| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155218 | A. Building<br>B. Wing | 03/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Great Lakes Healthcare Center | 2300 Great Lakes Dr<br>Dyer, IN 46311 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents with dry scaly skin were treated, treatments were completed, and abrasions were assessed and monitored for 7 of 7 residents reviewed for non-pressure related skin conditions, interventions were in place for a resident with diarrhea for 1 of 1 resident reviewed for diarrhea, and medications were held and administered with and without parameters for 4 of 5 residents reviewed for unnecessary medications. (Residents J, H, F, E, B, G , C, D, L, K, and M)Findings include: 1. During random observations, on 3/16/26 at 10:44 a.m. and 3/17/26 at 11:03 a.m., Resident J was observed in bed wearing a short sleeved hospital gown. At those times both of her arms were noted with very dry and fragile skin. Her legs were hanging out over the linens and both legs were observed with very dry and scaly skin.<br><br>During a random observation on 3/18/26 at 8:05 a.m., the resident was observed sitting up in a wheelchair with no pressure relieving cushion in the bottom of the chair. She was wearing short sleeves and her arms were observed with dry flaky skin. Her legs were also observed with dry flaky skin. At 2:00 p.m., 2 CNAs pushed the resident into her room and were going to put her bed using the Hoyer (mechanical) lift. The resident was placed into bed and her incontinent brief was removed. At that time, one of the CNAs provided incontinence care and patted her buttocks dry. LPN 7 entered the room with a tube of Calmoseptine lotion to apply to the resident's buttocks. At that time, the resident's legs were observed still dry with flaky skin.<br><br>During a random observation on 3/19/26 at 9:25 a.m., 1:30 p.m., and 2:30 p.m. the resident was observed up in a wheelchair, dressed in a short sleeve shirt. There was no cushion in the wheelchair.<br><br>At 3:30 p.m. on 3/19/26, LPN 3 went to open up the treatment cart to see if the resident's creams were inside the drawer. At that time, both of her creams were not available.<br><br>The record for Resident J was reviewed on 3/178/26 at 4:51 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), hemiplegia, aphasia, peg tube (a tube inserted directly into the stomach for nutrition), Alzheimer's disease, peripheral vascular disease and high blood pressure.<br><br>The admission Minimum Data Set (MDS) assessment, dated 2/25/26, indicated the resident was not cognitively intact for daily decision making. The resident was dependent on staff for ADLS and had a feeding tube. The resident had no pressure reducing device for the chair, and received applications or ointments other than to feet.<br><br>A Care Plan, dated 2/20/26, indicated the resident was at risk for pressure ulcer development, impaired skin integrity, or at risk for altered skin integrity. The approaches were to administer treatments as ordered by the medical provider.<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Physicians' Orders, dated 2/23/26, indicated to cleanse buttocks with soap and water and apply Zinc Oxide every shift and leave open to air. Apply Ammonia Lactate lotion to bilateral feet every shift and leave open to air.<br><br>The Treatment Administration Record (TAR) for 2/2026 indicated both treatments were signed out every shift as completed.<br><br>The TAR for 3/2026 for both treatments indicated they were blank and not completed on 3/4 all shifts, and 3/8 and 3/16/26 for the evening shift.<br><br>A Wound NP Note, dated 2/26/26, indicated the resident has no notable wounds, however would recommend Triad cream to Sacrum/ Buttocks every shift and prn (as needed) as preventative. Also recommend arm protectors, geri sleeves and pants to help prevent skin tears. Recommend the use of an emollient daily to the resident's skin routinely as the resident was was noted to have dry skin to the lower extremities.<br><br>During an interview 3/19/26 at 4:00 p.m., LPN 3, the Director of Nursing, and the Assistant Director of Nursing were made aware of the resident's dry scaly skin to her arms, feet and legs, no cushion to the wheelchair, and that LPN 7 gave the CNA Calmoseptine lotion to put on the resident's buttocks. They had no additional information to provide.<br><br>2. During an interview on 3/16/26 at 3:33 p.m., Resident H indicated his bandage had not been changed since last week. At that time, LPN 2 and PTA 2 were asked to stand the resident up so his bandage could be observed. The resident was assisted to stand up and LPN 2 removed his pants. The bandage his right buttock abscess was dated 3/12/26.<br><br>During an observation on 3/23/26 at 3:20 p.m., the Wound Nurse removed the resident's bandage from his buttocks area. The open wound on his buttocks was pink and red in color with minimal drainage. She performed the treatment as ordered.<br><br>The record for Resident H was reviewed on 3/18/26 at 2:30 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, fracture of left humerus, ileostomy, orthostatic hypotension, heart disease, chronic kidney disease, presence right artificial shoulder joint, and syncope.<br><br>The admission Minimum Data Set (MDS) was still in progress.<br><br>The 3/8/26 Nursing admission Assessment indicated the resident was cognitively intact for daily decision making.<br><br>A Care Plan, dated 3/13/26, indicated the resident was at risk for pressure ulcer development, impaired skin integrity, or at risk for altered skin integrity. The approaches were to administer treatments as ordered.<br><br>A Wound NP Note, dated 3/12/26, indicated the resident had an abscess to the right inner buttock that was present on admission and measured 3 centimeters (cm) in length by 0.5 cm in width, by 3.5 cm in depth. The wound base was 100% granulation tissue. The treatment was to cleanse the right inner buttock with wound cleanser, apply Calcium Alginate with Silver to base of the wound, and (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | secure with silicone bordered gauze every day and prn.<br><br>A Skin/Wound Note, dated 3/16/26 at 4:31 p.m., indicated the right inner buttock measured 2.8 cm in length, by 0.3 cm in width, and 2.8 cm in depth.<br><br>A Physician's Order, dated 3/12/26, indicated cleanse the right inner buttock with wound cleanser, apply Calcium Alginate with Silver to base of the wound, and secure with silicone bordered gauze every day and prn.<br><br>The Treatment Administration Record (TAR) for the month of 3/2026, indicated the right inner buttock treatment was blank and not signed out as being completed on 3/15 and 3/16/26. The treatment was signed out as being completed on 3/13 and 3/14/26.<br><br>During an interview on 3/16/26 at 3:45 p.m., the Wound Nurse indicated she did the bandage change with the wound NP last week on 3/12/26 and had not done the treatment since then.<br><br>During an interview on 3/23/26 at 9:00 a.m., the Director of Nursing had no additional information to provide.<br><br>3. During an observation on 3/19/26 at 9:25 a.m., Resident F was observed in bed with his eyes closed. At that time, an IV was infusing into a port in his right chest. CNA 5 and CNA 6 entered the room to reposition the resident in bed. The CNAs positioned the resident onto his left side and there was a drainage bag observed. CNA 5 lifted up the resident's gown and the tube was observed with sutures in the abdomen. There was no bandage covering the sutures.<br><br>The record for Resident F was reviewed on 3/18/26 at 9:10 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, colon, liver, rectal and large intestine cancer, severe protein malnutrition, adult failure to thrive, obstruction of bile duct, dysphagia, pressure ulcer of sacral region, and electrolyte and fluid balance disorder. The Modification of the admission Minimum Data Set (MDS) assessment, dated 3/3/26, indicated the resident was moderately impaired for daily decision making and had a pressure ulcer on admission.<br><br>A Care Plan, dated 2/25/26, indicated the resident had an alteration in liver functioning and gastrointestinal status related to a left biliary drain in place.<br><br>An MDS Note, dated 2/25/26, indicated the resident had left biliary drain in his abdomen.<br><br>A Physician's Order, dated 3/12/26, indicated to record biliary drain output every shift and monitor the site for signs and symptoms of infection.<br><br>A Physician's Order, dated 3/13/26, indicated to cleanse the biliary drain site with normal saline, pat dry, and cover with dry dressing every day shift.<br><br>There were no orders to empty the drain and record the output or clean the biliary site prior to 3/12/26.<br><br>The Treatment Administration Record (TAR) for 3/2026, indicated the output for the drain was not recorded for day shift on 3/15/26 and evening shift on 3/16/26.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 3/19/26 at 4:20 p.m., the Director of Nursing had no additional information to provide.<br><br>4. During a random observation on 3/18/26 at 9:17 a.m., CNA 2 was observed providing morning care for the resident. The resident was observed with extremely dry, flaky, and scaly skin to his lower extremities and both of his feet. There were large flakes of skin observed on the floor under the foot of the bed.<br><br>During a random observation on 3/19/26 at 11:00 a.m., CNA 1 was asked to remove the linens from the resident's legs. At that time, the resident was observed with extremely dry, flaky, and scaly skin to his lower extremities and both of his feet. There were large flakes of skin observed on the floor under the foot of the bed.<br><br>During a treatment observation on 3/20/26 at 1:43 p.m., the Assistant Director of Nursing lifted the bed linens and was able to observe the resident's dry skin as well as the flakes of skin on the floor under the foot of the bed.<br><br>The record for Resident E was reviewed on 3/19/26 at 11:55 a.m. Diagnoses included but were not limited to, stroke, dysphagia (difficulty swallowing) and peg tube.<br><br>The 1/28/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had no pressure ulcers.<br><br>A Care Plan, dated 10/30/25, indicated the resident had impaired skin integrity, or at risk for altered skin integrity related to skin tears to his buttocks.<br><br>There were no physician orders for any type of moisturizing cream for the resident's feet or legs.<br><br>A Wound NP Progress Note, dated 2/16/26, indicated the patient was noted to have dry skin to the lower extremities and feet. Recommend use of emollient daily to the legs and feet.<br><br>During an interview on 3/20/26 at 2:00 p.m., the Assistant Director of Nursing indicated the resident's feet and legs were dry. She observed the flakes of dry skin on the floor below the foot of the bed.<br><br>During an interview on 3/23/26 at 9:00 a.m., the Director of Nursing had no additional information to provide.<br><br>5. During a random observation on 3/17/26 at 8:40 a.m., CNA 1 was asked to remove the bed linens from Resident B so his lower extremities could be observed. At that time, the resident was observed with extremely dry, scaly and flaky skin to both legs and feet.<br><br>During a wound treatment on 3/20/26 at 1:53 p.m., both the Wound Nurse and the Assistant Director of Nursing were shown the resident's dry scaly skin to his feet and legs.<br><br>The record for Resident B was reviewed on 3/19/26 at 1:30 p.m. The resident was admitted to the facility on [DATE], discharged to hospital on 3/3/26 and returned on 3/10/26. Diagnoses included, but were not limited to, type 2 diabetes, severe protein malnutrition, stroke, psychotic disorder, major depressive disorder, pressure ulcer, contracture of right lower leg, anxiety disorder, depressive<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | disorder, seizures.<br><br>The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 3/3/26, indicated the resident was not cognitively intact for daily decision making and was dependent on staff for activities of daily living. The resident had a limited range of motion to both of his lower extremities and had one unstageable pressure ulcer.<br><br>A Care Plan, revised on 12/31/25, indicated the resident was at risk for pressure ulcer development, impaired skin integrity, or at risk for altered skin integrity.<br><br>There were no orders for any type of skin moisturizer for the resident's legs and feet.<br><br>A Wound NP note, dated 2/2/26, indicated to apply moisturizer to resident's skin routinely.<br><br>During an interview on 3/20/26 at 2:30 p.m., the Wound Nurse indicated the resident had no orders for any type of moisturizing cream or lotion for his dry flaky skin to his legs and feet.<br><br>During an interview on 3/23/26 at 9:00 a.m., the Director of Nursing had no additional information to provide.<br><br>6. The record for Resident G was reviewed on 3/23/26 at 8:30 a.m. Diagnoses included but were not limited to, diabetes, high blood pressure, heart disease and chronic kidney disease.<br><br>The Modification of the admission Minimum Data Set (MDS) assessment, dated 12/23/25, indicated the resident was not cognitively intact for daily decision making.<br><br>A Physician's Order, dated 12/18/25, indicated Lisinopril 5 milligrams (mg), give one tablet by mouth one time a day.<br><br>The 1/2026 Medication Administration Record (MAR) indicated the Lisinopril was coded with a 9 meaning see nursing notes and was not administered. The resident's blood pressure was 115/56.<br><br>The 2/2026 MAR indicated the Lisinopril was coded with a 5 meaning hold see nursing notes and was not administered. The resident's blood pressure was 110/50.<br><br>The 3/2026 MAR indicated the Lisinopril was coded with a 9 on 3/8/26 and 3/9/26 and the medication was not administered. The resident's blood pressure was 103/56 on 3/8/26 and 99/56 on 3/9/26.<br><br>A Nurses' Note, dated 1/7/26 at 9:46 a.m., indicated the medication was held because there was no high blood pressure noted.<br><br>A Nurses' Note, dated 3/8/26 at 10:38 a.m., indicated the medication was held for low blood pressure per physician orders.<br><br>There were no blood pressure parameters ordered by the physician to hold the Lisinopril.<br><br>During an interview on 3/23/26 at 2:45 p.m., the Regional Director of Clinical Operations indicated she (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | had no additional information on why the medication was held.<br><br>7. On 3/16/26 at 12:47 p.m., 3/18/26 at 9:52 a.m., and 3/19/26 at 9:19 a.m., Resident C was observed lying in bed. The resident had reddened scabbed areas to the tops of both hands. The top of his left hand had skin peeling. The resident had reddened abrasions to his outer right elbow and upper right arm.<br><br>Record review for Resident C was complete on 3/19/26 at 9:40 a.m. Diagnoses included, but were not limited to Parkinson's disease and hypertension.<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 2/11/26, indicated the resident was moderately cognitively impaired. The resident was dependent on staff for dressing, personal hygiene, bed mobility, and transfers.<br><br>A Care Plan, dated 8/12/22 and revised 1/29/26, indicated the resident was at risk for impaired skin integrity related to decline in functional status and Parkinson's disease. An intervention included to complete skin at risk assessments as needed.<br><br>A Weekly Skin Check, dated 3/13/26, indicated the resident had no skin issues noted.<br><br>Shower Sheets, dated 3/13/26 and 3/17/26, indicated the resident was showered and no skin concerns were documented.<br><br>There was a lack of documentation to indicate the resident's reddened and scabbed areas on his skin were assessed and or monitored.<br><br>During an interview on 3/19/26 at 2:35 p.m., the Divisional Director of Clinical Services indicated she could not provide any documentation the resident's skin issues had been assessed or were being monitored.<br><br>8. Record review for Resident D was completed on 3/18/26 at 1:42 p.m. Diagnoses included, but were not limited to atrial fibrillation, hypertension, and hypotension.<br><br>A Physician's Order, dated 1/26/26, indicated to give metoprolol tartrate (medication to lower your blood pressure) 50 mg (milligrams) two times a day for hypertension. Hold for SBP (systolic blood pressure, top number of blood pressure reading) less than 100. Hold for a heart rate less then 60.<br><br>The February and March 2026 Medication Administration Records (MAR) indicated the metoprolol was given when the blood pressure (BP) was out of parameters on the following dates and times:-2/2/26 PM: the BP was 91/59 and the metoprolol was given-2/6/26 PM: the BP was 90/61 and the metoprolol was given-2/8/26 PM: the BP was 92/68 and the metoprolol was given-2/22/26 PM: the BP was 98/62 and the metoprolol was given-2/23/26 AM: the BP was 92/62 and the metoprolol was given-2/27/26 AM: the BP was 99/66 and the metoprolol was given-3/13/26 AM: the BP was 87/58 and the metoprolol was given-3/18/26 AM: the BP was 97/67 and the metoprolol was given<br><br>A Physician's Order, dated 1/26/26, indicated to give midodrine hcl (medication to treat low blood pressure) 10 mg three times a day for hypotension. Hold if greater then 120.<br><br>The February and March 2026 MARs indicated the midodrine was given when the BP was out of<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | parameter on the following dates and times:-2/1/26 Afternoon: BP was 132/76 and the midodrine was given-2/1/26 PM: BP was 127/72 and the midodrine was given-2/15/26 AM: BP was 127/66 and the midodrine was given-2/15/26 Afternoon: BP was 127/66 and the midodrine was given-2/15/26 PM: BP was 133/65 and the midodrine was given-2/16/26 PM: BP was 125/83 and the midodrine was given-2/24/26 PM: BP was 122/57 and the midodrine was given-2/25/26 Afternoon: BP was 123/72 and the midodrine was given-2/26/26 PM: BP was 124/80 and the midodrine was given-3/3/26 Afternoon: BP was 123/78 and the midodrine was given-3/3/26 PM: BP was 130/72 and the midodrine was given-3/7/26 PM: BP was 127/64 and the midodrine was given<br><br>During an interview on 3/19/26 at 2:11 p.m., the Divisional Director of Clinical Services indicated she was unable to provide any documentation why the medications were given outside of the parameters when they should not have been given.<br><br>9. During an interview on 3/18/26 at 9:25 a.m., Resident L indicated she had diarrhea after dinner the previous night. She told the nurse about it, and she thought the nurse gave her an anti-diarrheal medication. She had frequent bouts of diarrhea, but medicine usually helped.<br><br>The record for Resident L was reviewed on 3/18/26 at 2:50 p.m. Diagnoses included, but were not limited to, diabetes.<br><br>The Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was cognitively intact for daily decision making, and required maximal assistance with activities of daily living (ADLs).<br><br>a. A Physician's Order, dated 11/28/25, indicated Loperamide HCl (an anti-diarrheal) every 6 hours as needed.<br><br>The Point-of-Care CNA documentation indicated the resident had watery stools on 3/6/26, 3/7/26 for 2 shifts, 3/12/26, and 3/18/26.<br><br>A 3/9/26 Alert Charting Note indicated the resident complained of diarrhea. Follow-up included giving Loperamide as needed.<br><br>The Medication Administration Record (MAR) for March 2026 indicated the resident had not received any doses of Loperamide.<br><br>b. A Physician's Order, dated 9/10/25, indicated Lantus (a long-acting insulin), 70 units to be given at bedtime. There were no parameters for holding the medication.<br><br>The Medication Administration Record (MAR) indicated the Lantus was not given on 2/2/26, 2/23/26, 3/13/26, and 3/15/26.<br><br>A Physician's Order, dated 11/9/25, indicated Insulin NPH and regular insulin 70/30 (a mix of short and long-acting insulins), 20 units to be given twice a day. There were no parameters for holding the medication.<br><br>The Medication Administration Record (MAR) indicated the 70/30 insulin evening dose was not given on 2/13/26, 2/22/26, and 2/27/26. The morning dose was not given on 3/15/26.<br><br>A Physician's Order, dated 9/30/25, indicated Novolog (a fast-acting insulin), 100 units to be given<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | three times a day. There were no parameters for holding the medication.<br><br>A Care Plan, updated 2/18/26, indicated the resident was diabetic. Interventions included administering insulin as ordered.<br><br>The Medication Administration Record (MAR) indicated the afternoon Novolog was not given on 2/9/26, 2/13/26, 2/14/26, 2/20/26, 3/5/26, 3/8/26, and 3/15/26. The evening dose was not given on 2/16/26 and 2/27/26.<br><br>A Physician's Order, dated 9/9/25, indicated Humalog (a fast-acting insulin), three times a day per the following sliding scale:<br><br>if blood sugar 181 - 230 = 4 units; 231 - 280 = 7 units; 281 - 330 = 10 units; 331 - 350 = 13 units; 351 - 400 = call MD,<br><br>The February and March MAR indicated no Humalog was givenas follows: on 2/1/26, the morning blood sugar was 399, the afternoon blood sugar was 228; On 2/3/26, the morning blood sugar was 371, the afternoon blood sugar was 189; On 2/6/26, the morning blood sugar was 252, the afternoon blood sugar was 400; On 2/10/26, the morning blood sugar was 400, the afternoon blood sugar was 330; On 2/15/26, the morning blood sugar was 365, the afternoon blood sugar was 183; On 2/20/26, the morning blood sugar was 400; On 2/23/26, the morning blood sugar was 219, the afternoon blood sugar was 226; On 2/24/26 the morning blood sugar was 400, the afternoon blood sugar was 267; On 2/28/26, the morning blood sugar was 400, the evening blood sugar was 294; On 3/1/26, the morning blood sugar was 400, the afternoon blood sugar was 208.<br><br>During an interview on 3/24/26 at 10:10 a.m., the Regional Director of Clinical Operations was informed of the findings and had no additional information to provide.<br><br>10. The record for Resident K was reviewed on 3/18/26 at 10:38 a.m. Diagnoses included, but were not limited to, acute cor pulmonale (right sided heart failure) and hypertension.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 1/20/26, indicated the resident had severe cognitive impairment, required maximal assistance with ADLs, and received all medications and nutrition via a feeding tube.<br><br>A Physician's Order, dated 1/11/26, indicated Metoprolol Tartrate (a medication used to treat high blood pressure and heart failure) 25 milligrams twice a day. There were no parameters for holding the medication.<br><br>The February and March MARs indicated the nurse held the following doses of the Metoprolol: 2/9/26 p.m., 2/13/26 p.m., 2/14/26 a.m., 2/23/26 a.m., 2/24/26 p.m., 3/1/26 a.m., 3/13/26 a.m., 3/14/26 a.m., and 3/15/26 a.m. and p.m.<br><br>During an interview on 3/19/26 at 10:55 a.m., LPN 1 indicated if there was not a specific ordered parameter, she would hold a blood pressure lowering medication for any resident if their systolic (top number of a blood pressure reading) blood pressure was less than 120.<br><br>When informed of the findings on 3/24/25, the Director of Nursing and Regional Director of Clinical Operations offered no additional information.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 11. The record for Resident M was reviewed on 3/20/26 at 10:12 a.m. Diagnoses included, but were not limited to, quadriplegia, diabetes, and peripheral vascular disease.<br><br>The Quarterly Minimum Data Set (MDS) assessment, dated 3/7/26, indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs) and had an arterial ulcer (a wound caused by poor blood flow).<br><br>A Physician's Order, dated 2/3/26, indicated to cleanse the right foot / heel with wound cleanser, pat dry with gauze, apply betadine-moistened gauze, cover with pad and rolled gauze, and secure with tape every day shift for wound care.<br><br>The record lacked documentation of wound care completed or refused on 3/1/26, 3/6/26, 3/7/26, 3/14/26, 3/15/26, and 3/21/26.<br><br>During an interview on 3/24/26 at 10:10 a.m., when informed of the findings, the Regional Director of Clinical Operations indicated she had no additional information to provide.<br><br>This citation is related to Intake 2794393.<br><br>410 IAC (Indiana Administrative Code) 16.2 3.1-37(a) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident who had a pressure ulcer received the care and services to promote healing related to treatments not being completed as ordered by the physician and signed out on the treatment records for 3 of 6 residents reviewed for pressure ulcers. (Residents F, E, B)Findings include:1. During an observation on 3/19/26 at 9:25 a.m., Resident F was observed in bed with his eyes closed. At that time an IV was infusing into a port in his right chest. CNA 5 and CNA 6 entered the room to reposition the resident in bed. The CNAs positioned the resident onto his left side and removed his brief. At that time there was an open bloody wound on the resident's coccyx area. There was no evidence of any cream or a bandage covering the wound. The record for Resident F was reviewed on 3/18/26 at 9:10 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, severe protein malnutrition, adult failure to thrive, dysphagia, pressure ulcer of sacral region, and electrolyte and fluid balance disorder. The Modification of the admission Minimum Data Set (MDS) assessment, dated 3/3/26, indicated the resident was moderately impaired for daily decision making and had a pressure ulcer on admission. The Care Plan, dated 2/25/26, indicated the resident was at risk for the development of a pressure ulcer. The approaches were to provide treatments as ordered by the physician. A Wound Nurse Practitioner (NP) note, dated 2/26/26, indicated the resident had a Stage 2 pressure ulcer (a partial-thickness skin loss involving the epidermis and dermis, presenting as a shallow, open, pink/red wound or a ruptured blister) to the sacrum/buttocks area that was present on admission. The ulcer measured 11 centimeters (cm) in length, by 5.5 cm in width, by 0.1 cm in depth. The wound base was 100% epithelial tissue (a primary tissue type composed of tightly packed cells arranged in continuous sheets or tubes that cover external skin, line internal cavities/organs, and form glands). The treatment recommendation was to cleanse with soap and water, pat dry, apply Zinc Oxide Paste and Collagen Particles to base of the wound, and leave open to air. Change every shift and prn (as needed) A Physician's Order, dated 2/26/26, indicated cleanse inner buttocks with soap and water, pat dry, and apply Zinc Oxide every shift and leave open to air until resolved.A Wound NP Note, dated 3/3/26, indicated the Stage 2 pressure ulcer was smaller in size and measured 4.5 cm in length by 2.5 cm in width, by 0.1 cm in width and the wound base was 100% epithelial tissue. The treatment recommendation remained the same as above.A Wound NP Note, dated 3/12/26, indicated the Stage 2 pressure ulcer was improving and measured 1 cm in length, by 1.5 cm in width, by 0.1 cm in depth and the wound base was 100% epithelial tissue. The treatment recommendations remained the same as above. A Wound NP Note, dated 3/19/26, indicated the Stage 2 pressure ulcer had worsened and measured 9.00 cm in length, 3.00 cm in width, and 0.10 cm in depth. The wound was now described as a Kennedy terminal ulcer and 70% epithelial tissue and 30% granulation tissue. The treatment was changed to a dry collagen silicone bordered suprabsorb foam bandage and change three times a week. The Treatment Administration Record (TAR) for 2/2026 and 3/2026 indicated the treatment of cleaning with soap and water and the application of Zinc Oxide cream was completed every day shift and not every shift as ordered by the physician. During an interview on 3/19/26 at 11:55 a.m., the Wound Nurse indicated the resident had the open area to his buttocks and it had worsened. He had been seen by the Wound NP and a treatment was in place. She had thought the treatment was being done every shift. During an interview on 3/19/26 at 4:20 p.m., the Director of Nursing was provided the information and had no additional information to provide. 2. During a wound treatment observation on 3/20/26 at 2:45 p.m., the Wound Nurse removed the bandage from Resident E's buttocks area. There was one pressure ulcer to the right buttock and one pressure ulcer to the left buttock. Both ulcers were clean and pink in color with minimal drainage.The record for Resident E was reviewed on 3/19/26 at 11:55 a.m. Diagnoses included but were not limited to, stroke, dysphagia (difficulty swallowing) and peg tube.The 1/28/26 Quarterly Minimum Data Set (MDS) assessment indicated the (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident was cognitively intact for daily decision making and had no pressure ulcers.A Care Plan, dated 10/30/25, indicated the resident had impaired skin integrity of skin tears noted to buttocks. A Wound NP Note, dated 2/16/26, indicated the resident had a new Stage 2 pressure ulcer to the right buttock that measured 1.0 centimeter (cm) in length, by 0.5 cm in width, by 0.1 cm in depth and was 100% epithelial tissue. The wound treatment was to cleanse the right buttocks with soap and water, apply Zinc Oxide to the wound base every shift and leave open to air. A Physician's Order, dated 2/16/26, indicated cleanse the right buttock with soap and water, pat dry, apply Zinc Oxide paste and leave open to air every shift. The 2/2026 Treatment Administration Record (TAR) indicated the treatment was left blank and not signed out as being completed for the day shift on 2/17 and 2/21/26 and the for the evening shift on 2/17/26. A Wound NP Note, dated 2/23/26, indicated the Stage 2 pressure ulcer was stable and measured 3.5 cm in length by 1.0 cm in width, by 0.1 cm in depth and had 100% epithelial tissue. The treatment remained the same as above. A Physician's Order, dated 2/23/26, indicated to cleanse both buttocks with soap and water, apply Zinc Oxide paste, and leave open to air every day shift. The TAR for the month of 3/2026, indicated the treatment for the buttocks was blank and not completed on the day shift on 3/3, evening shift 3/1, 3/3, and 3/6/26, and on the midnight shit on 3/3/26. A Wound NP Note, dated 3/16/26, indicated the Stage 2 pressure ulcer to the right buttocks now measured 2.7 cm in length, by 1 cm in width, by 0.1 cm depth. A new open area had developed and was identified as an abrasion to the left inner buttock. The treatment for the right buttocks was changed to apply skin prep to the outer edges, collagen with silver to the base of the wound and cover with a silicone bordered gauze. During an interview on 3/20/26 at 2:45 p.m., the Wound Nurse indicated treatments were supposed to be completed as ordered by the physician. During an interview on 3/23/26 at 9:00 a.m., the Director of Nursing had no additional information to provide. 3. During a wound treatment observation on 3/20/26 at 1:53 p.m., Resident B was observed lying in bed. At that time, his right leg was severely contracted and he had a wound vac observed to his right hip. The wound nurse removed the wound vac and the resident's pressure ulcer was red and pink in color with bloody drainage. The record for Resident B was reviewed on 3/19/26 at 1:30 p.m. The resident was admitted to the facility on [DATE], discharged to hospital on 3/3/26 and returned on 3/10/26. Diagnoses included, but were not limited to, type 2 diabetes, severe protein malnutrition, stroke, pressure ulcer and contracture of right lower leg.The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 3/3/26, indicated the resident was not cognitively intact for daily decision making and was dependent on staff for activities of daily living. The had 1 unstageable pressure ulcer.The Care Plan, dated 12/31/25, indicated the resident was at risk for pressure ulcers related to contractures to the right leg and arm. The resident had an actual altered skin integrity to the right hip. The approaches were to administer treatments as ordered by the physician. A Wound NP Note, dated 1/6/26, indicated the resident developed an abrasion to the right hip, that measured 7 centimeters (cm) by 5.5 cm in width by 0.1 cm.in depth. The treatment was to cleanse with wound cleanser, apply Xeroform to base of the wound, and secure with ordered gauze three times a week. The Wound NP saw and assessed the resident's right hip every week.A Wound NP Note, dated 2/2/26, indicated the wound was worsening and was now full thickness with slough (necrotic tissue) to wound bed. The wound measured 3.5 cm in length by 2 cm in width, by 0.1 cm in depth with 100% slough. The treatment was changed to cleanse with wound cleanser, apply Honey Hydrogel Sheet Dressing to base of the wound, and secure with bordered gauze change every day. A Wound NP Note, dated 2/9/26, indicated the wound now appeared as an unstageable pressure injury with greater depth and slough to the wound bed. The wound measured 3.5 cm in length by 3 cm in width by 0.5 cm in depth and had 100% slough. The treatment was changed to cleanse with wound cleanser, apply Collagen to base of the wound, and secure with a bordered gauze and change daily and prn. The Treatment Administration Record (TAR) for the month of 2/2026, had the order of cleanse the right hip with wound cleanser, pat dry with gauze, apply collagen, cover with bordered gauze every day shift. The treatment was blank and not completed on 2/15 and 2/21/23.A Wound NP (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Note, dated 2/23/26, indicated the wound to right hip was now noted with undermining and was malodorous after cleaning. The wound measured 4.5 cm in length, by 1.5 cm in width, and by 1.2 cm in depth with undermining from undefined o'clock to 3 o'clock of 1.6 cm. The wound was 100% granulation tissue. The treatment was changed at that time to cleanse with 0.25% Dakins solution, apply Collagen with silver to base of the wound, and secure with Bordered gauze every day and prn. A Physician's Order, dated 2/24/26, indicated to clean the right hip with Dakins 0.25% solution, pat dry with gauze, apply collagen with silver, cover with bordered gauze every day shift.The TAR for 2/2026 and 3/2026, indicated the treatment was blank and not completed on 2/26 and 3/2/26.During an interview 3/20/26 at 1:41 p.m., the Wound Nurse indicated the resident favored his right side and his right leg was contracted. He developed an abrasion to the right hip which turned into a pressure ulcer, however, the resident refused to stay off of the right hip and would refuse care from staff. The pressure ulcer was healing but then became infected so he was sent to the hospital and it was debrided. He returned with a wound vac and it was healing and doing better. The treatments were to be completed as ordered by the physician. This citation relates to Intake 2794393 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(1) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident who was admitted with a limited range of motion received the necessary treatment and services to prevent decline related to application of an orthotic device by the Physical Therapy (PT) for 1 of 3 residents reviewed for range of motion. (Resident B)Finding includes: During a random observation on 3/17/26 at 8:40 a.m., CNA 1 was asked to remove the bed linens from the resident so his lower extremities could be observed. At that time, the resident was observed with a serve contracture to his right leg. His leg was completely bent and he was unable to fully extend it.The record for Resident B was reviewed on 3/19/26 at 1:30 p.m. The resident was admitted to the facility on [DATE], discharged to hospital on 3/3/26 and returned on 3/10/26. Diagnoses included, but were not limited to, severe protein malnutrition, stroke, pressure ulcer, contracture of right lower leg, and seizures.The admission Minimum Data Set (MDS) assessment, dated 10/9/25, indicated the resident had a limited range of motion to both of his lower extremities.The Modification of the Significant Change (MDS) assessment, dated 3/3/26, indicated the resident was not cognitively intact for daily decision making and was dependent on staff for activities of daily living. The resident had a limited range of motion to both of his lower extremities. A Care Plan, dated 3/16/26, indicated the resident had an alteration in musculoskeletal status related to right leg contracture related to a stroke.A Physician's Order, dated 10/5/26, indicated physical therapy (PT) five times a week for four weeks. A PT evaluation and treatment note, dated 10/5/25, indicated the patient presented with a decline in functional mobility with decreased strength, impaired balance, reduced activity tolerance and decreased safety awareness. The patient would benefit from skilled PT services to address functional limitations. The reason for skilled services was the patient required skilled PT services to evaluate the need for an assistive device to facilitate with functional mobility and increase lower extremity strength. A new goal on the evaluation indicated the patient will safely wear least restrictive splinting/orthotic device one hour on and one hour off without skin irritation in order to inhibit abnormal positions (target 10/11/25).There was no documentation on the initial evaluation of the lower extremity strength, the degree of any contracture, and what the functional limitations of the lower extremities were on 10/5/25.The resident received PT five times a week with documentation of assist active range of motion to the lower extremities, however, the resident could not return the demonstration by himself. A PT Progress Note, dated 10/13/26, indicated active assist range of motion was performed to bilateral lower extremities to focus on strengthening and improve functional mobility. The resident could not return demonstration with the range of motion. A PT Progress Note, dated 10/14/26 and 10/16/26 indicated active assist range of motion was performed on bilateral lower extremities to improve overall functional mobility.A PT Progress Note, dated 10/21/26, indicated the resident's family was getting concerned the right lower extremity was becoming contracted. The therapist reviewed the goals and advised that wearing an orthotic device within the resident's toleration was part of the plan of care. A PT Progress Note, dated 10/28/26 indicated gentle manual stretch to the right lower extremity was completed with fair toleration due to increased pain with movement. A PT Progress Note, dated 11/3/26, indicated gentle manual stretch on the right lower extremity hamstrings was completed within the resident's toleration to increase range of motionA PT Progress Note, dated 11/5/26, indicated active assist range of motion was performed on bilateral lower extremities to improve overall functional mobility.A PT Progress Note, dated 11/12/26, indicated the orthotic device was introduced to the resident's right knee. The orthotic device was placed on the resident's right knee on 11/13, 11/15, 11/16, and 11/19/25, The resident was only able to tolerate 15 minutes of the right knee brace and the therapist had to remove it because of pain. There was no documentation the right knee brace/orthotic device was ever placed back on the resident's right knee<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | after 11/19/25. A Physical Therapy Recertification and Updated Plan of Treatment, dated 10/30/25 through 11/26/25, indicated therapeutic exercises for lower extremities to facilitate independence in mobility tasks, gentle manual stretch to right lower extremity as tolerated and continued treatment to prevent further decline may include orthotic management and training.A Physical Therapy Recertification and Updated Plan of Treatment, dated 11/25/25 through 12/22/25, indicated therapeutic exercises for lower extremities to facilitate independence in mobility tasks, gentle manual stretch to right lower extremity as tolerated and continued treatment to prevent further decline may include orthotic management and training. The resident decreased static balances and limitations in range of motion and strength impairments. Physician therapy was reduced from five times a week to three times a week at that time. A PT Discharge summary, dated [DATE], indicated a restorative nursing program was recommended to facilitate and maintain the resident's current level of performance and prevent further decline. Active range of motion to the left lower extremity and passive (gentle) range of motion to the right knee.A Physician's Order, dated 2/13/26, indicated gentle passive range of motion to the right knee, 10 times for one rep up to seven days a week. Restorative Nursing Notes indicated the resident received passive range of motion to the right knee 12 times from 2/14 through 3/3/26. During an interview on 3/23/26 at 9:30 a.m. PT 1 indicated he saw the resident some of the days for therapy but the therapist who did the initial evaluation was another therapist and only worked prn (as needed). He indicated the resident was confused and could not tolerate some of the exercises. He was unaware when the orthotic device was ordered or when it was available. He was also unaware why the orthotic device was not placed back on the resident after only 7 days of use. He only saw the resident when the other PT was not here in the building. During an interview at the above time, the Director of Rehabilitation (DOR) did not know the answers to any of the questions because she was not available and on leave during that time period. She had instructed the therapists to write down in their progress notes when orthotic devices were ordered and when they came in. She would look into the questions and try to contact the PT who saw the resident most of the time. During an interview on 3/23/26 at 1:37 a.m., Physical Therapist Assistant, (PTA) 1 indicated she treated the resident when he was in therapy. On the initial evaluation, the need for an orthotic device indicated there was some type of contracture or physical limitation. She indicated the right lower extremity was already partially contracted when he was admitted to the facility. She was unable to indicate the degree of limitations because that was not in her scope of practice. There was no documentation of what the lower extremity strength or the degree of the lower extremity limitations on the initial evaluation. She had an interview with the resident's sister on 10/21/26 and explained to the family there was a need for an orthotic device, however, there was a process to get the patient to that point for the device. She indicated the resident needed an increase in range of motion and stretching before the orthotic device would be put in place and thereapy needed to do more exercises for the knee to fit in the brace. The therapists can choose what goals they would want to work on, therefore range of motion may not have been completed every day and/or the orthotic device being fitted. She indicated the resident could only tolerate 15 minutes of the orthotic device to the knee because of pain, and the resident would refuse to even allow staff to touch his right leg during therapy. During an interview on 3/23/26 at 2:15 p.m., the DOR indicated she reviewed the PT's notes and there was no documentation of the resident's initial lower extremity strength or functional range of motion. She also indicated she read where the continuation of the orthotic device was to be utilized for the recertification for the continued physical therapy and it was not. There was no documentation by the physical therapist on why the device was not trialed anymore after 11/21/26. The Physical Therapist who completed the initial evaluation and treated the resident most of the time was unavailable to interview. During an interview on 3/23/26 at 3:55 p.m., the Restorative Nurse indicated his contracture to the right knee was the same today as it was when he was discharged from therapy on 2/12/26. She received the referral from therapy at that time for restorative therapy with the hopes of some improvement, so he was on the restorative case load, (continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | however sometimes he would not allow the staff to work with the right leg due to pain. He was discharged from restorative on 3/3/26 because he was admitted to the hospital and when he came back, she received another referral from therapy for functional maintenance program because there was no chance of improvement of the right leg. This citation relates to Intake 2794393.410 IAC (Indiana Administrative Code) 16.2-3.1-42(a)(2) |