STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainfield Health Care Center	3700 Clarks Creek Rd Plainfield, IN 46168

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure kitchen staff were knowledgeable of the dishwasher rinse temperature required for sanitization during 1 of 1 dishwasher observation. This deficient practice had the potential to affect 101 residents who received meals from the kitchen. Findings include:During an observation, on 5/17/26 at 10:14 a.m., [NAME] 9 started the dishwasher and observed the wash cycle reached 150 degrees Fahrenheit (F), and the rinse cycle reached 171 degrees F. At the same time, [NAME] 9 indicated the dishwasher was a high temperature sanitization, the temperatures were the normal temperatures the dishwasher reached for the wash and rinse cycles, and it was sufficient to sanitize the dishes. [NAME] 9 indicated she washed pots and pans after the meal was completed, the dishwasher had been used several times before it was checked and should have been warmed up. During an interview, on 5/17/26 at 11:26 a.m., the Dietary Manager indicated the dishwasher needed to reach 160 degrees F on the wash cycle and 180 degrees F on the rinse cycle in order to sanitize the dishes. During an interview, on 5/20/26 at 9:45 a.m., the Registered Dietitian (RD) indicated the dishwasher's rinse cycle had to reach at least 180 degrees F to sanitize the dishes. They discovered there was an issue with the temperature gauges on the dishwasher. The cook should have been aware of the required dishwasher temperatures for sanitization and had previously received training. On 5/18/26 at 9:49 a.m., the Executive Director (ED) provided a document titled, .Certified Conveyor Dishmachine., dated 2019, and indicated it was the policy currently being used by the facility. The policy indicated, .Operating temperatures-wash (min).high-temp 160 F Sanitizing Rinse (min).high-temp 180 F. 410 IAC (Indiana Administrative Code) 16.2-3.1-20(h)

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interview, the facility failed to develop and maintain a comprehensive, facility-specific assessment that accurately identified and documented the staffing resources necessary to care for its resident population, including the specific number and ratio of staff required to meet resident needs. This deficient practice had the potential to affect 103 of 103 residents residing in the facility. Findings include:On 5/18/26 at 12:10 p.m., the Administrator provided a copy of the Facility Assessment. The assessment was reviewed and indicated the following statistics: an average resident population consisting of 185 admissions/stays, including 106 ongoing stays (57.3%), and 134 long-stay residents (72.4%). The Facility Assessment indicated the facility had a resident population with significant care needs, which included, but was not limited to: 99 residents (53.5%) requiring assistance with activities of daily living (ADLs) 89 residents (48.1%) requiring maximal assistance or assistance from two or more staff members for ADL care 125 residents (67.6%) with psychiatric/mood diagnoses 102 residents (55.1%) with neurological conditions 166 residents (89.7%) requiring anticoagulation monitoring Residents residing on a designated Memory Care Unit requiring specialized dementia care and supervision Section II: Staffing, Training, Services, & Personnel, revealed the facility included generalized narrative statements indicating, The facility's overall staffing plan is based on resident acuity and an ?hours per patient day' (PPD) basis.The facility designates individual staff assignments. The assessment failed to specify the actual staffing resources required to meet resident needs, including the number and ratio of direct care staff, licensed nurses, management personnel, or ancillary staff needed for the facility's identified census and acuity. The Sufficiency Analysis Categories demonstrated the facility documented only the term Evaluated under the categories of Overall Staffing, Staff Training/Competencies/Skill Sets, and Services for multiple resident care domains, which included, but was not limited to: cognitive impairment/dementia, wandering and elopement and behavioral health needs. The Facility Assessment failed to provide measurable, facility-specific staffing determinations to care for its population in areas which included, but were not limited to: minimum number of nursing staff required per shift, required ratio of certified nursing assistants (CNAs) to residents, required ratio of licensed nurses to residents, staffing needs specific to the Memory Care Unit, staffing adjustments based on resident acuity, admissions, discharges, or behavioral health needs; and documentation demonstrating how staffing sufficiency was analyzed and determined. During an interview on 5/21/26 at 11:08 a.m., the Administrator indicated she had a brief opportunity to review the Facility Assessment when she was hired, but that the document had been created, updated, and revised by corporate staff off-cite from the facility. In her review, the Administrator indicated the assessment was not sufficiently detailed or specific to accurately identify the building's staffing needs, and the document failed to clearly specify the number and staffing ratios necessary to meet resident care demands based on census and acuity. On 5/21/26 at 1:37 p.m., the Administrator indicated there was no policy to address the Facility Assessment document procedures/requirements, but she located and provided a copy of the CMS guidelines, revised 5/10/24. The guidelines specified, .The facility assessment must address or include the following. The care required by the resident population, using evidence-based, data-driven methods that consider the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required underS 483.20;. The facility's resources, including but not limited to the following. Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies. All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	competencies related to resident care. The facility must use this facility assessment to. Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident specific dementia care plans were developed and utilized prior to psychotropic medications being initiated or increased for 4 of 5 residents reviewed for dementia (Residents 19, 76, 7, and 11). Findings include: 1. Resident 19's record was reviewed on 5/19/26 at 9:47 a.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, unspecified dementia (a decline in mental abilities severe enough to interfere with daily life) with mood disturbance. An admission Minimum Data Set (MDS) assessment, dated 5/1/26, indicated the resident had a moderate cognitive impairment. The resident's comprehensive care plan lacked documentation of a dementia care plan, including potential behaviors and behavioral interventions. A Medication Administration Record (MAR), dated April 2026, was reviewed. The MAR included a physician's order, dated 4/29/26, to monitor any targeted behavior each shift, document the number of episodes, interventions used, and the outcome of interventions. The MAR indicated the resident had zero behaviors during the month. A care plan, initiated on 4/29/26, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to dementia. The care plan included interventions regarding the resident's ADL status and level of assistance needed but lacked documentation of dementia related behaviors or behavior interventions. A MAR, dated May 2026, indicated the resident had zero behaviors during the month. A physician's order, dated 5/5/26, indicated Rexulti (atypical antipsychotic medication) 0.5 milligrams (mg) by mouth once daily for agitation/anxiety. Progress notes, dated 4/29/26 to 5/5/26, lacked documentation of behaviors or interventions provided to manage behaviors. A Nurse Practitioner (NP) progress note, dated 5/5/26, indicated the visit was medically necessary for ongoing skilled management of dementia with agitation and behavioral disturbance related to behavioral outbursts. The resident exhibited increased agitation including yelling at staff and the provider related to the facility's rules. The NP indicated to continue behavioral management strategies and initiate a trial of Rexulti. The note lacked documentation of specific behaviors that occurred, interventions attempted prior to the initiation of Rexulti, and what the aforementioned behavioral management strategies consisted of. A physician's order, dated 5/6/26, indicated the resident's trazodone (atypical antipsychotic) was increased from 150 mg to 200 mg by mouth daily at bedtime for insomnia (a common sleep disorder that makes it difficult to fall asleep, stay asleep, or get restful sleep). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress notes, dated 4/29/26 to 5/6/26, lacked documentation the resident exhibited insomnia or interventions attempted. An activities care plan, initiated on 5/7/26, indicated the resident's favorite activities were bingo, painting, and watching television. A physician's order, dated 5/16/26, indicated haloperidol (antipsychotic medication) 5 mg by mouth stat (immediately) for anxiety and agitation. A progress note, dated 5/16/26, indicated, At approximately 1815 [6:15 p.m.], resident verbalized to this writer that if he could not leave the facility, he would kill himself. Resident appeared highly anxious and restless, with noted diaphoresis [excessive, abnormal sweating] and rapid breathing. He was persistent in his request to go home. Resident's family was notified immediately. Family arrived approximately 1845 [6:45 p.m.] and provided emotional support, which resulted in some de-escalation of resident's distress. Interdisciplinary team.was notified promptly and provided instructions to maintain constant supervision of the resident until family arrival. Following the departure of the resident's daughter, IDT [interdisciplinary team] directed initiation of 1:1 monitoring for safety. On-call provider was contacted and issued an order for haloperidol 5 mg by mouth.stat, which was carried out as ordered. The note lacked documentation of further assessment of the suicidal ideation such as a plan in place, interventions attempted other than calling the resident's family, or why the haloperidol was administered despite the resident's family visit resulting in some de-escalation of the situation. An NP progress note, dated 5/18/26, indicated since the last evaluation the resident expressed suicidal ideation and stated if he could not leave the facility, he would kill himself. The resident appeared highly anxious and was persistent in his request to go home. The resident's family was notified and provided emotional support, and this resulted in some deescalation of his distress. A care plan, initiated on 5/18/26, indicated the resident expressed suicidal ideation due to wanting to leave the facility. Interventions indicated staff would encourage the resident's friends and family to visit, staff would encourage the resident to attend activities to help occupy the mind, medications administered as ordered, staff would listen to the resident's concerns, psychiatric consult referral, and staff would monitor for effectiveness and side effects of medication. During an interview, on 5/19/26 at 11:11 a.m., Certified Nurse Aide (CNA) 16 indicated Resident 19 exhibited behaviors at times including agitation, yelling out, and anxiety. CNA 16 indicated she knew what interventions to use with residents who had dementia and exhibited behaviors based on her getting to know them. CNA 16 indicated she thought there might have been a binder at the nurse's station with behavior interventions, but she was unable to locate anything. Behaviors interventions might have been included on the CNA plan of care sheet in the computer, but when she accessed it she indicated there were no behavior interventions, only interventions for falls. If a resident exhibited a behavior they were able to document it on a new alert and notify the nurse for them to document. 2. Resident 76's record was reviewed on 5/20/26 at 12:47 p.m. Diagnoses on the resident's profile included, but were not limited to, moderate vascular dementia (reduced or blocked blood flow to the brain, leading to cognitive decline and memory problems) with agitation. A quarterly Minimum Data Set (MDS) assessment, dated 3/9/26, indicated the resident had a severe cognitive impairment. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 12/6/25, indicated the resident received antianxiety medication and should be monitored for behaviors including agitation, anxiety, nervousness, compulsiveness, physical aggression, combativeness, excitation/irritability, verbal aggression, panic, and any other behaviors every shift. A physician's order, dated 12/6/25, indicated the resident received antipsychotic medication and should be monitored for behaviors including hallucinations, physical aggression, verbal aggression, paranoia, delusions, repetitive verbalizations that affect function, and any other behaviors every shift. A physician's order, dated 12/7/25 and discontinued 1/23/26, indicated sertraline (antidepressant) 25 milligrams (mg) by mouth at bedtime for depression. A physician's order, dated 12/8/25, indicated the resident exhibited anxious and depressive behavior which should be monitored every shift. A Medication Administration Record (MAR), dated December 2025, indicated the resident had zero behaviors during the month. Progress notes, dated December 2025, lacked documentation the resident exhibited behaviors. A physician's order, dated 1/23/26, indicated sertraline 50 mg by mouth at bedtime for depression for 7 days. A physician's order, dated 1/23/26, indicated sertraline 75 mg by mouth daily for depression, to be initiated on 2/1/26. A MAR, dated January 2026, indicated the resident had zero behaviors during the month. Progress notes, dated January 2026, lacked documentation the resident exhibited behaviors. A MAR, dated February 2026, indicated the resident had zero behaviors during the month. A MAR, dated March 2026, indicated the resident had zero behaviors during the month. Progress notes, dated March 2026, lacked documentation the resident exhibited behaviors. A physician's order, dated 3/30/26, indicated Depakote (anticonvulsant that can be used as a mood stabilizer) delayed release tablet, give 125 mg by mouth in the afternoon for dementia with behavioral disturbance. The resident's current care plans indicated the resident had bowel and bladder incontinence, activities of daily living (ADL) self-care performance deficit, and was at nutritional risk due to dementia. A care plan, developed on 5/11/26, indicated the resident had the potential to demonstrate physical behaviors related to dementia. The resident had become aggressive and physically hit another resident. Interventions were generalized and indicated analyze key times, places, circumstances, triggers, and what de-escalates behavior and document, assess and address for contributing sensory deficits, assess and anticipate the resident's needs, evaluate for side effects of medications, and (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychiatric consult as indicated. The resident's care plans lacked documentation of a resident-specific dementia care plan, including resident-specific interventions to utilize prior to the initiation or increase of psychotropic medications. During an interview, on 5/20/26 at 2:39 p.m., the [NAME] President (VP) of Clinical indicated dementia related interventions should have been included in the resident's care plans, and there was not any other location for staff to find interventions. During an interview, on 5/20/26 at 2:50 p.m., the VP of Clinical indicated she reviewed the resident's record and was unable to find a resident-specific dementia care plan. 3. Resident 7's record was reviewed on 5/21/26 at 10:44 a.m. Diagnoses on the resident's profile included, but were not limited to, Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior) unspecified. A quarterly Minimum Data Set (MDS) assessment, dated 3/13/26, indicated the resident had a severe cognitive impairment. A physician's order, dated 9/25/25, indicated the resident received antianxiety medication and should be monitored for behaviors including agitation, anxiety, nervousness, compulsiveness, physical aggression, combativeness, excitation/irritability, verbal aggression, panic, and any other behaviors every shift. A physician's order, dated 9/25/25, indicated the resident received antipsychotic medication and should be monitored for behaviors including hallucinations, physical aggression, verbal aggression, paranoia, delusions, repetitive verbalizations that affect function, and any other behaviors every shift. A physician's order, dated 9/25/25, indicated the resident required monitoring for anxiety and depression every shift. A physician's order, dated 1/17/26, indicated the resident should be monitored for any targeted behavior. A care plan, last revised on 1/29/26, indicated the resident was resistive to care related to dementia, refused labs, had a history of putting feces in the trash can, took off clothes in public, refused showers, removed décor off tables, at times did not sleep through the night, thought bugs were invading her body and blood was running down her fingers. Interventions were generalized and indicated allow the resident to make decisions about the treatment regime to provide a sense of control, educate resident, family, and caregivers of the possible outcomes of not complying with treatment or care, encourage as much participation and interaction by the resident as possible during care and activities, give a clear explanation of all care activities prior to and as they occur, and provide the resident with opportunities for choice during care provision. The care plan lacked documentation of resident-specific interventions. A physician's order, dated 2/24/26 and discontinued 4/30/26, indicated lorazepam (antianxiety medication) 0.5 milligrams (mg) by mouth twice daily for anxiety. A physician's order, dated 4/29/26, indicated lorazepam 0.5 mg by mouth three times daily for delusional disorders. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Medication Administration Record (MAR), dated April 2026, indicated the resident exhibited three occurrences of agitation, anxiety, verbal aggression and repetitive verbalizations that affect function, on 4/1/26, evening shift, which improved with being distracted or soothed and redirection. The resident exhibited one occurrence of agitation on 4/30/26, day shift. The MAR lacked documentation of interventions attempted or their efficacy for the agitation documented on 4/30/26. A progress note, dated 4/28/26, indicated the resident had a behavior of moving chairs in the dining area and grabbing chairs when other residents were about to sit. The resident argued with staff and residents and stated, These are my chairs. The resident was redirected with snacks and drinks which was effective. The note lacked documentation of why the lorazepam would have been increased if the interventions were effective. During an interview, on 5/21/26 at 2:40 p.m., the Registered Nurse (RN) Consultant indicated she was not able to find any additional documentation of non-pharmacological interventions attempted prior to the increase of the lorazepam. During an interview, on 5/19/26 at 11:50 a.m., the [NAME] President (VP) of Clinical indicated when a resident exhibited behaviors, two or three non-pharmacological interventions should have been attempted prior to medication changes. Behaviors, interventions attempted, and the efficacy of the interventions should have been documented on the MAR. Resident 19's care plan was reviewed, and she was unable to find a dementia care plan. 4. On 5/21/26 at 1:48 p.m. Resident 11's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to Parkinsons (a progressive neurological disorder that affects movement and the nervous system) disease and dementia (a decline in mental abilities severe enough to interfere with daily life). A progress note, dated 1/4/26, indicated Resident 11 was in the dining room when she put herself on the floor and refused to get back into her wheelchair, was throwing utensils and refused to take oral medications. The note indicated the on-call Nurse Practitioner (NP) was notified and a one-time dose of Intramuscular (IM) Haldol (an antipsychotic medication) was given. Resident 11 had active orders for behavior monitoring. The orders indicated the nurse should count the number of times the resident exhibited a target behavior related to anxiety and depression, and that number should be charted every shift along with any intervention put in place and outcome after that intervention. The order did not specify what behaviors they were targeting. Resident 11's January 2026 Electronic Medication Administration Record (eMAR) indicated she did not have any target behaviors on 1/4/26. A progress note, dated 1/15/26, indicated Resident 11 had increased anxiety and delusions related to looking for lost pets, being verbally loud, attempting to stand unassisted and refusing to take oral medications. The note indicated the on-call NP was notified and a one-time dose of IM Haldol was given. Resident 11's January 2026 eMAR indicated she did not have any target behaviors on 1/15/26. A progress note, dated 2/28/26, indicated Resident 11 had increased agitation and aggression related to attempting to throw her drink on staff members, refusing snacks, spitting oral medications out and (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being difficult to redirect. The note indicated the on-call NP was notified and a one-time dose of IM Haldol was given. Resident 11's February 2026 eMAR indicated she did not have any target behaviors on 2/28/26. A progress note, dated 3/29/26 indicated Resident 11 had behaviors related to biting, spitting and yelling at staff and her son, refusing to take oral medications and yelling and screaming. The note indicated the on-call NP was notified and a one-time dose of IM Haldol was given. Resident 11's March 2026 eMAR indicated she did not have any target behaviors on 3/29/26. Resident 11 had a pharmacy review done on 4/21/26 the recommendation for that review was to clarify the indication of use for Quetiapine (an antipsychotic medication contraindicated in those with dementia related psychosis) as it was indicated Resident 11 was on Quetiapine for dementia with mood disturbances. The NP indicated they would change the indication for use to psychosis due to known physiological condition. Resident 11 had an active order for Quetiapine related to f06.2 (a clinical medical code used for Psychotic disorder with delusions due to a known physiological condition). Resident 11's current medical diagnoses list was reviewed and lacked evidence that Resident 11 was diagnosed with psychotic disorder with delusions due to a known physiological condition. Resident 11's care plans were reviewed and lacked an individualized, person-centered care plan related to Resident 11's dementia care. On 5/20/26 at 10:53 a.m. a copy of a current facility policy titled, Psychotropic Drug Management dated 01/2025 was provided. That policy indicated, .Purpose. III. To ensure the resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s). IV. To ensure non-pharmacological interventions are considered and used when indicated, instead of, or in addition to, medication. IV. Psychotherapeutic drugs.will never be used for the convenience of staff. V. The facility will utilize individualized, non-pharmacological approaches to care (e.g., purposeful and meaningful activities). Meaningful activities are those that address the resident's customary routines, interests, preferences, and choices to enhance the resident's wellbeing. a. Centers for Medicare and Medicaid Services (CMS) has identified the following as inappropriate reasons to use antipsychotics:.VIII. Uncooperativeness (e.g. refusal/difficulty receiving care). G. The attending medical practitioner may order an emergency dose of a psychotherapeutic medication if the resident is in danger of harm to self or others. X. Nursing Responsibility A. Consider other factors that may be causing expressions or indications of distress before initiating a psychotropic medication, such as an underlying medical condition (e.g., urinary tract infection, dehydration, delirium), environmental (lighting, noise) or psychosocial stressors. 410 IAC (Indiana Administrative Code) 16.2-3.1-37

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's representative was notified of new medication orders for 1 of 6 residents reviewed for unnecessary medications (Resident 19), and the facility failed to ensure informed consent was obtained prior to the initiation or increase of psychotropic medications for 3 of 6 residents reviewed for unnecessary medications (Residents 19, 76, and 7). Findings include:1. During an interview, on 5/17/26 at 11:55 a.m., Resident 19's representative indicated they were not notified of medication changes. She found out later when the resident mentioned he thought his medications had been changed. Resident 19's representative indicated the facility had not notified her when the resident was started on Rexulti (antipsychotic medication) or when the trazodone (antidepressant) was increased. No informed consent was obtained for the psychotropic medications including discussion of black box warnings (warns of potential serious risks associated with a medication), benefits, risks, or other potential treatments. Resident 19's record was reviewed on 5/19/26 at 9:47 a.m. Census information indicated the resident was admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment, dated 5/1/26, indicated the resident had a moderate cognitive impairment. A physician's order, dated 5/5/26, indicated Rexulti 0.5 milligrams (mg) by mouth once daily for agitation/anxiety. The record lacked documentation an informed consent was obtained from the resident's responsible party for this medication. An order change progress note, dated 5/5/26, indicated a black box warning was identified for the Rexulti. The note included an area to document the responsible party's notification of the black box warning, but the area was left blank. A physician's order, dated 4/29/26 and discontinued on 5/6/26, indicated trazodone 150 mg by mouth daily at bedtime for insomnia. A physician's order, dated 5/6/26, indicated trazodone 200 mg by mouth daily at bedtime for insomnia. The record lacked documentation an informed consent was obtained from the resident's responsible party for the medication increase. An order change progress note, dated 5/6/26, indicated a black box warning was identified for the trazodone. The note included an area to document the responsible party's notification of the black box warning, but the area was left blank. The resident's record lacked documentation the resident's representative was notified of the new order for Rexulti or increase of trazodone.A physician's order, dated 5/16/26, indicated haloperidol (antipsychotic medication) 5 mg by mouth stat (immediately) for anxiety and agitation. The record lacked documentation an informed consent was obtained from the resident's responsible party for this medication. An order change progress note, dated 5/16/26, indicated a black box warning was identified for the haloperidol. The note included an area to document the responsible party's notification of the black box warning, but the area was left blank. During an interview, on 5/19/26 at 12:27 p.m., the [NAME] President (VP) of Clinical indicated she was unable to find documentation an informed consent had been obtained from the resident's representative for the initiation of the Rexulti and haloperidol and the increase of trazodone. The resident's representative was not notified of the new medication orders, and she should have been. 2. Resident 76's record was reviewed on 5/20/26 at 12:47 p.m. Diagnoses on the resident's profile included, but were not limited to, moderate vascular dementia (reduced or blocked blood flow to the brain, leading to cognitive decline and memory problems) with agitation. A quarterly Minimum Data Set (MDS) assessment, dated 3/9/26, indicated the resident had a severe cognitive impairment. A physician's order, dated 12/7/25 and discontinued 1/23/26, indicated sertraline (antidepressant) 25 milligrams (mg) by mouth at bedtime for depression. A physician's order, dated 1/23/26, indicated sertraline 50 mg by mouth at bedtime for depression for 7 days. A physician's order, dated 1/23/26, indicated sertraline 75 mg by mouth daily for depression, to be initiated on 2/1/26. The record lacked documentation an informed consent was obtained from the resident's representative for the sertraline increase. An order change progress note, dated 1/23/26, indicated a (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	black box warning was identified for the sertraline. The note included an area to document the responsible party's notification of the black box warning, but the area was left blank. A physician's order, dated 3/30/26, indicated Depakote (anticonvulsant that can be used as a mood stabilizer) delayed release tablet, give 125 mg by mouth in the afternoon for dementia with behavioral disturbance. The record lacked documentation an informed consent was obtained from the resident's representative for the Depakote. An order change progress note, dated 3/31/26, indicated a black box warning was identified for the Depakote. The note included an area to document the responsible party's notification of the black box warning, but the area was left blank. During an interview, on 5/20/26 at 2:50 p.m., the [NAME] President (VP) of Clinical indicated she reviewed the resident's record and was unable to find documentation informed consent was obtained when the resident's psychotropic medications were changed. 3. Resident 7's record was reviewed on 5/21/26 at 10:44 a.m. Diagnoses on the resident's profile included, but were not limited to, Alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior) unspecified. A quarterly Minimum Data Set (MDS) assessment, dated 3/13/26, indicated the resident had a severe cognitive impairment. A physician's order, dated 2/24/26 and discontinued 4/30/26, indicated lorazepam (antianxiety medication) 0.5 milligrams (mg) by mouth twice daily for anxiety. A physician's order, dated 4/29/26, indicated lorazepam 0.5 mg by mouth three times daily for delusional disorders. The record lacked documentation informed consent was obtained from the resident's responsible party for the medication increase. An order change progress note, dated 4/29/26, indicated a black box warning was identified for the lorazepam. The note included an area to document the responsible party's notification of the black box warning, but the area was left blank. During an interview, on 5/19/26 at 12:27 p.m., the [NAME] President (VP) of Clinical indicated informed consent should have been obtained for new orders or increases of psychotropic medications. During an interview, on 5/21/26 at 2:40 p.m., the Nurse Consultant indicated she was not able to find documentation informed consent was obtained from the resident's representative for the lorazepam increase. On 5/19/26 at 1:50 p.m., the Executive Director (ED) provided a document titled, Informed Consent, dated 2/26/25, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To ensure that the Facility respects the resident's right to make an informed consent decision prior to deciding to undergo certain medical therapies and procedures. Policy: I. The Attending Physician will determine when material circumstances have changed so that an informed consent is required from the resident before providing treatment. The Attending Physician will then obtain an informed consent from the resident or authorized representative before allowing the resident to make a decision to undergo a therapy or procedure that requires an informed consent. The use of an informed consent will be done for but not limited to the use of: A. Psychotherapeutic Drugs. I. Obtaining Informed Consent A. The Attending Physician (or attending licensed healthcare professional who orders the therapy) must obtain informed consent before initiating a treatment or procedure that requires informed consent. i. An informed consent is required but not limited to, the administration of psychotherapeutic drugs. ii. The resident or representative must sign an informed consent form.iii. Upon procuring the informed consent, the Attending Physician must document itin the resident's medical record. iv. When obtaining consent for use of psychotherapeutic drugs, the resident will: a. Receive an informed consent form.stating the risks and benefits for the use of these medications. b. When admitted with orders for psychotherapeutic drugs, licensed staff will verify with the resident that the risks and benefits have been explained to them prior to consent or use. c. Have risks and benefits for use explained to them. d. Receive a new consent if medications change or dosage is increased. On 5/19/26 at 1:50 p.m., the Executive Director (ED) provided a document titled, Resident Rights, dated August 2020, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: I. State and federal laws guarantee certain basic rights to all residents of the Facility. These rights include, but are not limited to, a resident's right to.D. Be fully informed and participate in his/her treatment including being fully informed in a language that he or (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she can understand of his/her total health status including his/her medical condition.R. Treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(n)(2) 410 IAC (Indiana Administrative Code) 16.2-3.1-5(a)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to code the Minimum Data Set (MDS) accurately for 2 of 8 residents reviewed for MDS accuracy (Resident 2 and 81).Findings include:1. On 5/20/26 at 2:04 p.m., a record review was completed for Resident 2. She had the following diagnoses which included but were not limited to diabetes, hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and hyperlipidemia (high cholesterol).A significant change Minimum Data Set (MDS) assessment, dated 11/13/25, section A1500 Preadmission Screening and Resident Review indicated the resident did not have a level II.The Notice of PASRR Level II Outcome, dated 6/30/22, indicated Resident 2 received a PASRR level II with the determination of Long Term Approval without Specialized Services.2. On 5/20/26 at 11:25 a.m., a record review was completed for Resident 81. She had the following diagnoses which included but were not limited to acute kidney failure, hypertension, anemia, diabetes, insomnia, and anxiety.The quarterly MDS, dated [DATE], section N Medications indicated Resident 81 was taking an anticoagulant.The Medication Administration Record (MAR) for February 2026 was reviewed and lacked documentation of Resident 81 receiving an anticoagulant.The physician orders for February 2026 lacked an order for an anticoagulant.On 5/21/26 at 1:10 p.m., the Regional MDS Nurse indicated the items were not coded correctly and informed the MDS coordinators of the errors.A policy titled, RAI (Resident Assessment Instrument) was provided by the Executive Director (ED) on 5/21/26 at 9:53 a.m. It indicated, .The facility will make error corrections in and resubmit to IQIES (Internet Quality Improvement and Evaluation System).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to submit a new level one Pre-admission Screening and Resident Review (PASRR) (a federally mandated process to prevent inappropriate placements of individuals with Serious Mental Illness [SMI] or Intellectual/Developmental Disabilities [I/DD] into Medicaid-certified nursing facilities) when new SMI were added for a resident for 1 of 7 residents reviewed for PASRR compliance (Resident 12). Findings include:On 5/19/26 at 10:22 a.m. Resident 12's medical record was reviewed. On 3/16/26 new diagnoses of dementia and major depressive disorder were added to Resident 12's diagnoses list.The record lacked evidence of a new level one PASRR assessment being done when these new SMI diagnoses were added.On 5/21/26 at 2:03 p.m. the Executive Director (ED) indicated they did not do a new level one PASRR assessment for Resident 12 when the new diagnoses were added on 3/16/26. She indicated they had initiated a new level one at that time.On 5/21/26 at 9:53 a.m. a copy of a current facility policy titled Pre-admission Screening and Resident Review (PASRR), dated 6/2020 was provided. That policy indicated, .V. A negative Level 1 screen permits admission to proceed and ends the PASARR process, unless a possible serious mental disorder or intellectual disability arises later.410 IAC (Indiana Administrative Code) 16.2-3.1-16(d)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident's risk for pressure ulcers (localized damage to the skin and underlying soft tissue from prolonged pressure) was addressed for a resident who developed pressure ulcers and failed to ensure the resident's low air loss mattress (specialized mattress) was set appropriately for 1 of 4 residents reviewed for pressure ulcers (Resident 9). Findings include:During an observation, on 5/17/26 at 10:53 a.m., Resident 9 was lying in bed on a low air loss mattress. The control unit was hanging on the resident's foot board. A dial on the control board was turned all the way to the right on firm. The dial included weights between the softest and firmest settings. During an observation, on 5/20/26 at 10:47 a.m., the Wound Nurse completed Resident 9's treatment. The resident was lying in bed on a low air loss mattress. The dial on the low air loss mattress control unit was turned all the way to the right on firm. At the same time, the Wound Nurse indicated low air loss mattress settings were based on the resident's weight. The dial included weights so they would know where to set it. The Wound Nurse indicated the resident weighed about 170 pounds, and he would adjust the mattress accordingly. The physician's orders for the low air loss mattresses were ordered at to comfort instead of including their specific weight. The Wound Nurse indicated the staff had probably provided care, turning the mattress to firm, and forgot to turn it back. During an observation, on 5/21/26 at 9:26 a.m., Resident 9 was lying in bed. The low air loss mattress was set to 190 pounds. Resident 9's record was reviewed on 5/19/26 at 2:18 p.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, dementia (a decline in mental ability severe enough to interfere with daily life) in other diseases classified elsewhere. A patient risk profile indicated the resident's Braden score (assessment to determine the resident's risk for pressure ulcer development), dated 1/21/26, indicated a very limited risk. A baseline care plan, dated 1/21/26, lacked documentation the resident was at risk for skin breakdown. A care plan, initiated on 1/21/26, and in place prior to the resident's pressure ulcer development, indicated the resident was at risk for pressure ulcers related to dementia and the need for assistance with activities of daily living. Interventions indicated administer medications as ordered and monitor and document side effects and effectiveness, avoid positioning the [resident name] on her, do not massage over bony prominences, use mild cleansers for perineal care, and ensure heels were floated with the use of two pillows. The care plan lacked documentation of resident specific interventions. A patient risk profile indicated the resident's Braden score, dated 1/27/26, indicated a very limited risk. An admission Minimum Data Set (MDS) assessment, dated 1/27/26, indicated the resident had a severe cognitive impairment and was not at risk of pressure ulcer development. A patient risk profile indicated the resident's Braden score, dated 2/3/26, indicated a very limited risk. A patient risk profile indicated the resident's Braden score, dated 2/12/26, indicated a very limited risk. A significant change MDS assessment, dated 3/20/26, indicated the resident had a significant cognitive impairment, was at risk of pressure ulcer development, and had two stage three pressure ulcers (a serious skin injury characterized by full-thickness tissue loss exposing subcutaneous fat) which were not present upon admission. A wound summary indicated the resident developed a stage three pressure ulcer to the coccyx (tailbone), on 3/18/26, and the area healed on 4/15/26. The resident developed a stage 3 pressure ulcer to the left hip, on 3/17/26, which measured 4 centimeters (cm) in length, 4 cm in width, and 0.01 cm in depth, with slough (dead, non-viable tissue) covering the wound bed. The area to the left hip remained a stage 3, and was measured, on 5/14/26, at 2 cm in length, 2 cm in width, and 1.4 cm in depth. The wound bed remained covered in slough. A patient risk profile indicated the resident's Braden score, dated 4/20/26, indicated a very limited risk, despite the resident having developed two stage three pressure ulcers. A physician's order, dated 4/22/26, indicated low air loss mattress with bolsters to comfort settings and check every shift. A weight, dated 5/19/26, indicated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident weighed 162.4 pounds. During an interview, on 5/21/26 at 9:27 a.m., Certified Nurse Aide (CNA) 14 indicated she did not know how to set the low air loss mattresses. The CNAs did not change the settings or know how to adjust them. She had not received any training on low air loss mattresses or how to adjust them. During an interview, on 5/21/26 at 9:29 a.m., Licensed Practical Nurse (LPN) 15 indicated the staff did not adjust low air loss mattress. The low air loss mattresses were set by the Wound Nurse and left how they were set. She had not received any training on how to adjust the low air loss mattresses. If there was an issue with one she would have tried to troubleshoot and let the Wound Nurse know. On 5/21/26 at 10:38 a.m., the Executive Director provided an undated document titled, Operations, and indicated it was the policy currently being used by the facility. The policy indicated, .2. Pressure Adjustment Knob: The pressure adjustment knob controls the air pressure in the mattress. Turning the knob clockwise will increase the pressure; counter-clockwise decreases the pressure. Higher pressures will support heavier residents. The pressure should be adjusted according to individual comfort preferences. On 5/21/26 at 12:51 p.m., the ED provided a document titled, Pressure Injury Prevention, last revised in January 2026, and indicated it was the policy currently being used by the facility. The policy indicated, .Purpose: To identify residents at risk for skin breakdown, implement measures to prevent and/or manage pressure injury and minimize complications and promote optimal skin health. Policy: The facility will assess, monitor, and implement evidence-based interventions to prevent pressure injuries. Residents at risk will receive individualized care plans addressing key risk factors such as moisture control, pressure redistribution, positioning, mobility, and nutrition. 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(1)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on record review, observation, and interview, the facility failed to provide nephrostomy (a procedure where a thin, flexible tube is inserted through the skin of your lower back directly into the kidney to drain urine) monitoring and care for a resident with tubes for 1 of 1 resident reviewed for nephrostomy tubes (Resident 8).Findings include: On 5/19/26 a record review was completed for Resident 8. She had the following diagnoses which included but were not limited to tachycardia (fast heart beat), anemia (a common blood condition where your body lacks enough healthy red blood cells or hemoglobin to carry oxygen to its tissues), and chronic kidney disease (a condition in which your kidneys are damaged or have a problem with their structure that prevents them from filtering blood the way they should).Resident 8 had a care plan indicating she had nephrostomy tubes dated 5/14/24. She was not observed wearing an abdominal binder as care planned. A treatment order, dated 8/22/25, indicated Resident 8 had nephrostomy tubes for her left and right kidneys and the dressings should be changed on shower days on Monday and Thursday.Her record lacked orders to observe the sites for signs and symptoms of infection, placement, care of the insertion sites, enhanced barrier precautions, and to monitor for any output post flushing with 10ml (milliliter) of saline. An Admit/Remit note, dated 5/13/26 at 6:25 p.m., indicated Resident 8 returned from the hospital.Resident 8's progress notes lacked documentation of the nephrostomy tubes. On 5/21/26 at 11:25 a.m., Registered Nurse (RN) 8 was observed demonstrating care of the nephrostomy tubes. She was able to unclamp the left tube but unable to unclamp the right tube. The tubes had dressings covering the insertion sites, but they were undated. On 5/21/26 at 11:30 a.m., Resident 8 indicated the staff were not caring for her tubes since she had been back from the hospital on 5/13/26.On 5/21/26 at 11:34 a.m., during an interview with the Medical Assistant (MA) from the nephrologist office. She indicated the dressings should be completed to the insertion sites and the tubes could be flushed if they were clamped. On 5/21/26 at 1:00 p.m., the Director of Nursing indicated they were changing the dressings two times per week and flushing the tubes daily.A policy titled, Nephrostomy Tube, Care of was provided by the Executive Director (ED) on 5/26/26 at 9:48 a.m. It indicated, .verify there is a physician order for this procedure, review the resident's care plan to assess for any special needs of the resident.410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview the facility failed to ensure pharmacy recommendations were appropriately reviewed and addressed timely by a medical professional for 2 of 5 Residents (Resident 11 and 81) reviewed for unnecessary medications.Findings include:A pharmacy recommendation dated 10/28/25 indicated Resident 11 had an order for Aspirindaily, Carbidopa/Levodopa (a medication used to treat Parkinson's disease.) extended release three times a day and Nitrofurantoin (an oral antibiotic used primarily to treat and prevent uncomplicated bacterial urinary tract infections). The pharmacist recommended to discontinue the Aspirin due to risk of bleeding, discontinue Nitrofurantoin due to liver toxicity and lowering the frequency of Carbidopa/Levodopa from three times a day to two times a day. The Nurse Practitioner (NP) indicated they would discontinue Aspirin, keep Carbidopa/Levodopa according to neurology orders and keep Nitrofurantoin with no rational for keeping that medication. The recommendation was signed 10/30/25.A pharmacy recommendation dated 11/16/25 indicated Resident 11 had an order for Nitrofurantoin. The pharmacist recommended discontinue that order due to liver toxicity. The NP indicated they would discontinue Nitrofurantoin and the recommendation was signed on 11/20/25.Resident 11 had a discontinued order for Nitrofurantoin with a discontinued date of 11/23/25.A pharmacy recommendation dated 12/16/25 indicated Resident 11 had an order for Aspirin daily, Carbidopa/Levodopa extended release three times a day. The pharmacist recommended discontinue the Aspirin due to risk of bleeding and lowering the frequency of carbidopa/levodopa from three times a day to two times a day. The recommendation lacked a response or signature for those recommendations.Resident 11 had a discontinued order for Aspirin with a discontinue date of 1/6/26.A pharmacy recommendation dated 1/25/26 indicated Resident 11 had an order for Hydroxyzine (a prescription antihistamine used to treat anxiety) every 6 hours as needed. The pharmacist recommended adding a stop date after 14 days or discontinuing the medication. The recommendation lacked a response or signature for those recommendations.A pharmacy recommendation dated 2/20/26 indicated Resident 11 had an order for Lorazepam (a prescription medication used to treat anxiety) every 8 hours as needed. The pharmacist recommended adding a stop date after 14 days or discontinuing the medication. The recommendation lacked a response or signature for those recommendations.A pharmacy recommendation dated 3/20/26 indicated Resident 11 had an order for Hydroxyzine every 6 hours as needed. The pharmacist recommended adding a stop date after 14 days or discontinuing the medication. The NP indicated they would discontinue Hydroxyzine and the recommendation was signed on 3/30/26.Resident 11 had a discontinued order for Hydroxyzine with a discontinue date of 3/30/26. A pharmacy recommendation dated 3/20/26 indicated Resident 81 had an order for Aspirin daily,Omeprazole (a stomach acid reducer) daily, Famotidine (a stomach acid reducer) 20mg daily and Duloxetine (an antidepressant) 90mg daily. The pharmacist recommended discontinue Aspirin and Omeprazole due to Clopidegrel (an antiplatelet blood thinner) use, adjust the Famotidine dose from 20mg daily to 20mg every other day due to poor kidney function and reduce the Duloxetine dose from 90mg daily to 60mg daily. The NP indicated they would reduce the Duloxetine dose to 60mg daily, but did not address the recommendations for Aspirin, Omeprazole or Famotidine. The recommendation was signed on 3/30/26.A pharmacy recommendation dated 4/21/26 indicated Resident 81 had an order for Aspirin daily, Omeprazole daily and Famotidine 20mg daily. The pharmacist recommended discontinue Aspirin and Omeprazole due to Clopidegrel use and adjust the Famotidine dose from 20mg daily to 20mg every other day due to poor kidney function. The recommendation lacked a response or signature for those recommendations.Resident 81 had an active order for Aspirin daily, Omeprazole daily and Famotidine 20mg daily.On 5/20/26 at 10:53 a.m. a copy of a current facility policy titled Psychotropic Drug Management dated 01/2025 was provided. That policy indicated, .H. The Attending physician will respond to any irregularities reported by the pharmacist as described in section VI (D) by reviewing the irregularities and documenting in the (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's medical record that the irregularity has been reviewed, and what, if any, action has been taken to address it. If no action has been taken, the attending physician must document his/her rationale. ii. Documentation by the Attending Physician must occur within 30 days of issuance of the pharmacist's report, unless the irregularity is an emergent issue requiring immediate action.According to the Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM) skilled nursing facilities are required to have a physician review any pharmacy recommendations and respond in writing whether they accept or reject the recommendation. If a recommendation is rejected the physician must document a clinical rational for why the recommendation was rejected.410 IAC (Indiana Administrative Code) 16.2-3.1-25(h)