

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER Newburgh Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 10466 Pollack Ave Newburgh, IN 47630	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were given at the ordered time for 2 of 3 residents during morning medication pass, and signed as given on the Electronic Medication Administration Record (EMAR) for 1 of 3 residents reviewed for pharmaceutical services. (Resident B, Resident C, Resident D) Finding includes: 1. On 2/9/26 at 10:58 a.m., QMA 2 (Qualified Medication Aide) was observed preparing medications for Resident D. The following medications were observed to be taken out of the packaging and put into a medication cup: aspirin (nonsteroidal anti-inflammatory) 81 mg (milligram) ferrous sulfate ((mineral supplement) 325 mg QMA 2 was observed to look for Resident D's Lasix (diuretic) 40 mg in the medication cart. LPN 3 came to the cart, and QMA 2 left to go look for more of the medication. At 11:04 a.m., LPN 3 (Licensed Practical Nurse) indicated she had already given Resident D her morning medications, and she would let QMA 2 know when she got back to the cart. LPN 3 indicated she had been passing morning medications and had been called away to do other things. The QMA 2 then took over. LPN 3 indicated she had not signed off on the EMAR for the medications she gave that morning. The EMAR was red, indicating the medications had not been signed by LPN 3 as given.2. On 2/9/26 at 11:10 a.m., QMA 2 was observed to prepare the following medications for Resident B: clonazepam (anti-anxiety/anticonvulsant) 0.5 mg escitalopram oxalate (antidepressant) 10 mg escitalopram oxalate (antidepressant) 20 mg glimepiride (antidiabetic) 1 mg tamsulosin HCl (alpha-blocker) 0.4 mg metformin (antihyperglycemic agent) HCl 500 mg meclizine HCL (antiemetic/antivertigo) 25 mg On 2/9/26 at 11:39 a.m., QMA 2 was observed to prepare the following medications for Resident C: aspirin (nonsteroidal anti-inflammatory) 81 mg Tylenol (analgesic/antipyretic) 325 mg (2) atenolol (beta-blocker) 25 mg citalopram hydrobromide (antidepressant) 10 mg celecoxib (nonsteroidal anti-inflammatory) 100 mg docusate sodium (stool softener) 100 mg Refresh tears ophthalmic solution 1 drop in both eyes cranberry capsule (dietary supplement) 500 mg The medications observed prepared for Resident B and Resident C were scheduled on the EMAR for 8:00 a.m. On 2/9/26 at 12:37 p.m., the Director of Nursing provided the current policy for administering medications with a revision date of December 2012. The policy included but was not limited to: .Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one (1) hour before or after their prescribed time, unless otherwise specified (for example, before and after meal orders) .The individual administering the medication must initial the resident's MAR (Medication Administration Record) on the appropriate line after giving each medication and before administering the next ones .This citation relates to Intake 2693241. 3.1-25(b)(3)</p>

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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