STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155269	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Lake Nursing & Rehabilitation Center	1900 Jeanwood Dr Elkhart, IN 46514

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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 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 observation, record review, and interview, the facility failed to ensure blood pressure parameters were followed as ordered for 2 of 3 residents reviewed for blood pressure parameters. The facility also failed to ensure areas of bruising were assessed and monitored and heel boots were applied as ordered for 2 of 4 residents reviewed for skin conditions non-pressure related. (Residents 10, 6, 62, and 110)Findings include:1. The record for Resident 10 was reviewed on 4/15/26 at 3:52 p.m. Diagnoses included, but were not limited to, hypertension and atherosclerotic heart disease. A Care Plan, dated 5/17/18 and reviewed on 4/1/26, indicated the resident was at risk for ineffective tissue perfusion related to the diagnoses of hyperlipidemia (elevated lipids), history of stroke, cardiomyopathy, coronary artery disease, and hypertension. Interventions included, but were not limited to, administer medications as ordered. The Quarterly Minimum Data Set (MDS) assessment, dated 3/31/26, indicated the resident was moderately cognitively impaired. The April 2026 Physician's Order Summary (POS) indicated the resident was to receive Clonidine HCl (a medication to treat high blood pressure) 0.3 milligrams (mg) three times a day. Hold if the resident's systolic (top number) blood pressure was less than 140 The March 2026 Medication Administration Record (MAR) indicated the resident received the Clonidine on the following dates and times even though her systolic blood pressure was less than 140: -3/1/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/3/26 at 2:00 p.m. -3/5/26 at 8:00 a.m. and 2:00 p.m. -3/6/26 at 2:00 p.m. and 8:00 p.m. -3/7/26 at 2:00 p.m. -3/8/26 at 8:00 p.m. -3/9/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/12/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/13/26 at 2:00 p.m. -3/14/26 at 8:00 a.m. and 2:00 p.m. -3/15/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/17/26 at 8:00 a.m. and 2:00 p.m. -3/19/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/20/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/23/26 at 8:00 a.m. and 2:00 p.m. -3/24/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/25/26 at 8:00 a.m. and 8:00 p.m. -3/26/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/27/26 at 2:00 p.m. -3/28/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/29/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. -3/30/26 at 2:00 p.m. and 8:00 p.m. -3/31/26 at 8:00 a.m., 2:00 p.m., and 8:00 p.m. The April 2026 MAR indicated the resident received the Clonidine on the following dates at times even though her systolic blood pressure was less than 140: -4/2/26 at 2:00 p.m. and 8:00 p.m. -4/3/26 at 2:00 p.m. and 8:00 p.m. -4/4/26 at 2:00 p.m. -4/5/26 at 2:00 p.m. -4/6/26 at 2:00 p.m. -4/7/26 at 8:00 a.m. -4/9/26 at 2:00 p.m. and 8:00 p.m. -4/10/26 at 2:00 p.m. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/12/26 at 2:00 p.m. -4/13/26 at 8:00 p.m. -4/14/26 at 2:00 p.m. and 8:00 p.m. During an interview on 4/20/26 at 9:00 a.m., the Director of Nursing indicated she would have to review the order and the MARs for March and April. 2. The record for Resident 6 was reviewed on 4/15/26 at 9:29 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, atrial fibrillation, heart disease, heart failure, major depressive disorder, adjustment disorder with anxiety and depressed mood. The 4/8/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. A Physician's Order, dated 8/1/24, indicated Carvedilol (a medication used to treat high blood pressure) 12.5 milligrams (mg) two times a day, hold if blood pressure was under 110/60. A Physician's Order, dated 3/20/25, indicated Hydralazine (a medication used to treat high blood pressure) 50 mg three times a day, at 8 a.m., 2 p.m., and 8 p.m., hold if blood pressure was under 110/60. The 1/2026 Medication Administration Record (MAR) indicated the Carvedilol tablet 12.5 mg was administered on the following days outside of the parameters: 7 a.m. to 11 a.m. on 1/1 and 1/21/26 7 p.m. to 11 p.m. on 1/12, 1/15, and 1/25/26 The 1/2026 MAR indicated the Hydralazine tablet 50 mg was administered on the following days outside of the parameters: 8:00 a.m. on 1/8, 1/10, and 1/21/26 2:00 p.m. on 1/8 1/18, 1/19, and 1/29/26 8:00 p.m. on 1/1, 1/12, 1/15, and 1/25/26 The 2/2026 MAR indicated the Carvedilol tablet 12.5 mg was administered on the following days outside of the parameters: 7 a.m. to 11 a.m. on 2/2, 2/4, 2/9, 2/13, 2/16, 2/18, and 2/26/26 7 p.m. to11 p.m. on 2/1, 2/11, and 2/25/26 The 2/2026 MAR indicated the Hydralazine tablet 50 mg was administered on the following days outside of the parameters: (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:00 a.m. on 2/2, 2/9, 2/13, 2/16, and 2/26/26 2:00 p.m. on 2/1, 2/12, 2/16, 2/21, and 2/26/26 8:00 p.m. on 2/1, 2/11, 2/25/26 The 3/2026 MAR indicated the Carvedilol tablet 12.5 mg was administered on the following days outside of the parameters: 7 a.m. to 11 a.m. on 3/1, 3/3, 3/5, 3/15, 3/21, 3/27, and 3/28/26 7 p.m. to 11 p.m. on 3/1, 3/4, 3/21, 3/24, 3/27, 3/29, and 3/30/26 The 3/2026 MAR indicated the Hydralazine tablet 50 mg was administered on the following days outside of the parameters: 8:00 a.m. on 3/1, 3/3, 3/5, 3/15, 3/21, 3/27, and 3/28/26 2:00 p.m. on 3/1, 3/4, 3/5, 3/7, 3/27, and 3/29/26 8:00 p.m. on 3/1, 3/4, 3/21, 3/24, 3/27, and, 3/30/26 The 4/2026 MAR indicated the Carvedilol tablet 12.5 mg was administered on the following days outside of the parameters: 7 a.m. to 11 a.m. on 4/1 and 4/8/26 7 p.m. to 11 p.m. on 4/4, 4/6, and 4/14/26 The 4/2026 MAR indicated the Hydralazine tablet 50 mg was administered on the following days outside of the parameters: 8:00 a.m. on 4/8/26 2:00 p.m. on 4/4/26 8:00 p.m. on 4/4, 4/6, and 4/14/26 During an interview on 4/16/26 at 1:15 p.m., the Director of Nursing indicated she notified the Nurse Practitioner (NP) and the Medical Doctor (MD) and the order was changed/clarified. She had no additional information to provide. 3. During random observations on 4/14/26 at 10:30 a.m. and 3:20 p.m., Resident 62 was observed with purple and red bruises to her right and left arms. The record for Resident 62 was reviewed on 4/15/26 at 4:35 p.m. Diagnoses included, but were not limited to, heart disease, heart failure and high blood pressure. The admission Minimum Data Set (MDS) assessment, dated 3/5/26, indicated the resident was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively intact for daily decision making. A Care Plan, dated 3/4/26, indicated the resident was at risk for bruising related to antiplatelet use. The approaches were to observe for bruises. A Physician's Order, dated 4/2/26, indicated Aspirin 81 milligrams (mg) daily. There were no physician's orders to monitor bruising. There was no documentation in nursing progress notes from 4/2-4/14/26 regarding any bruising to the resident's upper arms. The 4/8/25 Weekly Skin Assessment indicated the resident had no bruising to her upper arms. There was no weekly skin assessment completed for 4/15/26. During an interview on 4/16/26 at 3:30 p.m., the Director of Nursing indicated she was unaware of any bruising to the resident's arms and would look into the matter. During an interview on 4/16/26 at 4:00 p.m., the Wound Nurse indicated she just went and assessed the resident and she does have some dark purple areas to the right arm and some smaller ones on the left arm. Nursing staff were to do a skin event when new bruising was observed and it would be followed in wound management typically for three days, sometimes she would keep the resident on longer. She indicated when residents were admitted or readmitted with bruising and she knew where they came from, she would not put them in wound management because she was aware of the origin. The Wound Nurse indicated geri sleeves would be the new intervention to prevent further bruising. The Wound Management Form, dated 4/16/26, indicated the following bruised areas to the resident's arms: right lower arm was 2 centimeters (cm) by 2 cm right lateral lower arm 3 cm by 2 cm left lower arm 6 cm by 3 cm 4. During an observation on 4/13/26 at 1:26 p.m., Resident 110 was observed sitting in his wheelchair with both legs in the dependent position. At that time, his legs were darkened and with some edema (swelling). During an interview at that time, the resident indicated he was supposed to have some type of compression socks on both legs, but they told him they ran out. He had no heel boots on either leg. During random observations on 4/14/26 at 10:39 a.m., 4/15/26 at 10:50 a.m., 12:10 p.m., 2:20 p.m., and 4/16/26 at 8:09 a.m., the resident was observed with no heel boots to his legs. The record for Resident 110 was reviewed on 4/14/26 at 3:42 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, cellulitis of the left lower limb, heart (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disease, peripheral vascular disease, and heart failure. The admission Minimum Data Set (MDS) assessment, dated 4/7/26, indicated the resident was cognitively intact for daily decision making and had no skin issues. A Care Plan, dated 4/2/26, indicated the resident was at risk for skin breakdown due to rare skin moisture and limited mobility. The approaches were to provide heel boots to bilateral lower extremities, on at all times. A Physician's Order, dated 4/2/26, indicated heel checks to bilateral heels every shift and heel boots to bilateral lower extremities on at all times every shift. A Nurse's Note, dated 4/2/26 at 8:50 a.m., indicated a head to toe skin assessment was completed. The resident had dark pink skin discoloration to the left calf related to cellulitis with two plus edema to both lower extremities. The 4/2026 Medication Administration Record indicated the heel boots were signed out as being applied from 4/13-4/15/26. During an interview on 4/16/26 at 3:30 p.m., the Director of Nursing indicated the resident only needed the heel boots when he was in bed, the order had been changed to reflect that. 410 IAC (Indiana Administrative Code) 16.2 3.1-37(a)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate and physician orders were obtained for the use of oxygen for 3 of 5 residents reviewed for respiratory care. (Residents 110, 109, and 74)Findings include:1. During random observations on 4/13/26 at 3:30 p.m., and 4/14/26 at 10:39 a.m. and 3:17 p.m., Resident 110 was observed wearing oxygen via nasal cannula. The oxygen was set at seven liters per minute and connected to the concentrator in the room. The record for Resident 110 was reviewed on 4/14/26 at 3:42 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, cellulitis of the left lower limb, chronic respiratory failure with hypoxia (low oxygen levels), heart disease, peripheral vascular disease, and heart failure. The admission Minimum Data Set (MDS) assessment, dated 4/7/26, indicated the resident was cognitively intact for daily decision making, had no skin issues, and received oxygen while a resident. A Care Plan, dated 4/2/26, indicated the resident was at risk for ineffective tissue perfusion related to heart failure. The approaches were to administer oxygen as ordered. A Care Plan, dated 4/2/26, indicated the resident had potential for impaired gas exchange related to chronic respiratory failure with hypoxia and heart disease. The approaches were to administer oxygen as ordered. A Physician's Order, dated 4/2/26, indicated oxygen at two liters per nasal cannula. During an interview on 4/15/26 at 3:30 p.m., the Director of Nursing had no additional information to provide. 2. During random observations on 4/13/26 at 10:50 a.m., 12:42 p.m., and 3:30 p.m., and on 4/14/26 at 10:40 a.m. and 1:36 p.m., Resident 109 was observed wearing oxygen vial nasal cannula at 2.5 liters per minute on the concentrator in her room. On 4/15/26 at 2:15 p.m. the resident was observed in bed wearing oxygen per nasal cannula at three liters per minute on the concentrator. At 3:30 p.m., Agency LPN 1 was in the resident's room and was asked to observe the oxygen rate on the concentrator. The LPN indicated the rate was set at three liters per minute. She adjusted the level back to two liters per minute. The record for Resident 109 was reviewed on 4/16/26 at 10:19 a.m., Diagnoses included, but were not limited to, compression fracture, COPD (chronic obstructive pulmonary disease), pleural effusion (fluid in the pleural space of the lungs), heart disease, chronic kidney disease, high blood pressure, and depression. The admission Minimum Data Set (MDS) assessment, dated 4/9/26, indicated the resident was moderately impaired for daily decision making and used oxygen while a resident. The resident was admitted with one Stage 2 pressure ulcer (a partial-thickness skin loss involving a shallow, open ulcer or blister, often pink/red and moist, caused by prolonged pressure or friction) at the time of admission. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan, dated 4/8/26, indicated the resident had potential for impaired gas exchange related to COPD and pleural effusion. The approaches were to administer oxygen as ordered. A Physician's Order, dated 4/3/26, indicated oxygen at two liters every shift. During an interview on 4/15/26 at 3:30 p.m., Agency LPN 1 indicated the oxygen should have been set at two liters per minute. During an interview on 4/16/26 at 10:50 a.m., the Director of Nursing had no additional information to provide. 3. On 4/13/26 at 2:56 p.m., Resident 74 was observed in bed and appeared short of breath. She was wearing oxygen vial nasal cannula at 3.5 liters. On 4/14/26 at 10:24 a.m., the resident was wearing oxygen via nasal cannula at 3.5 liters. The record for Resident 74 was reviewed on 4/14/26 at 1:13 p.m. Diagnoses included, but were not limited to, dementia, heart failure, low blood pressure, depression, and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 3/5/26, indicated the resident was moderately impaired for daily decision making and required oxygen therapy. The resident required partial to moderate assistance with showering, toileting, lower body dressing and personal hygiene. A Care Plan, dated 4/25/24, indicated the resident had potential for impaired gas exchange related to congestive heart failure, pleural effusion, and emphysema. Approaches were to administer oxygen as ordered and assess vital signs and lung sounds as needed. A Physician's order, dated 4/6/26 and discontinued on 4/8/26, indicated to administer oxygen via nasal cannula continuously at 2.5 liters/minute. There was no current physician's order for oxygen therapy. During an interview on 4/15/26 at 10:34 a.m., the Director of Nursing (DON) indicated she understood the oxygen concern. No additional information was provided. 410 IAC (Indiana Administrative Code) 16.2-3.1-47(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to staff failing to wear the correct personal protective equipment (PPE) for residents in enhanced barrier precautions and droplet isolation for 1 of 3 pressure ulcer treatments observed and 3 of 9 residents observed during medication administration. The facility also failed to ensure multi-use equipment was disinfected after each use for 3 of 3 residents who were observed having their vital signs checked. (Residents 43, 117, 74, 109, 108, 54, and 40)Findings include: 1.On 4/16/26 at 9:51 a.m., the Wound Nurse and the Assistant Director of Nursing (ADON) entered Resident 43's room to complete a treatment to the resident's sacrum. The Wound Nurse washed her hands and the ADON sanitized her hands prior to donning gloves. Neither one of the nurses donned a gown at that time. The ADON repositioned the resident to his right side and the Wound Nurse pulled down the resident's pants and removed the dressing to the sacrum. After removing the dressing, the Wound Nurse removed her gloves, washed her hands and then donned clean gloves and a gown and proceeded to do the treatment to the resident's sacrum. The ADON remained in the room with the Wound Nurse and assisted with repositioning the resident before and after the treatment. She did not wear a gown during that time. On 4/16/26 at 1:10 p.m., LPN 4 entered the resident's room to administer his nasal spray. LPN 2 accompanied LPN 4 and indicated she was in orientation and just observing. The resident was seated on the side of his bed and was asking for help getting back into bed after receiving the nasal spray. LPN 2 donned a pair of gloves and proceeded to assist the resident back into bed. She lifted the resident's legs and helped him reposition himself. A sign on the resident's door indicated the resident required Enhanced Barrier Precautions which consisted of wearing a gown and gloves during direct resident contact. During an interview on 4/20/26 at 9:10 a.m., the Infection Preventionist indicated the Wound Nurse and the ADON should have donned a gown prior to repositioning the resident and removing the dressing. She also indicated LPN 2 should have donned a gown before assisting the resident with repositioning. 2. On 4/17/26 at 11:19 a.m., LPN 3 proceeded to Resident 117's room to disconnect her intravenous (IV) antibiotic. The LPN sanitized his hands and donned a pair of gloves. He proceeded to disconnect the IV from the port and flushed the IV with normal saline. He did not donn a gown while disconnecting the antibiotic and flushing the line with normal saline. A sign on the resident's door indicated she required Enhanced Barrier Precautions which consisted of a gown and gloves during direct resident contact. During an interview on 4/20/26 at 9:10 a.m., the Infection Preventionist indicated the LPN should have worn a gown while disconnecting the IV. 3. On 4/17/26 at 11:41 a.m., LPN 4 was observed preparing medications for Resident 74. A sign on the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's door indicated she required Droplet Precautions. During an interview at that time, the LPN indicated the resident was in isolation for pneumonia. Prior to entering the resident's room, the LPN sanitized his hands, donned a gown, N95 mask, and gloves. He entered the resident's room and administered her medication. The LPN did not wear any eye protection. The sign on the door of the resident's room indicated for droplet precautions, staff were to wear a gown, an N95 mask, gloves, and eye protection. At that time, face shields were observed in the isolation cart. During an interview on 4/20/26 at 9:35 a.m., the Infection Preventionist indicated the LPN should have put on a face shield prior to entering the resident's room. 4. During a random observation on 4/13/26 at 12:41 p.m., CNA 1 assisted Resident 109 out of bed and into the wheelchair to use the bathroom. The CNA helped the resident to stand up and pulled down her pants and brief and assisted the resident on the toilet. At that time, there was a bandage observed to the resident's sacral area. The CNA only donned clean gloves to assist the resident and did not don an isolation gown. During a random observation on 4/13/26 at 3:30 p.m., LPN 1 was asked to perform a skin assessment for the resident. She assisted the resident onto her right side and removed her pants and brief. The resident had a bandage on her sacral area. The LPN only donned a pair of gloves and no isolation gown. During an interview at that time, the LPN Indicated the resident had pressure ulcer to the sacral area. During a random observation on 4/16/26 at 7:20 a.m., there was a sign on the outside of the resident's door which indicated Enhanced Barrier Precautions. The appropriate personal protective equipment when coming in contact with the resident was to wear gloves and a gown. During an interview on 4/20/26 at 9:12 a.m., the Infection Preventionist indicated both staff persons should have worn a gown prior to having contact with the resident. The facility policy titled, Enhanced Barrier Precautions was provided by the Administrator on 4/13/26 and identified as current. The policy indicated, enhanced barrier precautions was an intervention designed to reduce the transmission of resistant organisms that employeed targeted use of gown and glove use during high contact resident care activities. Use of Personal Protective Equipment – Gown and Gloves: Don gloves and gown prior to a high-contact care activity. Examples of high-contact resident care activities include: -Dressing -Bathing/Showering (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, dialysis device and access site, tracheostomy/ventilator -Wound care: any skin opening requiring a dressing -Change PPE and perform hand hygiene before caring for another resident 5. During a random observation on 4/13/26 at 10:33 a.m., LPN 1 was observed checking Resident 108's blood pressure and pulse oximetry on a multi-use/function blood pressure machine. After she finished, she pushed the machine out of the room and placed it against the wall by the medication cart. She did not immediately sanitize the machine. At 10:37 a.m., she still had not sanitized the machine and continued to pass medication to other residents. 6. During a random observation on 4/16/26 at 8:13 a.m., RN 1 was observed checking Resident 54's blood pressure and pulse oximetry with a multi-use/function blood pressure machine in the memory care dining room. After she was done checking the resident's vital signs she pushed the cart back to the medication cart, placed it against the wall, and plugged it into the outlet. She did not immediately sanitize the machine. At 8:34 a.m. RN 1 pushed the multi-use/function blood pressure machine into Resident 40's room to check his vital signs. The RN checked his blood pressure and pulse oximetry and pushed the machine back to the medication cart and plugged it into the outlet. She did not immediately sanitize the machine. During an interview on 4/16/26 at 8:45 a.m., RN 1 indicated she did not sanitize the machine after each resident. During an interview on 4/16/26 at 2:45 p.m., the Director of Nursing indicated the facility had no policy for cleaning the multi-use/function blood pressure machine. She had no additional information to provide. The current 2/2025 Standard and Transmission-Based Precautions (Isolation) policy, provided by the Administrator on 4/13/26 at 10:31 a.m., indicated shared equipment should be cleaned and disinfected in between each resident use. 410 IAC (Indiana Administrative Code)16.2 3.1-18(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure ulcer treatments were completed as ordered by the physician for 1 of 3 residents reviewed for pressure ulcers. (Resident 109)Finding includes:During an interview on 4/13/26 at 11:00 a.m. Resident 109 indicated her pressure ulcer bandage does not get changed every day. During a random observation on 4/13/26 at 12:41 p.m., CNA 1 assisted the resident to the bathroom. At that time, the resident had a bandage observed to her sacrum with a date of 4/11/26. The CNA observed the bandage as well and indicated the date was 4/11/26. On 4/13/26 at 3:30 p.m., LPN 1 was asked to perform a skin assessment for the resident. At that time, the resident was assisted to her right side and the LPN removed her pants and brief. The bandage on the resident's sacrum was dated 4/11/26. During an interview at that time, LPN 1 indicated she had not changed the bandage and she believed the treatment was supposed to be done every day. During a wound treatment on 4/16/26 at 7:17 a.m., the Wound Nurse removed the resident's bandage on her sacrum. The pressure ulcer had minimal drainage and was red in color. The record for Resident 109 was reviewed on 4/16/26 at 10:19 a.m., Diagnoses included, but were not limited to, compression fracture, COPD (chronic obstructive pulmonary disease), pleural effusion (fluid in the pleural space of the lungs), heart disease, chronic kidney disease, high blood pressure, and depression. The admission Minimum Data Set (MDS) assessment, dated 4/9/26, indicated the resident was moderately impaired for daily decision making. The resident was admitted with one Stage 2 pressure ulcer (a partial-thickness skin loss involving a shallow, open ulcer or blister, often pink/red and moist, caused by prolonged pressure or friction).A Care Plan, dated 4/6/26, indicated the resident had impaired skin integrity and was admitted with a pressure ulcer to the sacrum. The approaches were to provide the treatment as ordered by the physician.A Physician's Order, dated 4/6/26, indicated cleanse wound with wound cleanser, pat dry, apply triad paste and foam dressing once a day. The 4/2026 Medication Administration Record indicated the pressure ulcer treatment was signed out as being completed on 4/11 and 4/12/26. A Wound Nurse Practitioner (NP) Progress Note, dated 4/6/26, indicated the pressure ulcer measured 1 centimeter (cm) in length by 0.5 cm in width, by 0 cm in depth. The wound base had 100% of epithelial tissue. A Wound NP Progress Note, dated 4/14/26, indicated the pressure ulcer measured 0.5 cm in length, by 0.5 cm in width, by 0 cm in depth. The wound base had 100% of epithelial tissue. During an interview on 4/16/26 at 9:15 a.m., the Wound Nurse indicated she worked Monday through Friday and nursing staff were responsible to do the treatments on the weekends. She indicated the treatment should have been done as ordered by the physician. During an interview on 4/16/26 at 10:50 a.m., the Director of Nursing had no additional information to provide. 410 IAC (Indiana Administrative Code) 16.2 3.1-40(a)(2)

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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. Based on record review and interview, the facility failed to ensure food and/or fluid intake was documented for residents with a history of weight loss for 3 of 3 residents reviewed for nutrition. (Residents 4, 6, and 74)Findings include: 1. The record for Resident 4 was reviewed on 4/16/26 at 3:07 p.m. Diagnoses included, but were not limited to Alzheimer's disease with early onset and end stage renal disease with dependence on renal dialysis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/13/26, indicated the resident was cognitively impaired for daily decision making. He had sustained an unplanned weight loss and was receiving dialysis. A Nutrition At Risk (NAR) progress note, dated 4/9/26, indicated the resident had a significant weight loss of 10.9% within the last 90 days. A Care Plan, reviewed on 4/10/26, indicated the resident was at risk for altered nutritional status due to Alzheimer's disease, type 2 diabetes, dementia, end stage renal disease, hyperlipidemia, depressive disorder, and anxiety. Interventions included, but were not limited to, monitor food and fluid intake at meals. The Food Consumption Log for the dates of 3/17/26 through 4/15/26, indicated meal intakes were not documented on the following dates: -3/17/26 no breakfast or lunch intake -3/18/26 no lunch intake -3/19/26 no lunch intake -3/20/26 no intake documented for all three meals -3/21/26 no intake documented for all three meals -3/22/26 no intake for breakfast or lunch -3/23/26 no intake for dinner -3/24/26 no intake for lunch -3/26/26 no intake for breakfast or lunch -3/27/26 no intake for dinner -3/28/26 no intake for breakfast or lunch -3/29/26 no intake for breakfast or lunch (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/31/26 no intake for breakfast or lunch -4/3/26 no intake documented for all three meals -4/4/26 no intake for breakfast or lunch -4/5/26 no intake for breakfast or lunch -4/6/26 no intake for breakfast or dinner -4/7/26 no intake for dinner -4/8/26 no intake for breakfast or lunch -4/9/26 no intake for lunch -4/10/26 no intake for breakfast or dinner -4/11/26 no intake for breakfast or lunch -4/12/26 no intake for breakfast or lunch -4/13/26 no intake for breakfast -4/14/26 no intake documented for all three meals -4/15/26 no intake for lunch During an interview on 4/17/26 at 2:40 p.m., the Director of Nursing indicated the resident's food intake should have been documented and he may have been at dialysis for some of the days breakfast wasn't documented. During an interview on 4/20/26 at 11:30 a.m., the Unit Manager indicated the resident received breakfast before he went to dialysis. 2. The record for Resident 6 was reviewed on 4/15/26 at 9:29 a.m. Diagnoses included, but were not limited to, dementia, type 2 diabetes, atrial fibrillation, heart disease, heart failure, major depressive disorder, adjustment disorder with anxiety and depressed mood. The Annual Minimum Data Set (MDS) assessment, dated 3/3/26, indicated the resident had a significant weight loss and weighed 126 pounds. The 4/8/26 Quarterly MDS assessment indicated the resident was not cognitively intact for daily decision making, weighed 133 pounds, and had no weight loss. A Care Plan, updated 3/2026, indicated the resident was at risk for altered nutrition related to dementia. A Care Plan, updated 3/2026, indicated the resident required assistance and/or monitoring of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutrition. The approaches were to document the percentage of breakfast, lunch, and dinner intakes. A Physician's Order, dated 4/9/26, indicated a regular diet with super cereal with breakfast, ice cream with lunch, and yogurt with breakfast. The resident's weights were as follows: 9/1/25 144 pounds 10/5/25 140 pounds 11/3/25 139 pounds 12/3/25 137 pounds 1/5/26 136 pounds 2/2/26 133 pounds 3/3/26 126 pounds 4/1/26 133 pounds A Registered Dietitian (RD) Progress Note, dated 3/5/26, indicated the resident had a significant weight loss at 30, 90 and 180 days. The breakfast meal was not documented in the point of care charting on 1/2, 1/5, 1/6, 1/7 , 1/9, 1/11, 1/12, 1/13, 1/14, 1/15, 1/16, 1/17, 1/18, 1/19, 1/21, 1/22, 1/23, 1/27, 1/29, 1/30, 1/31, 2/1, 2/3, 2/4, 2/7-2/10, 2/11, 2/12, 2/14, 2/17, 2/18, 2/20, 2/21, 2/27, 2/28, 3/1, 3/2, 3/3, 3/2, 3/3, 3/4, 3/5, 3/6, 3/7, 3/8, 3/9-3/16, 3/22, 3/23, 3/25, 3/26, 3/27, 3/28, 3/29, 3/30, 4/2, 4/5, 4/6, 4/7, 4/10, 4/12, and 4/14/26. The lunch meal was not documented in the point of care charting on 1/1, 1/2, 1/5, 1/6, 1/7 . 1/8, 1/11,1/14, 1/15, 1/16, 1/17, 1/18, 1/19, 1/21, 1/22, 1/23, 1/25, 1/25, 1/27, 1/28, 1/31, 2/3, 2/4, 2/5, 2/8-2/10, 2/11, 2/12, 2/14, 2/15, 2/18, 2/21, 2/22, 2/23, 2/24, 2/25, 2/26, 2/27, 2/28, 3/1, 3/2, 3/3, 3/5, 3/6, 3/8-3/14, 3/16, 3/21-3/23, 3/25, 3/29, 3/31, 4/2, 4/4, 4/5, 4/6, 4/10, 4/12, 4/13, and 4/14/26. The dinner meal was not documented in the point of care charting on 1/2, 1/3, 1/5, 1/7, 1/9, 1/10, 1/11, 1/12, 1/19, 1/24, 1/27, 2/7-2/10, 2/15, 2/18, 2/21, 2/22, 2/24, 2/27, 3/9-3/11, 3/22, 3/23, 3/24, 4/1, 4/2, and 4/7/26. During an interview on 4/16/26 at 1:15 p.m. the Director of Nursing indicated staff were to complete the meal consumptions after every meal. The facility had no policy for review. 3. The record for Resident 74 was reviewed on 4/14/26 at 1:13 p.m. Diagnoses included, but were not limited to, dementia, heart failure, low blood pressure, depression, and dysphagia (difficulty swallowing). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 3/5/26, indicated the resident was cognitively impaired for daily decision making and required supervision for eating. The resident weighed 101 pounds and had a mechanically altered diet. On 10/6/25, the resident weighed 106 pounds. On 4/7/26, the resident weighed 85 pounds The resident had a 19.8% weight loss in 6 months. A Physician's Order, dated 12/10/24, indicated to offer the resident an additional 120 milliliters (ml) of fluid every shift. A Care Plan, reviewed on 3/6/26, indicated the resident was at risk for fluid imbalance related to heart failure, dementia, dysphagia, muscle weakness, use of a diuretic medication, and nectar/mildly thick fluids. Approaches were to offer additional 120 ml of fluid every shift and record fluid intake. A Care Plan, reviewed on 3/6/26, indicated the resident had a nutritional risk related to congestive heart failure, dementia, COPD, and a mechanically altered diet with thickened liquids. Approaches were to monitor food/fluid intake at meals, monitor weight, and notify the physician and family with significant weight loss. A Care Plan dated 3/6/36, indicated the resident required assistance with care, nutrition, hydration, and elimination. Approaches were to document breakfast, lunch, and dinner percentage and fluid consumption. The Food Consumption log, dated 3/1-4/16/26, indicated the following: - No dinner was documented on 3/8, 4/6, 4/10, 4/12, and 4/14/26. - No lunch was documented on 3/1, 3/3, 3/4, 3/5, 3/8, 3/11, 3/13, 3/15, 3/18, 3/19, 3/20, 3/26, 3/28, 3/29, 3/30, 3/31, 4/2, 4/5, 4/8, 4/11, and 4/15/26. -No breakfast was documented on 3/1, 3/5, 3/7, 3/8, 3/12, 3/15, 3/16, 3/19, 3/24, 3/26, 3/28, 3/29, 3/30, 3/31, 4/2, 4/5, 4/10, 4/11, 4/12, 4/13, 4/14, and 4/15/26. - No food consumption was documented on 3/2, 3/9, 3/10, 3/14, 3/21, 3/22, 3/23, 4/4, and 4/9. A Physician's Order, dated 4/9/26, indicated to give mirtazapine (appetite stimulant) 7.5 milligrams (mg) at bedtime. During an interview on 4/20/26 at 10:50 a.m., the Director of Nursing (DON) indicated there were meals and fluids not documented. No additional information was provided. 410 IAC (Indiana Administrative Code) 16.2-3.1-46(a)(1)