STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155325	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Health and Rehabilitation	900 Anson St Salem, IN 47167

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to follow appropriate infection control guidelines related to perineal care, bathing, and isolation for 6 of 8 residents reviewed for infection prevention. (Residents E, F, G, B, C, and D)Findings include:1.During an observation on the North Left Hall, on 12/18/25 at 9:09 a.m., Certified Nurse Aide (CNA) 5 was leaving a resident's room with a trash bag of soiled briefs and wipes. She brought the trash bag to soiled utility room and disposed of it in the bin. She performed hand hygiene after disposing of the bag. During an observation, on 12/18/25 at 9:57 a.m., of Resident E receiving incontinence care by CNA 3 and she walked into the resident's room without performing hand hygiene. She applied gloves and removed the sheet from the resident. It was soiled, so she laid it on the floor beside the resident's bed. She provided incontinence care and removed her gloves. She placed the pillow under the resident's right side and covered him. The blanket was removed from the foot of the bed and placed on top of the soiled sheet on the floor. Without performing hand hygiene, she applied clean gloves to gather the soiled sheet and blanket from the floor and then placed them into a trash bag. She took the soiled linen and soiled brief and wipes in another trash bag to the soiled utility room. She removed her gloves and left the soiled utility room without performing hand hygiene. She went to the nurse's station and used the phone at the desk. During an interview, on 12/18/25 at 10:11 a.m., CNA 3 indicated she would knock at the door, enter the resident's room, and ask if it was okay to perform incontinent care. She would use one wipe with each swipe or fold the wipe for each swipe. She should wash her hands after leaving the resident's room. She indicated she did not perform hand washing during the care. The record for Resident E was reviewed on 12/18/25 at 11:40 a.m. The diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage, frontotemporal neurocognitive disorder, depression, severe dementia with a behavioral disturbance, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or chronic kidney disease, acute on chronic diastolic (congestive) heart failure, chronic kidney disease, stage 3b, atherosclerosis of the autologous vein of the coronary artery bypass grafts with forms of angina pectoris, the presence of a cardiac pacemaker, acute embolism and thrombosis of the deep veins of the left proximal lower extremity, persistent atrial fibrillation, thrombocytopenia, hemiplegia and hemiparesis following a cerebral infarction, type 2 diabetes mellitus with diabetic chronic kidney disease, anemia, chronic normocytic anemia, and obstructive sleep apnea. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, dated 10/8/25 and revised 10/17/25, indicated the resident required assistance with toileting due to incontinence, impaired mobility, altered awareness. The interventions, dated 10/8/25, indicated to check for incontinent care as needed, check every 2 hours for incontinence. The care plan, dated 1/8/26, indicated the resident had a desire to improve or maintain his current functional status. The interventions, dated 10/8/25, included, but were not limited to, assist with bathing as needed per resident preference. Offer showers two times per week, partial bath in between. The admission Minimum Data Set (MDS) assessment, dated 10/14/25, indicated the resident was severely cognitively impaired. He had impairment with upper and lower extremities and was dependent for eating, toileting hygiene, showers or bathing, and personal hygiene. 2.During an observation, on 12/18/25 at 10:14 a.m., CNA 3 used hand sanitizer and applied Personal Protective Equipment (PPE) of a gown, gloves and mask to enter Resident F's room. He was in isolation for a urinary tract infection (UTI) and later vomiting. The resident requested that his cup be filled with ice water. The CNA exited Resident F's room into the hallway and removed her PPE. She brought it down the hall to the housekeeping cart and threw it away in the cart trash bag. She returned and opened the resident's door and stepped just inside the room to place the cup on the bedside table of the resident. She left the room without performing hand hygiene and entered the room of Resident H to answer his call light. She was behind the privacy curtain but indicated the resident didn't want anything. She used hand sanitizer once she left the room. The record for Resident F was reviewed on 12/18/25 at 11:50 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, paraplegia, hypertension, mononeuropathies of the left lower limb, gastro-esophageal reflux disease, neuromuscular dysfunction of the bladder, major depressive disorder, sleep disorders, hypokalemia, psychotic disorder with hallucinations due to a known physiological condition. The care plan, dated 4/5/24 and revised 12/17/25, indicated the resident was at risk of transferring or becoming colonized with a Methicillin Resistant Organism (MDRO) and required enhanced barrier precautions due to (an indwelling medical device, a chronic wound that required a dressing, or colonization or infection with a MDRO in which contact precautions do not apply. The interventions, dated 4/5/24, included, but was not limited to, use standard precautions including hand hygiene in addition to Enhanced Barrier Precautions (EBP). The care plan, dated 6/28/23 and revised 12/17/25, indicated the resident required assistance with toileting due to neuromuscular dysfunction of the bladder, paraplegia, dependence on his wheelchair, history of falls, age, medications, tethering equipment, required staff assistance with ADLs, history of cystostomy, and a boil to the right. The interventions, dated 6/28/23 included, but were not limited to, assist with incontinence care as needed, and observe for signs of a urinary tract infection. The physician's order, dated 12/17/25, indicated the resident was in isolation due to having an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. The type of isolation is droplet contact related to vomiting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly MDS assessment, dated 9/24/25, indicated the resident was cognitively intact. He required set up or clean up assistance with eating, substantial to maximal assistance with toileting and showering or bathing. 3.On 12/18/25 at 10:20 a.m., CNA 3 observed drips of what she called water were down the length of the hallway. The CNA obtained a clean towel and using her foot cleaned down the drips on the floor. She stopped halfway down the hall to turn the towel over and continue cleaning. She folded the towel again and dried the floor up to the housekeeping cart. The towel was brought to the soiled utility room with her bare hand. She walked down another North Right Hall and applied PPE. Resident G was in isolation for lice. His roommate, Resident K, indicated he wanted a drink of Kool-Aid. The CNA removed her PPE and placed it in the trashcan in the room. She brought the trash bag to the soiled utility room and left. She had not performed hand hygiene. She walked to the nurse's station and handled the paperwork on the desk. She then used hand sanitizer. 4.During an observation, on 12/18/25 at 10:35 a.m., CNAs 3 and 4 entered Resident E's room. CNA 3 had gathered the towels, washcloths, clean blanket, sheet and pillowcases and brought them into the resident's room and placed them on the nightstand. CNA 3 found the bath basins under the resident's sink. She filled the basins with warm water, placed them on the bedside table, and placed washcloths into both basins. At that time CNA 3 indicated there had been no issues with having bath basins. She had never seen staff use any other pan for resident baths. She started looking for clothes for the resident with the help of CNA 4. The resident's liquid baby soap was placed between the basins. CNA 3 obtained a wet washcloth and added the soap to it. She washed the resident's hair and CNA 4 began washing the resident's legs. The soiled washcloths were placed into a trash bag in the trashcan. CNA 3 removed her gloves and applied clean gloves. They dried the resident and placed clothes on him. The soiled linens were bagged. Both CNAs transferred the resident into his wheelchair. CNA 4 removed the bags to soiled utility. She was not observed performing hand hygiene before and during the resident's care. CNA 3 removed her gloves and made the resident's bed. At this time, CNA 3 indicated she had washed her hand prior to the care. 3. The record for Resident G was reviewed on 12/18/25 at 12:20 p.m. The diagnoses included, but were not limited to, cerebral infarction due to occlusion or stenosis of the left middle cerebral artery, aphasia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus with hyperglycemia, atherosclerotic heart disease of native coronary artery without angina pectoris, hypertension, gastro-esophageal reflux disease without esophagitis, glaucoma-left eye-blindness, unqualified visual loss, left eye, normal vision right eye, dysphagia, oropharyngeal phase, other speech and language deficits following nontraumatic intracerebral hemorrhage, hypothyroidism, hyperlipidemia, obstructive sleep apnea, major depressive disorder, recurrent, mild, insomnia, cerebrovascular disease, dysphagia following cerebrovascular disease, and generalized anxiety disorder. The care plan, dated 5/22/23 and revised 12/4/25, indicated the resident required assistance with toileting due to age, history of falls, medications, requires staff assistance/supervision with transfers, ambulation and mobility, unsteady gait, chairfast, altered awareness, stroke, left side hemiplegia, vision loss, glaucoma, anxiety, weakness, left knee pain, anemia, obesity. The interventions, dated 5/22/23, assist with incontinent care as needed and observe for signs of urinary tract infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's order, dated 12/18/25, indicated to apply [NAME] Crème Rinse topically for Lice once a day. The physician's order, dated 12/25/25, indicated to apply [NAME] Crème Rinse. Apply to the hair and beard per box instructions one time. The physician's order, dated 12/18/25, indicated the resident was in isolation due to having an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. During an observation, on 12/10/25 at 11:55 a.m., the drink cart had already arrived on the North Left Hall. At 12:02 p.m., The lunch meal cart had arrived and the lunch trays were delivered to residents on the North Left Hall and the North Right Hall. The CNAs were using hand sanitizer between trays. At the end of the early meal trays, there was one lunch tray on the top shelf of the meal cart. A CNA pushed the cart into the Main Dining Room and left it near the windows between two tables. During an interview, on 12/18/25 at 12:14 p.m., Licensed Practical Nurse (LPN) 6 indicated the CNAs took the meal trays that had been refused, back to the kitchen for disposable. They kept the cart in the dining room to place meal trays once residents finished eating. During an interview, on 12/18/25 at 12:16 p.m., CNA 3 indicated the trays that were refused by residents were put back on the cart. No staff should eat the meal once it was refused. She had not seen any staff eating the food on the trays. During an interview, on 12/18/25 at 12:24 p.m., the Director of Nursing (DON) indicated staff should foam their hands going in a room for care and upon leaving a room from care. The should perform hand hygiene before touching a resident and after touching the dirty areas during care. The soiled linens should be bagged and removed from the rooms. The PPE should be removed inside the resident's room and placed inside the isolation bag in the resident's room. 4. During an observation, on 12/18/25 9:20 a.m., CNAs 7 and 8 were about to start incontinence care for Resident B. CNA 7 did not wash her hands prior to putting on gloves and starting the procedure. CNA 8 used a small hand sanitizer for hand hygiene and put on gloves. The brief was removed by CNA 7and the resident rolled to her left side by both CNAs. The used brief was placed in the trash can along with their dirty gloves. CNA 8 gathered clothes from the closet for the resident to be changed into. CNA 7 cleaned the resident front to back with 2 wipes and a new brief was put back on the resident. No hand hygiene after cleaning the resident. CNA 8 had gloves on and dressed the resident then removed her gloves and performed hand hygiene. CNA 7 sat the resident up to the side of the bed, the fabric incontinence pad was removed gloveless by CNA 7. Both CNAs transferred the resident from the side of the bed to her wheelchair. The record for Resident B was reviewed on 12/18/25 at 10:25 a.m. The resident's diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction, contracture-left hand, type 2 diabetes mellitus, and hypertension. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, dated 7/16/23 and revised 12/12/25, indicated the resident required assistance with toileting due to age, required staff assistance with ADL's, history of falls, left arm contracture, left side hemiplegia, stroke, weakness, seizures. The interventions, dated 7/16/25 and revised 12/12/25, included, but were not limited to, assist with incontinent care as needed, check every 2 hours for incontinence, document any abnormal findings and notify Medical Director (MD), and assess and document skin condition weekly and as needed. The Quarterly MDS assessment, dated 12/1/25, indicated the resident was cognitively intact. The resident was always incontinent of bowel and bladder. The resident required substantial assistance with toilet hygiene, bath, upper/lower body dressing, footwear, and personal hygiene. During an interview, 12/18/25 at 10:00 a.m., CNA 7 indicated that she should wash her hands before touching the resident, during the process of care when her gloves had to be removed, and after she finished with the resident's care. 5. During an observation, on 12/18/25 at 9:56, CNA 7 performed hand hygiene and put gloves on. She took off Resident C's brief and CNA 7 cleaned the resident front to back with one wipe and a new brief was put back on the resident. The dirty brief was put in the trash with dirty gloves. CNA RW then washed her hands and put new gloves on to take the trash to the room labeled Pantry and placed the trash in the appropriate spot. The record for Resident C was reviewed on 12/18/25 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia, chronic pain syndrome, difficulty in walking and paranoid schizophrenia. The care plan, dated 10/16/22 and revised 12/17/25, indicated the resident required assistance with toileting due to weakness, decreased mobility, incontinence, dementia, irritable bowel syndrome (IBS-C). The interventions, dated 10/16/22 and revised 12/17/25, included, but were not limited to, assist with incontinent care as needed, check every 2 hours for incontinence, document any abnormal findings and notify the MD, assess and document skin condition weekly and as needed. The Quarterly MDS assessment, dated 12/1/25, indicated the resident was cognitively intact. The resident required supervision/touch assistance for toileting, personal hygiene and lower body dressing. The resident required maximal assistance for showering/bathing and putting on footwear. 6. During an observation, on 12/18/25 at 10:10 a.m., Resident D was a non-verbal resident and needed incontinence care. CNA 8 washed her hands at the sink and applied gloves. The bed was raised, then the CNA removed the resident's pants. The brief was taken off and using one wipe the CNA made a swipe front to back, used another side and wiped again front to back. She then repeated the cleaning with another wipe. The CNA turned the resident to her left side against the wall. The brief and dirty gloves were placed in the trash. The CNA performed hand hygiene and put on gloves. The rectum was cleaned with one wipe and new brief placed on the resident. The bed was lowered. The CNA used hand sanitizer, picked up the trash and clothes without gloves. The CNA took the dirty clothing and trash to the room labeled Pantry and placed the items in the appropriate spot. The CNA did not use hand sanitizer until she made it to the nurse's station and touched the counter (continued on next page)

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	155325	A. Building B. Wing	12/18/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record for Resident D was reviewed on 12/18/25 at 11:00 a.m. The resident's diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage with loss of consciousness, speech and language deficits, epilepsy, sleep difficulty, and dysphagia. The care plan, dated 5/16/19, and revised 12/11/25, indicated the resident required assistance with toileting due to impaired mobility, impaired cognition, incontinence, history of subarachnoid hemorrhage, weakness, severe intellectual disabilities, epilepsy, encephalopathy, required assistance with transfers, hygiene and clothing management. The interventions, dated 5/16/19 and revised 12/11/25, included, but were not limited to, incontinent of bowel and bladder- check every 2 hours for incontinence, assist with elimination, assist with incontinent care as needed, document any abnormal findings and notify the MD. The Quarterly MDS assessment, dated 11/20/25, indicated the resident's cognition was not assessed. The resident was non-verbal. The resident was dependent on staff for eating, oral hygiene, toileting, bathing, upper/lower body dressing, footwear, and personal hygiene. The skills competency for bed baths was provided by the Director of Nursing Services, on 12/18/25 at 12:47 p.m. It included: 3. Perform Hand Hygiene.18. Change bath water and gloves, complete hand hygiene, and use clean gloves and towel.23. Change bath water and gloves, complete hand hygiene, and use clean gloves and towel.29. Perform hand hygiene. The skills competency for donning and doffing PPE was provided by the Director of Nursing Services, on 12/18/25 at 12:47 p.m. It included: 1. Perform hand hygiene.12. Perform hand hygiene and exit the room.16. Perform hand hygiene and exit the room. The hand hygiene policy was provided by the Director of Nursing Services, on 12/18/25 at 12:47 p.m. It included, but was not limited to,: To provide a standardized approach to hand hygiene.5 moments of hand hygiene: before touching a resident, before a clean or aseptic procedure, after body fluid exposure risk, after touching a resident, and after touching a resident's surroundings . This citation relates to Intake 2612775. 3.1-18 (a)