STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155270	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Core of Dale	510 W Medcalf Road Dale, IN 47523

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies to carry out the functions of food and nutrition services. The Dietary Manager lacked appropriate certification. Finding includes: On 9/16/25 at 8:05 A.M., the current Dietary Manager indicated she started in that role on 9/5/25 and lacked a current certification and was working to become re-certified. On 9/25/25 at 9:48 A.M., the Director of Nursing (DON) provided a current, undated, Dietary Manager job description as their policy that indicated, Required Qualifications Minimum requirements include one of the following: Certification as a dietary manager. Certification as a food service manager .Must also meet State requirements for food service managers or dietary managers . This Federal tag relates to Intake 2607081.3.1-20(h)

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

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to appropriately test the dishwasher to verify it was functioning correctly. Staff lacked knowledge of the test strips used to test the sanitation chemicals in 1 of 2 observations of dishwasher use. Finding includes: On 9/16/25 at 8:05 A.M., the Dietary Manager indicated she was unsure of what kind of dishwasher the facility had, and that staff checked to make sure the temperature reached 120 degrees Fahrenheit. At that time, she indicated that the staff failed to test the dishwasher with chlorine strips and was unable to find strips.During an observation on 9/16/25 at 8:18 A.M., Maintenance 11 indicated the dishwasher is a low-temperature dishwasher, and he verified the temperature reached 120 degrees Fahrenheit daily. At that time, he indicated he was not a dietary employee, so he did not check the chemicals on the dishwasher.During an interview on 9/16/25 at 9:45 A.M., the Maintenance Supervisor indicated the dishwasher should be tested with a chlorine strip every shift. At that time, she located a container of strips and tested the dishwasher. The strip showed 10 parts per million (ppm). The Maintenance Supervisor indicated it should be at 100 ppm.During an interview on 9/16/25 at 10:30 A.M., the Director of Nursing (DON) indicated kitchen staff should notify maintenance of any problems. At that time, she indicated they were not aware of the problem, and a call had been placed to the manufacturer of the dishwasher.On 9/16/25 at 9:45 A.M., the Maintenance Supervisor provided a current manual as a policy, dated 10/29/07, that indicated chlorine levels should be between 50-100 ppm.This Federal tag relates to Intake 2607081.3.1-21(i)(3)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview and record review, the facility failed to deliver mail to the residents on Saturdays. Ten of ten anonymous residents interviewed indicated they failed to get mail every Saturday. Findings include: During a resident council meeting on 9/23/25 at 9:41 A.M., an anonymous resident indicated they failed to receive mail on Saturdays and they would like to receive it, but their Business Office Manager was not at the facility on Saturday's to deliver it. During an interview on 9/23/25 at 9:44 A.M., the Business Office Manager indicated she delivered mail to the residents and since she does not work on Saturdays, the residents do not receive mail on Saturdays. On 9/25/25 at 11:04 A.M., the Director of Nursing (DON) provided a current, undated, Residents Mail and Finances policy that indicated, .All personal mail is given to the Activities Director to take to the residents . 3.1-3(s)(1)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to ensure accurate resident assessments for 10 of 13 resident records reviewed. Minimum Data Set (MDS) assessments did not reflect accurate resident information. (Resident 6, Resident B, Resident D, Resident 3, Resident 1, Resident 8, Resident 2, Resident 19, Resident 23, Resident C)Findings include: 1. On 9/18/25 at 10:48 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, alcohol-induced dementia, anxiety, depression, and bipolar disorder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/26/25, indicated a moderate cognitive impairment. The MDS assessment indicated the use of antipsychotic, antidepressant, hypnotic, opioid, anticoagulant, antiplatelet, and hypoglycemic medications. The MDS assessment indicated a gradual dose reduction (GDR) had been completed on 4/16/25, as well as a contraindication to a GDR on 4/16/25. Current physician orders included, but were not limited to: duloxetine (Cymbalta) (antidepressant) 60mg (milligrams) once a day, dated 4/16/25. Gabapentin Oral Capsule (anticonvulsant) 300mg at bedtime, dated 2/27/25. Buspirone (antianxiety) 5mg three times a day, dated 3/6/25. Lamictal (anticonvulsant) 100mg once a day, dated 7/13/25. Resident 3 lacked a current physician order for an antipsychotic medication. Resident 3 lacked a current physician order for a hypnotic medication. Resident 3 lacked a current physician order for an anticoagulant medication. Resident 3's July 2025 medication administration record (MAR) lacked documentation that an antipsychotic, hypnotic, or anticoagulant had been administered during the look-back period for the 7/26/25 MDS assessment. A social services note, dated 4/16/25, indicated a GDR meeting had taken place with a contraindication to decrease Cymbalta due to the resident was taking it for neuropathy. No medications were approved for a GDR at that time. On 9/25/25 at 11:56 A.M., the MDS Coordinator indicated she thought Lamictal was an antipsychotic, but was actually an anticonvulsant and should have been marked on the 7/26/25 MDS assessment. She indicated hypnotic and anticoagulant should not have been marked as given on the MDS assessment, and buspirone could have been marked as the antipsychotic. She further indicated the MDS assessment should have only indicated contraindication on 4/16/25, as a GDR did not take place. 2. On 9/25/25 at 9:23 A.M., Resident 6's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent quarterly MDS assessment, dated 8/23/25, indicated no cognitive impairment, and independent with bed mobility. The MDS assessment indicated bed rails were used daily for physical restraints. Resident 6's clinical record lacked a physician's order for physical restraints. Resident 6's clinical record lacked a care plan for the use of physical restraints. On 9/25/25 at 8:58 A.M., Resident 6 was observed lying in bed. The left side of the bed was against the wall, and a side rail was observed on the right side of the bed. At that time, Registered Nurse (RN) 8 indicated no one on that hall utilized restraints, and bed rails were used as enablers only. 3. On 9/25/25 at 9:33 A.M., Resident B's clinical record was reviewed. The most recent quarterly MDS assessment, dated 7/29/25, indicated a moderate cognitive impairment, substantial to maximum assistance (helper does more than half the effort) with bed mobility, and use of side rails for physical restraints. Resident B's clinical record lacked a physician's order for physical restraints. Resident B's clinical record lacked a care plan for the use of physical restraints. On 9/24/25 at 8:47 A.M., RN 18 indicated Resident B used bed rails to help move in bed as an enabler, but they were not used as restraints. 4. On 9/18/25 at 12:51 P.M., Resident D's clinical record was reviewed. The most recent annual MDS assessment, dated 8/2/25, indicated a moderate cognitive impairment, independent with bed mobility, and use of side rails for physical restraints. Resident D's clinical record lacked a physician's order for physical restraints. Resident D's clinical record lacked a care plan for the use of physical restraints. On 9/25/25 at 8:49 A.M., Resident D was observed lying in bed with the side rail on the right side. At that time, RN 18 indicated Resident D wanted the side rail to assist with transfers. She indicated the side rails were not used as restraints. 5. On 9/19/25 at 8:55 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), diabetes mellitus type II, and bipolar disorder. The most recent quarterly MDS assessment, dated 7/12/25, indicated Resident 1 was cognitively intact and was taking a hypnotic and anticoagulant medication and not taking an anticonvulsant or antiplatelet medication. The July 2025 Medication Administration Record (MAR) was reviewed from 7/1/25 to 7/12/25 and included, but was not limited to, the following medications administered to Resident 1: Plavix (antiplatelet) 75 mg daily, ordered 6/28/25 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lamotrigine (anticonvulsant) 100 mg daily, ordered 2/28/25 melatonin (over-the-counter sleep aid)10 mg at bedtime, ordered 2/27/25 On 9/25/25 at 11:44 A.M., during an interview with the MDS Coordinator, she indicated that Plavix and melatonin were coded incorrectly as an antiplatelet and hypnotic. The lamotrigine was missed and should have been included in medications as an anticonvulsant. 6. On 9/18/25 at 9:54 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia without behaviors, schizophrenia, and bipolar disorder. The most recent significant change MDS assessment, dated 8/4/25, indicated Resident 8's cognition was severely impaired, totally dependent on staff for toileting, showering, bed mobility, and transfers, and was not receiving hospice services at that time. Physician Orders included, but were not limited to, (hospice company name) to provide services, ordered 1/22/25. During an interview on 9/24/25 at 9:12 A.M., RN 8 indicated Resident 8 was currently receiving hospice services. On 9/25/25 at 11:53 A.M., during an interview with the MDS Coordinator, she indicated that hospice services was marked no in error. 7. On 9/19/25 at 12:40 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder and dementia with behaviors. The most recent quarterly MDS assessment, dated 8/23/25, indicated Resident 2's cognition was moderately impaired, taking an anticoagulant and diuretic medication, and not taking an anticonvulsant or an antiplatelet medication. The August 2025 MAR was reviewed from 8/1/25 to 8/23/25 and included, but was not limited to, the following medications administered to Resident 2: Plavix (antiplatelet) 75 mg daily, ordered 2/27/25 Depakote sprinkles (anticonvulsant) 125 mg by mouth three times a day for dementia, ordered 4/18/25 The physician's orders and August 2025 MAR lacked a diuretic medication being administered to Resident 2. On 9/25/25 at 11:51 A.M., the MDS Coordinator indicated the resident had received Plavix and Depakote, but not a diuretic medication, during the lookback period. The MDS assessment medications were coded incorrectly. 8. On 9/19/25 at 12:30 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, depression, and anxiety disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent quarterly MDS assessment, dated 9/6/25 indicated no cognitive impairment, and independent with bed mobility. The MDS indicated that bed rails were used daily for physical restraints. Resident C's clinical record lacked a physician's order for physical restraints. Resident C's clinical record lacked a care plan for the use of physical restraints. On 9/17/2025 9:06 A.M., Resident C was observed asleep in his bed. The head of his bed was against the wall, and there was a side rail that was observed on both sides of the bed. 9. On 9/23/25 at 12:24 P.M., Resident 19's clinical record was reviewed. Diagnosis included, but was not limited to, muscular dystrophy. The most recent quarterly MDS assessment, dated 7/19/25, indicated no cognitive impairment, and independent with bed mobility. The MDS indicated that bed rails were used daily for physical restraints. Resident 19's clinical record lacked a physician's order for physical restraints. Resident 19's clinical record lacked a care plan for the use of physical restraints. On 9/25/25 at 8:56 A.M., Resident 19 was observed sitting in a wheelchair in his room. At that time, the head of his bed was against the wall with a side rail on the right side of the bed. Resident 19 indicated it was to help him roll. 10. On 9/23/25 at 12:43 P.M., Resident 23's clinical record was reviewed. Diagnosis included, but was not limited to, stroke affecting the left dominant side. The most recent quarterly MDS assessment, dated 7/19/25, indicated no cognitive impairment, and independent with bed mobility. The MDS indicated that bed rails were used daily for physical restraints. Resident 23's clinical record lacked a physician's order for physical restraints. Resident 23's clinical record lacked a care plan for the use of physical restraints. On 9/25/25 at 9:00 A.M., Resident 23 was observed sitting in his wheelchair in his room. At that time, the head of his bed and the right side of the bed were against the wall. A side rail was observed on the left side. Resident 23 indicated he used the bed rail to get up and down in bed. During an interview on 9/25/25 at 9:01 A.M., Registered Nurse (RN) 8 indicated they do not have any restraints in the facility. All side rails are utilized as enablers. During an interview on 9/25/25 at 11:39 A.M., the MDS Coordinator indicated all side rails in the building were utilized for mobility. She indicated the facility does not use restraints and was unsure if restraints should have been coded on the MDS for the side rails. During an interview on 9/25/25 at 11:45 A.M., the MDS Coordinator indicated she used the Resident Assessment Instrument (RAI) manual as the policy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure specific, comprehensive care plans were revised for 4 of 4 reviewed for behaviors related to sexual offenders. Care plans were not revised to include specific behaviors, restrictions, and interventions. (Resident B, Resident C, Resident D, Resident F)Findings include:On 9/24/25 at 9:55 A.M., a binder was provided by the Director of Nursing (DON) with a list of registered sexual offenders that were currently residents or had previously been a resident at the facility.The Sex Offender Registry list on the [NAME] County Sheriff's Department website was retrieved on 9/24/25 at 2:20 P.M. The list included registered sex offenders who have been convicted of a sexual offense and were mandated to register as a sexual offender annually and were within a one mile radius of the facility address (510 [NAME] St Dale, Indiana 47523). The registry included 16 residents currently residing at the facility. It included the type of offense, but lacked specific details about the resident's conviction and restrictions. Resident B was listed as a sex offender (a general category for individuals convicted of sex offenses). Resident C and Resident D were listed as a sexually violent predators (a specific designation for offenders deemed a high risk to re-offend and a threat to the public).1. On 9/25/25 at 11:51 A.M., Resident B was observed sitting in a wheelchair in the dining room.On 9/25/25 at 9:33 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis.The most recent quarterly MDS assessment, dated 7/29/25, indicated a moderate cognitive impairment.A current Behavior Care Plan, (last reviewed date unknown), indicated Resident D had the potential for sexually inappropriate behavior related to sexual offender history. Interventions included the following:Monitor for inappropriate sexual behaviorsInvolve resident in activitiesEncourage appropriate communication and socializationNotify SSD if behaviors occurExplain to the resident why behaviors were inappropriate1:1 (staff to resident watch) as needed15 minute checks (staff to observe resident every 15 minutes) as neededPsychology services as neededChildren present under age [AGE] to remain supervised by an adult.The care plan lacked resident specific sexual offender history and behaviors, restrictions, and interventions.2. On 9/16/25 at 12:58 P.M., Resident C was observed sitting in his bed.On 9/19/25 at 12:30 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure, diabetes mellitus type II, anxiety disorder, and depression.The most recent quarterly MDS assessment, dated 9/6/25, indicated Resident C was cognitively intact. A current Behavior Care Plan, initiated 6/11/25 and last reviewed on 9/7/25, indicated Resident D had the potential for behaviors that included sexually inappropriate behavior related to sex offender history, verbal aggression (yelling, cursing), and refusing medications. Interventions, initiated on 6/11/25, included the following:Monitor for inappropriate sexual behaviorsInvolve resident in activitiesEncourage appropriate communication and socializationNotify SSD if behaviors occurExplain to the resident why behaviors were inappropriate1:1 (staff to resident watch) as needed15 minute checks (staff to observe resident every 15 minutes) as neededPsychology services as neededChildren present under age [AGE] to remain supervised by an adultThe care plan lacked resident specific sexual offender history and behaviors, restrictions, and interventions.3. On 9/24/25 at 9:08 A.M., Resident D was observed in his motorized wheelchair telling a nurse that he was leaving the facility to go to church.On 9/18/25 at 12:51 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, psychoactive substance abuse, unspecified sexually transmitted disease, and noncompliance with other medical treatment and regimen.The most recent annual MDS assessment, dated 8/2/25, indicated a moderate cognitive impairment.A current Behavior Care Plan, initiated on 5/19/25 and revised on 5/27/25, indicated Resident D had the potential to be physically aggressive. Interventions, initiated on 5/19/25, included the following:The resident's triggers for physical aggression were not getting what he wants when he (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wants it. The resident's behaviors were de-escalated by promptly assisting resident as soon as possibleAdminister medications as ordered and monitor/document for side effects and effectivenessAnalyze and document time of day, places, circumstances, triggers, contributing sensory deficits and what de-escalated behaviorAssess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc.Provide physical and verbal cues to alleviate anxietyGive positive feedbackAssist with verbalization of source of agitationAssist to set goals for more pleasant behaviorEncourage seeking out of staff member when agitatedGive the resident as many choices as possible about care and activitiesModify environment: Adjust room temperature to comfortable level, Reduce noise, dim lights, place familiar objects in room, keep door closed, etcMonitor and document observed behavior and attempted interventions in behavior log as neededMonitor/document/report any signs and symptoms of resident posing a danger to self and others as neededPsychiatric/Psychogeriatric consult as indicatedThe resident needed ample amount of personal spaceWhen the resident becomes agitated: Intervene before agitation escalates. Guide away from source of distress, engage calmly in conversation. If response was aggressive, staff to walk calmly away, and approach later.The care plan lacked resident specific sexual offender history and any restrictions.4. On 9/24/25 at 2:15 P.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to diabetes mellitus type II, chronic kidney disease, and history of stroke.A current Behavior Care Plan, initiated 6/10/25, indicated Resident F had the potential for behaviors that included sexually inappropriate behavior related to a history of inappropriate behavior and making inappropriate comments to staff. Interventions, initiated on 6/10/25, included the following:Encourage appropriate communication and socializationInvolve resident in activitiesMonitor for inappropriate sexual behaviorPsychology services as neededNotify social services if behavior occurredSocial service visits as neededThe care plan lacked resident specific sexual offender history and behaviors, restrictions, and interventions.On 9/25/25 at 8:57 A.M., an email, dated 8/22/25 at 12:16 P.M., addressed to the Social Services Director (SSD) from Resident F's parole officer was provided by the DON and indicated, . The Indiana Parole Board issued a warrant for [resident name] due to him having the cell phone. We started looking into it more and there were several pornographic photos and videos on it as well as a head shot image of a minor girl. [resident last name] denied it was his, however, there is no way to prove it since it was in his possession. These are major rule violations and [resident last name] was very well aware he was not to have a phone as well as images like that . Most likely the Sheriff's Dept [department] will serve the warrant and possibly today. A Discharge Summary Note on 8/22/25 at 5: 49 P.M., indicated resident was discharged due to violation of his parole by the sheriff's office.During an interview on 9/24/25 at 8:43 A.M., the Social Services Director (SSD) indicated there were currently sexual offenders residing in the facility and the office registered them on the sexual offender registry. There were restrictions to follow with the residents currently on probation and those residents were visited by the probation officers monthly, and once a resident was no longer on probation, they have no restrictions to enforce. They just have to abide by the laws in Indiana. She indicated they kept files on all the sexual offenders in the building at the office that included the resident specific restrictions to follow and these restrictions were on the resident care plans. If a resident was on probation, they were not allowed to go into the community without someone with them. She indicated staff were informed of behaviors, whether the resident was on probation, and the restrictions they had to enforce. During an interview on 9/25/25 at 9:10 A.M., Registered Nurse (RN) 8 indicated the staff communicate through verbal nurse to nurse report if there were any behavioral flare-ups to closely monitor. They were trained to de-escalate and separate residents if they were combative with each other but not on what to expect dealing with sexual offenders or personal safety. She indicated the facility was particular on which male residents they put on the East Hall (women's hall). Kids that come to the facility have to be supervised at all times. She indicated Resident B was not allowed to go to the East Hall for any reason. They were not notified which residents were sex offenders. Most of the time, they found out on their own from other (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff and it was verbally understood who can and can't do things. They monitor all residents for behaviors.On 9/25/25 at 9:53 the DON indicated all the residents were treated the same regardless of why they were in the facility. She indicated they were a behavioral health facility, not a typical nursing home, and all their residents have behaviors of some sort. She wasn't sure how staff was supposed to know the specific restrictions for the residents that were sexual offenders. For Resident F, they did not know at that time that he was not allowed to have electronics until they were notified by cops. They have not incorporated the restrictions (if known) into resident specific interventions for the residents. During an interview on 9/25/25 at 1:40 P.M., the Administrator indicated after the nearby school closed a few years ago, they started admitting sexual offenders. They work closely with the parole officers who let the facility know what the residents can and can not do. On 9/25/25 at 8:30 A.M., a current Care Plan Revision Policy, last revised 8/27/24, was provided by the DON and indicated, The purpose of this procedure is to provide a consistent process for reviewing and revising the resident specific care plan . The comprehensive care plan will be reviewed, and revised as necessary . The MDS Coordinator or appropriate staff member, will review and update the resident's care plan and intervention(s) as needed . On 9/25/25 at 1:55 P.M., a current Facility Safety Plan for Offenders Policy/Procedure, dated 9/25/25, was provided by the DON and indicated, It is the policy of this facility to maintain the safety of the residents, staff, visitors, and the community in the presence of residents with a history of a violent/sexual offense.This citation relates to Intake 2609464.3.1-35(d)(2)(B)

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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 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, interview, and record review, the facility failed to ensure a homelike environment for 6 of 15 resident rooms reviewed for the environment. Rooms and a hall had a strong urine odor, peri-cleanser and cream (used for incontinence care) were found in a resident refrigerator, call light strings in the bathrooms were soiled, and grab bars and the toilet seat were loose. (East Hall, [NAME] Hall, Resident rooms and or shared bathrooms, Rooms 101, 102, 103/105, 108/110, 207/209, 204/206)Findings include:1. On 9/16/25 12:33 P.M., room [ROOM NUMBER] and the private bathroom was observed with a strong urine odor.On 9/24/25 at 9:10 A.M., the same was observed. 2. On 9/16/25 at 12:35 P.M., room [ROOM NUMBER], there was cream in an open clear cup and a bottle of peri-cleanser observed in Resident 8's refrigerator with three cans of soda.On 9/24/25 at 9:11 A.M., the same was observed.On 9/24/25 at 9:23 A.M., Certified Nurse Aide (CNA) 22 indicated those shouldn't be stored there, took them out, and discarded them in the trash can. 3. On 9/16/25 12:38 P.M., room [ROOM NUMBER]'s bathroom (shared with room [ROOM NUMBER]) was observed with a strong urine odor.On 9/24/25 at 9:08 A.M., the same was observed. 4. On 9/16/25 at 12:46 P.M., room [ROOM NUMBER] and bathroom (shared with 110) was observed with a strong urine odor, the handle bars and the toilet seat they were connected to were loose, and the call light cord was brown.On 9/24/25 at 9:06 A.M., the same was observed. 5. On 9/16/25 at 12:48 P.M., room [ROOM NUMBER]'s bathroom (shared with room [ROOM NUMBER]) was observed with a brown call light cord that was wrapped around a grab bar.On 9/24/25 at 9:04 A.M., the same was observed. 6. On 9/16/25 at 12:57 A.M., room [ROOM NUMBER]'s bathroom (shared with room [ROOM NUMBER]) was observed with a brown call light cord and a strong urine odor.On 9/24/25 at 9:02 A.M., the same was observed. During an interview on 9/24/25 at 9:25 A.M., Housekeeper 5 indicated they do have rooms that smell because the residents forget to flush or did't hold the handle down long enough. At that time, she indicated staff located the source and used bio enzymatic odor eliminator spray. They cleaned the rooms and bathrooms daily and as needed. If the call light cord was brown, it would need to be changed by maintenance. The housekeeper was responsible for taking the resident refrigerator temperatures daily and when they looked inside at thermometer, if there was something in it that shouldn't be, they would discard it. On 9/25/25 at 9:29 A.M., the Director of Nursing (DON) indicated the facility didn't really have a policy for the environment but they would follow the regulations. This citation relates to Intake 2607081. 3.1-19(f)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155270	A. Building B. Wing	09/25/2025

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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 interview and record review, the facility failed to ensure a notice of transfer or discharge notice and a bed hold policy was given to residents or resident representatives for 2 of 2 residents reviewed for hospitalizations. There was no documentation of a resident or representative receiving a notice of transfer or discharge and a bed hold at the time of hospitalization. (Resident 1, Resident 7)Findings include: 1. On 9/18/25 at 9:38 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and anxiety disorder. Resident 7 was admitted from the facility to the hospital on 7/21/25 and returned to the facility from the hospital on 7/28/25. Resident 7 was admitted from the facility to the hospital on 8/19/25 and returned to the facility from the hospital on 8/20/25. Resident 7 was admitted from the facility to the hospital on 8/31/25 and returned to the facility from the hospital on 9/3/25. Resident 7's clinical record lacked a notice of transfer/discharge and bed hold policy given to the resident or a representative at the time of the transfers. 2. On 9/19/25 at 8:55 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type II diabetes, and bipolar disorder. Resident 1 was admitted from the facility to the hospital on 7/27/25 and returned to the facility on 8/4/25. Resident 1's clinical record lacked a notice of transfer/discharge and bed hold policy given to the resident or a representative at the time of the transfer. On 9/24/25 at 9:43 A.M., the Social Services Director (SSD) indicated that when a resident is transferred from the facility, the nurses fill out the transfer and discharge notice along with the bed hold policy. A copy of them was kept in her office in a binder, but not put into the clinical record. On 9/25/25 at 1:55 P.M., a current non-dated Notice of Transfer/Discharge Policy was provided by the Director of Nursing (DON) and indicated, . A copy of the completed and signed transfer/discharge notice will be placed in the clinical record . On 9/25/25 at 2:29 P.M., a current Bed Hold Policy, dated 8/22/24, was provided by the DON and indicated, . The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file . 3.1-12(a)(6)(A)

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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 observation, interview, and record review, the facility failed to ensure services provided by the facility met professional standards for 1 of 2 residents reviewed for nutrition. A resident's weights were not transferred into the clinical record, the medical provider and family were not notified of weight loss, the dietitian's recommended orders were not put into place, and the resident continued to have weight loss. (Resident G)Finding includes:On 9/19/25 at 12:06 P.M., Resident G was observed sitting in a Broda chair in the dining room while staff fed him.On 9/18/25 at 12:48 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/12/25, indicated Resident G's cognitive status could not be assessed and was dependent on staff for eating, showering, toileting, bed mobility, and transfers. He was on a mechanical diet (consisting of foods that are modified to be easy to chew and swallow) and experienced a weight loss. His current weight was 156.0 pounds (lbs) and height was 66 inches.Current orders included, but were not limited to,weight monthly, ordered 3/1/25magic cup (supplement) at 5:00 P.M. with supper daily, ordered 2/1/25regular diet with mechanical soft texture, ordered 2/27/25A current Nutrition Care Plan, last revised 7/12/25, included, but was not limited to, the following interventions initiated on 6/27/24:Monitor monthly weightsMonitor/record/report to Medical Doctor (MD) as needed, a significant weight loss (greater than 5% in one month, greater than 7.5% in three months, or 10% in six monthsProvide and serve supplements to me as orderedRegistered Dietitian (RD) to evaluate and make recommendations as neededThe most recent Nutritional Risk Assessment, dated 7/12/25, completed by the RD recommended to increase the magic cup from daily to twice daily.The clinical record lacked documentation of the resident being seen by the RD since 7/12/25.The Medication Administration Record (MAR) for September 2025 was reviewed from 9/1/25 through 9/17/25 and indicated Resident 41 was only getting the magic cup with his supper.The clinical record lacked documentation of notification to the MD or Nurse Practitioner (NP) of the weight loss.On 6/1/25, the resident weighed 166.4 lbs. On 7/1/25, the resident weighed 155.6 lbs, which was a weight loss of 6.49%.The clinical record lacked documentation of notification to the MD or Nurse Practitioner (NP) of the weight loss.The clinical record lacked documentation of any weights completed since then.On 9/24/25 at 9:23 A.M., Certified Nurse Aide (CNA) 22 CNAs weighed the residents when the nurse notified them to do it. She indicated that, to her knowledge, he only got a magic cup with his supper.On 9/24/25 at 9:35 A.M., Registered Nurse 8 indicated he was a monthly weight. He should get the magic cup as ordered. At that time, she indicated the dietary manager usually went through the clinical records and looked for weight loss. They would notify the dietician, MD, and DON, and they would decide what to do. To her knowledge, the RD came to the facility monthly. During an interview on 9/24/25 at 10:06 A.M., the Dietary Manager indicated she just took over (9/5/25) and didn't have a list of residents with weight loss currently in the facility.On 9/25/25 at 9:40 A.M., the RD indicated she came to the facility 8 hours per month. The process was to see all residents on admission, quarterly, and as needed. Nursing or the Dietary Manager would refer her for evaluation. She had not seen the resident in August or 9/19/25 when she was at the facility. She was not sure why there was not a recent weight in Resident G's clinical record or why his magic cup was not increased. On 9/25/25 at 9:53 A.M., the Director of Nursing indicated the Assistant Director of Nursing (ADON) had papers on her desk with August and September 2025 weights for Resident G. His August weight was 154.4 lbs, and his September weight was 145.6 lbs, but these were not put into the clinical record. She said the resident had aspiration pneumonia recently, which could have been the cause of the weight loss, but generally, he ate well. She would usually be the one to notify the MD of the RD recommendations and was not sure why the magic cup was not increased after the 7/12/25 visit. She also had no visit notes from the dietician in August or September. She indicated that the weights not being in the clinical record would have caused the dietitian to miss seeing him, and the MD not being notified.On (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/25/25 at 12:06 P.M., a current Nutritional Risk Program Policy, last revised 9/10/13, was provided by the DON and indicated, It is the policy of this facility to monitor the weight status of each resident and that appropriate interventions be initiated should weight decline or incline unplanned . This citation relates to Intake 26070813.1-46(a)(1)