STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155303	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Spring Senior Living at Jasonville	800 E Ohio St Jasonville, IN 47438

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure residents were provided informed consent prior to an increase in psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident 34, Resident 33)Findings include:1. On 1/28/26 at 9:04 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety (a mental condition characterized by excessive or unrealistic anxiety), and Alzheimer's disease (a brain condition that slowly damages your memory, thinking, learning and organizing skills).A review of the physician's orders indicated the following:On 10/10/25 an order for Sertraline (brand name Zoloft, medication used to treat depression) 100 mg, two tablets daily, was prescribed for major depressive disorder and generalized anxiety.A review of a progress note, dated 10/9/25, indicated Zoloft was increased to 200 mg daily by the psychiatry Nurse Practitioner.The clinical record lacked documentation that indicated informed consent was provided to the resident and/or the resident representative, regarding treatment options, risks, and benefits of psychotropic medication prior to the increase in the psychotropic medications.During an interview with the DON (Director of Nursing) on 1/28/26 at 1:30 p.m., she indicated there was not an informed consent obtained prior to the increase of the psychotropic medications. 2. On 1/28/26 at 11:26 a.m., Resident 33's clinical record was reviewed. The diagnoses included, but were not limited to, schizophrenia (a serious mental health condition that affects how people think, feel and behave), vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), and bipolar disorder (a chronic mental illness characterized by extreme mood swings, ranging from high-energy mania to deep, hopeless depression).A review of the physician's orders indicated the following:On 4/8/25, an order for Clozaril (an antipsychotic medication used to treat treatment-resistant schizophrenia and to reduce suicide risk in schizophrenia/schizoaffective disorder) 50 mg (milligram) twice daily was prescribed for bipolar disorder and schizophrenia.On 10/10/25, an order for Clozaril 25 mg twice daily, to be taken with Clozaril 50 mg to equal 75 mg, was prescribed.A review of a progress note, dated 10/9/25, indicated Clozaril was increased to 75 mg twice daily by the psychiatry Nurse Practitioner.The clinical record lacked documentation that indicated informed consent was provided to the resident and/or the resident representative, regarding treatment options, risks, and benefits of psychotropic medication prior to the increase in psychotropic medications.During an interview with the DON (Director of Nursing) on 1/28/26 at 1:30 p.m., she indicated there was not an informed consent obtained prior to the increase of psychotropic medications. On 1/28/26 at 3:23 p.m., the DON provided a copy of the facility policy named, Psychotropic Medication Use, dated July 2022, she indicated this was a current policy used by the facility. A review of the policy indicated, .3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences . Residents (and/or representatives) have the right to decline treatment with psychotropic mediations. a. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives .3.1-3(n)(2)

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

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to implement the Gradual Dose Reduction (the tapering of psychotropic drugs) (GDR) recommendation and failed to have the physician limit the use of as needed antianxiety medication to 14 days for 2 of 5 residents reviewed for unnecessary medications. (Resident 1 and Resident 24) Findings include: 1. On 1/28/26 at 9:05 a.m., Resident 1 was observed to be on her bed watching the television. On 1/28/26 at 9:36 a.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, atrial fibrillation, major depressive disorder, generalized anxiety disorder, and shortness of breath. The January 2026 Medication Administration Record (MAR) indicated Resident 1 was administered the following:- Mirtazapine (antidepressant) 15 mg (milligrams) at bedtime for depression and for appetite stimulant, initiated 10/23/25. - Lorazepam (antianxiety) 0.5 mg every 12 hours as needed for anxiety, initiated 1/8/26. The medication order lacked a stop date of 14 days. The Progress notes indicated the following: - On 1/8/26 at 12:34 p.m., Resident 1's medications were discussed during the Gradual Dose Reduction/Behavior meeting. The recommendation from the meeting was to discontinue the mirtazapine. - On 1/8/26 at 12:50 p.m., Resident 1 was seen by the physician. The physician ordered lorazepam 0.5 mg twice daily as needed. The progress notes lacked documentation of Resident 1 declining the gradual dose reduction of mirtazapine. The psychiatry progress note, dated 1/8/26, indicated to discontinue mirtazapine 15 mg due to weight gain. The physician visit note, dated 1/8/26, indicated Resident 1 had complaints of shortness of breath on exertion with minimal activity. The physician ordered lorazepam 0.5 mg twice a day as needed for anxiety. The stop date was 3 months. The care plan indicated Resident 1 was on an antidepressant medication therapy related to depression. The intervention was to consult with the pharmacy, health care provider to consider dosage reduction when clinically appropriate. During an interview on 1/28/26 at 2:22 p.m., the Director of Nursing (DON) indicated Resident 1 did not want the mirtazapine discontinued. The clinical record lacked documentation of Resident 1 refusal of the gradual dose reduction or the 14 days stop date of the lorazepam. 2. On 1/28/26 at 11:37 a.m., Resident 24 was observed to be ambulating in the hallway. On 1/28/26 at 11:40 a.m., Resident 24's clinical record was reviewed. The diagnoses included, but were not limited to, schizophrenia, generalized anxiety disorder, and major depressive disorder. The January 2026 Medication Administration Record (MAR) indicated the following:- Clozapine (antipsychotic medication) 150 mg once a day for schizophrenia, initiated 8/6/25. - Clozapine 200 mg once a day for schizophrenia, initiated 8/5/25. - Risperidone (antipsychotic medication) 2 mg twice a day, initiated 8/5/25. The Progress notes, dated 1/8/26 at 12:45 p.m., indicated Resident 24's medications were discussed during the Gradual Dose Reduction/Behavior meeting. The recommendation from the meeting was to start Zoloft (antidepressant) 50 mg and to decrease risperidone to 1.5 mg twice a day. The clinical record lacked documentation of implementation of the gradual dose reduction or the discussion with the Resident 24's family. The psychiatry progress note, dated 1/8/26, indicated an attempt to gradual dose reduction of risperidone. Resident 24 was on 2 antipsychotic medications. The care plan indicated Resident 24 used psychopharmacological medication related to schizophrenia. The intervention was to consult with the pharmacy, health care provider to consider dosage reduction when clinically appropriate. During an interview on 1/28/26 at 2:22 p.m., the DON indicated Resident 24's gradual dose reduction was not implemented. Resident 24's family was in the hospital and could not notify him of the gradual dose reduction. The clinical record lacked documentation of the attempt to notify the family of the gradual dose reduction. On 1/28/26 at 3:23 p.m., the DON provided the facility policy, Psychotropic Medication Use, dated 7/2022, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .11. Residents on psychotropic medications receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	these medications 12. Psychotropic medications are not prescribed or given on a PRN [as needed] basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days . 3.1-48(a)(2)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure MDS (Minimum Data Set) assessments were completed within the allotted timeframes for 2 of 6 residents reviewed for resident assessments. (Resident 3, Resident 34)Findings include:1. On 1/22/26 at 10:21 a.m., Resident 3's clinical record was reviewed. The diagnoses included, but were not limited to, depression and alcoholic cirrhosis of the liver (irreversible scarring of the liver caused by long-term, excessive alcohol consumption, which replaces healthy tissue and causes liver failure).Resident 3 was admitted to the facility on [DATE].The resident's MDS assessments indicated the admission MDS assessment dated , 10/19/25, was not completed or signed until 11/5/25.During an interview with the MDS nurse and the DON (Director of Nursing) on 1/28/26 at 1:30 p.m., it was indicated the admission MDS assessment was not completed within 14 calendar days of the admission date. The DON indicated the facility did not have a resident assessment policy and they used the RAI tool criteria for timeframe of completion.On 1/28/26 at 2:00 p.m., the Resident Assessment Instrument (RAI), Version 3.0 User's Manual, dated 10/2025, was reviewed. The RAI indicated the admission MDS assessment must be completed within 14 calendar days after the admission date.2. On 1/28/26 at 9:04 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease (is a brain condition that slowly damages your memory, thinking, learning and organizing skills), pain and generalized anxiety disorder (a mental condition characterized by excessive or unrealistic anxiety).A review of Resident 3's MDS assessments indicated the Annual MDS assessment with an Assessment Reference Date (ARD) of 10/30/25 was not completed or signed until 1/2/26.During an interview with the MDS nurse and the DON (Director of Nursing) on 1/28/26 at 1:30 p.m., they indicated the Annual MDS assessment was not completed within 14 calendar days of the ARD. The DON indicated the facility did not have a resident assessment policy and they use the RAI tool criteria for timeframe of completion.On 1/28/26 at 2:00 p.m., the Resident Assessment Instrument (RAI), Version 3.0 User's Manual, dated 10/2025, was reviewed. The RAI indicated the Annual MDS Assessment was to be completed within 14 calendar days after the ARD.

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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 - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure an accurate MDS (Minimum Data Set) assessment for 2 of 5 residents reviewed for unnecessary medications. (Resident 34, Resident 33)Findings include:1. On 1/28/26 at 9:04 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety (a mental condition characterized by excessive or unrealistic anxiety), and Alzheimer's disease (a brain condition that slowly damages your memory, thinking, learning and organizing skills).A review of the physician's orders indicated, on 5/29/25, Depakote Sprinkles (an anticonvulsant medication used to treat seizure disorders, mental/mood conditions) capsule 125 MG (milligrams) 1 capsule by mouth two times a day was discontinued.A review of a psychiatry progress note, dated 1/8/26, indicated Depakote was discontinued on 5/29/25 and was not a current medication. A review of the Annual MDS assessment, dated 10/30/25, section N0415K1: Anticonvulsants indicated, yes, the resident was taking an anticonvulsant medication.During an interview with the MDS Coordinator and DON (Director of Nursing) on 1/28/26 at 1:35 p.m., they indicated the resident was not on an anticonvulsant medication during the observation period for the Annual MDS assessment, dated 10/30/25. The DON indicated the section for Anticonvulsant medication use should have been marked no. The DON indicated the facility did not have a MDS policy, they utilized the RAI (Resident Assessment Instrument) tool to complete MDS assessments.On 1/28/26 at 2:00 p.m., the RAI, Version 3.0 User's Manual, dated 10/2025, was reviewed. The RAI indicated for section N0415, High-Risk Drug Classes: Use and Indication, .Anticonvulsant: Check if an anticonvulsant medication was taken by the resident at any time during the 7-day observation period . 2. On 1/28/26 at 11:26 a.m., Resident 33's clinical record was reviewed. The diagnoses included, but were not limited to, schizophrenia (a serious mental health condition that affects how people think, feel and behave), vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), and bipolar disorder (a chronic mental illness characterized by extreme mood swings, ranging from high-energy mania to deep, hopeless depression).A review of the Quarterly MDS Assessment, dated 11/20/25, Section I: Active Diagnoses, the diagnoses of Non-Alzheimer's Dementia, Bipolar Disorder, and Schizophrenia were marked no.A review of the physician orders indicated the following:- Depakote Tablet Extended Release (a medication used to manage manic episodes associated with bipolar disorder) 500 mg (milligrams), give three tablets by mouth in the evening for diagnosis of Bipolar disorder, initiated 2/27/25.- Clozaril (antipsychotic used to treat treatment-resistant schizophrenia) tablet 50 mg, give one tablet two times a day for diagnoses of bipolar disorder and Schizophrenia, initiated 4/8/25. - Trazodone HCl (antidepressant medication) tablet 100 mg, give one tablet by mouth at bedtime for diagnosis of Schizophrenia, initiated 5/9/25.- Namenda (a medication to treat moderate to severe dementia) tablet 10 mg, give one tablet by mouth two times daily for diagnosis of Vascular Dementia, initiated 5/29/25. A review of the psychiatry progress note, dated 10/9/25, indicated the resident had active diagnoses of Schizophrenia, Vascular Dementia, and bipolar disorder.During an interview with the MDS Coordinator and DON on 1/28/26 at 1:35 p.m., they indicated the resident did have active diagnoses of Non-Alzheimer's Dementia, Bipolar disorder, and Schizophrenia during the assessment period for the Quarterly MDS Assessment, dated 11/20/25. The DON indicated Section I: Active Diagnoses should have been marked yes. She indicated the facility did not have a MDS policy, they utilized the RAI tool to complete MDS assessments.On 1/28/26 at 2:00 p.m., the RAI, Version 3.0 User's Manual, dated 10/2025, was reviewed. The RAI indicated for section I0100-I8000: Active Diagnoses in the Last 7 Days , .Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period .3.1-31(d)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure a medication was labeled properly with an open date and a discard date in 1 of 1 medication rooms observed. Finding includes:On 1/23/26 at 1:30 p.m., the medication room refrigerator was observed to have a vial of tuberculin PPD (medication used to test for tuberculosis) without an open date or discard date. The DON (Director of Nursing) indicated there was no dates written on the open vial. She indicated that all open multidose medication vials should be labeled with an open date and discard date of 28 days after opening. On 1/28/26 at 3:20 p.m., the DON provided the facility's policy, Labeling of Medication Containers, dated April 2019 and indicated it was a current policy being used by the facility. A review of the policy indicated .All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations .4. Labels for stock medications include all necessary information, such as .c. the expiration date when applicable . 3.1-25(k)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection control practices for 1 of 1 resident reviewed for urinary catheters. Urinary catheter tubing and drainage bag was observed on the floor. (Resident 5) Findings include: On 1/21/26 at 1:43 p.m., Resident 5 was observed in the resident's room. Resident 5's urinary catheter tubing and drainage bag were observed lying on the floor. On 1/22/26 at 2:55 p.m., Resident 5 was observed propelling in the wheelchair in the hallway in the hallway. Resident 5's urinary catheter tubing and drainage bag were observed lying on the floor.On 1/23/26 at 10:20 a.m., Resident 5 was observed propelling in the wheelchair into the chapel. Resident 5's urinary catheter tubing and drainage bag were observed lying on the floor.On 1/28/26 at 12:45 p.m., Resident 5's clinical record was reviewed. The diagnoses included, but were not limited to, urinary tract infection, neuromuscular dysfunction of bladder (nerve damage that disrupts signals between the brain and bladder, causing retention or incontinence), and chronic kidney disease (common disease that means your kidneys are losing their ability to filter waste products from your blood). A physician's order, dated 1/8/26, indicated the resident had a urinary catheter for neurogenic bladder (a condition that causes loss of bladder control because of brain, spinal cord, or nerve problems).During an interview on 1/28/26 at 2:30 p.m., the Director of Nursing (DON) indicated the resident's urinary catheter tubing and drainage bag should not be touching the floor. On 1/28/26 at 3:20 p.m., the DON provided the facility's policy, Catheter Care, Urinary, dated August 2022 and indicated it was the policy being used by the facility. The policy indicated .The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections .Infection Control .2. Be sure the catheter tubing and drainage bag are kept off the floor .3.1-18(b)(1)