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

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

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents who were dependent on staff for Activities of Daily Living (ADLS) received the care and assistance needed related to showers, greasy hair, dirty fingernails, and facial hair for 5 of 12 residents reviewed for ADLS. (Residents 96, H, C, 95, and 19)Findings include: 1. During an interview on 3/16/26 at 4:03 p.m., Resident 96 indicated he does not always get a shower two times a week. The record for Resident 96 was reviewed on 3/19/26 at 10:16 a.m Diagnoses included, but were not limited to, stroke, need for assistance with personal care, depressive disorders, and depression. The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 12/18/26, indicated the resident was moderately impaired for daily decision making and needed substantial to max assist for bathing and personal hygiene. The resident had a limited range of motion impairment to one side for both upper and lower extremities. A Care plan, revised on 12/18/25, indicated the resident had a behavior problem of refusing care such as showers. Shower sheets provided by the facility indicated at the top of the form, there was a section to check if the resident refused or accepted the shower/bed bath. There were shower sheets for the following days: 1/2, 1/6, 1/9, 1/12, 1/13, 1/16, 1/21, 1/22, 1/23, 1/27, 1/30, 2/3, 2/6, 2/10, 2/13, 2/17, 2/20, 2/24, 2/27, 3/3, 3/6, 3/10, 3/13, and 3/18/26, however, the only time there was a check mark in accepted the shower was on 1/12, 1/16, 1/22, 2/3, 2/24, 2/27, 3/3, and 3/18/26. During an interview on 3/23/23 at 9:00 a.m., the Director of Nursing had no additional information to provide. 2. During an interview on 3/16/26 at 3:23 p.m., Resident H indicated he needed assistance with eating, because his right arm was healing from an old fracture and he just recently fell at home and his left arm was in a sling and fractured as well. He indicated it was hard for him to eat and set up his meal tray by himself, and most times staff would just bring his tray in and place it in front of him and not help him eat or set it up. The resident indicated no staff had asked him if he wanted to brush his teeth or even set him up to brush his teeth. He also indicated staff had not helped him or provided morning care and he had been sweating a lot and needed to be cleaned up. During an observation on 3/18/26 at 8:05 a.m., the resident was observed eating his breakfast. At that time, there were no staff observed in the room assisting him with his food. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/26 at 9:20 a.m., the resident indicated no staff had helped him or provided oral care. 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. The admission Minimum Data Set (MDS) was still in progress. The 3/8/26 Nursing admission Assessment, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 3/12/26, indicated the resident had a fracture to the left humerus. The approaches were to provide assistance with ADLs. In the CNA task section there was no documentation oral care was provided on 3/16/26. Shower sheets, provided by the facility indicated the resident received a shower on 3/13 and 3/17/26. During an interview on 3/23/26 at 9:00 a.m., the Director of Nursing was given the information and had no additional information to provide. 3. 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's fingernails were long and had a dark debris underneath them. 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. 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 personal hygiene. During an interview on 3/19/26 at 2:11 p.m., the Divisional Director of Clinical Services indicated the staff should have observed the resident's fingernails were long and dirty and cleaned and offered to cut them. She could not provide any information the resident had refused to have them cleaned or cut. 4. On 3/17/26 at 2:02 p.m., 3/18/26 at 9:58 a.m., and 3/19/26 at 11:49 a.m., Resident 95 was observed sitting in a reclining geriatric chair. The resident's fingernail were long with a dark debris underneath them. His hair was not combed and his beard was long and unkempt. Record review for Resident 95 was completed on 3/19/26 at 11:07 a.m. Diagnosed included, but were not limited to, stroke, hemiplegia, and dementia. The Quarterly MDS assessment, dated 3/4/25, indicate the resident was cognitively impaired. The resident was dependent on staff for personal hygiene. During an interview on 3/19/26 at 2:11 p.m., the Divisional Director of Clinical Services indicated the staff should have observed the resident's fingernails were long and dirty and cleaned and offered to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cut them. The resident's hair should have been combed and his beard trimmed. She could not provide any information the resident had refused to have his fingernails cleaned and cut or his beard cut. A facility policy titled, Routine Resident Care and provided as current from the facility on 3/23/26, indicated, 3. Unlicensed Staff: .b. Routine care by a nursing assistant included but is not limited to the following: i. Assisting or provides for personal care . 5. During a random observation on 3/16/26 at 3:28 p.m., Resident 19 had greasy hair and a strong smell of body odor. At that time, she indicated she had not had a shower in 2 weeks. She was supposed to get showers twice a week, but did not receive them, and she did not refuse care. The resident's record was reviewed 3/17/26 at 3:49 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis of one side of the body) due to a stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 2/4/26, indicated the resident was cognitively intact for daily decision making, and was dependent in activities of daily living (ADLs). A Care Plan, revised on 8/8/25, indicated the resident had an ADL self-care deficit, and was totally dependent in bathing. The Shower Sheet and Body/Skin Inspection Form for Nurse Aides for February and March 2026 indicated the following: the week of 2/15/26 to 2/21/26 no showers were accepted or refused; the week of 2/22/26 to 2/28/26 one shower was offered and accepted; the week of 3/1/26 to 3/7/26 no showers were accepted or refused; and the week of 3/15/26 to 3/21/26 one shower was offered and accepted. During an interview on 3/23/26 at 9:30 a.m., the Administrator was informed of the findings and offered no additional information. 410 IAC (Indiana Administrative Code)16.2- 3.1-38(a)(2)(A) 410 IAC (Indiana Administrative Code)16.2- 3.1-38(a)(3)(A) 410 IAC (Indiana Administrative Code)16.2- 3.1-38(a)(3)(B) 410 IAC (Indiana Administrative Code)16.2- 3.1-38(a)(3)(C) 410 IAC (Indiana Administrative Code)16.2- 3.1-38(a)(3)(D) 410 IAC (Indiana Administrative Code)16.2- 3.1-38(a)(3)(E)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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. 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. 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. 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. 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. 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. 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. 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. The Treatment Administration Record (TAR) for 2/2026 indicated both treatments were signed out every shift as completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. The admission Minimum Data Set (MDS) was still in progress. The 3/8/26 Nursing admission Assessment indicated the resident was cognitively intact for daily decision making. 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. 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 secure with silicone bordered gauze every day and prn. 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. During an interview on 3/23/26 at 9:00 a.m., the Director of Nursing had no additional information to provide. 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. 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. 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. An MDS Note, dated 2/25/26, indicated the resident had left biliary drain in his abdomen. 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. 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. There were no orders to empty the drain and record the output or clean the biliary site prior to 3/12/26. 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. During an interview on 3/19/26 at 4:20 p.m., the Director of Nursing had no additional information to provide. 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. During a random observation on 3/19/26 at 11:00 a.m., CNA 1 was asked to remove the linens from (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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 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, or at risk for altered skin integrity related to skin tears to his buttocks. There were no physician orders for any type of moisturizing cream for the resident's feet or legs. 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. 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. During an interview on 3/23/26 at 9:00 a.m., the Director of Nursing had no additional information to provide. 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. 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. 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 disorder, seizures. 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was moderately cognitively impaired. The resident was dependent on staff for dressing, personal hygiene, bed mobility, and transfers. 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. A Weekly Skin Check, dated 3/13/26, indicated the resident had no skin issues noted. Shower Sheets, dated 3/13/26 and 3/17/26, indicated the resident was showered and no skin concerns were documented. There was a lack of documentation to indicate the resident's reddened and scabbed areas on his skin were assessed and or monitored. 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. 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. 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. 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 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. The February and March 2026 MARs indicated the midodrine was given when the BP was out of 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 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when they should not have been given. 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. The record for Resident L was reviewed on 3/18/26 at 2:50 p.m. Diagnoses included, but were not limited to, diabetes. 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). a. A Physician's Order, dated 11/28/25, indicated Loperamide HCl (an anti-diarrheal) every 6 hours as needed. 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. A 3/9/26 Alert Charting Note indicated the resident complained of diarrhea. Follow-up included giving Loperamide as needed. The Medication Administration Record (MAR) for March 2026 indicated the resident had not received any doses of Loperamide. 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. 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. 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. 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. A Physician's Order, dated 9/30/25, indicated Novolog (a fast-acting insulin), 100 units to be given three times a day. There were no parameters for holding the medication. A Care Plan, updated 2/18/26, indicated the resident was diabetic. Interventions included administering insulin as ordered. 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. A Physician's Order, dated 9/9/25, indicated Humalog (a fast-acting insulin), three times a day per the following sliding scale: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if blood sugar 181 - 230 = 4 units; 231 - 280 = 7 units; 281 - 330 = 10 units; 331 - 350 = 13 units; 351 - 400 = call MD, 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. 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. 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. 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. 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. 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. 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. When informed of the findings on 3/24/25, the Director of Nursing and Regional Director of Clinical Operations offered no additional information. 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. 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). 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. This citation is related to Intake 2794393. 410 IAC (Indiana Administrative Code) 16.2 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure over the counter medications and creams were labeled correctly related to resident names and directions for use for 1 of 1 treatment cart and 1 of 3 medications carts observed. (The East Unit treatment and medication carts)Findings include:1. During an observation on 3/19/26 at 2:24 p.m., the East Unit medication cart had an over the counter bottle of Extra Strength pain relief medication. The bottle was labeled with only the resident's name and room number. There were no directions for use or the physician's name on it. During an interview at that time, the Assistant Director of Nursing indicated there bottle should have been labeled with the directions for use. 2. During a random observation on 3/19/26 at 3:30 p.m., LPN 3 was asked to open the treatment cart. At that time, there were seven opened creams and ointments from the pharmacy with no label or name on them. The creams identified were Zinc Oxide, Calmoseptine, and Voltaren gel. During an interview at 3:45 p.m., the Divisional Director of Clinical Operations the creams/ointments were from the facility's pharmacy and should not be in the cart without a resident's name on them. The current 9/2025 Storage of Medications policy, provided by the Regional Director of Clinical Operations on 3/23/26 at 4:31 p.m., indicated all medications dispensed by the pharmacy were stored in a container with the pharmacy label. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(j)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed deliver snacks to the residents who wanted them for 1 of 1 bedbound resident reviewed for nutrition and 3 of 5 residents in the Resident Council meeting. (Residents L, 44, 86, 121)Findings include:1. During an interview on 3/16/26 at 11:25 a.m., Resident L indicated if she asked for snacks, the CNAs routinely did not bring them to her. The resident's record was reviewed on 3/18/26 at 2:50 p.m. Diagnoses included, but were not limited to, diabetes, and need for assistance with personal care. A Care Plan, updated 3/25/25, indicated the resident had a behavior problem of not wanting to get out of bed. Interventions included offering snacks.A Care Plan, updated 10/17/25, indicated the resident had acute and chronic pain. Interventions included non-pharmacological measures including offering fluids and snacks. 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). The record lacked documentation of snacks being provided or offered.During an interview on 3/20/26 at 10:21 a.m., the Kitchen Manager indicated snacks were always available on the nursing units. If a resident wanted a snack, the CNAs should deliver one to them. 2. During a meeting with the Resident Council on 3/19/26 at 1:14 p.m., Residents 44, 86, and 121 indicated that trays of snacks are left at end of hall, and staff does not deliver them to the residents. All three residents indicated they had each asked for snacks several times in the past and been told there were no snacks available. During an interview on 3/24/26 at 9:35 a.m., Resident 44 indicated a CNA told him again on the previous night that no snacks were available, but that when he wheeled himself down the hall, he could see a tray of snacks in the kitchenette. During an interview on 3/19/26 at 4:34 p.m., the Regional Nurse Consultant was informed of the findings and indicated she had no additional information to provide. 410 IAC (Indiana Administrative Code) 16.2 1.3-21(e)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food was served under sanitary conditions related passing food and beverages that were uncovered down the hallway for 2 of 2 meals observed and for 1 of 3 units observed. (The lunch and breakfast meal and the East unit)Findings include: 1. During the lunch meal observation on the East Unit on 3/16/26 at 12:36 p.m., a dietary employee brought a large covered cart to the unit with the lunch trays. At that time, staff took the cart and pushed it down the hallway and started to pass the room trays to the residents in their rooms. They carried the tray down the hall to the room, rather than pushing the cart door to door. The dessert was uncovered on the lunch tray. The staff continued to pass the trays down all three hallways until the cart was empty. None of the trays had the dessert covered. 2. During the breakfast meal observation on 3/18/26 at 8:17 a.m., staff on the East Unit were observed passing breakfast trays. There was a large covered cart that was parked on one of the hallways with the breakfast trays. At that time, staff were pulling a tray out of the cart, pouring coffee (from the beverage cart) into a cup and walking down the hallway with the meal tray to the resident's room. The coffee cup was not covered as there were no lids for staff to put over them. Staff continued to pass the trays with the coffee cups uncovered for all of the trays. During an interview on 3/18/26 at 8:30 a.m., the Regional Director of Clinical Operations was made aware of the issue and provided the policy for passing meal trays to residents in their rooms. The revised and current 2/2023 Meal Distribution policy, provided by the Regional Director of Clinical Operations on 3/18/26 at 8:54 a.m., indicated all food that was transported to dining areas that was not adjacent to the kitchen was to be covered. 410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the resident's environment was clean and in good repair related to dirty floors, bed rails, tables, and enteral feeding poles, as well as torn privacy curtains and uncontained wash basins, urinals and plastic cylinders for 3 of 3 units. (The South, West, and East units).Findings include:During the Environmental Tour on 3/24/26 at 10:45 a.m., with the Administrator, the Maintenance Director, the Housekeeping Director, and the District Manager of Housekeeping, the following was observed: South Unit a. room [ROOM NUMBER] - the return ceiling vent was dirty as well as the entire floor. The base of tube feeding pole observed by bed two had a large amount of dried enteral feeding on top on it. There were two residents who resided in the room. [NAME] Unit a. room [ROOM NUMBER] - the over bed table was dirty and there was a pink wash basin observed on the floor in the bathroom as well as a clear cylinder container on the back of the toilet. There were two residents who resided in the room and shared the bathroom. b. room [ROOM NUMBER] - the padding on the bed rails for bed two were cracked and dirty. There was a large amount of food crumbs in the bed as well. There were two residents who resided in the room. c, room [ROOM NUMBER] - there were clear plastic cylinders on the back of the toilet that were uncontained and a pink wash basin uncontained on the floor. The storage bins in the bathroom were dirty. There were two residents who used the bathroom. d. room [ROOM NUMBER] - The bed rails for bed one were dirty as well as the table where the television was placed. There was an uncontained urinal, a clear plastic cylinder and a wash basin on the floor. There were two residents who resided in the room and shared the bathroom. e. room [ROOM NUMBER] - the resident in bed one had some personal items stored in a bed pan on top of the closet shelf. There were two residents who resided in the room. f. room [ROOM NUMBER] - there were two uncontained clear plastic cylinders observed on the back of the toilet. There were two residents who shared the room. g. room [ROOM NUMBER] - the privacy curtains were falling off the hooks and ripped in several areas. There were two residents who resided in the room. h. room [ROOM NUMBER] - the bathroom floor was was stained behind the toilet and the floor by the heat register was peeling. There were two residents who resided in the room and shared the bathroom. East Unit a. room [ROOM NUMBER] - the base of the tube feeding pole was dirty with a large amount of dried enteral feeding. The floor in the residents room was dirty against the base board and the privacy curtain was not on some of the hooks. The white cloth chair was heavily soiled with brown stains. There was one resident who resided in the room. b. room [ROOM NUMBER] - the base of the IV pole was dirty with dried enteral feeding. There was an uncontained urinal on the floor by the night stand. There was one resident who resided in the room. c. room [ROOM NUMBER] - the white cloth chair in the room was heavily soiled with brown stains. There was one resident who resided in the room. d. room [ROOM NUMBER] - the white cloth chair in the room was heavily soiled with brown stains. There was one resident who resided in the room. During an interview on 3/24/26 at 11:00 a.m., the Administrator indicated all of the above was in need of cleaning and/or repair. During an interview on 3/24/26 at 1:45 p.m., the Regional Nurse Consultant indicated the facility had no policy for the storage of wash basins, cylinders, and urinals. The multi-use equipment should have been stored off the floor and contained in a plastic bag. 410 IAC (Indiana Administrative Code) 16.2-3.1-19(f)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a dependent resident received the alternate meal choice they requested for 1 of 1 resident reviewed for choices. (Resident L)Finding includes:During an interview on 3/16/26 at 11:25 a.m., Resident L indicated she did not get to choose what she ate. Her meal trays were brought to her room by the aide, and if she did not want what was brought, she would request the alternate meal. She indicated more than half of the time, the aides would not bring the alternate meal, and she would not eat. The resident's record was reviewed on 3/18/26 at 2:50 p.m. Diagnoses included, but were not limited to, diabetes, and need for assistance with personal care. 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). During an interview on 3/20/26 at 10:21 a.m., the Kitchen Manager indicated alternate meals were always available. If a resident wanted the alternate meal, they would tell the aide and they would tell him. During a Resident Council meeting on 3/19/26 at 1:14 p.m., Resident 86 indicated if he wanted the alternate meal, he would have to notify the kitchen himself because the aides would not bring it to him. 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. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(u)

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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. Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded related to the resident's use of oxygen for 1 of 26 resident records reviewed. (Resident M)Finding includes:During random observations on 3/17/26 at 11:00 a.m., 3/18/26 at 10:17 a.m., 3/19/26 at 2:25 p.m., and 3/20/26 at 10:00 a.m., Resident M was observed wearing oxygen via a nasal cannula. During an interview on 3/20/26 at 10:01 a.m., LPN 6 indicated the resident always wore oxygen. The record for Resident M was reviewed on 3/20/26 at 10:12 a.m. Diagnoses included, but were not limited to, quadriplegia.A Physician's Order, dated 2/17/26, indicated oxygen to be delivered at 2 liters per minute per nasal cannula.The Quarterly Minimum Data Set (MDS) assessment, dated 3/7/26, indicated the resident had severe cognitive impairment, and was dependent in activities of daily living (ADLs). The MDS assessment did not indicate the resident was on oxygen. There was no care plan for oxygen.During an interview on 3/24/26 at 11:05 a.m., MDS 1 indicated she coded that the resident did not use oxygen because she found two progress notes that indicated the resident did not require supplemental oxygen, but she could not recall if she observed the resident to determine if she used oxygen. During an interview on 3/24/26 at 11:15 a.m., the Regional Director of Clinical Operations indicated a visual observation should have been completed when the MDS assessment was done. 410 IAC (Indiana Administrative Code) 16.2-3.1-31(i)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure professional standards of quality were maintained related to a CNA placing an enteral tube feeding on hold before a change in position for 1 of 3 residents reviewed for tube feeding. (Resident E)Finding includes:During a pressure ulcer treatment observation on 3/20/26 at 2:45 p.m., CNA 3 and CNA 4 were in Resident E's room to help the Wound Nurse with a bandage change. The resident was lying in bed with an enteral tube feeding infusing into the peg tube (a tube that was directly inserted into the stomach for nutrition) and his head of the bed was elevated to 45 degrees. At that time, the Wound Nurse told the CNAs they could position the resident onto to his right side. CNA 3 then walked over to the tube feeding pump and placed it on hold. She lowered the head of the bed to a flat position and both CNAs repositioned the resident onto his right side. 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 resident was cognitively intact for daily decision making. The resident had issues with coughing while eating and had a peg tube, which he received 51% or more of total calories a day. The resident had no pressure ulcers.A Physician's Order, dated 3/17/26, indicated enteral feed of Jevity 1.2 at 85 milliliters (ml) per hour, up at 1:00 p.m., and when total volume reached 1530 ml take down. During an interview on 3/20/26 at 2:47 p.m., the Wound Nurse indicated the CNA was not supposed to turn off or place the peg tube on hold.During an interview on 3/23/26 at 9:00 a.m., the Director of Nursing had no additional information to provide.The undated, but identified as current, Routine Resident Care policy, provided by the Regional Clinical Director of Operations on 3/23/26 at 2:44 p.m., indicated licensed staff will include the following services based on their scope of practice: tube feedings. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(g)(2)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) was not initiated as requested by the resident who had a signed Do Not Attempt Resuscitation (DNR) form for 1 of 1 resident reviewed for death. (Resident 119) Finding includes:Record review for Resident 119 was completed on [DATE] at 10:59 a.m. Diagnoses included, but were not limited to, stroke, hypertension, end stage renal disease, and diabetes mellitus.An Indiana Physician Orders For Scope Of Treatment (POST), form indicated it was a physician's order for scope of treatment based on the patient's current medical condition and preferences. The form had the section CPR: patient had no pulse and not breathing. The CPR section was not checked. The DNR section was checked. The form was signed and name printed by the resident on [DATE]. The form was also signed by the treating Physician.The admission Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact. A Physician's Order, dated [DATE], indicated CPR.A Nurses Note, dated [DATE] at 12:50 a.m., indicated while doing rounds the resident was unresponsive. The resident had no carotid pulse felt. A sternum chest rub was given and no response. Vital signs were checked and unable to obtain. Oxygen at 2 liters was applied, CPR initiated, and 911 contacted.A Nurses Note, dated [DATE] at 1:39 a.m., indicated 911 was in the building and transfer of life saving measures (CPR) was surrendered to 911 paramedics and CPR continued. The resident was unable to be revived.During an interview on [DATE] at 2:10 p.m., the Regional Director of Clinical Operations indicated the physician's orders were not updated to include the DNR status because the physician did not date the POST form after signing it. The staff should have clarified the POST form the resident signed on [DATE] with the physician prior to the resident's death on [DATE].A facility policy titled, Advance Directive (Resident's Right to Choose) received as current from the facility on [DATE], indicated, .10. Any decision making regarding the resident's choices in their medical order for life-sustaining treatment and/or their advance directive will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care .410 IAC (Indiana Administrative Code) 16.2-3.1-4(f)(5)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 Level of Harm - Minimal harm or potential for actual harm 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 Level of Harm - Minimal harm or potential for actual harm 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident 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 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm 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 Level of Harm - Minimal harm or potential for actual harm 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)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interview, the facility failed to ensure residents with a urinary catheter received the necessary treatment and services related to not assessing urinary output as ordered for 2 of 3 residents reviewed for urinary catheters. (Residents D and 53)Findings include:1. 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.The admission Minimum Data Set (MDS) assessment, dated 2/1/26, indicated the resident was cognitively intact. The resident was dependent on staff for bed mobility, transfers, and toileting hygiene. The resident had an indwelling urinary catheter.A Physician's Order, dated 1/28/26, indicated to measure and record output every shift from the indwelling urinary catheter.The February and March 2026 Treatment Administration Records (TARs) indicated the urinary output was not recorded on the following days and shifts: - Days: 2/1, 2/2, 2/7, 2/12, 2/16, 2/17, 2/20, 2/23, 2/26, 2/27, 3/3, 3/7, 3/13, 3/14 and 3/17/26- Evenings: 2/3, 2/19, 3/3, 3/6, and 3/8/26 - Night: 2/13, 2/19, 2/25, 2/26, 2/28, 3/1, 3/3, and 3/11/26The record lacked any documentation the resident's urinary output amount was recorded on the above dates and shifts. 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 the urinary output was recorded on the above dates and shifts. 2. Record review for Resident 53 was completed on 3/19/26 at 3:39 p.m. Diagnoses included, but were not limited to, end stage renal disease and obstructive uropathy.The admission MDS assessment, dated 1/18/26, indicated the resident was cognitively impaired. The resident required a substantial maximal assistance from staff for assistance in toileting hygiene. The resident had an indwelling urinary catheter.The March 2026 Physician's Order Summary (POS) indicated an order to measure and record output every shift from the indwelling urinary catheter.The February and March 2026 TARs indicated the urinary output was not recorded on the following days and shifts: - Days: 2/12, 2/13, 2/16, 2/17, 2/20, 2/23, 2/25, 3/13, and 3/17/26- Evenings: 2/24, 3/15, and 3/16/26- Nights: 2/13 and 3/16/26The record lacked any documentation the resident's urinary output amount was recorded on the above dates and shifts. During an interview on 3/23/26 at 2:00 p.m., the Regional Director of Clinical Operations indicated she was unable to provide any documentation the urinary output was recorded on the above dates and shifts. A policy was provided but did not pertain to recording urinary output.410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident with a physician's order for intravenous (IV) fluids received the correct amount over a 24 hour period for 1 of 1 resident reviewed for hydration. (Resident F)Finding includes:During a random observation on 3/16/26 at 10:49 a.m., Resident F was observed in bed with an IV infusing into a port located in his right chest. The IV fluid was a one liter bag of 0.9% Normal Saline and the date on the bag was 3/16/26. The IV fluid was flowing to gravity rather than via an infusion pump. During a random observation on 3/17/26 at 11:13 a.m., the resident was observed in bed with the same IV bag of 0.9% Normal Saline, dated 3/16/26, hanging and infusing per gravity into the resident's port. At 2:57 p.m., the same IV of 0.9 Normal Saline, dated 3/16/26 was still infusing per gravity into the resident's port. During a random observation on 3/18/26 at 8:05 a.m., the resident's IV of 0.9% Normal Saline, dated 3/16/26, was still infusing per gravity into the resident's port. At 9:00 a.m., the IV bag, dated 3/16/26 was almost empty and still infusing to gravity. During a random observation on 3/18/26 at 1:15 p.m., the resident's IV of 0.9% Normal Saline, dated 3/18/26, was infusing per gravity into the port. 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. The resident had coughing or choking while swallowing and complaints of difficulty or pain when swallowing, and weighed 72 pounds. He received parental/Intravenous fluids and a mechanical diet. A Care Plan, revised on 3/16/26, indicated the resident was at risk for dehydration or potential fluid deficit related to malnutrition and metastatic colon and liver cancer. The resident has dehydration as evidenced by laboratory results and was receiving IV fluids for hydration of 0.9% Normal Saline times three days. A Physician's Order, dated 3/14/26, indicated Sodium Chloride 0.9%, use 50 milliliters (ml) per hour intravenously every shift for dehydration for three days.A Nurses' Note, dated 3/11/26 at 6:50 p.m. indicated the resident has been receiving an IV of 0.9% Normal Saline related to a dietary issue ordered by Nurse Practitioner. Nurses' Notes, dated 3/14, 3/16 and 3/17/26 indicated the resident refused to eat after several attempts. The resident did not receive the required IV fluids from 3/16-3/18/26 as the same IV bag was hanging from 3/16/26. During an interview on 3/18/26 at 9:10 a.m., the East Unit Manager was informed the resident's IV was still the same one hanging from 3/16/26. She indicated she was aware the resident had an IV but was unaware it the same bag from two days prior. During an interview on 3/19/26 at 4:20 p.m., the Director of Nursing had no additional information to provide. 410 IAC (Indiana Administrative Code) 16.2-3.1-46(b)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to ensure a bolus enteral feeding was administered correctly for 1 of 3 residents reviewed for Tube Feeding. (Resident K)Finding includes: The record for Resident K was reviewed on 3/18/26 at 10:38 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), gastrostomy (a feeding tube inserted through the abdomen), and protein calorie malnutrition.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 nutrition via a feeding tube.During observation of a bolus tube feeding administration on 3/19/26 at 10:43 a.m., LPN 1 flushed Resident K's feeding tube with water, plunged through a syringe. She then administered 237 ml (milliliters) of tube feeding formula, plunged via a syringe, followed by another plunged water flush. At that time, LPN 1 indicated she administered all feeding tube bolus feedings, flushes, and medications, by plunging with a syringe, not via gravity. During an interview on 3/19/26 at 11:34 a.m., the Director of Nursing was informed of the finding and indicated she would check the policy. During an interview on 3/19/26 at 11:54 a.m., the Regional Director of Clinical Operations indicated bolus feedings should not be forced, and that the nurse would be educated. A policy, titled, Enteral General Nutritional (tube feeding) Guidelines, received as current from the Regional Director of Clinical Operations on 3/19/26 at 11:56 a.m., indicated, . Begin pouring prescribed tube feeding bolus amount slowly into the 60cc piston syringe allowing the formula to flow through the G-Tube or PEG tube maintaining fluid level in syringe until delivery is complete . Do not force solution with plunger .410 IAC (Indiana Administrative Code) 16.2-3.1-44(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure supplemental oxygen was set at the correct flow rate for 1 of 2 residents reviewed for respiratory care. (Resident M)Finding includes:During random observations on 3/17/26 at 11:00 a.m. and 3/20/26 at 10:01 a.m., Resident M was observed wearing oxygen via a nasal cannula at 1 lpm (liter per minute). During an interview on 3/20/26 at 10:01 a.m., LPN 6 indicated the resident's oxygen should have been set at 2 lpm, and she did not know why it was not. The resident was unable to change the flow rate herself. The record for Resident M was reviewed on 3/20/26 at 10:12 a.m. Diagnoses included, but were not limited to, quadriplegia.A Physician's Order, dated 2/17/26, indicated oxygen to be delivered at 2 liters per minute per nasal cannula.The Quarterly Minimum Data Set (MDS) assessment, dated 3/7/26, indicated the resident had severe cognitive impairment, and was dependent in activities of daily living (ADLs). During an interview on 3/20/26 at 10:50 a.m., the Divisional Director of Clinical Services and the DON were informed of findings. No additional information was received. 410 IAC (Indiana Administrative Code) 16.2 3.1-47(a)(6)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to create and follow a care plan including specific interventions to address the mental health of a resident who recently lost their mother for 1 of 1 resident reviewed for Mood/Behavior. (Resident 77)Finding includes:During an interview on [DATE] at 12:48 p.m., Resident 77 indicated his mother passed away two weeks ago. He felt very sad and hopeless and had been crying a lot. During an interview on [DATE] at 9:04 a.m., the resident indicated he had been feeling paranoid and anxious since his mother died two weeks and one day ago, and he was unable to sleep. Listening to the radio his mother gave him or drinking soda sometimes helped him feel a little better. He indicated he was not aware of anything different staff was doing to help him with his grief. The record for Resident 77 was reviewed on [DATE] at 2:07 p.m. Diagnoses included but were not limited to, bipolar disorder, depression, schizophrenia, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was cognitively intact for daily decision making, and was dependent with ADLs. A Medication Administration Note, dated [DATE], indicated the resident refused treatments due to depression related to the loss of his mother. The only intervention documented was, aware of consequences NP [nurse practitioner] aware. A psychiatry note, dated [DATE], indicated the resident was experiencing significant grief-related symptoms. Grief was added as a resident diagnosis in the note. A Social Service Note, dated [DATE], indicated the resident's family member called in requesting help setting up transportation to get the resident to his mother's funeral. The record lacked any other social service notes regarding the resident's mental health and grief. The record lacked a care plan to monitor or treat the resident's grief. During an interview on [DATE] at 11:27 a.m., the Social Service Director indicated she had been trying to check in on the resident more frequently, and that she should have updated the care plan and included specific interventions to address and monitor the resident's mood and behavior related to the recent loss of his mother. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure there was adequate monitoring of a resident's heart rate per the physician's orders prior to the administration of a blood pressure medication for 1 of 5 residents reviewed for unnecessary medications. (Resident D)Finding includes: 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.A Physician's Order, dated 1/26/26, indicated to give metoprolol tartrate (medication to lower 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.The January, February and March 2026 Medication Administration Records (MARs) did not have a section on the MAR to document the heart rate prior to administering the metoprolol. The heart rate was not monitored on the PM times prior to administering the metoprolol for the months of January, February, and March 2026. 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 the resident's heart rate was monitored on the PM administration times prior to administering the metoprolol. She would fix the order on the MAR to include heart rate. A facility policy was not provided.410 IAC (Indiana Administrative Code) 16.2-3.1-48(a)(3)

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, record review, and interview, the facility failed to post the State Long-Term Care Ombudsman's contact information. This had the potential to affect 112 residents who resided in the facility. Finding includes:During a Resident Council meeting on 3/19/26 at 1:31 p.m., Resident 86 indicated he had been trying to contact the ombudsman and ask them to join a resident council meeting. The contact information he had was for the previous area ombudsman. He indicated he was not aware there was a new ombudsman, and that there was no ombudsman information posted in the facility. On 3/19/26 at 1:53 p.m., no ombudsman information was observed at front desk. At that time, the front desk staff indicated she had the ombudsman information taped on her side of the desk, but it was not posted for public view. During an interview on 3/19/26 at 4:34 p.m., the Regional Nurse Consultant was informed of the finding. No additional information received.