STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebrooke Rehabilitation Center	990 N 16th St New Castle, IN 47362

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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 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. 2. Review of the clinical record of Resident B, on 5/16/25 at 11:51 a.m., indicated the diagnoses included, but were not limited to, diabetes mellitus, major depressive disorder, anxiety disorder, primary open-angle glaucoma, age-related cataract, unspecified hearing loss, and anorexia. The Significant Change MDS assessment, dated 3/26/25, indicated the resident was severely impaired for daily decision making and was dependent on the staff for showers. The preference for customary routine for Resident B, dated 3/26/25, indicated it was very important for the resident to have a shower. The plan of care for Resident B, dated 4/8/25, indicated the resident required assistance with ADLs related to Alzheimer's disease. The interventions included, but were not limited to, offer showers two times a week. Resident B's profile, dated 4/28/25, indicated to provide assistance with bathing as needed per resident preference and offer showers two times per week with a partial bed bath in between. The shower report for Resident B, dated March 2025, indicated the resident received a complete bed bath instead of a shower on 3/4/25, 3/7/25, 3/18/25 and 3/28/25. The shower report for Resident B, dated April 2025, indicated the resident received complete bed bath instead of a shower on 4/4/25, 4/8/25, 4/25/25 and 4/29/25. The shower report for Resident B, dated 5/15/25, indicated the resident received a complete bed bath instead of a shower. During an interview with the Director of Nursing Services (DNS) on 5/19/25 at 2:30 p.m., she indicated the staff were informed of what resident preferences were by the resident profile. The preferences for daily routine provided by the Executive Director, on 5/19/25 at 1:51 p.m., indicated the purpose was to identify and develop a plan of care that reflects a resident's past and current daily customary routines. This citation relates to Complaint IN00459386. 3.1-3(u)(1) (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide showers as preferred for 2 of 3 residents reviewed for activities of daily living (ADLs). (Resident B and Resident E) Findings include: 1. During an interview with Resident E's daughter on 5/14/25 at 1:00 p.m., she indicated she did not think her mother was receiving her showers as regularly as she preferred. The clinical record for Resident E was reviewed on 5/16/25 at 9:42 a.m. The diagnoses included, but were not limited to, dementia, chronic kidney disease, repeated falls, and chronic pain syndrome. The admission Minimum Data Set (MDS) assessment, dated 4/17/25, indicated the resident was severely cognitively impaired for daily decision making. The resident was dependent on the staff for showering. The plan of care for Resident E, dated 4/4/25, indicated the resident required assistance with ADLs related to a mobility deficit, recent right hip fracture, and dementia. The interventions included, but were not limited to, assistance with bathing as needed per resident preference and to offer showers two times per week. The preference for customary routine and activities for Resident E, dated 4/15/25, indicated the resident preferred to have a shower. The shower report for Resident E, dated April 2025, indicated the resident received a bed bath instead of a shower on 4/3/25, 4/7/25, 4/14/25, 4/17/25, 4/22/25, 4/25/25, and 4/29/25. The shower report for Resident E, dated May 2025, indicated the resident received a bed bath instead of a shower on 5/3/25, 5/7/25, and 5/14/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a chair cushion was in place for a resident with stage 2 pressure ulcers (partial thickness skin loss) for 1 of 1 resident reviewed for pressure ulcers. (Resident E) Findings include: The clinical record for Resident E was reviewed on 5/16/25 at 9:42 a.m. The diagnoses included, but were not limited to, dementia, repeated falls, and chronic pain syndrome. During an observation on 5/14/25 at 1:25 p.m., Resident E had a chair cushion laying on the floor beside a chair. An interview with Resident E's daughter at that time indicated she had soiled the cushion the day before. So, the staff took the cover off for washing and put the cushion on the floor. During an observation on 5/15/25 at 10:26 a.m., Resident E was sitting in a wheelchair with no cushion in the seat. The cushion was lying on the floor beside a chair. The admission Minimum Data Set (MDS) assessment, dated 4/17/25, indicated Resident E was severely cognitively impaired, was at risk for pressure ulcers, and used a pressure reducing device for her chair. A wound management detail report, dated 4/28/25, indicated Resident E had stage 2 pressure ulcers to her right and left buttocks. A plan of care for Resident E, dated 4/4/25, indicated the resident was at risk for skin breakdown due to weakness, decline in mobility, and incontinence of bowel and bladder with moist skin. The interventions included, but were not limited to, have a Roho cushion in chair/wheelchair. During an interview with the Executive Director (ED) on 5/19/25 at 2:30 p.m., he indicated it was nursing's responsibility to ensure a cushion was in Resident E's wheelchair. A Skin Management Program policy was provided by the ED on 5/19/25 at 11:27 a.m. The policy indicated . Procedure for Wound Prevention . 3. Interventions to prevent wounds from developing and or promote healing will be initiated based upon the individual's risk factors to include but no limited to the following . All residents who utilize a wheelchair will have a pressure redistribution cushion in chair . 3.1-40(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was weighed, as ordered, and a resident was provided with an adaptive drinking device, as ordered, for 2 of 6 residents reviewed for nutrition. (Resident 50 and Resident 59) Findings include: 1. The clinical record for Resident 59 was reviewed on 5/15/25 at 12:39 p.m. His diagnoses included, but were not limited to, hemiplegia and hemiparesis and malnutrition. He was admitted to the facility on [DATE]. The 5/6/25 ADL (activities of daily living) care plan indicated he required assistance with eating with an intervention to assist with eating and drinking, as needed. The vitals section of the clinical record indicated a weight of 100 pounds and a BMI (body mass index) of 16. 64 (less than 18.5 was considered underweight) on 5/5/25. The 5/5/25 Malnutrition Criteria assessment indicated he met the criteria for malnutrition. The physician's orders indicated, Regular, Honey Thick/Moderately Thick, Pureed, Special Instructions: magic cup with breakfast and lunch; nosey cup, effective 5/14/25. An observation of Resident 59 was conducted on 5/15/25 at 12:40 p.m. He was in bed in his room with his lunch meal in front of him on his bedside table. His food was pureed, and he had what appeared to be vomit on the cloth napkin placed over his chest. His drink was in a regular cup, not a nosey cup. Resident 59 attempted to take a drink from the cup. Some of the liquid from the cup went into his mouth, but most of it ran out of the underside of the cup onto his chin and onto the napkin. LPN (Licensed Practical Nurse) 5 was retrieved for observation at that time. An interview was conducted with LPN 5, on 5/15/25 at 12:46 p.m., after the above observation. He indicated Resident 59 did not have a nosey cup, and it was not on his meal ticket for him to have one. The 5/15/25 lunch meal ticket for Resident 59 did not reference a nosey cup. The Adaptive Eating Devices policy was provided by the Executive Director on 5/19/25 at 1:05 p.m. It indicated Adaptive eating devices are available for those who need them . The type of adaptive equipment needed will be listed on the tray ticket and culinary will provide as ordered. 2. The clinical record for Resident 50 was reviewed on 5/16/25 at 9:27 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and atrial fibrillation. A physician's order, dated 2/12/25, indicated Resident 50 was to have bi-weekly weights, on the 1st and 3rd Monday of the month. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly Minimum Data Set (MDS) assessment, dated 3/5/25, indicated Resident 50 was severely cognitively impaired and had weight loss of 5% or more in the last month. A follow-up nutrition review, dated 3/5/25, indicated Resident 50 had a weight loss of 10.2% in 17 days. The Electronic Health Record (EHR) for Resident 50 recorded the following weights: 2/4/25- 147 pounds, 2/21/25- 132 pounds, 4/7/25- 126 pounds, 4/23/25- 121 pounds, and 5/7/25- Weight not obtained due to refusal. The Treatment Administration Record (TAR), for March 2025, indicated Resident 50 did not have any weights recorded for the month or refusals of weights documented. The plan of care for Resident 50, dated 5/1/24, indicated the resident was at a nutritional risk, related to weight loss. The interventions included, but were not limited to, monitoring weight. During an interview with the Director of Nursing Services (DNS) on 5/19/25 at 2:36 p.m., she indicated it was nursing's responsibility to obtain weights and to document any refusals of weight in the EHR. The DNS indicated she did not know why Resident 50's weights were not obtained in March 2025. A Resident Weight Monitoring policy was provided by the Executive Director (ED) on 5/19/25 at 1:53 p.m. It indicated .to weigh residents no less than monthly or per physician orders .4. Bi-Monthly Weights will be obtained at a minimum for the following residents: Residents who may be at risk for insidious weight loss . Residents who have experienced a significant weight loss of 5% in 30 days, 7.5% in 90 days or 10% in 180 days . 3.1-21(h) 3.1-46(a)(1)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to implement interventions when residents were kissing in the common area on the memory care unit for 1 of 1 observation of behaviors (Resident 35 and Resident 53). Findings include: During an observation on 5/14/25 at 1:22 p.m., Resident 35 was sitting at a dining room table when Resident 53 bent down and kissed Resident 35 on the lips. This was reported to Registered Nurse (RN) 7. Certified Nurse Aide (CNA) 6 attempted to separate the residents and was unable to. Resident 35 and Resident 53 were holding hands, going up and down the hallway, and into their shared bedroom with the door shut unsupervised. CNA 6 indicated she attempted to separate them, but they were roommates and there was nothing she could do. CNA 6 indicated the residents were care planned for behaviors, but she was unsure what the interventions were. RN 7 was unsure what the interventions were and was looking them up on the computer. The Memory Care Coordinator indicated she had not seen this behavior of them kissing before and only previously noted the residents' holding hands. During an observation at 1:43 p.m., Resident 35 and Resident 53 continued to walk down the hallway while holding hands and going into their bedroom unsupervised with the door shut. When queried at 1:47 p.m., what the Memory Care Coordinator was going to do about this behavior, she indicated she did not know what to do because she had not dealt with this type of behavior before. The Memory Care Coordinator indicated she would talk to someone about it and probably would have to separate them. During this observation, no staff attempted to intervene between Resident 35 and Resident 53 for 25 minutes. Review of the record of Resident 35, on 5/16/25 at 11:20 a.m., indicated the diagnoses included, but were not limited to, Alzheimer's disease, dementia, major depressive disorder, anxiety, and psychotic disorder with delusion. The Significant Change Minimum Data Set (MDS) assessment for Resident 35, dated 3/16/25, indicated the resident was severely impaired for daily decision making. The resident had wandering that significantly intruded on the privacy of other residents. Review of the record of Resident 53, on 5/19/25 at 11:48 a.m., indicated the diagnoses included, but were not limited to, Alzheimer's disease, dementia, and major depressive disorder. The Annual Minimum Data Set (MDS) assessment for Resident 53, dated 3/18/25, indicated the resident was severely impaired for daily decision making. The resident had wandering that significantly intruded on the privacy of other residents. A progress note for Resident 53, dated 5/15/25 at 10:02 a.m., indicated the resident was found kissing a peer. The staff attempted to redirect the resident. The potential root cause was unmet affection. After lunch staff were cleaning up and the environment was noisy and busy. The resident had a cognitive decline and had dementia. The staff were to redirect the resident from others and into an activity. The resident was also moved to another room. During an interview with the Executive Director on 5/19/25 at 11:28 a.m., he indicated the facility did not have a dementia care policy. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing Services (DNS) on 5/19/25 at 2:27 p.m., she indicated the nurses had access to the care plans and CNAs had access to the resident's profile. The dementia care training provided by the facility would also help staff with knowledge on what interventions to utilize for behaviors. 3.1-37(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper infection control measures were maintained during incontinence care for 1 of 1 resident observed for pressure ulcers. (Resident E) Findings include: The clinical record for Resident E was reviewed on 5/16/25 at 9:42 a.m. The diagnoses included, but were not limited to, dementia, repeated falls, and chronic pain syndrome. The admission Minimum Data Set (MDS) assessment, dated 4/17/25, indicated Resident E was severely cognitively impaired, was at risk for pressure ulcers, and was dependent on staff for toileting needs. During an observation of Resident E on 5/16/25 at 9:51 a.m., Certified Nurse Aide (CNA) 2 and CNA 3 entered Resident E's room to clean her up after being incontinent of bowel and bladder while lying in bed. CNA 2 and CNA 3 both donned gowns and gloves due to the resident being in Enhanced Barrier Precautions (EBP) due to wounds on the right and left buttock and labia. CNA 3 was cleaning Resident E's peri-area (area between the anus and the genitals) with a soapy wet washcloth. Each dirty washcloth used was then placed on Resident E's fitted sheet at the end of the bed. After cleaning Resident E's peri-area, the soiled pad underneath her was removed, placed in the trash, and a clean pad was placed underneath the resident. CNA 3 then took the soiled washcloths off the bed and placed them into a plastic bag. The fitted sheet was not changed, and Resident E was then covered with a clean sheet. During an interview with CNA 3 on 5/16/25 at 10:14 a.m., CNA 3 indicated the soiled linens/washcloths should have been placed into a plastic bag after each use to be disposed of and not placed directly onto Resident E's bed. During an observation of Resident E on 5/16/25 at 12:15 p.m., Resident E's daughter pointed out that there was a washcloth with dried up stool laying in Resident E's windowsill and smears of dry stool on the right side of Resident E's fitted bed sheet. An interview was conducted with Registered Nurse (RN) 4 on 5/16/25 at 12:27 p.m. RN 4 indicated the soiled washcloth should have been placed into a plastic bag after use and the soiled sheet should have been changed, bagged, and both taken to the soiled utility room. A Nursing Skills Competency: Perineal Care checklist was provided by the Executive Director (ED) on 5/19/25 at 11:27 a.m. It indicated to gather supplies including plastic bag at foot of bed or on chair for soiled linens. 3.1-18(b)(4)