STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155236	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avon Health & Rehabilitation Center	4171 Forest Pointe Circle Avon, IN 46123

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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 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 observations and interviews, the facility failed to ensure medications and topical gels were labeled and stored appropriately in medication carts and failed to ensure expired medications were not stored on medication carts or in the medication storage room refrigerator. This deficient practice had the potential to affect 60 of 60 residents residing on 100, 300, and 400 halls (Residents 128, 127, 74, 26, 132, 75, and 80). Findings include:On 2/23/26 at 10:00 a.m. the 100-hall medication cart was reviewed with Licensed Practical Nurse (LPN) 5. The findings were as follows: 1. Resident 128 had an Incruse Ellipta (a once-daily, long-acting inhaler) 62.5 micrograms (mcg) that had no open date. LPN 5 wrote a date of 2/22 on the bag indicating she had opened it on the 22nd but forgot to put a date on it. 2. Resident 127 had Arnicare topical gel (a homeopathic topical gel used to temporarily relieve muscle pain) that was stored in the same drawer and next to oral medications. On 2/23/26 at 10:30 a.m. 300-hall medication cart was reviewed with Registered Nurse (RN) 6. The findings were as follows: 1. Resident 74 had a Trelegy (a once-daily, combination prescription inhaler) dated 1/10.2. Resident 74 had an albuterol inhaler (a rapid-acting inhaler) dated 1/10.3. Resident 26 had an albuterol inhaler dated 1/10.4. Resident 132 had Diclofenac topical gel (a nonsteroidal anti-inflammatory drug (NSAID) applied topically to relieve joint pain) stored in the same drawer and next to oral medications.5. A bottle of Over the Counter (OTC) vitamin D3 with a written label on the bottle, but the label had been rubbed off so much it was unreadable. On 2/23/26 at 11:00 a.m. the 400-hall medication cart was reviewed with LPN 7. The findings are as follows: 1. Resident 75 had a bottle of Memantine Hydrochloride (a prescription NMDA receptor antagonist used to treat moderate to severe dementia) that had no pharmacy label on it. LPN 7 indicated she believed it had originally come in a box with a pharmacy label on it, but the box must have gotten thrown away at some point. She indicated they had written the resident's nickname on the lid of the bottle, but there should be a pharmacy label on the bottle. 2. There were several OTC medications, vitamin D3 5000 units (u), vitamin B12 1000mcg, align probiotic, aspirin 81mg and Centrum women's multi-vitamin all that had only AM or PM written on them. There were no labels and no Resident name. LPN 7 indicated the medications were Resident 80's, and that the am and pm indicated when the medications were to be given. LPN 7 indicated the resident's family wrote the AM and PM on the bottles. On 2/23/26 at 11:30 a.m. the 400-hall medication storage refrigerator was reviewed with LPN 7. The findings are as follows: 1. There was a loose vial of Tubersol (A diagnostic tool used to detect tuberculosis infection. It is administered via intradermal injection, with results read 48-72 hours later) that was open and did not have an open date on it. On 2/23/26 at 12:28 p.m. a copy of a current facility policy titled, Medication Storage, dated 11/1/23 was provided. That policy indicated, .3. External products:.drugs for external use are stored separately from internal.8.the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for.outdated.deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Medications policy. On 2/23/26 at 12:28 p.m. a copy of a current facility guideline titled, Product Expiration Dates, dated 5/2023 was provided. That guideline indicated albuterol inhalers (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired one week after opening if they were stored outside of the foil package and Ellipta's including Trelegy and Incrusa, expired 42 days after they were opened. This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1-25(j), 16.2-3.1-25 (m), and 3.1-25(n).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to reconcile a resident's medications upon discharge for 1 of 3 residents reviewed (Resident 125).Findings include:On 2/23/26 at 10:05 a.m., a record review was completed for Resident 125. She had the following diagnoses which included but were not limited to muscle weakness, cerebral infarction (stroke), aphasia (difficulty speaking), major depressive disorder, and osteoporosis.Resident 125 discharged from the facility with family on 1/27/26 at 4:08 p.m.During an interview with the Director of Nursing (DON) on 2/23/26 at 1:32 p.m., she indicated the resident was discharged in a rush and her medications were gathered and sent with her.Resident 125's record lacked documentation of medication reconciliation when the resident discharged on 1/27/26.According to Resident 125's physician orders indicated medications that should have been reconciled included: Alendronate (used for arthritis) 70 mg (milligrams), atorvastatin (for high cholesterol) 80 mg, cholecalciferol (a supplement) 50 mcg, famotidine (for the stomach) 20 mg, miraLAX (for constipation) 17 gm (grams), mirtazapine (for depression) 30 mg, potassium chloride 10 meq (milliequivalent), prenatal (a supplement) 27-1mg, thiamine (a supplement) 100 mg, Eliquis (a blood thinner) 2.5 mg, Keppra (for seizures) 100mg/ml (milliliter), protonix (for the stomach) 40 mg, and lactulose (used for constipation) 10gm/30 ml.A policy titled, Drug Disposition, revised on 7/24, was provided by the DON on 2/23/26 at 11:20 a.m. It indicated, Discontinued, outdated, or deteriorated medication shall not be maintained or used in the facility. Medications shall be disposed of in compliance with federal, state, and local laws.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, interview, and record review, the facility failed to develop and provide the resident and/or family representative with a copy of the resident's baseline care plan and physician orders within 48 hours of admission for 3 of 4 resident reviewed (Residents 123, 125, and 52). Findings include:1. On 2/20/26 at 12:08 p.m., a record review was completed on Resident 123. He had the following diagnoses which included, but were not limited to, muscle weakness, myocardial infarction (heart attack), history of falling, arthritis, and essential hypertension. Resident 123 had an admission assessment completed on 1/15/25 at 6:40 p.m. The care plan section of the assessment was left blank. On 1/20/26 at 12:00 a.m., a Living Well Meeting was conducted for Resident 123. It indicated Resident 123's daughter was present, but the document lacked a signature indicating she received a copy of the care plan and physician orders. 2. On 2/23/26 at 10:05 a.m., a record review was completed for Resident 125. She had the following diagnoses which included, but were not limited to, muscle weakness, cerebral infarction (stroke), aphasia (difficulty speaking), major depressive disorder, and osteoporosis. Resident 125 had an admission assessment completed on 12/29/25 at 8:00 p.m. The care plan section of the assessment addressed only her fall potential. On 1/17/26 at 1:54 p.m., a Living Well Meeting was conducted for Resident 125. It indicated a phone call was held with the daughter. The section was left blank, indicating the daughter did not receive a copy of the care plan and physician orders. On 2/24/26 at 11:03 a.m., the Director of Nursing (DON) indicated they used the Living Well assessment for the baseline care plans. 3. On 2/19/26 at 11:00 a.m., Resident 52 was initially observed. She was seated in a wheelchair in her room and waited for lunch to be delivered. She indicated she was a new resident and there for rehabilitation (rehab) after a fall at home and surgery at the hospital. She felt weak and was afraid of falling again. On 2/20/26 at 10:27 a.m., Resident 52's call light was observed illuminated and blinking. Housekeeper 3 stopped an unidentified passing Certified Nursing Aide (CNA) and indicated Resident 52 had been waiting a while and needed to use the bathroom, she was afraid she was going to have an accident. The CNA indicated an apology, and that she was the only CNA for the hall at that time and would go to Resident 52 next. On 2/20/26 at 10:35 a.m., the CNA entered Resident 52's room to assist her to the toilet. On 2/23/26 at 10:53 a.m., Resident 52's record was reviewed. She was admitted on the Friday evening of 2/6/26 and resided on the rehab hall. She was admitted for the need for assistance with personal care and rehabilitation following a fall at (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	home which resulted in a fracture that required surgical intervention at the hospital. She had additional diagnoses which included, but were not limited to, a history of falling, and stroke. A nursing admission assessment, dated 2/6/26, the baseline care plan section of the assessment was left blank. She had a fall risk assessment, dated 2/6/26, which indicated she was at risk for falls. A care plan for her risk of falls was not implemented with interventions the following Monday, 2/9/26. On 2/24/25 at 11:15 a.m., the DON provided a copy of the policy titled, Baseline Care Plan, dated 11/1/23. It indicated, .The baseline care plan will be developed within 48 hours of a resident's admission .A supervising nurse shall verify within 48 hours that a baseline care plan has been developed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to follow physician's orders regarding the parameters of blood pressure medications for 2 of 5 residents reviewed for unnecessary medications (Residents 7 and 9) and daily weights for 2 of 5 residents reviewed for unnecessary medications (Residents 126 and 70). Findings include: 1. Resident 7's record was reviewed on 2/20/26 at 11:55 a.m. Diagnoses on the resident's profile included, but were not limited to, essential primary hypertension (high blood pressure) and chronic diastolic congestive heart failure (left side of the heart becomes thick and leads to fluid build-up in the body). A physician's order, dated 8/13/25, indicated hydralazine (blood pressure medication) 25 milligrams (mg) by mouth three times daily for hypertension, hold if systolic blood pressure (top number of blood pressure) was less than 110, and notify the physician if the medication needed to be held. A physician's order, dated 11/27/25, indicated isosorbide (dilates blood vessels) extended release (ER) 30 mg by mouth once daily for hypertension, hold if systolic blood pressure was less than 110 or diastolic blood pressure (bottom number of blood pressure) was less than 60. A physician's order, dated 11/27/25, indicated losartan (blood pressure medication) 100 mg by mouth once daily for hypertension, hold if systolic blood pressure was less than 110 or diastolic blood pressure was less than 60. A physician's order, dated 11/26/25, spironolactone (blood pressure medication) 25 mg by mouth once daily for heart failure, hold if systolic blood pressure was less than 110 or diastolic blood pressure was less than 60. A Medication Administration Record (MAR), dated December 2025, indicated the resident's diastolic blood pressure was less than 60 on 12/1/25, 12/2/25, and 12/15/25, at the time of the administration of the isosorbide, losartan, and spironolactone. The MAR lacked documentation the isosorbide, losartan, or spironolactone were held, or the physician was notified of the resident's blood pressure. A MAR, dated January 2026, indicated the resident's systolic blood pressure was less than 110, on 1/1/26 at bedtime, on 1/4/26 in the evening, and on 1/5/26 in the morning, at the times of the scheduled hydralazine administrations. The MAR lacked documentation the hydralazine was held, or the physician was notified of the resident's blood pressure. The resident's systolic blood pressure was less than 110 on 1/5/26 in the morning, and the resident's diastolic blood pressure was less than 60, on 1/11/26, 1/14/26, 1/15/26, and 1/23/26, in the morning at the time of the scheduled isosorbide, losartan, and spironolactone administrations. The MAR lacked documentation the isosorbide, losartan, or spironolactone were held, or the physician was notified of the resident's blood pressure. A MAR, dated February 2026, indicated the resident's systolic blood pressure was less than 110, on 2/14/26 in the morning, and the resident's diastolic blood pressure was less than 60, on 2/3/26, 2/4/26, 2/11/26, and 2/20/26, in the morning, at the time of the scheduled isosorbide, losartan, and spironolactone administrations. The MAR lacked documentation the isosorbide, losartan, or spironolactone were held, or the physician was notified of the resident's blood pressure. Progress notes, dated December 2025, January 2026, and February 2026, lacked documentation the blood pressure medications were held as ordered by the physician or the physician was notified when (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's blood pressures were outside of the parameters. A care plan, goal target dated 5/13/26, indicated the resident had essential primary hypertension of unknown origin. Interventions included, but were not limited to, check the resident's blood pressure as ordered by the physician, observe for patterns, and administer blood pressure medications as ordered by the physician. During an interview, on 2/23/26 at 9:38 a.m., the Director of Nursing (DON) indicated blood pressure medications should have been held as ordered by the physician, according to the parameters. There had been an issue with the staff not holding the medications at times, and they were working on it. 2. On 2/24/26 at 11:24 a.m., a record review was completed for Resident 9. He has the following diagnoses which included but were not limited to hypertension and heart disease. Resident 9 had an order, dated 12/8/25, for metoprolol succinate extended release (ER) (a medication used to treat high blood pressure) 50 mg one time daily for hypertension. Hold for systolic blood pressure less than 95 or a pulse less than 60. On 2/9/26 Resident 9's blood pressure was 92/56 and his pulse was 72. The February MAR indicated the nurse administered his metoprolol and did not hold it as ordered. Resident 9 had a care plan, dated 11/29/24, indicating he had hypertension of unknown origin. The goal indicated his blood pressure would be managed to a range with his care plan interventions. An intervention indicated he would take his blood pressure medications as ordered. On 2/23/26 at 12:45 p.m., during an interview with the DON she indicated the facility was performing a quality assurance performance improvement plan (QAPI) for parameters for compliance. She indicated the nurse practitioner prescribed a lot of parameters and they were trying to decrease the number of orders. 3. On 2/24/26 at 11:32 a.m., a record review was completed for Resident 126. He had the following diagnoses which included, but were not limited to, muscle weakness, respiratory failure, and congestive heart failure (CHF). Resident 126 had an order, dated 12/14/25, for daily weights on day shift for heart failure, notify the physician of weight gain of more than 2 pounds in one day or 5 pounds in a week. The January MAR indicated between 1/4/26 and 1/5/26 he had a weight gain of 2.6 pounds. Resident 126's record lacked documentation the physician was not notified. The February MAR indicated between 2/1/26 and 2/2/26 he had a weight gain of 3.4 pounds. Resident 126's record lacked documentation the physician was not notified. The February MAR indicated between 2/5/26 and 2/6/26 he had a weight gain of 3.4 pounds. Resident 126's record lacked documentation the physician was not notified. Resident 126 had a care plan, dated 12/3/25, indicating he had heart failure as evidenced by shortness of breath. The goal was for resident to allow himself to be weighed as the physician ordered. An intervention indicated he would be monitored for shortness of breath, edema (swelling), (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	periorbital (eye) edema, sacral (back) edema, dry cough, distended neck veins, weight gain, crackles and wheezes in lungs. 4. On 2/23/26 at 9:47 a.m., Resident 70's record was reviewed. He was a long-term care resident with diagnosis which included, but was not limited to, congestive heart failure (CHF). He had a current physician's order, dated 12/30/25, for daily weights related to CHF. A nutrition progress note, dated 1/12/26 at 2:19 p.m., indicated Resident 70 triggered for a 5% weight gain since December, a 7.5% weight loss since October, and a 10% weight loss since September. Resident's weight fluctuated due to diagnosis of heart failure and recent illnesses. On 1/13/26 he was re-started on a daily diuretic, Torsemide 20 milligrams a day, for CHF and bilateral lower edema. A nursing progress note, dated 1/15/26 at 10:17 p.m., indicated he continued on his diuretic and edema was still noted in his bilateral lower extremities. Resident 70's daily weights were noted missing on the following dates: January 8, 12, 16, 17, 21, and 30; and February 3, 5, 6, 9, 12, 13, 17, and 21, 2026. The policy titled, Following Physician Orders/Parameters, dated 5/2018 and revised 4/2024, indicated, .To administer resident care in a safe and effective manner and following physician orders and ordered parameters.All licensed healthcare providers shall consult the resident's medical orders for the appropriate physician/clinician order prior to administering or performing a resident procedure.check MAR/TAR for physician/clinician order.Licensed healthcare personnel will consult and follow the physician/clinician order when performing any resident procedures.Note any contraindications the resident may have prior to performing a procedure.Check for vitals signs, other tests to be done as prescribed by resident's physician/clinician.evaluate resident for appropriate or accurate response to orders.Notification of Physician/Clinician will be made with resident refusals of physicians order. This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1-37(a).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure a Hoyer lift (mechanical lift) transfer was completed safely to prevent falls for 1 of 2 residents reviewed for accidents (Resident 4). The deficient practice was corrected by 2/13/26 prior to the start of the survey and was therefore past noncompliance. Findings include:During an interview, on 2/19/26 at 10:40 a.m., Resident 4 indicated he was dropped out of the Hoyer lift when a bolt came off, and he fell. Resident 4's record was reviewed on 2/23/26 at 12:44 p.m. Diagnoses on the resident's profile included, but were not limited to, acquired absence of left leg, below the knee. A progress note, dated 2/3/26 at 9:30 a.m., indicated the writer was alerted to an emergency in the resident's room and arrived to find the resident on the floor. The staff assisted the resident back to bed. A progress note, dated 2/3/26 at 10:47 a.m., indicated there were new orders for x-rays related to the resident's fall. A situation, background, assessment, recommendation (SBAR) note, dated 2/3/26 at 12:44 p.m., indicated the resident complained of pain after being observed on the floor between the mechanical lift wheelbase. The nurse practitioner (NP) ordered x-rays of the lumbar and thoracic area (lower back). A progress note, dated 2/3/26 at 6:26 p.m., indicated the resident had x-rays performed after the fall, but they were unable to be read due to poor imaging related to the resident's anatomy. The resident no longer complained of pain, the physician and NP were consulted, and agreed further imaging would be ordered if necessary. An interdisciplinary team (IDT) note, dated 2/4/26 at 12:04 p.m., indicated a staff member assisted the resident with transferring, and the resident fell to the floor. The staff member utilized the mechanical lift for the transfer, the equipment malfunctioned, and the resident fell. The root cause was the resident was being transferred with a staff member present, and the equipment malfunctioned. The intervention was to remove the equipment from the resident's room. A care plan, goal target dated 5/3/26, indicated the resident required assistance with activities of daily living (ADLs) due to the left below the knee amputation. Interventions included, but were not limited to, the resident required the assistance of two staff members and the Hoyer lift for transfers. On 2/24/26 at 11:12 a.m., the Director of Nursing (DON) indicated the facility investigated the resident's fall from the Hoyer lift and provided the investigation file. The investigation file included the following information. -A document titled, Suspension Form-Internal Investigation, dated 2/3/26, indicated Certified Nurse Aide (CNA) 4 was suspended pending the investigation into the resident's fall. CNA 4 transferred the resident utilizing a Hoyer lift without a second staff member for assistance. The investigation included awaiting x-ray results and staff interviews. The employee's conduct included, Employee did not follow policy on utilizing two people for Hoyer lift transfer. This is a violation.from the employee handbook. The corrective action plan indicated, Ensure that you are utilizing a second person for all Hoyer lift transfers. -An undated written statement from CNA 4 indicated, At around 9 am [sic] on 2/3/26 I was going into [resident's room number] to get [resident's name] up and in his chair. I looked down the hall and didn't see another employee so I made the choice to perform the hoyer transfer by myself. I got the weight hoyer from [hall number], the set up the hoyer to lift him. I held him over the bed for a few seconds to get his weight, then proceeded to move the hoyer to his chair. The hoyer moved fine and I got it in place, put the breaks [sic] on, and started to turn him to line him up with the chair when the hoyer broke. He fell straight down. I went to the hall and got a nurse, she took pictures of the broken hoyer, asked if the resident was in pain and where. She then got 3 more people to lift him back into bed. -A CNA job specific orientation checklist indicated CNA 4 was trained on using a Hoyer lift on 12/30/25. -A statement from the DON, dated 2/3/26, indicated, On 2/3/26, I was notified of an incident involving a Hoyer lift during a resident transfer. An investigation was immediately initiated. HFA [Health Facility Administrator], Maintenance, and the writer assessed the equipment and determined that the lift had malfunctioned during use. It appears that a bolt snapped during the transfer, resulting in mechanical failure. The resident was lowered to (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the floor during the incident. Upon review of the circumstances surrounding the transfer, it was identified that the transfer was not completed in accordance with facility policy for mechanical lift use. The involved staff member was interviewed and acknowledged understanding of the facility's Safe Resident Handling/Transfers policy. The employee has been suspended pending further investigation. -A maintenance logbook documented monthly lift checks, from February 2025 to February 2026. -A statement from the Administrator, dated 2/3/26, indicated, On February 3rd, I met with the Director of Plant Operations to address the reported malfunction involving the Hoyer lift in question. During our discussion, he confirmed that the device had been quarantined, fully inspected, and fixed to return to working condition and put back on the floor. He also provided documentation showing completed and passed audits for the facility's Hoyer lifts for the prior 3 months. The Regional Director of Property Management conducted an onsite investigation to assess the circumstances surrounding the reported malfunction. During the visit, a comprehensive inspection was performed on all mechanical lifts within the facility to verify their operational integrity and ensure that all equipment met safety and compliance standards. This review included evaluating maintenance practices, confirming documentation of recent inspections, and identifying any areas requiring corrective action. -A teachable moment, dated 2/3/26, was signed by the maintenance staff. The teachable moment indicated, .Upon reviewing the incident, it was noted that the missing lock nut on the sling attachment was not identified during the regular inspections. While issues like this can sometimes be difficult to detect, it is important that our inspection forms and procedures allow for clear, consistent documentation and close attention to all critical parts of the equipment, such as bolts, nuts, and sling attachments. -The Hoyer lift manufacturer's guidance for cleaning and maintenance, dated 1/13/25, indicated functional checks should be periodically performed, at least once a year, including checks of the control of mechanical parts such as hooks, pins, and screws. During an interview, on 2/24/26 at 10:11 a.m., the DON indicated a bolt came out of the hydraulic arm of the Hoyer lift during the resident's transfer, and the Hoyer lift broke. When the bolt came out, the resident fell down. The staff member was alone performing the Hoyer lift transfer, which was not consistent with the facility's policy. Two people actively participating in the transfer were required per their facility policy for Hoyer lift transfers. On 2/24/26 at 10:46 a.m., the DON provided a document titled, Safe Resident Handling/Transfers, dated 2/28/24. The policy indicated, .Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and promote a safe, secure and comfortable experience for the resident.Compliance Guidelines.6. The staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if the equipment is not functioning properly.8. Two staff members must be utilized when transferring residents with a mechanical lift. The deficient practice was corrected by 2/13/26 after the facility implemented a systemic plan that included the following actions: immediate assessment by the charge nurse of the effected resident for follow-up care, transfer status audit for all residents completed by 2/6/26, staff members who provided assistance to residents with mechanical lift transfers received education on proper mechanical lift use completed prior to their next scheduled shift, ongoing maintenance processes updated and implemented by 2/13/26, and a Quality Assurance and Performance Improvement (QAPI) plan implemented with the completion of an audit tool for scaled ongoing monitoring. The plan was fully implemented by 2/13/26. This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1-45(a)(2).