STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munster Med-Inn	7935 Calumet Ave Munster, IN 46321

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview the facility failed to implement measures to prevent resident-to-resident verbal and physical abuse to a cognitively impaired dependent resident (Resident C) by his roommate (Resident B), who had a history of behaviors and recent verbal abuse toward Resident C, resulting in a physical altercation where Resident B struck Resident C in the face causing observed bruising, a bloody nose and swelling to his left jaw and cheek as well as facial fractures for 2 of 8 residents reviewed for abuse. The immediate jeopardy began on 12/11/25 when a resident with a history of known physical and verbal behaviors was involved in a resident-to-resident verbal altercation with his roommate, which later escalated on a different day into a resident-to-resident physical altercation causing harm and a fractured facial bone. The Administrator, Director of Nursing, [NAME] President of Operations, and Nurse Consultant were notified of the immediate jeopardy at 5:20 p.m. on 1/27/26. The immediate jeopardy was removed, and the deficient practice corrected on 12/29/25, prior to the start of the survey, and was therefore Past Noncompliance.Finding includes: a. The record for Resident B was reviewed on 1/22/26 at 9:40 a.m. Diagnoses included, but were not limited to, vascular dementia with behaviors, chronic kidney disease stage 4, traumatic subdural hemorrhage (brain bleed), hemiplegia (weakness) on the right side, delusional disorder, intellectual disabilities, psychotic disorder with delusions, and anxiety.The 9/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had no behaviors and was moderately impaired for daily decision making. A Behavior Note, dated 10/9/25 at 10:46 a.m., indicated the resident was observed ambulating around his room without assistance. The staff responded to the resident and tried to assist him to the wheelchair, as he became verbally aggressive with staff, yelling and threatening them. A Behavior Note, dated 10/15/25 at 3:37 a.m., indicated the resident got out of bed again. While attempting to assist him back to bed, he grabbed the staff's wrist and squeezed it hard. A Behavior Note, dated 10/16/25 at 1:57 p.m., indicated the resident was sitting in the dining room and started yelling aggressive words across the room. A Behavior Note, dated 11/3/25 at 9:18 a.m., indicated the resident was being pulled up in bed by 2 CNAs and spit on both. The Annual MDS assessment, dated 11/12/25, indicated the resident was moderately impaired for decision making. The resident had little interest in doing things, felt down and tired, and had trouble concentrating. The resident had not displayed any hallucinations or delusions, but had physical, verbal and other behaviors that occurred in the last 1 to 3 days during the assessment reference period. The resident's behaviors significantly interfered with care and activities and had an impact on others of significant risk of physical injury, disruption of care and the living environment. The resident's behaviors had worsened since last assessment, and he needed substantial to max assist with transfers. The resident received antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. A Care Plan, revised on 11/20/25, indicated the resident displayed verbal behavioral symptoms not directed toward others as evidenced by yelling and using profanity towards self. The approaches were to separate the resident from others as needed. A Care Plan, revised on 11/20/25, indicated the resident was at risk for complications related to receiving antipsychotic medications due to behavior management. The approaches were to monitor/record occurrence of for target behavior symptoms (Specify: pacing, (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. A contracted Behavioral Nurse Practitioner (NP) note, dated 11/5/26 at 11:00 p.m., indicated they received a call from social service regarding the resident and he continued to exhibit more agitated behaviors and fluctuation in mood. The medication of Depakote (an anticonvulsant used for mood disorders) would be restarted as it was previously discontinued as part of a gradual dose reduction. A Behavior Note, dated 11/6/25 at 11:21 a.m., indicated the resident was observed spitting on staff during care. A Behavior Note, dated 11/28/25 at 3:45 p.m., indicated the resident was observed in activities. At that time, he started to yell an outburst about killing. The resident was moved to a different seat but the outbursts and yelling continued. He was moved to the hallway. There was no other documentation or interventions done after the resident had the outburst about killing. A Medication Administration note, dated 12/3/25 at 11:12 p.m., indicated the resident was yelling at roommate while roommate was sleeping, prn (as needed) Lorazepam (an antianxiety medication) 0.5 milligrams (mg) given for agitation and anxiety. A Medication Administration note, dated 12/5/25 at 1:28 a.m., indicated the resident was yelling at roommate, prn Lorazepam 0.5 milligrams given for agitation and anxiety. A Behavior Note, dated 12/11/25 at 2:38 a.m., indicated, Writer heard resident yelling, went in to check on resident. Resident was standing up hovering over roommate yelling. CNAs and writer assisted resident back into bed, PRN lorazepam given. Resident in bed relaxing, safety measures in place. There were no additional interventions put into place and Resident B was not moved to another room after he was observed yelling and hovering over Resident C on 12/11/25. An Incident Note, dated 12/28/25 at 11:10 p.m., indicated Resident was involved in a physical altercation with his roommate. Residents were separated and body assessment completed. [Resident B] has no injuries. Resident was placed on 1:1 supervision. Resident sister and MD were notified and orders received to transfer resident to emergency room for psych evaluation. Report called in to ER nurse. (sic) A Nurses' Note, dated 12/29/25 at 2:42 p.m., indicated Resident B would be transferred to a neuro psych hospital by ambulance in 30 minutes. The facility IDOH (Indiana Department of Health) incident report, dated 12/28/25, indicated Resident B and Resident C were in a physical altercation, both were immediately separated. The nurse assessed Resident C and he was noted with facial bruising/discoloration and some bleeding from his nose. Resident B had no injuries; however, both residents were sent to the emergency room. The police, physician, and family were all notified. The follow up investigation indicated both residents resided in the memory care unit and were roommates. The incident was not witnessed, however upon entering the room the CNA observed Resident B to have blood on his clothing and Resident C had blood around his nose with redness and discoloration to the side of his face. Resident C could not initially articulate what had happened, however, upon re-questioning, admitted something had occurred but indicated his roommate did not want to speak about it. Review of the facility's investigation indicated all staff on shift at the approximate time of the incident were interviewed. It was determined that staff provided care to both residents at approximately 9:45 p.m., and both residents were resting quietly in bed. At approximately 11:10 p.m., the CNA was doing initial rounds after shift change and found the residents in the above-mentioned condition. Both residents were sent to the hospital, and Resident C sustained a depressed fracture involving the anterior wall of the left maxilla (upper jawbone) and associated maxillary hemorrhage (bleeding). He returned to the facility that day, and Resident B was transferred to an inpatient neuro psych facility. A facility documented interview from CNA 1 indicated changed both of them on 8 am and 8:30 pm, had a family emergency and had to leave around 10:30 pm, heard loud yelling from a male voice stating something like turn off the light I did not know who it was and I was in the lounge area did not think anything of it due to residents yelling all the time. (sic)A facility documented interview from LPN 1 indicated I started working that side about 8 pm when other nurse left. Did not see much of them during the shift. Right at shift change Resident B yelled out something but I could not make out what happened, it was like jibberish [sic]. He was in his room. I am not sure if the aide went to his room, but I did not. I (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	never saw him display any aggressive behavior toward staff for residents. The other nurse gave his meds. I was in the hallway around 10 pm. There were still residents up in the dining room, so we were getting them together to go to bed. Resident B is known to yell out. The police report, dated 12/28/25 at 11:19 p.m., indicated responded to call from the facility in reference to assault that just occurred. They called stated that one of the residents attacked his roommate. The victim was observed laying [sic] in bed with a bloody face and multiple bruises and swelling to the face and mouth area. He was unaware of what happened due to reported dementia . The incident occurred between 10 p.m. and 11 p.m.A CAT scan (diagnostic imaging test using X-rays and a computer to create detailed 3D pictures of bones, organs, and tissues) of the facial bones was completed at the hospital for Resident C on 12/29/25. The impression was 6 mm (millimeter) depressed fracture involving the anterior wall of the left maxilla (upper jawbone/cheek) with associated maxillary hemorrhage (bleeding). b. The record for Resident C was reviewed on 1/27/26 at 12:05 p.m. Diagnoses included, but were not limited to, dementia, anxiety, and Alzheimer's Disease. The 11/14/25 Quarterly MDS assessment indicated the resident was not cognitively intact for daily decision making and needed substantial to max assist with ADLs. During an interview on 1/27/26 at 2:00 p.m., the Director of Nursing indicated she was not aware of the incident that happened on 12/11/25. She indicated staff were to report to her or the Administrator of any new or worsening behaviors. During an interview on 1/27/26 at 2:00 p.m., the Nurse Consultant indicated she was unaware of the incident that happened on 12/11/25 as well and staff were to report any new behaviors a resident exhibited. The behavior policy had not changed, and it was the same one in place when both incidents happened. Staff were inserviced regarding behavior reporting during all staff meetings and were also assigned some computer training. There was no 5th Floor Unit Manager during both incidents and the unit managers on floors one through four were all overseeing some aspect of resident care for the fifth floor. The Memory Care Director was also to oversee behaviors. During an interview on 1/27/26 at 2:20 p.m., the Memory Care Director indicated she was not aware of the incident on 12/11/25 when Resident B was observed yelling and hovering over Resident C in their room. She indicated staff were to let her know of any type of behavior any of the residents displayed. During an interview on 1/28/26 at 3:30 p.m., CNA 1 indicated she was taking care of Resident B and Resident C on 12/28/25. She told the nurse she received many phone calls from home and had to leave early at 10:30 p.m., due to a family emergency. It was her first time working on the memory care unit, so she was not familiar with any of the residents. She was told by other staff that Resident B yells out all the time. She checked on all her residents before she left and that was before 10:00 p.m. She was in the lounge (located right across from Residents B and C's room) on the phone with her family and she heard Resident B yelling, however, the nurses were in the hallway, so she did not feel she had to get up and check on him, because they were standing right there, so she remained on the phone with her family dealing with the emergency. The current 12/31/24 Behavior Management policy, provided by the Assistant Administrator on 1/27/26 at 9:00 a.m., indicated when a resident exhibited behaviors, it was the responsibility of the staff member that witnessed the behavior to report it to the resident's care staff and document the behavior accordingly. If the behavior was disruptive to others, the resident should be temporally separated from others.The current 9/1/24 Abuse Prevention and Reporting policy, provided by the Assistant Administrator on 1/27/26 at 9:00 a.m., indicated the resident had the right to be free from abuse and neglect. Any incident or allegation involving abuse or neglect will result in an investigation and should be documented. All alleged violations involving abuse or neglect were reported to the Administrator immediately but not later than two hours after the allegation was made. The past noncompliance immediate jeopardy began on 12/11/25. The immediate jeopardy was removed and the deficient practice corrected by 12/29/25 after the facility implemented a systemic plan that included the following actions: The facility immediately put a plan of correction into place and had a quality assurance meeting with the department heads. All staff were then inserviced on the different types of abuse and reporting abuse. Staff were also inserviced on the behavior management program for any (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident with new or worsening behaviors and when and who to report those behaviors. The residents were separated and Resident B returned to a private room on a different floor. This citation relates to Intakes 2698383, 2704995, 2705043, and 2710478.3.1-27(a)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility staff failed to report resident-to-resident verbal abuse from a resident with known behaviors (Resident B) towards his roommate (Resident C) to administration, which resulted in a lack of interventions to prevent later physical abuse for 2 of 8 residents reviewed for abuse. (Residents B and C) The immediate jeopardy began on 12/11/25 when a resident with a history of known physical and verbal behaviors was involved in a resident-to-resident verbal altercation with his roommate, which later escalated on a different day into a resident-to-resident physical altercation causing harm and a fractured jawbone. The Administrator, Director of Nursing, [NAME] President of Operations, and Nurse Consultant were notified of the immediate jeopardy at 5:20 p.m., on 1/27/26. The immediate jeopardy was removed, and the deficient practice corrected, on 12/29/25, prior to the start of the survey and was therefore Past Noncompliance. Finding includes:The record for Resident B was reviewed on 1/22/26 at 9:40 a.m. at 9:40 a.m. Diagnoses included, but were not limited to, vascular dementia with behaviors, chronic kidney disease stage 4, traumatic subdural hemorrhage (brain bleed), hemiplegia (weakness) on the right side, delusional disorder, intellectual disabilities, psychotic disorder with delusions, and anxiety.The 9/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had no behaviors and was moderately impaired for daily decision making. The Annual MDS assessment, dated 11/12/25, indicated the resident was moderately impaired for decision making. The resident had little interest in doing things, felt down and tired, and had trouble concentrating. The resident had not displayed any hallucinations or delusions, but had physical, verbal and other behaviors that occurred in the last 1 to 3 days during the assessment reference period. The residents' behaviors significantly interfered with care and activities and had an impact on others of significant risk of physical injury, disruption of care and the living environment. The resident's behavior had worsened since last assessment, and he needed substantial to max assist with transfers. The resident received antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. A Care Plan, revised on 11/20/25, indicated the resident displayed verbal behavioral symptoms not directed toward others as evidenced by yelling and using profanity towards self. The approaches were to separate the resident from others as needed. A Care Plan, revised on 11/20/25, indicated the resident was at risk for complications related to receiving antipsychotic medications due to behavior management. The approaches were to monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. A Medication Administration note, dated 12/3/25 at 11:12 p.m., indicated the resident was yelling at roommate while roommate was sleeping, prn Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) given for agitation and anxiety. A Medication Administration note, dated 12/5/25 at 1:28 a.m., indicated the resident was yelling at roommate, prn Lorazepam 0.5 milligrams (mg) given for agitation and anxiety. A Behavior Note, dated 12/11/25 at 2:38 a.m., indicated Writer heard resident yelling, went in to check on resident. Resident was standing up hovering over roommate yelling. CNAs and writer assisted resident back into bed, PRN lorazepam given. Resident in bed relaxing, safety measures in place. There were no new interventions, and Resident B was not moved to another room after he was observed yelling and hovering over Resident C. There were no documented notifications to the Director of Nursing, Administrator or charge nurse or interventions implemented after all the above incidents. Both residents remained in the same room. An Incident Note, dated 12/28/25 at 11:10 p.m., indicated Resident was involved in a physical altercation with his roommate. Residents were separated and body assessment completed. [Resident B] has no injuries Resident was placed on 1:1 supervision. Resident sister and MD were notified and orders received to transfer resident to emergency room for psych evaluation. Report called in to ER nurse. (sic) Per the facility investigation, Resident C was (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sent to the hospital and diagnosed with a depressed fracture involving the anterior wall of the left maxilla (upper jawbone) and associated maxillary hemorrhage (bleeding).Cross reference F600. During an interview on 1/27/26 at 2:00 p.m., the Nurse Consultant indicated she was unaware of the incident that happened on 12/11/25 as well and staff were to report any new behaviors a resident has. The behavior policy had not changed, and it was the same one in place when both incidents happened. Staff were inserviced regarding behavior reporting during all staff meetings and had additional computer training. There was no 5th Floor Unit Manager during both incidents and the unit managers on floors one through four were all overseeing some aspect of resident care for the fifth floor. The Memory Care Director was also to oversee behaviors. During an interview on 1/27/26 at 2:20 p.m., the Memory Care Director indicated she was not aware of the incident on 12/11/25 when Resident B was observed yelling and hovering over Resident C in their room. She indicated staff were to let her know of any type of behavior any of the residents displayed. During an interview on 1/28/26 at 6:13 a.m., LPN 2 indicated she was the nurse on duty 12/11/25 and was taking care of both residents. The resident yelled all the time, so that was nothing new, however, she did not report that Resident B was observed hovering over Resident C's bed and yelling at him to anyone. At that time, there was no 5th floor unit manager. During an interview on 1/28/26 at 7:18 a.m., RN 1 indicated she was primarily the full time day shift nurse on the fifth floor (memory care unit). She was unaware of the incident that took place on 12/11/25 between Resident B and Resident C. There was supposed to be an end of shift report given to the oncoming nurse so if there were any new or worsening behaviors a resident had exhibited, it should have been passed down to the next shift so they would be able to monitor them. During an interview on 1/28/26 at 11:30 a.m., Nurse Consultant 1 indicated a behavior management meeting was held monthly with the NP from the contracted behavioral center, the pharmacist, the Memory Care Director, some of the nurse managers and the Director of Nursing. They primarily discuss GDR (gradual dose reduction) actions for residents and would review behaviors. She was unsure if the resident was reviewed after the 12/2025 incidents. The current 12/31/24 Behavior Management policy, provided by the Assistant Administrator on 1/27/26 at 9:00 a.m., indicated when a resident exhibited behaviors, it was the responsibility of the staff member that witnessed the behavior to report it to the resident's care staff and document the behavior accordingly. If the behavior was disruptive to others, the resident should be temporally separated from others.The past noncompliance immediate jeopardy began on 12/11/25. The immediate jeopardy was removed and the deficient practice corrected by 12/29/25 after the facility implemented a systemic plan that included the following actions: The facility immediately put a plan of correction into place and had a quality assurance meeting with the department heads. All staff were then inserviced on the different types of abuse and reporting abuse. Staff were also inserviced on the behavior management program for any resident with new or worsening behaviors and when and who to report those behaviors. This citation relates to Intakes 2698383, 2704995, 2705043, 2710478.3.1-28(c)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident assessed without limited range of motion upon therapy discharge received recommended restorative services resulting in the development of a contracture to the right hand for 1 of 4 residents reviewed for range of motion. (Resident M)Finding includes:During random observations on 1/20/26 at 12:41 p.m., on 1/21/26 at 9:12 a.m.,1/22/26 at 9:24 a.m. and 1:18 p.m., and on 1/23/26 at 8:00 a.m. and 8:17 a.m., Resident M was observed in bed. At those times, the resident's right hand was closed in the shape of a fist. The resident indicated he could not move that hand or open it. There was no anticontracture device observed in his hand. The record for Resident M was reviewed on 1/23/26 at 11:05 a.m Diagnoses included, but were not limited to, stroke, monoplegia of upper limb affecting right side and dementia. The 12/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a functional limited range of motion to his upper extremity on one side. A Care Plan, dated 12/12/25, indicated the resident was at risk for complications related to the diagnosis of a stroke. The approaches were monitor any changes, weakness, or paralysis of an extremity. An Occupational Therapy (OT) evaluation and plan of treatment for the certification period of 4/3/25 through 6/26/25 indicated the resident's right upper extremities range of motion and strength, shoulder, elbow and wrist were impaired, however there was no contracture.An Occupational Therapy Discharge summary, dated [DATE], indicated the discharge recommendations were for 24 hour care with restorative program. Restorative program for active range of motion exercises on left upper extremity and passive range of motion to right upper extremity.During an interview on 1/23/26 at 11:19 a.m., the Restorative Nurse indicated she was unaware of the recommendation for restorative therapy. When she received a paper for a restorative referral, she would then evaluate the resident to see if they were a candidate, sometimes she would pick them up and sometimes she wouldn't. During an interview on 1/23/26 at 12:06 p.m., Occupational Therapist (OT) 1 indicated Resident M did not have a contracture back in June 2025, he was seen by OT and at that time there was a referral to restorative nursing, however, he was unsure if he was picked up by restorative when released by OT. He indicated he would evaluate him today and will pick him for active therapy to see what he can do about the right hand. During an interview on 1/23/26 at 1:53 p.m. OT 1 indicated he had just evaluated the resident and picked him for a right hand contracture. During an interview on 1/27/26 at 2:00 p.m., the Director of Nursing had no additional information to provide. 3.1-42(a)(1)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to ensure the mandatory submission of staffing information, based on payroll data, was electronically submitted to iQIES. This had the potential to affect the 164 residents who resided in the facility. The deficient practice was corrected on 12/18/25, prior to the start of the survey, and was therefore past noncompliance. The facility identified the concern and immediately reviewed all PBJ data for the affected submission period. All previous submissions were audited and all prior submissions had been submitted and received timely. Administrative staff responsible for PBJ submission were re-educated immediately on CMS PBJ requirements and submission timelines. A standardized PBJ submission process was implemented, including monthly internal deadlines ahead of CMS due dates. All PBJ submission information will be reviewed by [NAME] President (VP) of Operations, VP of Quality Measures, and Senior HR director 15 days prior to CMS submission due date. A second audit will be completed by Senior HR director 5 days prior to CMS submission due date to ensure that all submissions are transmitted and received timely. Finding includes:Nurse Staffing information was reviewed on 1/27/26 at 10:00 a.m. The CMS Payroll Based Journal (PBJ) Staffing Data report for FY Quarter 4 2025 indicated the facility failed to submit data.During an interview on 1/27/26 at 4:20 p.m., the [NAME] President (VP) of Operations indicated he was able to pull up the submission log of PBJ for the 4th quarter for the facility. The information from iQIES indicated there was a connection error and files failed to send. He indicated Nurse Consultant 2, the Human Resource (HR) Director Consultant, and himself all sit down quarterly and go over all the schedules before submitting to iQIES. During an interview on 1/27/26 at 4:20 p.m., Nurse Consultant 2 indicated she had called iQIES on 12/17/25 and they informed her it was the facility's responsibility to make sure the PBJ was transmitted and submitted. She indicated the HR Director, the VP of Operations and herself met on 11/11/25 to finalize the 4th quarter PBJ as it was due on 11/14/25. She did not check to ensure submission had gone through.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents were assessed to self-administer medications and had Physician's Orders for the medication for 5 of 5 residents reviewed for self-administration of medication. (Residents P, 161, 155, Q and X)Findings include:1. During a random observation on 1/21/26 at 1:20 p.m., Resident P was observed in her room in bed. A bottle of Rolaids was observed on the resident's overbed table. During an interview at that time, the resident indicated she needed the Rolaids due to her stomach problems. During a random observation on 1/22/26 at 9:19 a.m., the bottle of Rolaids remained on the resident's overbed table. The record for Resident P was reviewed on 1/23/26 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, need for assistance with personal care, anxiety, and pressure ulcer of the sacral region. The Quarterly Minimum Data Set (MDS) assessment, dated 1/6/26, indicated the resident was cognitively intact. The resident did not have a care plan related to self-administering medications. A Physician's Order, dated 10/7/25, indicated the resident was to receive Calcium Carbonate (an antacid) Oral Tablet Chewable 500 milligrams (mg) give 2 tablets by mouth every 4 hours as needed for dyspepsia (indigestion). There was no physician's order for the resident to self administer the medication. A Self-Administration of Medication assessment had not been completed for the resident. During an interview on 1/23/26 at 2:58 p.m., the Third Floor Unit Manager indicated the Rolaids must have come up from the First Floor with the resident and the bottle shouldn't have been in the resident's room. 2. During a random observation on 1/20/26 at 11:11 a.m., Resident 161 was observed sitting in a chair in his room. At that time, there was a plastic medication cup with five pills sitting on the window sill. During an interview at that time, Resident 161 indicated the nurse gave him his pills while he was eating breakfast, and he told her to come back after he was finished eating. The nurse left the room with pills but came back after he was finished eating and handed him the cup and walked out of the room. He indicated he only took 5 of them at that time and left the other ones in the cup to take later. At 11:13 a.m., the 4th Floor Unit Manager and LPN 3 were called into the resident's room to observe the medication inside the cup. LPN 3 then asked the resident why he did not take the pills and he explained to her the same thing that he had indicated earlier. The record for Resident 161 was reviewed on 1/22/26 at 1:34 p.m. Diagnoses included, but were not limited to, type 2 diabetes, stroke, high blood pressure, heart disease, and dementia with moderate anxiety. The 1/7/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively (continued on next page)

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Munster Med-Inn	7935 Calumet Ave Munster, IN 46321

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact for daily decision making. There was no self-administration of medication assessment or a physician's order for the resident to self-administer his own medications. During an interview on 1/20/26 at 11:15 a.m., LPN 3 indicated she was aware she was to stay with the resident while they consume their medications. 3. During a random observation on 1/20/26 at 10:41 a.m., Resident 155 was not in her room and was in the bathroom with the door closed. At that time, there was a plastic cup with 8 pills observed on the night stand. At 10:44 a.m. the medication cup was removed and taken to the nurse's station. LPN 3 was sitting behind the counter and when the medication cup of pills was placed on the counter she looked surprised. She took the medication cup of pills back to the room where the resident was in the bathroom to administer her the medication. The record for the resident was reviewed on 1/22/26 at 1:21 p.m. Diagnoses included, but were not limited to, heart disease, anorexia, major depressive disorder, high blood pressure, and anxiety. The 12/12/25 Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A 7/30/25 Self-Administration of Medication Assessment indicated the resident could self administer medications, but did not specify which ones. There was no order for the resident to self-administer her own medication prior to 1/20/26. During an interview on 1/20/26 at 10:44 a.m., LPN 3 indicated she was aware she was to stay with the residents while they consume their medications. During an interview on 1/20/26 at 10:45 a.m., the 4th Floor Unit Manager indicated nurses were to stay with the residents while they took their medications. 4. During an interview on 1/20/26 at 11:10 a.m., Resident Q indicated many times the nurse would come in and just leave his pills in the cup on the table and leave the room, so he did not know what he was taking. The record for Resident Q was reviewed on 1/23/26 at 9:50 a.m. Diagnoses included, but were not limited to, Parkinson's disease, emphysema, dementia, dysphagia (difficulty swallowing) heart disease, high blood pressure, and, anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/25, indicated the resident was cognitively intact for daily decision making and dependent on staff for bathing and personal hygiene. There was no order for the resident to self-administer his own medications nor was there an assessment for the resident to self-administer his own medications. During an interview on 1/27/26 at 2:00 p.m., the Director of Nursing had no additional information to provide. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During observation of a medication pass on 1/22/26 at 9:53 a.m., LPN 6 placed Resident X's inhaler on her bedside table, and left the room. The resident self-administered the inhaler. At 10:00 a.m., LPN 6 returned to the resident's room, took the inhaler, and returned it to the medication cart. The resident's record was reviewed on 1/22/26 at 2:20 p.m. Diagnoses included, but were not limited to, chronic respiratory failure and blindness. The Quarterly Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was cognitively intact for daily decision making, required substantial assistance with activities of daily living (ADLs), and had severely impaired vision. A Physician's Order, dated 12/24/25, indicated albuterol sulfate inhaler (a breathing medication), 2 puffs inhaled two times a day. There was no order for self-administration. The record lacked a self-administration assessment. During an interview on 1/22/26 at 10:05 a.m., LPN 6 indicated she knew the resident was able to self-administer because she was familiar with the resident. She was not aware of a self-administration assessment. During an interview on 1/27/26 at 12:50 p.m., the DON indicated a resident needed to be assessed as safe to self-administer medications before being allowed to do so. A policy titled, Self-Administration of Medications—Clinically Appropriate, received as current from the Director of Nursing as current on 1/28/26 at 9:17 a.m., indicated, . The resident has right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. When a resident requests to self-administer medication(s), it is the responsibility of the interdisciplinary team (IDT) to determine that it is safe before the resident exercises that right. A resident may only self-administer after the IDT has determined which medications may be self-administered. 3.1-11

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to facial hair, long and dirty fingernails, bathing, greasy hair, incontinence care, providing assistance with meals and adaptive equipment for eating for 10 of 13 residents reviewed for ADLs. (Residents P, O, H, G, M, K, Q, R, L and N)Findings include:1. During an interview on 1/21/26 at 1:20 p.m., Resident P indicated that she had not had a shower since she had been admitted in October, only bed baths, and she needed her hair washed. Observation at that time, indicated the resident's hair was matted in the back. The record for Resident P was reviewed on 1/23/26 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, need for assistance with personal care, anxiety, and pressure ulcer of the sacral region. The Quarterly Minimum Data Set (MDS) assessment, dated 1/6/26, indicated the resident was cognitively intact and dependent on staff for showering and bathing. A Care Plan, dated 10/10/25 and reviewed on 12/30/25, indicated the resident had an ADL self care performance deficit related to diabetes mellitus with neuropathy (nerve damage) and her need for assistance with transfers and bed mobility. The bathing documentation report that had been completed in the Task section of the record was provided by the facility. The months of October 2025, November 2025, December 2025, and January 2026 were reviewed. The resident's first documented shower was on 1/7/26 and the next shower was documented on 1/14/26. All of the other bathing documentation indicated the resident received partial and/or complete bed baths. There was no documentation indicating the last time the resident had her hair washed. During an interview on 1/27/26 at 2:00 p.m., the Nurse Consultant indicated the resident should have received a shower prior to January 7, 2026. 2. On 1/21/26 at 10:18 a.m., Resident O was observed in her room in bed. She was observed with a heavy growth of facial hair on her chin and her fingernails were long with chipped areas of nail polish. During an interview at that time, the resident indicated she didn't like her fingernails that long and she wanted the hair on her chin removed. On 1/22/26 at 9:17 a.m. and 1:30 p.m., the facial hair remained to the resident's chin and her fingernails remained long. On 1/23/26 at 9:49 a.m. and 10:20 a.m., the facial hair remained to the resident's chin and her fingernails remained long. During an interview on 1/23/26 at 10:20 a.m., the resident indicated the staff just wash her up and get her dressed. They don't ask her if she wants her fingernails cut or her whiskers removed. The record for Resident O was reviewed on 1/22/26 at 2:39 p.m. Diagnoses included, but were not limited to, stroke, mild intellectual disabilities, and anxiety. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS) assessment, dated 11/12/25, indicated the resident was moderately impaired for daily decision making and she was dependent on staff for showering, bathing, and personal hygiene. A Care Plan, last reviewed on 11/14/25, indicated the resident was limited in functional self care performance deficit related to dementia. Interventions included, but were not limited to, the resident was dependent upon one staff for weekly showers and she required extensive assist of one staff with personal hygiene and oral care. Bathing and nail care documentation was completed in the Task section of the record and documentation from 1/10/26 through 1/22/26 was reviewed. A complete bed bath was documented as being completed on 1/10, 1/11, 1/12, 1/13, 1/14, 1/15, 1/17, 1/18, 1/19, 1/20, 1/21 and 1/22/26. No showers were documented as being completed. Nail care was documented as being completed on 1/14, 1/15, 1/17, 1/18, 1/19, 1/20, and 1/21/26. During an interview on 1/23/26 at 10:21 a.m., the Third Floor Unit Manager indicated the resident should have been asked if she wanted her facial hair removed and her nails trimmed and she would take care of it herself today. She also indicated nail care should not have been documented as complete if it wasn't done. 3. During random observations on 1/20/26 at 12:30 p.m.,1/21/26 at 10:10 a.m., on 1/22/26 at 9:20 a.m., on 1/23/26 at 9:30 a.m., and 10:50 a.m., Resident H was observed sitting in a broda chair. At those times, her hair was unkempt and matted down in the back. The record for Resident H was reviewed on 1/23/26 at 10:20 a.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, major depressive disorder, intellectual disabilities and anxiety. The resident had refused to be interviewed. The 11/8/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, dependent on staff for bathing, and needed substantial to max assist for personal hygiene. A Care Plan, revised on 6/18/25, indicated the resident had an ADL self-care performance related to stroke. There was no care plan indicating the resident refused showers, baths or having her hair washed. The CNA task section indicated the resident had a shower on 12/8 and 12/17/26. Those were the only two showers documented for all of 11/2025, 12/2025 and 1/2026. The CNA task section indicated a documented complete bed bath was completed for the resident on 11/1-11/9, 11/10-11/13, 11/17-11/19, 11/22, 11/23, 11/14, 11/26, 11/27, 12/1-12/4, 12/6-12/8, 12/11-12/14, 12/16, 12/25, 12/26, 12/30, 12/31, 1/3, 1/5, 1/6, 1/7, 1/8, 1/15, 1/13, 1/18, and 1/19/26 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The shower book indicated the resident was to receive a shower on Mondays and Thursday. There was no documentation the resident's hair was washed or the resident refused to have her hair washed or be bathed. During an interview on 1/23/26 at 2:11 p.m., CNA 3 indicated she mostly worked the 3-11 shift, and that was when the resident received her showers. The CNA indicated they have a no rinse shampoo they used for complete bed baths. During an interview on 1/27/26 at 10:20 a.m., The 4th floor unit manager had no additional information to provide. During an interview on 1/27/26 at 2:00 p.m., the Nurse Consultant indicated the documentation in the task section was not accurate regarding the difference between a partial bed bath and a complete bed bath. 4. During an interview on 1/20/26 at 12:10 p.m., Resident G indicated her hair had not been washed in a very long time and she does not get a bath or shower at least two times a week. She only gets changed for incontinence one time a shift and that was towards the end of each shift. The last time she was changed was between 3:00 a.m. and 4:00 a.m. The resident's hair was matted in the back. During an observation on 1/22/26 at 9:23 a.m., the resident was observed in bed watching television. At that time, she indicated her hair still had not been washed and she was changed for incontinence right before the shift change around 6:30 a.m. During an observation on 1/22/26 at 1:11 p.m., the resident was observed in bed and indicated she was last changed around 10:20 a.m. that morning. The resident's hair was still matted down in the back. On 1/22/26 at 2:52 p.m., CNA 2 entered the resident's room to provide incontinence care for the resident. During an interview at that time, the CNA indicated she had last changed her some time before her lunch break and could honestly not remember. The CNA donned clean gloves to both hands and removed the incontinence brief. There was a large amount of dried dark yellow urine noted inside the brief. The resident was cleaned and a new brief was placed on her. CNA 2 indicated she was aware the resident was supposed to be checked and/or changed every two hours for incontinence. The record for Resident G was reviewed on 1/22/26 at 1:47 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, left side hemiplegia (paralysis), stroke, dementia with behaviors, type 2 diabetes, high blood pressure, anemia, constipation, and urinary incontinence. The Quarterly Minimum Data Set (MDS) assessment, dated 12/17/25, indicated the resident was cognitively intact for daily decision making and was dependent on staff for bathing and personal hygiene. A Care Plan, dated 9/30/25, indicated the resident was at risk for bladder incontinence related to dementia. The approaches were to change frequently and as needed. A Care Plan, dated 10/7/25, indicated the resident required assistance with ADLs, including toileting (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and bathing, related to stroke. The approaches were to offer assist with personal hygiene and provide showers two times a week. The CNA task section under bladder incontinence indicated the resident was incontinent and was only documented two times a day on 12/24, 12/25, 12/29, 12/31/25, 1/6/26, 1/9, 1/12, 1/18 and 1/20/26. The incontinence was only checked one time a day on 1/13/26. The resident only received a complete bed bath on 11/1-11/5 12/24, 12/25, 12/29, 12/31/25, 1/2, 1/3, 1/4, 1/5, 1/6, 1/9, 1/10, 1/11, 1/15, 1/16, 1/17, 1/18, 1/19, 1/20, and 1/21/26. There was no documentation the resident had her hair washed with those complete bed baths. During an interview on 1/23/26 at 2:10 p.m., the 3rd Floor Unit Manager indicated residents were to be checked or changed every two hours and a complete bed bath meant for the resident to have their hair washed. During an interview on 1/27/26 at 2:00 p.m., the Director of Nursing had no additional information to provide. 5. During random observations on 1/20/26 at 12:41 p.m., on 1/21/26 at 9:12 a.m.,1/22/26 at 9:24 a.m. and 1:18 p.m., and on 1/23/26 at 8:00 a.m. and 8:17 a.m., Resident M was observed in bed. At those times, the resident's hair was matted with dry flakes of skin noted. His fingernails on both hands were very long and dirty with a dark substance underneath them. During an observation of the breakfast meal on 1/23/26 at 8:17 a.m., the resident was observed feeding himself with normal silverware and no other adaptive equipment. He was only able to use his left hand, as his right hand was in shape of a fist and he could not move his arm by himself. He was able to eat his oatmeal from the styrofoam bowl until he could not get the last couple of bites because the bowl started move around and eventually fell on top of his abdomen. At that time, he was able to scrape the rest of the oatmeal out of the bowl because his lower abdomen was acting as a back drop for him. During an observation 1/23/26 at 1:45 p.m., the resident was observed up and dressed sitting in a wheelchair in the dining room. At that time, the insides of both ears were dirty with a yellow residual. There were flakes of dandruff on the back of his shirt and his hair was slightly matted in the back. During an interview on 1/23/26 at 1:45 p.m., the 3rd Floor Unit manager indicated a complete bed bath meant the resident should have been washed from head to toe including hair. She was unaware the resident needed adaptive equipment to help him eat. She indicated his nails should have been clipped and cleaned as needed. The record for Resident M was reviewed on 1/23/26 at 11:05 a.m Diagnoses included, but were not limited to, stroke, monoplegia of upper limb affecting right side, dysphagia (difficulty swallowing), COPD, chronic respiratory failure, major depressive disorder, dementia, and heart failure. The 12/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, needed set up assistance with eating, and was dependent on staff for bathing and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, dated 9/29/25, indicated the resident had an ADL self-care performance deficit related to weakness and decreased physical mobility. The CNA task section for bathing indicated there was no documentation of refusals of showers or nail care. The resident received a complete bed bath on 11/1, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/9, 11/10, 11/12-11/15, 11/18, 11/19, 11/20, 11/21-11/29, 12/1-12/13, 12/15-12/24 12/25, 12/26, 12/29, 12/30, 12/31, 1/1/26, 1/3, 1/4, 1/5-1/10, 1/12, 1/13, 1/14, 1/15, 1/16, 1/19, and 1/22/26. The resident received nail care on 12/25, 12/26, 12/30, 12/31, 1/1/26, 1/3-1/10, 1/12, 1/13, 1/16, and 1/22/26. During an interview on 1/27/26 at 2:00 p.m., the Director of Nursing had no additional information to provide. 6. During a random observation on 1/23/26 at 8:07 a.m., Resident K was observed in bed with the head of the bed low and her eyes were closed. Her breakfast tray was observed on over bed table untouched. At 8:15 a.m., the breakfast tray was still observed on the over bed untouched. During an interview at that time, the 4th Floor Unit Manager was unaware the resident had not been fed. She indicated the resident did eat all meals but needed to fed. The unit manager walked to the other hall and asked CNA 4 if he had fed the resident and he indicated No not yet. CNA 3 walked down the hall and both CNA 3 and CNA 4 indicated they both arrived to work at 7:00 a.m., and they both could not recall what time the breakfast trays arrived to the floor, but the normal time was at 7:15 a.m. Both CNAs indicated the resident needed to fed. During an interview on 1/23/26 at 8:20 a.m., the 4th Floor Unit Manager indicated she arrived to work at 7:30 a.m., and the trays were coming off the elevator. During an interview on 1/23/26 at 8:30 a.m., the Dietary Food Manager indicated all the trays arrived to the floors today on time, so the 4th floor received the cart at 7:15 a.m. The record for Resident was reviewed on 1/23/26 at 3:30 p.m. Diagnoses included, but not limited to, Alzheimer's disease, type 2 diabetes, major depressive disorder, dementia, and protein calorie malnutrition. The 11/18/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed supervision or touching assistance for eating. She received hospice services. The CNA task section under eating in the last 14 days indicated the resident was coded as being dependent with 1 person physical assist with eating. During an interview on 1/23/26 at 10:50 a.m., CNA 4 indicated he was not aware that someone put her tray in the room so he did not know she needed to be fed right away. He indicated all of his residents were in bed for breakfast. During an interview on 1/27/26 at 2:00 p.m., the Director of Nursing had no additional information to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide. 7. During an interview on 1/20/26 at 11:10 a.m., Resident Q indicated his nails needed to be cleaned and trimmed. At that time, his nails were observed to be long and dirty and his hair was greasy and disheveled. During random observations on 1/22/26 at 9:14 a.m. and on 1/23/26 at 9:25 a.m., the resident was observed in bed. At those times his nails were long and dirty and his hair was greasy and disheveled. The record for Resident Q was reviewed on 1/23/26 at 9:50 a.m. Diagnoses included, but were not limited to, Parkinson's disease, emphysema, dementia, dysphagia (difficulty swallowing) heart disease, high blood pressure, and, anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/25, indicated the resident was cognitively intact for daily decision making and dependent on staff for bathing and personal hygiene. A Care Plan, revised on 11/30/24, indicated the resident had an ADL self-care performance deficit related to Parkinson's disease. There was no care plan for the resident to be only bathed on Thursdays. There was no care plan the resident refused care. The CNA task under the section bathing indicated nail care was completed on 12/25, 12/28, 12/29, 12/31/25, 1/1, 1/2, 1/3, 1/7, 1/8, 1/12, 1/13. 1/14, 1/16, 1/17, 1/19, 1/20, 1/21, and 1/22/26. There was no documentation the resident refused nail care. The CNA task under the section bathing indicated the resident received a complete bed bath on 12/25, 12/26, 12/29, 12/30, 12/31, 1/1, 1/2-1/5, 1/7, 1/10-1/15, 1/17, 1/19, and 1/21/26. The resident received a shower on 12/25, 12/29, 12/31, 1/3, 1/7, 1/8, 1/12-1/14, 1/19, 1/20, 1/21, and 1/22/26. There was no documentation the resident's hair was washed or that he refused bathing. During an interview on 1/23/26 at 2:17 p.m., CNA 3 indicated the resident was supposed to get a shower on Thursdays only. She was told there was a care plan conference and resident agreed to have a shower on Thursday only. The resident would refuse to have his hair washed and nails trimmed at times. During an interview on 1/27/26 at 10:17 a.m., the 4th Floor Unit Manager indicated a complete bed bath was whatever he allowed them to do. She was then asked what a complete bed bath meant and the unit manager indicated wash from head to toe. The unit manager indicated there was a care plan meeting and there was supposed to be a care plan that the resident only wanted a shower on Thursdays. She was unaware there was no care plan for only being bathed on Thursdays. She had no additional information to provide after being informed of all the completed bed baths and showers that were documented in the CNA task section. During an interview on 1/27/26 at 2:00 p.m., the Director of Nursing had no additional information to provide. 8. On 1/21/26 at 10:07 a.m., Resident R was observed seated in a wheelchair in his room. He was (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munster Med-Inn	7935 Calumet Ave Munster, IN 46321

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unshaven and had dried blood around the left side of his nose. He indicated he had an infection in his nose and had not received a shower yet. On 1/28/26 at 10:40 a.m., the resident was in bed. His face was unshaven. He indicated he had not received a shower since he had been at the facility. He had asked for one last week and was told he would get one next week. The resident's record was reviewed on 1/28/26. Diagnoses included, but were not limited to, cellulitis and abscess of mouth, spinal stenosis and dependence on renal dialysis. The resident was admitted to the facility on [DATE]. The Brief Interview for Mental Status, dated 1/16/26, indicated the resident was cognitively intact. The bathing tasks for January 2026 lacked documentation the resident had received a shower or bath since admission, all dates were marked not applicable. During an interview on 1/28/26 at 10:45 a.m., LPN 4 indicated the resident was scheduled for showers on Thursday and Saturday evenings. She worked days and was unable to provide additional information why they had not been given. During an interview on 1/28/24 at 10:54 a.m., the Nurse Consultant was made aware the resident had not received any showers since admission. No additional information was provided. 9. During random observations on 1/20/26 at 11:15 a.m., 1/23/26 at 9:29 a.m., and 1/23/26 at 9:40 a.m., Resident L was observed to have long facial hair. The resident's record was reviewed on 1/27/26 at 10:52 a.m Diagnoses included but were not limited to, dementia, unspecified psychosis, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, indicated the resident had moderate cognitive impairment, and required moderate assistance with ADLs. The resident's record lacked documentation of resident refusal of care. A Care Plan, revised 6/14/25, indicated the resident had an ADL self-care performance deficit. The care plan did not indicate the resident had a preference to maintain her facial hair. During an interview on 1/27/26 at 3:50 p.m., the Director of Nursing (DON) was informed of the findings, and offered no further information. 10. During random observations on 1/21/26 at 9:08 a.m., 1/22/26 at 2:50 p.m., and 1/27/26 at 9:05 a.m., Resident N was observed to have long facial hair. The resident's record was reviewed 1/28/26 at 8:34 a.m Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 12/9/25, indicated the resident had moderate cognitive impairment, and required moderate assistance with activities of daily living (ADLs). The resident's record lacked documentation of resident refusal of care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, revised 9/2825, indicated the resident had an ADL self-care performance deficit. The care plan did not indicate the resident had a preference to maintain her facial hair. During an interview on 1/27/26 at 3:50 p.m., the Director of Nursing (DON) was informed of the findings, and offered no further information. This citation relates to Intake 2704995. 3.1-38(a)(2)(A) 3.1-38(a)(2)(C) 3.1-38(a)(2)(D) 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to ensure skin tears were assessed and monitored and treatments were completed as ordered for 1 of 3 residents reviewed for non-pressure related skin conditions, interventions were in place for a resident with hypoglycemia (low blood sugar) for 1 of 1 resident reviewed for hospitalization, and medications were held without parameters for 2 of 5 residents reviewed for unnecessary medications. (Residents D, Y, X, and V)Findings include: 1.The closed record for Resident D was reviewed on 1/22/26 at 8:57 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, stroke, and allergic contact dermatitis. The Quarterly Minimum Data Set (MDS) assessment, dated 11/27/25, indicated the resident was moderately impaired for daily decision making and she required partial to moderate assistance from staff for rolling left to right and for bed to chair transfers. A Care Plan, dated 3/20/24 and reviewed on 11/28/25, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to the diagnosis of dementia and history of stroke with low back pain. Interventions included, but were not limited to, the resident required extensive assist by staff to turn and reposition in bed and to move between surfaces. A Physician's Order, dated 7/29/25 and listed as current on the December 2025 Physician's Order Summary (POS), indicated the resident was to wear geri-sleeves (protective skin covering) to the bilateral legs and arms when not wearing long pants or socks. May remove for hygiene. Ensure that resident is wearing sleeves and/or long pants or long socks every shift for skin tears. An Incident Note, dated 12/14/25 at 9:30 p.m., indicated the resident was being pushed in her wheelchair in her room to her bed by staff after being toileted. The writer had witnessed the resident hit her arm against the bed rail while being transported to her bed by the resident's assigned CNA, causing and sustaining two skin tears to the resident's right posterior upper and lower arm, along with a small abrasion to the resident's right ring finger. Orders were received to dress the wound and to monitor until healed. A Physician's Order, dated 12/14/25, indicated the resident's right upper and right lower posterior arm skin tears were to be cleansed with normal saline, pat dry, apply Xeroform (a type of non-adhering gauze dressing), dry gauze, and then wrap with kerlix daily until healed. A Wound Care Note, dated 12/15/25 at 1:28 a.m. and 2:20 p.m., indicated the resident had a new skin condition noted, there had been no reports of signs or symptoms of further injury or infection, no change in mental status or cognition, no reported change in ADL ability or mobility, and no change in orders related to the event. There was no documentation related to the skin tears in the Wound Round section of the resident's record. The December 2025 Treatment Administration Record (TAR) indicated the treatment to the resident's right arm was signed out as 9 (see nurse's notes) on 12/15 and 12/16/25. An Administration Note completed on 12/15/25 at 2:05 p.m., indicated the resident was being followed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by wound care to complete the treatment to the right upper and lower arm. The same documentation was completed on 12/16/25 at 3:55 p.m. During an interview on 1/28/26 at 3:32 p.m., the Director of Nursing (DON) indicated the nurse coded a 9 on 12/15 and 12/16/25 because she did not complete the treatment due to the Wound Nurse was supposed to complete the treatment and she thought she had to document something on the TAR. The DON also indicated an assessment of the skin tears should have been completed and documented by Wound Care. The facility policy titled Skin Condition Assessment and Monitoring Pressure and Non-Pressure was provided by the DON on 1/28/26 at 3:54 p.m. The policy indicated, A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. 3. Resident Y's record was reviewed on 1/23/26 at 2:10 p.m. Diagnoses included, but were not limited to, diabetes mellitus and congestive heart failure. The admission Minimum Data Set assessment, dated 12/20/25, indicated the resident was cognitively intact and received hypoglycemics (medications used to lower blood sugar). An Alert Note, dated 12/20/25, indicated the resident was found to be clammy and not his normal self. Oxygen was applied and blood sugar level was obtained. Blood sugar was found to be low at 47 milligrams/deciliter (mg/dl). 911 was called and resident was transferred to the hospital. There was no indication in the record the physician had been notified, or interventions had been attempted prior to transfer. An Alert Note, dated 12/20/25, indicated the resident had been admitted to the hospital with diagnosis of hypoglycemia. During an interview on 1/27/26 at 12:05 p.m., the Director of Nursing (DON) indicated a resident with hypoglycemia should be assessed, blood sugar obtained, then attempt to give carbohydrates or administer emergency glucagon (glucose). The policy Hypoglycemia Protocol, dated 4/5/25, was received from the DON and indicated, .Give some form of glucose if resident is conscious .Contact physician if blood sugar is below 60 unless there are specific call parameters .If the resident is unable to swallow not fully conscious: Notify physician and prepare glucagon from the emergency drug kit for administration . 3. During observation of a medication pass on 1/22/26 at 9:37 a.m., LPN 6 checked Resident X's blood pressure, and indicated it was 153/58. At 9:53 a.m., LPN 6 administered one tablet of each of the following medications to Resident X: allopurinol (for gout), anastrozole (for breast cancer), atorvastatin (for cholesterol), escitalopram (for depression or anxiety), folic acid (a supplement), montelukast (for asthma), linagliptin (for diabetes), and vitamin D3. No metoprolol tartrate (a medication that reduces the workload of the heart and lowers blood pressure) or amlodipine besylate (a medication that improves blood flow through the heart and lowers blood pressure) were administered. The resident's record was reviewed on 1/22/26 at 2:20 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, diabetes, breast cancer, blindness, and congestive heart failure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was cognitively intact for daily decision making, required substantial assistance with activities of daily living (ADLs), and had severely impaired vision. The January 2026 Medication Administration Record (MAR) indicated the resident was to receive metoprolol tartrate, 50 mg (milligrams) by mouth twice daily at 9:00 a.m. and 5:00 p.m., and amlodipine besylate, 10 mg every day at 9:00 a.m. There were no blood pressure parameter orders for holding either of the two medications. During an interview on 1/22/26 at 1:50 p.m., LPN 6 indicated she did not give the resident her metoprolol or amlodipine because the resident's diastolic blood pressure (bottom number of blood pressure reading) was below 60 and she did not want the resident to pass out. She indicated there were no ordered blood pressure parameters for holding either medication. During an interview on 1/27/26 at 12:50 p.m., the DON indicated a physician's order was required to hold a medication. 4. The record for Resident V was reviewed on 1/23/26 at 10:36 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) following a stroke, diabetes, and adult failure to thrive. The 12/10/25 Quarterly Minimum Data Set (MDS) indicated the resident was cognitively intact for daily decision making and was dependent in activities of daily living (ADLs) and transfers. The January 2026 Medication Administration Record (MAR) indicated the following: a. Lantus insulin, 15 units each morning, to be given daily at 6:00 a.m. The documentation box was blank on 1/16, 1/17, 1/20, and 1/21. There were no notes or orders related to the blanks. b. Entresto (a medication used to reduce the risk of cardiovascular death), 1 tab twice a day. The 5:00 p.m. dose was held on 1/1, 1/4, 1/13, 1/17, and 1/18. There were no parameters or orders for holding the medication. c. Metoprolol 12.5 mg twice a day. The 5:00 p.m. dose was held on 1/1, 1/3, 1/4, 1/12, 1/13, 1/15, 1/17, 1/18, and 1/20. The 9:00 a.m. dose was held on 1/22/26. There were no parameters or orders for holding the medication. d. Humalog (a rapid-acting insulin) sliding scale (dosed according to blood sugar level) daily at 6:00 a.m., 11:00 a.m., and 4:00 p.m. The 6:00 a.m. blood sugar and administration documentation boxes were blank on 1/16, 1/17, 1/20, and 1/21. There were no notes or orders related to the blanks. A Care Plan, revised on 6/30/25, indicated the resident required daily insulin therapy related to a diagnosis of diabetes. Interventions included administering insulin as ordered. A Care Plan, revised on 6/30/25, indicated the resident had the potential for complications related to ischemic cardiomyopathy (heart disease that leads to heart failure). Interventions included to give medications as ordered. During an interview on 1/27/26 at 3:50 p.m., the DON was informed of the findings and offered no (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	further information. This citation relates to Intakes 2698383 and 2699928. 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interview, the facility failed to ensure proper medication storage related to medications at the bedside for residents who did not self-administer medications and loose pills observed in the medication carts for 4 of 5 units. (Residents P and 145, Second, Third, Fourth, and Fifth Floors)Findings include: 1.During a random observation on 1/21/26 at 1:20 p.m., a syringe of normal saline wrapped in plastic was observed on Resident P's bedside stand. On 1/22/26 at 9:19 a.m., the syringe of normal saline remained on the resident's bedside stand. The record for Resident P was reviewed on 1/23/26 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, need for assistance with personal care, anxiety, and pressure ulcer of the sacral region. The Quarterly Minimum Data Set (MDS) assessment, dated 1/6/26, indicated the resident was cognitively intact. The resident did not have a care plan related to self-administering medications. The resident did not have a Self-Administration of Medication Assessment completed. During an interview on 1/23/26 at 2:58 p.m., the Third Floor Unit Manager indicated the resident was receiving IV (intravenous) antibiotics and the syringe of normal saline should not have been left in her room. 2. During observation of an intravenous medication administration for Resident 145 on 1/23/26 at 4:50 p.m., LPN 5 left a prefilled saline syringe in the resident's room after medication administration was complete. At that time, she indicated she thought it was ok to leave them in the room because there was no needle on them. During an interview on 1/27/26 at 3:50 p.m., the Director of Nursing (DON) indicated the syringes should not be left in the resident's room. 3. On 1/27/26 at 11:49 a.m., the 5th floor Odd Hall Medication Cart was observed with RN 1. There were 5 loose pills in the bottom of the drawers of the cart. At that time, RN 1 indicated it was the nurse's responsibility to ensure the carts were clean. 4. On 1/28/26 at 10:02 a.m., the 2nd floor Odd Hall Medication Cart was observed with LPN 7. There were 9 loose pills in the bottom of the drawers of the cart. At that time, LPN 7 indicated it was the nurse's responsibility to ensure the carts were clean. 5. On 1/28/26 at 10:13 a.m., the 3rd floor Odd Hall Medication Cart was observed with LPN 8. There were 34 loose pills in the bottom of the drawers of the cart. There was dark, sticky spillage in the bottom two drawers. At that time, LPN 8 indicated it was the nurse's responsibility to ensure the carts were clean, but sometimes the unit managers cleaned them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 1/28/26 at 10:20 a.m., the 4th floor Even Hall Medication Cart was observed with LPN 3. There were 6 pills loose in the third drawer. The bottom drawer had dark, sticky spillage with an additional 3 loose pills stuck in it. At that time, LPN 3 indicated they needed to clean out the cart drawers. A policy titled, Medication Storage, received as current from the Director of Nursing as current on 1/28/26 at 9:17 a.m., indicated, . Facility should ensure that medications and biologicals are stored in an orderly manner . Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet / cart or locked medication room that is inaccessible by residents and visitors. 3.1-25(m)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to food debris on shelves and refrigerator doors, lime build up on the outside of the dishwasher, lack of sanitation solution in the sanitizing buckets, and food not labeled and dated in the pantries located on the units for 1 of 1 kitchen and 5 of 5 units. (The Main Kitchen and the First, Second, Third, Fourth, and Fifth Floors) Findings include: 1. During the Kitchen Sanitation Tour on 1/20/26 at 9:07 a.m., with the Food Service Manager (FSM) the following was observed: a. There was dried spillage on the front door of the reach in freezer that housed the frozen health shakes. b. Two sanitation buckets registered zero parts per million (ppm) of quaternary solution.c. An accumulation of lime build up was observed on the outside of the dishwasher.d. The floor underneath the dishwasher had an accumulation of dirt and debris. e. The cabinet next to the dishwasher had food debris on the shelves. During an interview at that time, the FSM indicated the above was in need of cleaning and the sanitation buckets should have registered for chemical solution. 2. On 1/28/26 at 10:40 a.m., there was dried red juice spillage on the bottom shelf of the refrigerator located in the Third Floor Pantry. There was also a box of Kentucky Fried Chicken with no name and date, a ziplock bag of stale bread with a room number but no date, and two plastic containers of food with no name or date. 3. On 1/28/26 at 10:44 a.m., a plastic container of food was observed in the refrigerator in the Second Floor Pantry. The container had a resident's name but no date. During an interview at that time, the Second Floor Unit Manager indicated the container wasn't in the refrigerator yesterday when she cleaned and the resident's son must have brought it in last night. 4. On 1/28/26 at 10:50 a.m., a yellow substance was observed in a brown plastic bowl in the refrigerator in the Fourth Floor Pantry. The bowl was covered with plastic wrap and there was no name or date. There was a take out container with a resident's name on it but no date. 5. On 1/28/26 at 2:12 p.m., a bag of chicken wings was observed in the refrigerator of the Fifth Floor Pantry. The bag was not labeled or dated. 6. On 1/28/26 at 2:19 p.m., a take out container of soup with no name or date was observed in refrigerator 1 in the First Floor Pantry. Refrigerator 2 was observed with dried juice spillage. During an interview on 1/28/26 at 2:55 p.m., the Assistant Administrator indicated the food in the pantries were to be labeled and dated. The facility policy titled, Food Items Brought from Outside-Safe Storage was provided by the Administrator on 1/20/26 at 10:15 a.m. The policy indicated all resident foods and beverages shall be labeled with the resident's name and dated. 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to wearing gloves in the hallway, not changing gloves after providing incontinence care and bathing, not wearing personal protective equipment (PPE) in enhanced barrier precaution rooms, and failing to disinfect multi-use equipment during random infection control observations. (Resident 128 and Second and Third Floor)Findings include:1. During a random observation on 1/22/26 at 1:57 p.m., Housekeeper 1 was observed on the Second Floor wearing gloves in the hallway. She proceeded to the soiled utility room to dispose of some garbage. She continued to wear the gloves after exiting the soiled utility room. She then proceeded to the nurse's station carrying a broom and was wearing the same pair of gloves. At 2:08 p.m., the Housekeeper was pushing her cart down the odd hall and was wearing gloves. At 2:14 p.m., the Housekeeper continued to walk up and down the odd hall while wearing gloves. During an interview on 1/27/26 at 2:00 p.m., the Nurse Consultant indicated the Housekeeper should not have been wearing gloves in the hallway. 2. During a partial bed bath observation on 1/22/26 9:58 a.m., CNA 3 entered Resident 128's room and donned a pair of clean gloves to both hands. The resident was observed lying in bed and had a peg tube (a tube inserted directly into the stomach for nutrition). The enteral feeding was turned off at that time. The CNA did not don an isolation gown prior to the start of the bed bath. The CNA filled the yellow wash basin with water and soap and then removed her covers and the hospital gown. She washed her face, under her arms, and her abdomen. The CNA then unfastened the strap on her brief and rolled her over to the left side. She removed it and there was a large amount of fresh bowel movement inside the brief. CNA 3 proceeded to clean the resident's buttocks and peri area with the same water and gloved hands. After providing incontinence care and with the same gloved hands, she put deodorant under the resident's arms and put another a shirt over her head and through her arms. With the same gloved hands, she provided oral care, put ointment on her lips, brushed the resident's hair by smoothing it with her gloved hands, and then applied lotion to the resident's face and legs. At 10:24 a.m., LPN 3 entered the room and donned clean gloves to both hands. She lifted up the resident's shirt and touched the peg tube, opened the clasp, and flushed the peg tube with water. After flushing the peg tube she connected the enteral tube feeding and started the pump. LPN 3 did not don an isolation gown prior to flushing the peg tube. There was a sign located on the outside of the resident's door that indicated Enhanced Barrier Precautions. If coming in contact with the resident staff should don gloves and an isolation gown. During an interview on 1/27/26 at 10:22 a.m. CNA 3 indicated she did not wear an isolation gown and thought she only needed to wear gloves when coming in contact with a resident with a peg tube. During an interview on 1/27/26 at 10:24 a.m., LPN 3 indicated she was aware she needed to wear gown while working around or with the resident's peg tube. During an interview on 1/27/26 at 2:00 p.m., Nurse Consultant 1 had no additional information to provide. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy titled, Infection Prevention and Control Program, received as current from the Administrator as current on 1/20/26 at 10:15a.m. indicated the facility's standard precautions were to wear gloves when coming in contact with blood or body fluid. Gloves were to be changed and hand hygiene performed before moving from a contaminated body site to a clean body site during resident care. 3. During observation of a medication pass on the 3rd floor on 1/22/26 at 9:37 a.m., LPN 6 checked Resident X's blood pressure, pulse oximetry, and temperature. LPN 6 then checked the vital signs of 5 other residents on using the same equipment, without cleaning it between residents. During an interview on 1/22/26 at 10:00 a.m., LPN 6 indicated reusable equipment should be cleaned in between each resident use, but she did not clean it. During an interview on 1/22/26 at 10:50 a.m., the Infection Preventionist indicated equipment should be cleaned after each resident use. There should be disinfecting wipes on each medication cart available for use, and staff was educated at upon hire and annually, at minimum, on how to clean reusable equipment. A policy titled, Infection Prevention and Control Program, received as current from the Administrator as current on 1/20/26 at 10:15a.m. indicated, . The facility cleaning / disinfection policies include handling of equipment shared among residents (e.g., blood pressure cuffs, rehab therapy equipment, etc) . Facility has policies and procedures to ensure reusable medical devices are cleaned and reprocessed appropriately prior to use on another resident. 3.1-18(b)

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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 record review and interview, the facility failed to ensure resident's right to make choices were honored related to showers given per preference for 1 of 1 resident reviewed for choices. (Resident U)Finding includes:During an interview on 1/20/26 at 10:44 a.m., Resident U indicated he preferred to have showers but was only being given bed baths since he had a stroke. The resident's record was reviewed on 1/22/26 at 2:55 p.m. Diagnoses included, but was not limited to, multiple sclerosis, cerebral infarction and peripheral vascular disease. The Quarterly Minimum Data Set assessment, dated 12/22/25, indicated the resident was cognitively intact, had range of motion impairment to both sides and was dependent for toileting and transfers.The Quarterly Preferences for Customary Routine and Activities, dated 5/8/25, indicated it was very important to the resident to choose between a tub bath, bed bath, shower or sponge bath. The bathing tasks for November and December 2025 and January 2026 indicated the resident received one shower on 12/11/25. The remaining days he was given either a partial bed bath or a complete bed bath. There was one refusal documented on 12/21/25.During an interview on 1/27/26 at 2:40 p.m., the Unit 2 Manager indicated the resident's transfer status changed after he had a stroke and he was no longer able to sit in the shower chair. He needed to use the reclining shower chair, which was too big to fit in the shower and that was why he was being given bed baths.During an interview on 1/27/26 at 3:55 p.m., the Nurse Consultant indicated the resident was only able to use the reclining chair that did not fit in Unit 2's shower. She indicated the shower on Unit 1 was larger and would accommodate the reclining shower chair. The resident would be taken to that shower from then on.3.1-3(u)(3)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure as needed (PRN) anti-anxiety medications were not prescribed longer than 14 days. The facility also failed to ensure interventions were attempted prior to administering PRN anti-anxiety medications for 2 of 6 residents reviewed for unnecessary medications. (Residents P and B)Findings include: 1.The record for Resident P was reviewed on 1/23/26 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, need for assistance with personal care, anxiety, and pressure ulcer of the sacral region. The Quarterly Minimum Data Set (MDS) assessment, dated 1/6/26, indicated the resident was cognitively intact and she had received anti-anxiety medication within the last seven days. A Care Plan, dated 10/2/25 and reviewed on 12/30/25, indicated the resident used anti-anxiety medication related to having an anxiety disorder. A Physician's Order, dated 10/1/25, indicated the resident was to receive Xanax (an anti-anxiety medication) 0.25 milligrams (mg) every 24 hours PRN for agitation or anxiety until 11/26/25. The resident had received the Xanax 37 times during that time frame. A Physician's Order, dated 11/26/25, indicated the Xanax had been reordered and was to be administered every 24 hours PRN through 12/26/25. The resident had received the Xanax 17 times during that time frame. A Physician's Order, dated 12/27/25, indicated the Xanax had again been reordered and was to be administered every 24 hours PRN through 1/20/26. The resident had received the Xanax 13 times during that time frame. A Physician's Order, dated 1/27/26, indicated the resident was to receive the PRN Xanax every 24 hours for anxiety or restlessness. During an interview on 1/28/26 at 3:00 p.m., the Director of Nursing indicated the PRN Xanax initially should have been ordered for 14 days at a time and she would get a clarification order to see if the Xanax could be administered routinely. 2. The record for Resident B was reviewed on 1/22/26 at 9:40 a.m. at 9:40 a.m. Diagnoses included, but were not limited to, vascular dementia with behaviors, chronic kidney disease stage 4, traumatic subdural hemorrhage (often fatal, medical emergency where blood collects between the brain's outer covering and the brain surface, usually from ruptured bridging veins caused by severe head injury), hemiplegia (weakness) on the right side, delusional disorder, intellectual disabilities, psychotic disorder with delusions, and anxiety. The 9/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had no behaviors and was moderately impaired for daily decision making. The Annual MDS assessment, dated 11/12/25, indicated the resident was moderately impaired for decision making. The resident had little interest doing things, felt down and tired, and had trouble (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrating. The resident had not displayed any hallucinations or delusions, but had physical, verbal and other behaviors that occurred in the last 1 to 3 days during the assessment reference period. The resident's behaviors significantly interfered with care and activities, and had an impact on others of significant risk of physical injury, disruption of care and the living environment. The resident's behaviors had worsened since last assessment and he needed substantial to max assist with transfers. The resident received antipsychotic, antianxiety, antidepressant, and an anticonvulsant medications. A Care Plan, revised on 11/20/25, indicated the resident displayed verbal behavioral symptoms not directed toward others as evidenced by yelling and using profanity towards self. The approaches were to provide diversional activities to reduce behavioral symptoms, redirect and intervene during periods of increased agitation, and separate the resident from others as needed. A Care Plan, revised on 11/20/25, indicated the resident took prn (as needed) anti-anxiety medications related to agitation and aggressive behaviors. A Physician's Order. dated 10/9/25, indicated Lorazepam tablet 0.5 milligrams (mg), give 0.5 mg by mouth every 12 hours as needed for agitation and aggressive behaviors for 14 days. The 10/2025 Medication Administration Record (MAR) indicated the Lorazepam was administered on the following days with no non-pharmacological interventions attempted prior: -10/10/25 at 8:58 a.m. and 11:15 p.m. -10/13/25 at 12:30 a.m. -10/16/25 at1:56 p.m. -10/17/25 at 11:03 p.m. -10/21/25 at 5:41 p.m -10/23/25 at 12:55 a.m. A Physician's Order, dated 11/4/25, indicated Lorazepam tablet 0.5 mg, give 0.5 mg by mouth every 12 hours as needed for agitation or anxiety for 30 days. The 11/2025 MAR indicated the Lorazepam was administered on the following days with no non-pharmacological interventions attempted prior: -11/4/25 at 1:26 p.m. - 11/6 at 11:23 am, -11/7/25 at 9:18 a.m. -11/8/25 at 12:37 a.m. -11/11/25 at 11:43 p.m. -11/15/25 at 4:05 p.m. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/16/25 at 4:10 a.m. and 11:49 p.m. -11/18 at 2:23 a.m. 11/20/25 at 12:47 a.m. -11/21/25 at 3:05 a.m. -11/26/25 at 11:35 p.m. -11/27/25 at 11:24 p.m. -11/30/25 at 4:10 a.m. A Physician's Order, dated 12/2/25, indicated Lorazepam tablet 0.5 mg, give 0.5 mg by mouth every 12 hours as needed for agitation or anxiety for 30 days. The 12/2025 MAR indicated the Lorazepam was administered on the following days with no non-pharmacological interventions tried: -12/3/25 at 12:03 a.m. and 11:12 p.m. -12/5/25 at 1:28 a.m. -12/11/25 at 2:22 a.m. and 11:34 p.m. -12/17/25 at 11:18 p.m. -12/18/25 at 11:15 p.m. -12/20 at 11:53 p.m. -12.23/25 at 12:09 a.m. -12/26/25 at 1:30 a.m. During an interview on 1/27/26 at 2:00 p.m., the Nurse Consultant indicated prn anti-anxiety medications should only be ordered for 14 days. During an interview on 1/28/26 at 6:13 a.m., LPN 2 indicated she was the nurse on duty on 12/11/25 when the resident was observed hovering over his roommate's bed and yelling at him. She administered the prn Lorazepam at that time as well. She was aware staff were to try redirection or distraction before the administration of the prn anti-anxiety. She indicated the resident yelled all the time. During an interview on 1/28/26 at 11:30 a.m., the Nurse Consultant had no additional information to provide. 3.1-3(w)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure a resident was involved in and informed of new medications ordered by the physician for 1 of 1 resident reviewed for care planning decision. (Resident 17)Finding includes: During an interview on 1/21/26 at 9:37 a.m., Resident 17 indicated she was given an iron pill but was never informed who ordered it. She indicated she some labs done and then after that the iron pill appeared with her daily medication. The record for Resident 17 was reviewed on 1/27/26 at 11:15 a.m. Diagnoses included but were not limited to, heart failure, dementia, high blood pressure, hypothyroidism, anemia, and osteoarthritis.The 12/1/25 Annual Minimum Data Set assessment indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 7/16/25, indicated Ferrous Sulfate tablet 325 milligrams (mg), give 1 tablet by mouth one time a day for low Iron.A Physician's Order, dated 10/18/25 and discontinued on 1/22/26, indicated Levothyroxine Sodium tablet 150 micrograms (mcg), give by mouth in the morning.There was no documentation the resident was notified of the above medication additions or changes. During an interview on 1/28/26 at 9:00 a.m., the Nurse Consultant had no additional information to provide.3.1-35(d)(2)(B)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure professional standards of quality were maintained related to CNAs removing dressings to pressure ulcers for 1 of 5 residents reviewed for pressure ulcers. (Resident P)Finding includes: On 1/28/26 at 11:54 a.m., the Wound Nurse was observed providing wound care for Resident P. She prepared the supplies outside of the resident's room and donned a gown and gloves prior to entering. Upon entering the room, the resident was positioned on her left side and there was no dressing to the sacrum (a triangular bone at the base of the spine). CNA 5 was in the room at that time, she indicated she had just provided incontinence care and she removed the dressing because it was soiled. The Wound Nurse proceeded to treat the area to the sacrum. The record for Resident P was reviewed on 1/23/26 at 10:45 a.m. Diagnoses included, but were not limited to, type 2 diabetes, need for assistance with personal care, anxiety, and stage 4 pressure ulcer of the sacral region (skin breakdown that involves full-thickness tissue loss exposing underlying structures such as muscle, bone or tendon) of the sacral region.The Quarterly Minimum Data Set (MDS) assessment, dated 1/6/26, indicated the resident was cognitively intact and she had one stage 4 pressure ulcer that was present on admission. A Care Plan, reviewed on 12/30/25, indicated the resident had wounds to her left lateral ankle, left heel, sacrum, right upper and lower lateral calf, left lower medial shin, left lower lateral knee and left distal lateral leg. Interventions included, but were not limited to, follow facility policies/protocols for the prevention and treatment of skin breakdown.A Physician's Order, dated 11/13/25 and listed as current on the January 2026 Physician's Order Summary (POS), indicated the resident's sacral wound was to be cleansed with normal saline or wound cleanser, pat dry, apply skin prep to surrounding skin and apply Anasept (an antimicrobial skin and wound gel) soaked gauze to wound bed and cover with a dry dressing every day shift and as needed (PRN). During an interview on 1/28/26 at 3:00 p.m., the Director of Nursing indicated the CNA should not have removed the dressing to the resident's sacrum.The current Indiana Nurse Aide Curriculum indicated, the nurse aide would not administer any medications, perform treatment or apply or remove any dressings. Exception to the above would be the application of creams/ointments to intact skin as moisture barrier cream.3.1-35(g)(1)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for cognitively impaired and dependent residents for 2 of 2 residents reviewed for activities. (Residents 2 and K)Findings include: 1. On 1/22/26 at 9:34 a.m. and 1:39 p.m., Resident 2 was observed in his room in bed with his eyes open and his television turned on. On 1/23/26 at 10:40 a.m. and 2:30 p.m., the resident remained in his room in bed with his television turned on. The record for Resident 2 was reviewed on 1/27/26 at 9:15 a.m. Diagnoses included, but were not limited to, bone and prostate cancer, vascular dementia with mood disturbance, stroke, and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 8/21/25, indicated the resident had moderate cognitive impairment and music and animals such as pets were very important to him. The Quarterly MDS assessment, dated 11/6/25, indicated the resident remained moderately impaired for daily decision making and he had little interest or pleasure in doing things. He was also dependent on staff for bed to chair transfers. A Care Plan, dated 6/9/23 and reviewed on 12/4/25, indicated the resident had a variety of activity interests and general willingness to take part in group activity programs. Interventions included, but were not limited to, encourage and praise attendance, engagement and participation within programs, invite, encourage, and assist to programs of interest and preference. During an interview on 1/27/26 at 12:20 p.m., Activity Aide 1 indicated that she visited the resident daily. She also indicated the resident had really declined and was put on hospice. The One to One Activity Sheet had documentation in the top right hand corner which indicated the patient has severely declined. The One to One Sheet indicated the resident was seen on the following dates and what activity took place: -6/3/25 throwed [sic] ball back and forth from bed, resident enjoyed.-7/10/25 conversation-8/15/25 conversation-9/10/25 conversation-12/14/25 conversation-1/24/26 conversation During an interview on 1/27/26 at 5:00 p.m., the Activity Director indicated the resident had declined and he no longer got out of bed. Staff made sure his television was turned on and she would revise his care plan to reflect his current status and schedule one to one activities for him. 2. During a random observation on 1/20/26 at 10:57 a.m., Resident K was observed sitting upright in a broda chair in her room. There was no television or radio on and the resident was just staring forward. During random observations on 1/21/26 at 10:00 a.m. and 10:20 a.m., the resident was in bed with her eyes closed. There was no radio or television on. During random observations on 1/22/26 at 9:15 a.m. and 11:00 a.m., the resident was observed in bed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At those times the television was on with a cartoon show. During random observations on 1/23/26 at 8:07 a.m., 8:15 a.m., 9:30 a.m., and 10:50 a.m., the resident was observed in bed. At those times there was no radio or television on. On 1/23/26 at 2:00 p.m., the resident was observed up and dressed in the broda chair in front of the nurses' station. There was no activity happening. The record for Resident was reviewed on 1/23/26 at 3:30 p.m. Diagnoses included, but not limited to, Alzheimer's disease, type 2 diabetes, major depressive disorder, dementia, and protein calorie malnutrition. The 11/18/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily. She received hospice services and it was very important for her to listen to music. A Care Plan, revised on 12/2/25, indicated the resident had a variety of activity interests and general willingness to take part in group activity programs and at times prefer to engage in her own self-directed activities. The approaches were to encourage and praise attendance, engagement and participation within programs, invite, encourage and assist to programs of interest and preference, and offer programs that were new or outside of resident's past or assessed activity interests for potential leisure exploration and recreation variety. A Care Plan, revised on 12/2/25, indicated the resident displayed severe cognitive impairment and rarely or never made decisions. The approaches were to provide activities on a one to one basis and in small groups and turn on television or radio when the resident was in the room for increased stimulation as tolerated. The 1 to 1 documentation indicated the following and was completed by an activity aide: 11/1/25: one on one with resident not very open to activities11/15/25: 1 to 1 helped her find a TV show she liked11/30/25: 1 to 1 talked to the resident about some activities she would maybe enjoy12/6/25: brought some magazines to look at12/14/25: 1 to 1 just conversed with the resident a bit about old times12/21/25: watched tv with the resident 1/4/26: brought up activities again she refused1/18/26: the resident said she was tired so left her to rest There was no resident response to any of the above 1 to 1 documentation. In the task section under activities, 1 to 1 documentation was completed 12/29/25 through 1/26/26. During an interview on 1/27/26 at 11:30 a.m., the Activity Director indicated she was unaware the care plan was not up to date to reflect the resident. She indicated the resident resided on the 5th floor and was transferred to the 4th floor after she had declined. The resident was now on hospice, so she was not active at all in activities. She indicated all the 1 to 1 visits in the task section were all pop in visits with the resident and did not last long at all. She only had documentation of 1 to 1 visits done every 2 weeks. She was unaware of what should be done during the 1 to 1 visits. She indicated her staff needed to be educated on the visits. 3.1-33(b)(8)

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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. Based on observation, record review and interview, the facility failed to ensure interventions were in place and the correct treatment was provided for 2 of 4 residents reviewed for pressure ulcers. (Residents T and U)Findings Include:1.On 1/27/26 at 10:15 a.m., Resident T's wound care was observed with the Wound Nurse. The resident was positioned on his left side in his bed. There was a small pressure ulcer, approximately 0.5 centimeter long on his sacrum. The nurse cleansed the area with normal saline and gauze, patted it dry, then applied a hydrocolloid dressing to cover the wound.The resident's record was reviewed on 1/22/26 at 9:40 a.m. Diagnoses included, but were not limited to, fracture of the left humerus and cellulitis of the left lower extremity.The admission Minimum Data Set (MDS) assessment, dated 12/1/25, indicated the resident had moderate cognitive impairment and needed partial/moderate assist with bed mobility and transfers. A Physician's Order, dated 12/19/25, indicated to cleanse the sacrum with normal saline and/ or wound cleanser, apply skin prep to the surrounding skin and cover with a hydrocolloid.During an interview with the Wound Nurse following the wound care, she indicated she did not apply the skin prep as ordered. 2. On 1/22/26 at 10:38 a.m. and 1/23/26 at 8:45 a.m., Resident U was observed in bed. There was a standard mattress on the bed with a padded overlay. The resident's feet were on the mattress, there was no pillow present for offloading his heels or padded boots in place. The resident's record was reviewed on 1/22/26 at 2:55 p.m. Diagnoses included, but was not limited to, multiple sclerosis, cerebral infarction and peripheral vascular disease. The resident had a pressure ulcer to his sacrum /buttocks.The Quarterly Minimum Data Set assessment, dated 12/22/25, indicated the resident was cognitively intact, had range of motion impairment to both sides and was dependent for toileting and transfers.A Physician's Order, dated 5/10/23, indicated to suspend or offload heels while in bed. During an interview on 1/23/26 at 8:47 a.m., the Unit 2 Manager was made aware the resident's heels were not offloaded. She indicated he did not like to wear the boots, but there should be a pillow for offloading. This citation relates to Intake 2702705.3.1-40(a)(2)

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	155131	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munster Med-Inn	7935 Calumet Ave Munster, IN 46321

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview the facility failed to provide adequate supervision for a resident with swallowing precautions and failed to keep sharp objects out of a resident's room who resided on the memory care unit for 2 of 6 residents reviewed for accidents. (Residents M and 1)Findings include: 1. During a random observation on 1/21/26 at 9:12 a.m. Resident M was observed in bed eating breakfast. The resident was served eggs and some type of ground meat. The meal ticket indicated supervision with meals, no straws, and to check mouth after solids. The resident should be upright during the meal and to take small bites and alternate solids and liquids. The resident had a straw in his water cup. There was no staff in the room while he was eating. During a random observation 1/23/26 at 8:17 a.m., the resident was observed in bed eating his breakfast. He was served two scoops of scrambled eggs, a bowl of oatmeal and two pieces of toast. He was served a cup of thickened orange juice and carton of thickened milk. The resident was observed feeding himself with no staff supervision in the room. He ate his piece of white toast in 4 bites and did not take a drink. He then picked up the other piece of toast and ate that piece in 3 bites. After he was done eating the toast he took two drinks of orange juice. He then took a large bite of scrambled eggs and put it in his mouth, chewed half of it and then put another large scoop of eggs in his mouth. He then moved his tray around and picked up his spoon and started to eat the oatmeal. He ate all of the oatmeal without taking any sips of liquids. He then took 3 large sips of orange juice and covered his plate with the lid of the styrafoam container and pushed it away. During an interview on 1/23/26 at 8:29 a.m. with CNA 5, who was in the room assisting the roommate, indicated she was unsure if the resident needed assistance and supervision with his meals. She indicated He does pretty good by himself. She was then asked what the light pink and dark pink smiley faces above his bed meant and she indicated thicken liquids and swallowing precautions. The record for Resident M was reviewed on 1/23/26 at 11:05 a.m Diagnoses included, but were not limited to, stroke, monoplegia of upper limb affecting right side, dysphagia (difficulty swallowing), COPD, chronic respiratory failure, major depressive disorder, dementia, and heart failure. The 12/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had a functional limited range of motion to his upper extremity on one side. The resident needed set up assistance with eating, and was dependent on staff for bathing and personal hygiene. The resident had coughing or choking during meals or when swallowing medications, and received a mechanically altered diet. The resident received oxygen while a resident. A Care Plan, dated 12/12/25, indicated the resident had a swallowing problem related to dysphagia. There were no physician orders for swallowing precautions. A Physician's Order, dated 7/1/25, and on the current 1/2026 Physician Order Summary, indicated no added salt, mechanical soft texture and nectar thick liquids with double portions at breakfast. A Speech Therapy evaluation plan and treatment for dysphagia therapy, dated 8/1/2020, indicated recommend mechanical soft textures with nectar thick liquids, with close supervision and to use general swallow techniques and precautions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/26 at 8:30 a.m., The 3rd Floor Unit Manager indicated self feed with supervision meant someone had to be watching the resident eat. During an interview on 1/27/26 at 3:30 p.m., the Director of Nursing (DON) indicated they could not find the order in the computer, but the resident did have the smiley faces above his bed for both swallowing precautions and thickened liquids. 2. During random observations on 1/20/26 at 11:05 a.m., 1/21/26 at 9:31 a.m., and 1/23/26 at 9:39 a.m. a disposable razor was observed in a cup on Resident 1's over bed table. The resident indicated he shaved himself. He resided on the memory care unit. The resident's record was reviewed 1/23/26 at 2:19 p.m. Diagnoses included, but were not limited to, psychotic disorder, anxiety, dementia, and alcohol abuse The Medicare 5-Day Minimum Data Set (MDS) assessment, dated 12/27/25, indicated the resident had moderate cognitive impairment, required moderate assistance with activities of daily living (ADLs) and transfers. A Care Plan, revised on 12/24/25, indicated the resident became easily agitated with physical aggression as evidenced by throwing coffee on floor and / or at staff. Interventions included to remove any objects that may be thrown to maintain safety. A Care Plan, revised 7/30/25, indicated the resident was at risk for complications related to antiplatelet therapy use. Interventions included to use an electric razor. During an interview on 1/27/26 at 3:50 p.m., the Director of Nursing (DON) indicated the resident should not have a disposable razor in his room. 3.1-45(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review and interview the facility failed to ensure a resident received the correct diet as ordered for 1 of 4 residents reviewed for nutrition. (Resident 16)Finding includes:On 1/20/26 at 12:10 p.m., Resident 16 was observed in bed in his room. A staff member entered the room and brought his lunch tray. He asked for it to be set on the table for later. The lunch was a slice of meatloaf, one scoop of mashed potatoes with gravy and vegetable. The tray ticket indicated Heart Healthy diet, double portions. At 12:17 p.m., LPN 4 observed the lunch tray and ticket and indicated it was not double portion.The resident's record was reviewed on 1/22/26 at 1:16 p.m. Diagnoses included, but were not limited to, diabetes mellitus and dependence on renal dialysis.The Quarterly Minimum Data Set assessment, dated 12/4/25, indicated the resident was cognitively intact and needed set up assist for eating. A Physician's Order, dated 11/10/25, indicated CKD (Renal) diet, regular texture. There was no order for double portions. During an interview on 1/22/26 at 1:34 p.m., the Dietary Manager indicated she had received an order that morning for CKD diet and had just changed the order. The previous order had been for Heart Healthy diet. She indicated there was no order for double potions. 3.1-46(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure the residents' oxygen was set at the correct flow rate for 2 of 2 residents reviewed for oxygen. (Residents M and X)Findings include: 1. During a random observation on 1/20/26 at 12:41 p.m., Resident M was observed in bed wearing oxygen via nasal cannula. At that time, the oxygen flow rate was set at 0.5 liters per minute. During a random observation on 1/21/26 at 9:12 a.m., the resident was observed in bed wearing oxygen via nasal cannula. At that time, the oxygen flow rate was set at 1 liter per minute. The record for Resident M was reviewed on 1/23/26 at 11:05 a.m Diagnoses included, but were not limited to, stroke, monoplegia of upper limb affecting right side, dysphagia (difficulty swallowing), COPD, chronic respiratory failure, major depressive disorder, dementia, and heart failure. The 12/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision received oxygen while a resident. A Care Plan, revised on 12/12/25, indicated the resident required oxygen therapy related to respiratory failure. The approaches were oxygen via nasal cannula as ordered by the physician. A Physician's Order, dated 1/15/25, indicated Oxygen via nasal cannula at two liters per minute. During an interview on 1/23/26 at 2:00 p.m., the 3rd Floor Unit Manager was aware the oxygen rate was wrong on 1/22/26 as she changed it back to two liters. 2. During an observation on 1/20/26 at 11:13 a.m., Resident X was wearing oxygen via nasal cannula that was set at 4 lpm (liters per minute). During an observation on 1/21/26 at 1:50 p.m., Resident X was wearing oxygen that was set at 3.5 lpm. The resident's record was reviewed on 1/22/26 at 2:20 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, diabetes, blindness, and asthma. The Quarterly Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was cognitively intact for daily decision making, required substantial assistance with activities of daily living (ADLs) and moderate assistance with transfers, severely impaired vision. A Care Plan, revised on 7/22/25, indicated the resident required oxygen therapy. Interventions included to provide medications as ordered by the physician. A Physician's Order, dated 12/19/25, indicated oxygen via nasal cannula at 3 lpm continuously. During an interview on 1/22/26 at 1:50 p.m., LPN 6 indicated the resident's oxygen should be set at 3 lpm. During an interview on 1/27/26 at 3:50 p.m., the Director of Nursing (DON) was informed of the finding and offered no additional information. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled, Oxygen Administration, received as current from the Director of Nursing as current on 1/28/26 at 9:17 a.m., indicated, . Oxygen is to be administered at the liter flow ordered by the physician. 3.1-47(a)(6)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interview, the facility failed to ensure a scheduled pain medication was available and administered as ordered for 1 of 4 residents reviewed for pressure ulcers. (Resident F)Finding includes:Resident F's closed record was reviewed on 1/21/26 at 2:15 p.m. Diagnoses included, but were not limited to, diabetes mellitus, repeated falls, and unspecified protein calorie malnutrition.The Quarterly Minimum Data Set assessment, dated 11/17/25, indicated the resident was cognitively intact and had a stage 3 (full-thickness skin injury appearing as a deep crater where subcutaneous fat is visible, but muscle, tendon, or bone are not exposed) pressure ulcer.The Pain Care Plan, dated 6/19/23, indicated the resident was on pain medication related to cancer of left breast, chronic pain syndrome and arthritis. Interventions included, but were not limited to, administer analgesic medications as ordered.A Physician's Order, dated 4/9/24, indicated to give fentanyl transdermal patch (opioid pain medication), 50 micrograms/hour every 72 hours for pain.The November and December 2025 Medication Administration Record indicated the fentanyl patch was not administered on 11/21, 11/24, 11/27, 11/30, 12/3 and 12/6/25. Order Administration (OA) Notes indicated the following:11/21/25 - the medication was not available. 11/24/25 - message sent to the doctor to refill script.11/27/25 - unavailable, prescription needed, MD notified.12/3/25 - unavailable.12/6/25 - no script. During an interview on 1/22/26 at 3:15 p.m., the Director of Nursing indicated the Nurse Practitioner should have been notified and a script obtained. She later indicated they had received a new prescription for the fentanyl patch on 11/25/25, but the pharmacy didn't receive it. The Medication Orders policy was received but did not pertain to the above. This citation relates to Intake 2702705.3.1-37(a)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide routine dental services for 1 of 1 resident reviewed for Dental Services. (Resident V)Finding includes:During an interview on 1/21/26 at 10:46 a.m., Resident V indicated he had only seen the dentist once since he was admitted to the facility on [DATE]. On 1/22/26 at 9:31 a.m., Resident V's bottom lower teeth were observed to be broken and dark in color. At that time, he indicated his teeth had been breaking off, and that he wanted to see a dentist. The resident's record was reviewed on 1/23/26 at 10:36 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) following a stroke, diabetes, adult failure to thrive, and need for assistance with personal care. The 12/10/25 Quarterly Minimum Data Set (MDS) indicated the resident was cognitively intact for daily decision making and was dependent in activities of daily living (ADLs) and transfers. A Physician's Order, dated 12/3/25, indicated the resident may receive services of eye care physician, audiologist, dentist and podiatrist. The record lacked documentation of the resident receiving or refusing dental services since 2022. During an interview on 1/27/26 at 3:40 p.m., the Social Services Director indicated she could not find documentation that the resident had been offered dental services since 10/25/22. She indicated it should have been addressed at care conferences, and would follow up with resident. 3.1-24

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review, and interview, the facility failed to maintain clinical records that were complete and accurately documented related to incorrect documentation of medications administered for 1 of 36 records reviewed. (Resident X)Finding includes: During observation of a medication pass on 1/22/26 at 9:37 a.m., Resident X asked LPN 6 for Maalox (an anti-acid) and Miralax (a powdered laxative). LPN 6 questioned the resident which one of the medications she wanted. The resident indicated both of the medications were on her MAR (medication administration record), and that she needed both of them because they were for different problems. LPN 6 then prepared and administered Lactulose (a medication used to treat constipation or high ammonia levels) to the resident, and told her it was Miralax. The resident questioned why it was not mixed with water. LPN 6 indicated what she gave her did the same thing. The resident's record was reviewed on 1/22/26 at 2:20 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, diabetes, breast cancer, blindness, and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was cognitively intact for daily decision making, required substantial assistance with activities of daily living (ADLs), and had severely impaired vision. A Physician's Order, dated 12/12/25, indicated Miralax, 1 packet by mouth every 24 hours as needed for constipation.A Physician's Order, dated 12/12/25, indicated Maalox, 5 ml (milliliters) by mouth every morning and at bedtime for constipation.A Physician's Order, dated 12/12/25, indicated Lactulose, 15 ml by mouth every 24 hours as needed for constipation.On the January MAR, LPN 6 documented she administered Maalox to the resident, not Lactulose. During an interview on 1/22/26 at 10:00 a.m., LPN 6 indicated she gave the resident Lactulose because Miralax was not on the MAR, and the resident did not understand that. When informed the Miralax was on the MAR, LPN 6 indicated they must have just added it. LPN 6 indicated she signed out Maalox on the MAR in error, it should have been Lactulose. During an interview on 1/27/26 at 12:50 p.m., the Director of Nursing (DON) was informed of the findings and offered no further information.3.1-50(a)(1)3.1-50(a)(2)