STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155124	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermillion Convalescent Center	1705 S Main St Clinton, IN 47842

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. A. Based on observation, record review, and interview, the facility failed to ensure hand hygiene was performed during the medication pass and appropriate infection control techniques were utilized for 5 of 5 residents medication passes observed (Residents 33, 36, 48, 28, and 62). B. Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions (EBP) (use of gowns and gloves during high-contact resident care activities) were followed for 2 of 5 residents' medication passes observed (Residents 33 and 10). Findings include:A. On 8/15/25 at 8:06 a.m., Registered Nurse (RN) 22 was observed preparing medication for Resident 33. During the preparation, one of the pills fell onto the medication cart. RN 22 picked up the pill bare-handed and placed it into the medication cup. RN 22 entered Resident 33's room, put on gloves, and completed the resident's accu-check (finger stick to check blood sugar). The resident's blood sugar was 69 milligrams (mg)/deciliter (dl). RN 22 did not perform hand hygiene before or after the accu-check. At the same time, RN 22 indicated, based on the resident's accu-check results she would wait until later to administer the resident's medication and insulin. On 8/15/25 at 8:16 a.m., RN 22 prepared Resident 36's medication. RN 22 took a pair of gloves into Resident 36's room and placed them on the bedside table. RN 22 placed a pulse oximeter (used to estimate the oxygen saturation of a patient's blood and their pulse rate) on the resident's finger and indicated the resident's heart rate was 59 beats per minute (bpm). RN 22 did not clean the pulse oximeter before or after use or perform hand hygiene before or after administering medication to Resident 36. RN 22 took the gloves she had previously placed on the resident's bedside table with her when she left the resident's room. On 8/15/25 at 8:19 a.m., RN 22 checked Resident 48's blood pressure with a wrist cuff. RN 22 did not clean the wrist cuff before or after use or perform hand hygiene before or after the blood pressure check. RN 22 then prepared medication for Resident 48 and administered it to him. No hand hygiene was observed. On 8/15/25 at 8:25 a.m., RN 22 prepared Resident 28's routine insulin, checked her blood sugar, and indicated the resident did not require sliding scale insulin. RN 22 wore the same gloves that had been removed from Resident 36's bedside table to complete Resident 28's accu-check. RN 22 placed a pulse oximeter on the resident's finger and indicated the resident's heart rate was 70 bpm. RN 22 administered the resident's medication and insulin. RN 22 did not clean the pulse oximeter before or after use or perform hand hygiene before or after administering medication to Resident 28. On 8/15/25 at 8:42 a.m., RN 22 put on gloves and re-checked Resident 33's accu-check. The result was 137 mg/dl. RN 22 administered Resident 33's medication and insulin but did not perform hand hygiene before or after the administration. On 8/15/25 at 8:58 a.m., RN 22 checked Resident 62's blood pressure with the wrist cuff but did not clean the wrist cuff before or after its use. During an interview, on 8/15/25 at 8:59 a.m., RN 22 indicated she sometimes washed her hands when administering insulin, and she should have used hand sanitizer between resident medication administrations. She did not normally clean vital sign equipment between uses. She normally used bleach wipes to clean everything at the beginning of her shift, but she had not done it this morning. During an interview, on 8/15/25 at 9:20 a.m., the Director of Nursing (DON) indicated hand hygiene should have been performed before and after each residents' medication administration. The hand hygiene could have been hand sanitizer. Staff should have washed their hands at least every third (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident during medication pass. The vital sign equipment should have been cleaned after each use. During an interview, on 8/15/25 at 10:45 a.m., the DON indicated gloves placed on a resident's bedside table should not have been used on a different resident, and pills should not have been touched bare handed. On 8/15/25 at 10:01 a.m., the Regional Nurse Consultant provided a document titled, Medication Administration, last revised in April 2017, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To safely administer medications as per physicians' orders. Policy: Licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' orders. Infection Control: 1. Wash hands with soap and water. Prior to beginning med pass, after direct contact with resident if hands become visibly soiled. Before and after administering.injections.2. Use alcohol gel or foam before between each resident unless using soap and water. 3. Never touch medications with hands. B. On 8/15/25 at 8:42 a.m., Registered Nurse (RN) 22 entered Resident 33's room to administer medications. Certified Nurse Aide (CNA) 23 was giving the resident a bed bath, using a shower cap to wash her hair. CNA 23 was wearing gloves but no gown. A sign on the resident's bathroom door indicated the resident required EBP. Resident 33's record was reviewed on 8/15/25 at 10:12 a.m. Diagnoses on the resident's profile included, but were not limited to, hidradenitis suppurativa (a chronic, inflammatory skin condition characterized by painful, boil-like lumps that typically appear in areas where skin rubs together, such as the armpits, groin, and buttocks) and a history of Proteus mirabilis (bacteria often associated with urinary tract infections). A physician's order, dated 5/1/24, indicated the resident required EBP. During an interview, on 8/15/25 at 8:59 a.m., RN 22 indicated Resident 33 required EBP, but she was not sure why. CNA 23 should have worn EBP when giving the resident a bed bath, but she was not sure about when she was washing the resident's hair. On 8/15/25 at 12:05 p.m., Licensed Practical Nurse (LPN) 20 was observed administering Resident 10's medication via a gastrostomy tube (g-tube) (tube inserted into the stomach for feeding and medication administration). LPN 20 wore gloves but no gown. A sign on the resident's bathroom door indicated the resident required EBP. Resident 10's record was reviewed on 8/15/25 at 2:11 p.m. A physician's order, dated 4/1/24, indicated the resident required EBP. During an interview, on 8/15/25 at 12:10 p.m., LPN 20 indicated Resident 10 required EBP, but she was not sure why. It depended on what type of care was being provided if a gown and gloves were required, but a gown was not required for g-tube medication administration. During an interview, on 8/18/25 at 11:28 a.m., the Director of Nursing (DON) indicated staff should have worn a gown and gloves during bed baths and g-tube medication administration for residents who required EBP. On 8/18/25 at 11:30 a.m., the DON provided a document titled, Enhanced Barrier Precautions., dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: Enhanced Barrier Precautions (EBP) expand the use of PPE [personal protective equipment] beyond situations in which exposure to blood and body fluids is anticipated. These precautions entail the use of gown and gloves during ?high-contact' resident care activities that provide opportunities for transfer of multi-drug resistant organisms (MDROs) to staff hands and clothing to address the continued risk of transmission from residents with MDRO colonization, which can persist for long periods of time.and result in the silent spread of MDROs. Policy: This facility shall implement Enhanced Barrier Precautions.for those residents with an infection or colonization with a CDC [Centers for Disease Control]-targeted MDRO when Contact Precautions do not otherwise apply.Examples of ?high-contact' resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, bathing/showering.providing hygiene.device care or use.feeding tube. 3.1-18(l)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure informed consent documents for psychotropic medications had been obtained, for 2 of 5 residents reviewed for unnecessary medications (Residents 73 and 1). Findings include: 1.Resident 73's record was reviewed on 8/14/25 at 11:43 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia, severe, with agitation (dementia that severely impacts daily life and functioning with agitation), Alzheimer's disease (a progressive brain disorder that gradually impairs memory, thinking, and reasoning skills, eventually affecting the ability to perform simple tasks), anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that interferes with daily life), and irritability and anger. A significant change Minimum Data Set (MDS) assessment, dated 7/15/25, indicated the resident had severe cognitive deficit, physical behavioral symptoms directed towards others, and received an antipsychotic medication (drugs used to treat psychosis, a condition where a person experiences a disconnect from reality, often involving hallucinations and delusions). A physician's order, dated 8/8/25, indicated to administer one 25 milligram (mg) tablet of quetiapine (antipsychotic medication) by mouth at bedtime. The record lacked documentation of an informed consent form to administer the quetiapine 25 mg at bedtime. A physician's order, dated 8/14/25, indicated to administer one 5 mg tablet of melatonin (a dietary supplement containing a synthetic form of melatonin, a hormone naturally produced by the brain to help regulate the sleep-wake cycle) at bedtime. An informed consent form, dated 8/14/25, was observed to be signed by the resident's representative for consent to administer the melatonin. The form lacked documentation of consent to administer the quetiapine. During an interview, on 8/14/25 at 1:50 p.m., the south unit manager, Licensed Practical Nurse (LPN) 3, indicated the resident had returned from a recent hospital stay on the quetiapine. An informed consent document should have been completed at that time. She was unsure why the the quetiapine was not included on the informed consent document for the melatonin. During an interview, on 8/14/25 at 2:04 p.m., the Director of Nursing (DON) indicated the consent for the quetiapine should have been completed when the resident returned from the hospital on the medication or, at least, been included on the consent for the melatonin completed on 8/14/25. 2. On 8/18/25 at 9:47 a.m., the medical record of Resident 1 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnosis included but not limited to Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), chronic respiratory failure (a long-term condition where the lungs can't adequately exchange oxygen and carbon dioxide), and metabolic encephalopathy (a brain disorder caused by chemical imbalances in the body, often due to issues with organs like the liver or kidneys). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order, dated 5/27/25, indicated to administer Ativan (lorazepam) tablet; 0.5 mg (milligram) 1 tablet; oral. Give 1 tablet under the tongue every 4 hours as needed for a 6 month exacerbation of anxiety/agitation due to end-of-life circumstance/hospice as needed. A physician order, dated 5/30/25, indicated to administer (Zyprexa) Olanzapine tablet; 5 mg oral once a day. An annual Minimum Data Set (MDS) assessment indicated the resident required maximum assistance from staff for all daily care needs and indicated he was not cognitively intact. The record indicated the resident was administered two psychotropic medications for anxiety and agitation. The record lacked notification to the family of psychotropic medication administration. On 8/14/25 at 2:00 p.m., during interview the Director of Nursing (DON) indicated the hospice agency notified the family of the initiation of the medications. On 8/14/25 at 2:30 p.m., the Director of Nursing (DON) presented a nurses note from the hospice agency indicating medications had been reviewed however, the documentation lacked evidence of notification and consent of the family regarding administration of psychotropic medication. The DON acknowledged it was the responsibility of the facility to inform the responsible party and obtain consent for use of psychotropic medications. On 8/14/2025 at 3:07 p.m., the DON provided a document titled, Psychotropic Medication Consent use and gradual dose reduction, dated 4/2025, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedures.16. Residents receiving an order for a new psychotropic medication , or dose increase to existing orders, shall have consent obtained from the resident or their resident representative. The consent (either signed or documented as verbal consent obtained) shall demonstrate a. having been informed of the risks, benefits, and alternatives to use of the medication.c. having been informed of their right to refuse the medication. 3.1-3(n)(2) 3.1-3(n)(3)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to ensure the call light was within the reach of the residents for 2 of 24 residents reviewed for call light placement (Residents 25 and 23).Findings include:1. On 8/14/2025 at 1:32 p.m., during initial routine observation, observed Resident 25 sleeping in bed. Call light was not within reach of the resident. Unable to locate the call light. On 8/15/2025 at 1:34 p.m., observed Resident 25 sitting in a recliner in her room. The call light was attached to the middle of the curtain within the folds of the curtain residents bed at the foot of the bed. The resident was unable to answer any interview questions. On 8/18/25 at 10:40 a.m., during an interview Certified Nurse Aide (CNA) 6 indicated she makes sure the call light was within reach of residents even if the resident did not use the call light. On 8/18/25 at 11:50 a.m., during an interview Certified Nurse Aide (CNA) 8 indicated she would make sure the call light was within reach of the resident even if the resident did not use the call light. On 8/18/25 at 1:39 p.m., the medical record of Resident 25 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnoses included but not limited to Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), unspecified dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). A care plan, dated 8/6/2025, indicated the resident had cognitive loss and dementia the resident had the progressive cognitive and communicative deficits associated with a dementia diagnosis. Interventions included but were not limited to speak in a clear, low, calm tone of voice at a volume that is easily heard by the resident. The care plan lacked evidence of call light use or the residents ability to use a call light. 2. On 8/13/25 at 11:13 a.m., Resident 23 was observed up in his wheelchair, in his room. The call light was observed lying on the resident's bed, out of his reach. At the same time, the resident indicated if he needed assistance he was supposed to press the call light, but it had disappeared somewhere. When asked if he knew how to use the call light the resident indicated, Yeah, you just press it. On 8/15/25 at 1:49 p.m., Resident 23 was observed lying in bed. The call light was observed in the resident's recliner with linens piled on top of it. The recliner was approximately three feet from the resident's bed and out of the resident's reach. At the same time, the resident indicated he was supposed to have the call light, but he had no idea where it was. He would have used the call light for assistance if he needed it, if he was able to reach it. Resident 23's record was reviewed on 8/18/25 at 9:26 a.m. Diagnoses on the resident's profile included, but were not limited to, cerebral infarction (brain tissue death due to lack of blood supply) unspecified and hemiplegia (paralysis or severe weakness on one side of the body) affecting left side. A quarterly Minimum Data Set (MDS) assessment, dated 7/9/25, indicated the resident had a moderate cognitive impairment, functional limitation in range of motion, and required assistance with ADLs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, initiated on 8/6/25, indicated the resident required assistance to transfer from the bed and was able to use the call light to ask for assistance. During an interview, on 8/18/25 at 11:25 am., Certified Nurse Aide (CNA) 18 indicated Resident 23 was able to use the call light to ask for assistance, and it should have been kept within his reach. On 8/18/25 at 11:12 a.m., the Administrator provided a document titled, Call Light, dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: Resident will have a call light to summon facility personnel to ensure the resident's needs will be met. Policy: Resident's call light is to be within reach and answered promptly by facility personnel.Procedure.8. Call lights must remain functional and within reach of each resident. 3.1-3(a)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility failed to ensure a resident was provided showers as preferred for 1 of 1 residents reviewed for choices (Resident 51). Findings include: During an interview, on 8/13/25 at 3:28 p.m., Resident 51 indicated she thought that the staff often forgot about her, and she did not receive her showers as scheduled. She was unable to recall when her last shower was. Resident 51's record was reviewed on 8/15/25 at 10:10 a.m. A significant change Minimum Data Set (MDS) assessment, dated 8/6/25, indicated the resident was cognitively intact and required moderate assistance with showers and toileting. A care plan, dated 5/15/25, indicated the resident requires assistance from 1-2 staff in preforming activities of daily living (ADL's) related to shortness of breath, pain, and incontinence. Interventions included, but were not limited to, offer bathing choices, showers/baths per schedule and more frequently if requested and as needed, and nail care as needed. Review of shower schedule indicated Resident 51 was to receive her showers on Tuesday and Saturday evening shift. Review of shower sheets, dated June 2025, indicated Resident 51 received a shower on 6/10/25, 6/17/25, and 6/29/25. The record lacked documentation of any other showers provided for the month of June. Review of shower sheets, dated July 2025, indicated Resident 51 received a shower on 7/28/25 and 7/29/25. The record lacked documentation of any other showers provided for the month of July. Review of shower sheets, dated August 2025, lacked documentation that the resident had received a shower up to the date of August 15. During an interview, on 8/15/25 at 10:41 a.m., Licensed Practical Nurse (LPN) 10 indicated Resident 51 doesn't usually refuse her showers, she would normally take showers when offered. During an interview, on 8/15/25 at 2:47 p.m., Regional Nurse Consultant (RNC) was unable to provide documentation that Resident 51 had received two showers a week as requested for the last 3 months. During an interview, on 8/15/24 at 2:30 p.m., Director of Nursing (DON) indicated staff should be documenting when they provide showers. On 8/15/25 at 2:47 p.m., the RNC provided a document with a revised date of 9/17, titled, Resident Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: This facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility shall protect and promote the rights of the resident.3.1-3(u)(3)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical and verbal abuse for 1 of 2 residents reviewed for abuse (Resident 1).Findings include:On 8/18/25 at 9:36 a.m., an allegation of abuse was reported by the Regional Nurse Consultant (RNC). Review of facility reported incident indicated an allegation of abuse was reported to IDOH on 8/16/25 at 8:40 a.m., by the facility Administrator. The report indicated Certified Nursing Aides (CNAs) 8 and 12 were caring for Resident 1's roommate in the first bed. Both CNAs saw CNA 11 at the bedside of Resident 1 in the same room, pulling Resident 1's hand off of the side rail, pushing the resident's arm into his stomach, speaking abruptly to the resident, and using profanity. The CNAs 8 and 12 immediately intervened and prevented further interaction between CNA 11 and the resident. A skin tear was noted to Resident 1's right arm. The CNA 11 responded that it was there last night and she didn't do it. However, one of the other CNAs had cared for Resident 1 the evening before and indicated there was no skin tear observed at that time. The other CNAs contacted the nurse and CNA 11 was sent home. Resident 1's Brief Interview for Mental Status (BIMS) score of 99 indicated the resident was rarely able to communicate verbally. On 8/18/25 at 9:47 a.m., the medical record of Resident 1 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnoses included but not limited to Alzheimer's disease, chronic respiratory failure (a long-term condition where the lungs can't adequately exchange oxygen and carbon dioxide), and metabolic encephalopathy (a brain disorder caused by chemical imbalances in the body, often due to issues with organs like the liver or kidneys). A physician order, dated 8/16/25, indicated to cleanse area and apply steri strips (thin, adhesive bandages used to close and protect minor cuts and wounds) to the right upper arm times 1 application, leave open to air, and monitor the site every shift. An annual Minimum Data Set (MDS) assessment indicated the resident required maximum assistance from staff for all daily care needs and indicated he had limited cognition. A care plan, dated 6/5/25, indicated the resident required one to two staff to assist in performing ADL's (activities of daily living) due to highly impaired vision, decreased communication, and severely impaired cognitive skills. Interventions included, but were not limited to, provide assist with ADL's as resident requires, and encourage the resident to participate in ADLs as much as possible. A nursing progress note, dated 8/16/25 at 7:45 p.m., indicated the CNA (Certified Nurse Aide) alerted the nurse to a new skin tear on the right upper arm. The area was cleansed and steri strips applied per doctor order. The Director of Nursing (DON) and resident's family member were also notified. A wound report indicated a skin tear was reported on 8/16/25 at 8:40 a.m. Measurements were length - head to toe direction 3 centimeters (cm), width - hip to hip direction 0.25 cm. The color of alteration in skin was red, there was a small amount of exudate (drainage) present which was bright red thin and bloody. The wound tissues were very moist, drainage was on less than 25% of the dressing, and there was no odor present. Skin tear type was a partial flap (skin) loss and the flap cannot be repositioned to cover the wound. The area was cleansed and 6 steri strips applied. On 8/18/25 at 10:45 a.m., during an interview Licensed Practical Nurse (LPN) 7 indicated she had not observed any issues with the resident being combative with the staff. On 8/18/25 at 10:40 a.m., during interview Certified Nurse Aide (CNA) 6 indicated at times the resident had become a little combative but not very often and she had not had any issues providing care to the resident. On 8/18/25 at 1:17 p.m., during an interview the Regional Nurse Consultant (RNC) indicated she spoke with CNA 11. The CNA advised her she was trying to roll the resident over and tried to remove his arm from the rail. The CNA indicated she may have pulled too hard but did not cause the skin tear. The CNA informed her she was going to quit, and the CNA was no longer employed at the facility. On 8/18/25 at 1:43 p.m., during an interview CNA 8 indicated she was at the end of the bed of Resident 1's roommate. She heard a bump sound and turned around to look at Resident 1. She saw CNA 11 rip (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's arm off the side rail and slam his arm into his abdomen. She indicated CNA 11 was yelling and cussing at the resident. She heard the resident yelling out ouch that hurts, my arm, my arm. She indicated CNA 11 said Resident 1 had a skin tear and said she did not do that. CNA 8 went over to CNA 11, intervened, and advised her she would help her care for the resident. She then reported the incident to the nurse. She indicated the resident did resist care at times, but she did not observe him resisting care at that time. On 8/18/25 at 2:04 p.m., CNA 12 indicated she was in the room helping CNA 8 with Resident 1's roommate. She indicated she went to the bathroom in the residents' room. She came out and saw CNA 11 rip Resident 1's hand off the rail. CNA 11 started cussing and saying mean things to the resident. Resident 1 was saying ouch, ouch my arm, my arm. She indicated that CNA 8 intervened. CNA12 left the room to obtain a lift pad. CNA 8 then left the room to report the incident to the nurse. Resident 1 was not acting aggressive at the time. Resident 1 was blind, and they had to calmly talk to him. She indicated he was not aggressive with them. She thought he was afraid at the time because he did not usually talk much. On 8/15/2025 at 2:47 p.m., the (RNC) provided a document titled, Residents Rights, dated, and indicated it was the policy currently being used by the facility. The policy indicated, Policy. This facility shall treat each resident with respect and dignity and care for each resident in an environment that promotes maintenance of enhancement of his or her quality of life, recognizing each resident individuality. The facility shall protect and promote the rights of the resident. On 8/15/2025 at 2:47 p.m., the (RNC) provided a document titled, Abuse Prohibition, Reporting and Investigation, dated 9/2017, and indicated it was the policy currently being used by the facility.Physical abuse -includes hitting, slapping, pinching.Verbal abuse, oral.language that willfully includes disparaging and or derogatory terms to residents. 3.1-27(a)3.1-27(b)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermillion Convalescent Center	1705 S Main St Clinton, IN 47842

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the administrator was notified immediately of an allegation of abuse of 1 of 2 residents reviewed for abuse (Resident 1). Findings include:On 8/18/25 at 9:36 a.m., an allegation of abuse was reported by the Regional Nurse Consultant (RNC). Review of facility reported incident indicated an allegation of abuse was reported to IDOH on 8/16/25 at 8:40 a.m., by the facility Administrator. The report indicated Certified Nursing Aides (CNAs) 8 and 12 were caring for Resident 1's roommate in the first bed. Both CNAs saw CNA 11 at the bedside of Resident 1 in the same room, pulling Resident 1's hand off of the side rail, pushing the resident's arm into his stomach, speaking abruptly to the resident, and using profanity. The CNAs 8 and 12 immediately intervened and prevented further interaction between CNA 11 and the resident. A skin tear was noted to Resident 1's right arm. The CNA 11 responded that it was there last night and she didn't do it. However, one of the other CNAs had cared for Resident 1 the evening before and indicated there was no skin tear observed at that time. The other CNAs contacted the nurse and CNA 11 was sent home. Resident 1's Brief Interview for Mental Status (BIMS) score of 99 indicated the resident was rarely able to communicate verbally. On 8/18/25 at 9:47 a.m., the medical record of Resident 1 was reviewed. The resident was admitted to the facility on [DATE]. Admitting diagnoses included but not limited to Alzheimer's disease, chronic respiratory failure (a long-term condition where the lungs can't adequately exchange oxygen and carbon dioxide), and metabolic encephalopathy (a brain disorder caused by chemical imbalances in the body, often due to issues with organs like the liver or kidneys). A nursing progress note, dated 8/16/25 at 7:45 p.m., indicated the CNA (Certified Nurse Aide) alerted the nurse to a new skin tear on the right upper arm. The area was cleansed and steri strips applied per doctor order. The Director of Nursing (DON) and resident's family member were also notified. On 8/18/25 at 1:43 p.m., during an interview CNA 8 indicated she was at the end of the bed of Resident 1's roommate. She heard a bump sound and turned around to look at Resident 1. She saw CNA11 rip Resident 1's arm off the side rail and slam his arm into his abdomen. She indicated CNA 11 was yelling and cussing at the resident. She heard the resident yelling out ouch that hurts, my arm, my arm. She indicated CNA 11 said Resident 1 had a skin tear and said she did not do that. CNA 8 went over to CNA 11, intervened, and advised her she would help her care for the resident. She then reported the incident to the nurse. She indicated the resident did resist care at times, but she did not observe him resisting care at that time. On 8/18/2025 at 2:58 p.m., during an interview the Administrator indicated CNA 11 was sent home around 8 a.m. She indicated the incident happened around 7 a.m. CNA 11 was probably at the nurse's station playing on her phone between the time of the incident and being sent home. On 8/18/25 at 3:10 p.m., during an interview the Administrator indicated the facility called her at 8:45 a.m. She indicated CNA 11 was in the building for one and a half hours after the incident. However, she did not provide care to residents during that time. She indicated the nurse notified the nurse on call who then contacted the Social Services Director (SSD), and the SSD then called the Administrator. The Administrator indicated she was not immediately notified of the allegation of abuse. On 8/19/25 at 10:00 a.m., during an interview the SSD indicated she was notified at 8:45 a.m., by a CNA who witnessed the alleged abuse. She then notified the Administrator. She indicated she was unsure if the Administrator should be notified first. On 8/15/2025 at 2:47 p.m., the (RNC) provided a document titled, Abuse Prohibition, Reporting and Investigation, dated 9/2017, and indicated it was the policy currently being used by the facility.Physical abuse -includes hitting, slapping, pinching.Verbal abuse, oral.language that willfully includes disparaging and or derogatory terms to residents.If resident abuse, or suspicion of abuse is reported.2. The individual who witnessed the incident or who was informed of the allegation shall immediately notify a charge nurse assigned to the unit on which the resident resides.3. The charge (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse is responsible to notify the facility administrator and Director of Nursing immediately.4. Any facility personnel implicated in the alleged abuse shall be removed from resident care. 3.1-28(c)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure fingernail care was provided for 1 of 24 residents reviewed for activities of daily living (ADLs) (Resident 23). Findings include: On 8/13/25 at 11:13 a.m., Resident 23's fingernails on the right hand were observed to be long and jagged with dark debris underneath them. On 8/14/25 at 10:12 a.m., Resident 23 was observed up in his wheelchair. The resident's fingernails on the right hand remained long and jagged with dark debris underneath them. On 8/15/25 at 1:49 p.m., Resident 23 was observed lying in bed. The resident's fingernails on the right hand remained long and jagged with dark debris underneath them. On 8/18/25 at 9:12 a.m., Resident 23 was observed up in his wheelchair. The resident's fingernails on the right hand remained long and jagged with dark debris underneath them. Resident 23's record was reviewed on 8/18/25 at 9:26 a.m. Diagnoses on the resident's profile included, but were not limited to, cerebral infarction (brain tissue death due to lack of blood supply) unspecified and hemiplegia (paralysis or severe weakness on one side of the body) affecting left side. A quarterly Minimum Data Set (MDS) assessment, dated 7/9/25, indicated the resident had a moderate cognitive impairment, functional limitation in range of motion, and required partial/moderate assistance for personal hygiene. The assessment did not indicate the resident refused care. Progress notes, dated 7/19/25 to 8/18/25, lacked documentation the fingernail care was offered, provided, or refused. Shower sheets indicated the resident received a shower on 7/2/25, 7/6/25, 7/10/25, 7/23/25, 7/27/25, 7/30/25, 8/3/25, 8/6/25, 8/10/25, 8/13/25, and 8/17/25. The shower sheets lacked documentation fingernail care was offered, provided, or refused. A care plan, initiated on 7/22/25, indicated the resident required assistance of one or two staff members with ADLs. Interventions included, but were not limited to, nail care as needed. During an interview, on 8/18/25 at 11:23 a.m., Certified Nurse Aide (CNA) 16 indicated fingernail care should have been done as needed, and activity staff completed fingernail care at times as well. At the same time, CNA 17 indicated fingernail care should have been done with showers. If the resident refused care, it should have been documented on the shower sheets. During an interview, on 8/18/25 at 11:49 a.m., the Director of Nursing (DON) indicated she was not sure how often fingernail care should have been done, but she would check the policy. On 8/18/25 at 1:03 p.m., the DON provided a document titled, Fingernail Care, dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: Cleanliness and good grooming contribute to the dignity and self-esteem of resident. Policy: Nails should be kept short, clean, and free of rough or jagged edges. Fingernail care is provided when assigned, if fingernails appear soiled or have jagged edges, and as indicated. 3.1-38(a)(3)(E)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure they communicated effectively with the wound specialist nurse practitioner (NP) when a resident developed a new pressure ulcer and failed to ensure appropriate infection control techniques were utilized during a dressing change for 1 of 2 residents reviewed for pressure ulcers (Resident 3). Findings include:On 8/15/25 at 2:39 p.m., Licensed Practical Nurse (LPN) 10 and the Director of Nursing (DON) were observed completing Resident 3's dressing changes to the coccyx (tailbone) and right hip. LPN 10 washed her hands, donned gloves, and removed the dressings from the resident's coccyx and right hip while wearing the same gloves. LPN 10 removed her gloves and donned a new pair of gloves but did not perform hand hygiene during the glove change. LPN 10 cleansed the wound to the resident's coccyx, removed her gloves, and donned a new pair but did not perform hand hygiene during the glove change. LPN 10 applied skin prep (protective skin barrier) around the wound on the resident's coccyx, packed the wound with calcium alginate (a type of dressing that manages drainage), and covered it with a dry dressing. LPN 10 removed her gloves and retrieved a dressing from the resident's dresser bare handed for the next treatment. LPN 10 donned new gloves after retrieving the dressing but did not perform hand hygiene prior to donning the gloves. LPN 10 cleansed the wound on the resident's hip, patted it dry, and applied Medihoney (promotes wound healing by creating a moist wound environment) to the wound with a cotton swab. LPN 10 applied skin prep around the wound to the resident's right hip and covered it with a dry dressing. There was a foul odor noted during the dressing change. Resident 3's record was reviewed on 8/14/25 at 11:46 a.m. Census information indicated the resident was admitted on [DATE] and was hospitalized from [DATE] to 2/20/25. Diagnoses on the resident's profile included, but were not limited to osteomyelitis of vertebra, sacral and sacrococcygeal region and stage four (the most severe stage of a pressure injury, characterized by full-thickness skin and tissue loss extending into muscle, tendon, or bone) pressure ulcer of the sacral region. A significant change Minimum Data Set (MDS) assessment, dated 5/6/25, indicated the resident had a severe cognitive impairment, was dependent for activities of daily living (ADLs), and received pressure ulcer care. A nursing progress note, dated 7/3/24, indicated the resident was admitted to the facility with a stage two (partial thickness tissue loss, shallow open ulcer) pressure ulcer to the coccyx. A care plan, initiated on 7/3/24, indicated the resident had a stage two pressure ulcer to the coccyx. Interventions included, but were not limited to, treatment as ordered. A care plan, initiated 7/15/24, indicated the resident was at risk for pressure ulcer development. A nursing progress note, dated 7/17/24 indicated the stage two pressure ulcer to the resident's coccyx was healed. A Braden scale (assessment to determine pressure ulcer risk), dated 11/19/24, indicated the resident was at moderate risk for pressure ulcer development. A nursing progress note, dated 1/23/25, indicated the resident had a deep tissue injury (DTI) (damage to underlying soft tissues due to prolonged pressure and shearing) to the inner coccyx. The physician was notified, and a treatment was ordered. The note lacked documentation the contracted wound company was notified of the new wound. A wound management detail report, dated 1/23/25, indicated the resident had an unstageable DTI to the coccyx which measured 3 centimeters (cm) in length, 3.5 cm in width, and no depth. A care plan, initiated 1/23/25, indicated the resident had a pressure ulcer to the coccyx. Interventions included, but were not limited to, the resident was to be treated by the contracted wound management company. A nursing progress note, dated 1/24/25, indicated there was redness radiating down the resident's right buttock from the wound base. The area was tender to touch. The physician was notified, and an antibiotic was ordered. The noted lacked documentation the contracted wound company was notified of the wound changes and the antibiotic orders. A physician's order, dated 1/24/25, indicated ceftriaxone (antibiotic) one gram (gm) injected one time only for a localized skin and tissue infection. A physician's order, dated 1/24/25, indicated cephalexin (antibiotic) 250 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	milligrams (mg), 1 capsule by mouth 4 times daily for 7 days for a localized skin and tissue infection. An NP progress note from the contracted wound company, dated 1/29/25, indicated the facility requested the resident be evaluated for a new wound on the coccyx. The staff reported the resident had increased weakness and was ill which resulted in decreased mobility. The Director of Nursing (DON) reported the Medical Director was aware of the resident's decline. The NP noted an unstageable wound to the coccyx with surrounding redness, which measured 3.5 cm in length, 7 cm in width, and 0.1 cm in depth. The resident stated the area was painful. The NP discussed concerns regarding possible cellulitis (skin infection)/infection/osteomyelitis and the resident's high risk for sepsis (infection moving into bloodstream). The NP recommended an x-ray and wound culture and if any increased redness to the buttocks, fever, or chills were noted the medical director should have been notified and a transfer to the hospital for evaluation considered. The note lacked documentation the contracted wound company's NP was notified the resident's physician ordered antibiotics on 1/23/25. X-ray reports, dated 1/30/25, indicated x-rays of the lumbar (lower) spine, bilateral hips, and pelvis were completed due to pain and a DTI to the sacral region. The reports indicated osteoarthritic and degenerative disc changes. An NP progress note from the contracted wound company, dated 2/5/25, indicated the resident was followed for the unstageable wound on the coccyx. The redness on the right buttock was almost resolved. The wound was cleaner, had continued adhered sloughing (non-viable tissue to the wound bed), and remained unstageable. No odor was noted. The wound measured 3.5 cm in length, 4.5 cm in width, 0.1 cm in depth. The resident had increased pain and was unable to tolerate much debridement of the wound. The note lacked documentation the NP was notified the resident's physician ordered antibiotics on 1/23/25, the results of the ordered x-rays, or any information regarding the recommended wound culture. An NP progress note from the contracted wound company, dated 2/12/25, indicated the resident was followed for the unstageable wound to the coccyx. The Assistant Director of Nursing (ADON) reported the resident's wound was not improved. The resident complained of increased pain and yelled out when the wound was evaluated. There was a large amount of malodourous (foul smelling) purulent (thick, opaque drainage usually indicative of an infection) brown drainage from the wound. The wound bed was covered with thick, green/yellow sloughing. Induration (hardening of tissue) was noted to the right inner buttock. The NP recommended the resident be transferred to the Emergency Department (ED) for evaluation, intravenous (IV) antibiotics, wound culture, possible surgical debridement, and wound vac (a medical device which provided negative pressure promoting wound healing) placement. The wound measured 3.5 cm in length, 4.5 cm in width, and 1.3 cm in depth. The note lacked documentation the NP was notified the resident had already received antibiotics or any information regarding the previously recommended wound culture. The resident's record lacked documentation the wound culture was completed or a rationale for declining the wound culture after it was recommended by the wound NP, on 1/29/25, prior to the resident's hospital transfer on 2/12/25. Hospital documentation, dated 2/20/25, indicated the resident had a large unstageable pressure ulcer, covered with necrotic (dead) tissue, and foul smelling, to the sacral region. After debridement (medical/surgical procedure to remove dead tissue from a wound bed), the wound required wound vac therapy. The resident's discharge diagnosis was sacral wound with osteomyelitis. A nursing progress note, dated 2/20/25, indicated the resident returned from the hospital, after surgery to debride the wound and open up wound tunneling (tracts that extend from the main wound surface into deeper layers of tissue, creating passageways beneath the skin). Wound vac therapy was to be initiated once it arrived, and the resident had a peripherally inserted central catheter (PICC) line (used to give long-term IV medications) to the right upper chest. A nursing progress note, dated 2/24/25, indicated the resident continued on IV antibiotics. During an interview, on 8/13/25 at 3:26 p.m., the resident's family member indicated the resident developed a pressure ulcer that required surgical debridement. The surgical debridement left a very large open area. The wound developed at the facility. During an interview, on 8/15/25 at 12:23 p.m., the contracted wound company NP indicated if she was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspicious of osteomyelitis and an x-ray came back negative, then she would have probably recommended magnetic resonance imaging (MRI) (a non-invasive medical imaging technique that uses strong magnetic fields and radio waves to create detailed images of the body's internal structures). She was not able to see a lot of the chart if the records were on paper. If she really needed to see something, she would have had to request it. She checked her notes to see if she was aware of the x-ray results or if the wound culture was completed but was unable to find documentation. The NP indicated if she was notified of test results or an issue with obtaining a recommended test, then she would have noted it in her assessment notes. If it was not included in her notes, then she was not notified. If she had received a wound culture report, she likely would have recommended an oral antibiotic. The residents experienced a progressive decline, but the wound stabilized overall. During an interview, on 8/15/25 at 2:33 p.m., the Regional Nurse Consultant indicated she was not able to find any documentation the recommended wound culture was completed, but the resident was on an antibiotic around that time. During an interview, on 8/15/25 at 3:03 p.m., the DON indicated hand hygiene should have been completed between each glove change during the resident's dressing change. She was not sure if LPN 10 had hand sanitizer with her for the dressing change. She was not sure if the dressings could be removed from both wounds without changing gloves and completing hand hygiene. During an interview, on 8/15/25 at 3:11 p.m., the Regional Nurse Consultant indicated the resident's physician may not have wanted the wound culture at that time because the resident received antibiotics. She was unable to find documentation to support this. On 8/15/25 at 3:15 p.m., the Regional Nurse Consultant provided a document titled, Dressing-Clean Technique, dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: A clean dressing technique is used to provide an appropriate environment conducive to wound healing. Policy: All dressings are performed by licensed personnel per physician's order using clean technique unless another technique is specified by the physician.Procedure.2. Remove soiled dressing and discard into designated waste receptacle. 3. Remove gloves, wash hands, and put on a pair of clean gloves. 4. Cleanse wound with solution as specified by physician. 5. Apply dressing as specified by physician, touching only outer part of dressing. Remove gloves. On 8/18/25 at 1:03 p.m., the DON provided a document titled, Pressure Ulcers, dated October 2014, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To assure that residents with pressure ulcers will receive necessary care and treatment to promote healing, prevent new ulcers from developing and prevent infection. Policy: Pressure ulcers will be assessed and treated according to the Skin Management Program. Pressure Ulcer Definitions.Stage IV-Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or support structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers. 3.1-40(a)(1)

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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. Based on observation, record review, and interview, the facility failed to ensure a indwelling urinary catheter (catheter; a tube inserted into the bladder through the urethra to drain urine) was kept from touching the floor, for 1 of 2 residents reviewed for urinary catheters (Resident 73).Findings include: During a random observation, on 8/13/25 at 3:22 p.m., the resident was observed sitting in his wheelchair in the activity room. His catheter bag (bag where urine was collected) was covered with a cloth covering and was in contact with the floor. During a random observation, on 8/15/25 at 11:03 a.m., the resident was observed sitting in his wheelchair at the activity room table. The catheter bag was covered with a cloth covering and the tubing was in contact with the floor. Resident 73's record was reviewed on 8/14/25 at 11:43 a.m. The profile indicated the resident's diagnoses included, but were not limited to, infection and inflammatory reaction due to indwelling urethral catheter (germs have entered the urinary tract through the catheter, causing an infection), urinary tract infection (a common infection that occurs when bacteria enters and multiplies within the urinary tract), and neuromuscular dysfunction of bladder, unspecified (also called neurogenic bladder; when the bladder and the nerves that control it aren't communicating properly).A significant change Minimum Data Set (MDS) assessment, dated 7/15/25, indicated the resident had severe cognitive deficit and required an indwelling urinary catheter.A care plan, dated 7/28/25, indicated the resident required a Foley (brand name) catheter due to neurogenic bladder and was at risk for infection. Interventions included, but were not limited to, position catheter tubing and catheter bag in such a way to avoid contact with the floor. During an interview, on 8/15/25 at 11:03 a.m., Certified Nursing Assistant (CNA) 4 indicated a catheter bag and/or the tubing should never be allowed to touch the floor as it was an infection risk. During an interview, on 8/15/25 at 2:30 p.m., the Director of Nursing (DON) indicated catheter bags, or the tubing should be kept from contact with the floor. On 8/15/25 at 2:30 p.m., the DON provided a document, with a revision date of 1/2020, titled, Urinary Drainage Bag Maintenance, and indicated it was the policy currently being used by the facility. The policy indicated, .Rule: .Urinary drainage bag should not be allowed to touch the floor .Use the Following Procedure to Secure the Drainage Bag: .2 .Do not allow the urinary drainage bag or tubing to touch the floor 3.1-41(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure Aplisol (solution used to test for previous exposure to tuberculosis) solution was disposed of once past the use by date during 1 of 2 medication room observations. Findings include:On 8/15/25 at 2:00 p.m., the south medication room was observed with Licensed Practical Nurse (LPN) 7. An opened vial of Aplisol was in the refrigerator with an opened date of 6/30/25. At the same time LPN 7 indicated she was not sure how long Aplisol could be used after being opened. During an interview, on 8/15/25 at 3:11 p.m., the Regional Nurse Consultant indicated Aplisol could be used for 30 days after opening and then it should have been disposed of. On 8/15/25 at 3:15 p.m., the Regional Nurse Consultant provided a document titled, Aplisol, last revised in November 2013, and indicated it was the policy currently being used by the facility. The policy indicated, .Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. 3.1-25(o)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow antibiotic stewardship protocol program for 1 of 24 residents reviewed for antibiotic use (Resident 26). Findings include:During an interview, on 8/13/25 at 2:39 p.m., Resident 26 indicated she had been on a prophylactic for a while due to her getting urinary tract infections in the past. Resident 26's record was reviewed on 8/18/25 at 9:50 a.m. The profile indicated the resident's diagnoses included, but were not limited to, urinary tract infection (UTI- an infection in any part of the urinary system), acute kidney failure (sudden and rapid decline in kidney function), and dysuria (painful or uncomfortable urination). A significant change Minimum Data Set (MDS) assessment, dated 7/9/25, indicated Resident 26 was cognitively intact and had received an antibiotic medication. A physician order, dated 4/1/25 with no stop date, indicated to administer Macrobid (antibiotic) 100mg (milligram) one capsule by mouth at bedtime for UTI maintenance dose prophylactic. A care plan, dated 7/21/25, indicated the resident had urinary incontinence. Interventions, included but were not limited to, encourage adequate fluid intake and monitor for signs and symptoms of infection. The record lacked documentation of a care plan for prophylactic antibiotic use. Review of history and physical documentation, dated 4/29/25, indicated Resident 26 was to continue Macrobid for UTI prophylaxis. The record lacked any recent urinalysis lab work ordered. The medical record indicated the resident had been on the prophylactic antibiotic since her admission date of 4/1/25. The record lacked documentation that the physician had assessed the resident to determine the need for prophylactic long-term use of an antibiotic and lacked evidence that the physician had educated the resident and or responsible party regarding the long-term use of antibiotics. During an interview, on 8/18/25 at 12:00 p.m., the Director of Nursing (DON) indicated Resident 26 sees a urologist and had been on the prophylactic antibiotic since before her admission to the facility. She was aware that prophylactic antibiotic use long term can cause antibiotic resistance. During an interview, on 8/18/25 at 3:17 p.m., the Infection Prevention (IP) nurse 3 indicated the facility utilized Mcgreers criteria a surveillance tools for infections in the long-term care facility. During an interview, on 8/19/25 at 9:10 a.m., the DON indicated Resident 26 was placed on the prophylactic antibiotic due to chronic urinary tract infections. She further indicated the facility had not performed a urinalysis (a laboratory test that examines a urine sample for various physical, chemical, and microscopic characteristics) since the resident was admitted to the facility on [DATE]. On 8/18/25 at 10:30 a.m., the Regional Nurse Consultant (RNC) provided a document with a revised date of 6/18, titled, Antibiotic Stewardship Program (ASP), and indicated it was the policy currently being used by the facility. The policy indicated, .According to the CDC (Center for Disease Control), improving the use of antibiotics in healthcare to protect patients and reduce threat of antibiotic resistance is a national priority.It is the policy of the facility to implement an Antibiotic Stewardship Program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. The policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety.