EBP when providing high-contact care to residents with indwelling medical devices and residents with multidrug-resistant organisms. Gowns and gloves would be utilized in conjunction with standard precautions when care was provided to residents under EBP precautions.<br><br>Review of facility policy with a reviewed date of May 2020 titled, Handwashing/Hand Hygiene, revealed staff would perform hand hygiene before and after direct contact with residents, after removing gloves, and as a final step after removing and disposing of personal protective equipment. |