STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newburgh Health and Rehab	10466 Pollack Ave Newburgh, IN 47630

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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 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 ensure the Dietary Manager was certified for 1 of 1 Dietary Manager Qualifications reviewed. Finding includes:During an interview on 4/13/26 at 9:05 A.M., the Dietary Manager indicated that she did not have kitchen manager certification, but she was enrolled in a class to obtain it.On 4/16/26 at 11:13 A.M., the Dietary Manager's employee file was reviewed. The Dietary Manager began employment with the facility on 3/5/26 and was enrolled in a Certified Dietary Manager (CDM) course on 2/17/26. Her job application to the facility indicated that she was not a CDM and was still in school to obtain the certification.On 4/17/26 at 10:35 A.M., the Administrator provided a current Certified Dietary Manager (CDM) Job Description policy, dated 2025, that indicated Graduate of a Foodservice Manager Training Program or a 2-year or 4-year foodservice management or nutrition program. Successful completion of CDM Credentialing Exam with active CDM, CFPP (Certified Food Protection Professional) certification status. 410 Indiana Administrative Code (IAC) 16.2-3.1-20(e)

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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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that quarterly care conferences were conducted on 3 of 5 residents reviewed for unnecessary medications, 1 of 3 residents reviewed for MDS (Minimum Data Set) and 1 of 2 reviewed for choices. (Resident 8, Resident 25, Resident 38, Resident 7, Resident C) Findings include:1. On 4/14/26 at 9:19 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Diagnosis included, but was not limited to, hypertension. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 3/13/26, indicated Resident 8's cognition was not assessed, the resident required partial assistance for toileting, and substantial assistance from staff (staff do more than half of the work) for bathing. The clinical record lacked a care plan conference held since admission. 2. On 4/14/26 at 9:10 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage and bipolar disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/11/26, indicated Resident 7 was cognitively intact and was dependent on staff (staff do all the work) for toileting and bathing. The last care plan conference was completed on 11/25/25 with family in attendance. On 4/16/26 at 10:06 A.M., the Social Service Director (SDD) provided notes from the last completed care plan conference, dated 11/25/25. 3. On 4/14/26 at 1:20 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, cerebrovascular disease. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 3/4/26, indicated Resident C was not assessed for cognitive impairment, required setup assistance for transferring and eating, and required substantial to maximal assistance of staff (staff does more than half of the work) for toileting. The last care plan conference was completed on 10/14/25. On 4/16/26 at 10:06 A.M., the Social Service Director (SSD) provided notes from the last completed care conference, dated 10/14/25. 4. On 4/14/26 at 1:35 P.M., Resident 25 clinical record was reviewed. Diagnoses included, but were not limited to, wedge compression fracture of the second lumbar vertebra, unspecified dementia, and Alzheimer's Disease. The current Significant Change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 25 was cognitively intact. Resident 25 needed set help for eating, needed partial to moderate assistance for dressing, hygiene, and toileting, and substantial to maximum assistance for transferring. On 4/16/26 at 10:06 A.M., the Social Service Director (SDD) provided notes from the last complete care plan conference. The last care conference was dated on 7/22/25. 5. On 4/15/26 at 9:45 A.M., the clinical record for Resident 38 was reviewed. Diagnoses included, but (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were not limited to, muscle weakness and chronic combined systolic (congestive) and diastolic (congestive) diastolic heart failure. The current Quarterly MDS assessment dated [DATE] indicated Resident 38 was cognitively intact. Resident 38 needed set up assistance eating, needed substantial to maximum assistance for hygiene and dressing, and was dependent on transferring. On 4/16/26 at 10:06 A.M., the Social Service Director (SDD) provided notes from the last complete care plan conference. The last care conference was dated on 12/23/25. During an interview on 4/16/26 at 9:29 A.M., the SSD indicated that between when the last SSD left the position and when he started in the position, care plan conferences were not completed. On 4/17/26 at 10:40 A.M., the Administrator provided a current policy Care Planning dated 2/2026. The policy indicated .the facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan . 410 Indiana Administrative Code (IAC) 16.2-3.1-35(d)(2)(B)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed accurately for 3 of 4 residents reviewed for skin conditions and 1 of 3 residents reviewed for falls. (Resident C, Resident 7, Resident 8, Resident 49) Findings include:1. On 4/14/26 at 1:20 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, cerebrovascular disease. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 3/4/26, indicated Resident C was not assessed for cognitive impairment but was coded to indicate an assessment should be completed. During an interview on 4/16/26 at 2:20 P.M., the MDS Coordinator indicated that Resident C could have been assessed for cognitive impairment but wasn't because there was not any staff available to administer the test at the time the assessment was due. During an interview on 4/17/26 at 9:06 A.M., the Administrator indicated that a corporate MDS staff member completed MDS assessments during the time the facility did not have an in-house MDS Coordinator on staff. In-house nursing staff were responsible for completing the cognitive assessments. 2. On 4/14/26 at 9:10 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, bipolar disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/11/26, indicated Resident 7 was cognitively intact and did not receive an antianxiety medication during the 7-day lookback period. Physician orders included but were not limited to:hydroxyzine (an antianxiety medication) 25 milligrams (mg) tablet - Give one tablet by mouth three times a day for anxiety, dated 12/4/25 and discontinued on 3/1/26 The February 2026 electronic Medication Administration Record (eMAR) indicated Resident 7 received hydroxyzine 25 mg three times a day from 2/5/26 to 2/11/26. During an interview on 4/16/26 at 2:10 P.M., the MDS Coordinator indicated that Resident 7 received an antianxiety medication, but it was not coded. 3. On 4/14/26 at 9:19 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Diagnosis included, but was not limited to, hypertension. The most recent Significant Change MDS, dated [DATE], indicated Resident 8 required partial assistance for toileting, and substantial assistance from staff for bathing. The assessment indicated Resident 8's cognition should be assessed; the answers indicated Resident 8's cognition was not assessed. During an interview on 4/16/26 at 2:21 P.M., the MDS Coordinator indicated Resident 8's cognition was not assessed but should have been assessed during the most recent MDS assessment. 4. On 4/14/26 at 1:58 P.M. Resident 49's clinical record was reviewed. Diagnosis included, but was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not limited to, osteoarthritis. The most recent admission MDS Assessment, dated 3/19/26, indicated Resident 49 was cognitively intact, was dependent on staff (staff do all of the work) for toileting, bathing, and transfers, and had no skin conditions. Physician orders included, but were not limited to: Right lateral Shin: Clean with normal saline, apply Santyl (ointment) to wound bed, cover with absorbent pad and wrap with Kerlix (gauze) every day shift for wound healing; Start date 3/17/26 During an interview on 4/16/26 at 2:21 P.M., the MDS Coordinator indicated Resident 49's wound should have been coded on the most recent MDS Assessment. On 4/17/26 at 10:36 A.M., the Administrator provided a policy titled Conducting an Accurate Resident Assessment, dated 2/2026, that indicated Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument 410 Indiana Administrative Code (IAC) 16.2-3.1-31(c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview, and record review, the facility failed to ensure proper storage and labeling of medication for 4 of 4 medication carts observed. Loose pills and unlabeled medications were observed in the medication carts. (Front [NAME] Hall, Back [NAME] Hall, Front East Hall, Back East Hall, Resident 22, Resident 25, Resident 39) Findings include: On 4/13/25 at 8:55 A.M., the following loose pills were observed in the [NAME] Front Medication Cart:4 1/2 small white pill1/2 white oval pill1 small round white pill with number L 161/2 large white oval pill1 small round brown pill with *7251 small round white pill with number 9131 small white pill with numbers 3461/2 small round pink pill1 small round white pill with letter U1 small round white pill with Numbers 33461 blue and white capsule with the number PRIMA 361/2 small blue oval pill1 oval white pill with numbers 564 On 4/13/26 at 9:10 A.M., the following loose pills were observed in the [NAME] Back Hall Medication Cart:1/2 small round pill1 green oval pill with LU1 large white pill with the number 4831 small peach pill1 small white pill with the numbers 321 large white pill with the number PH 3201 small oval pill with the number 1111/4 yellow pill1/2 small white oval 1 bottle of fiber pills with [Resident 39] name but no label The following supplements with [Resident 22] name were found with no labels:2 bottles of Saw Palmetto1 bottle of Carnivora1 bottle of Graviola1 bottle of Catalova1 bottle of Organic Bone Minerals1 bottle of Collinsonia 1 bottle of Proto1 bottle of Tempa Cleanser On 4/13/26 at 9:20 P.M., the following loose pills were found in the East Front Medication Cart:1 Ferrous Sulfate pill1 tan and white colored capsule1 large white pill with number PH 0201 medium round yellow pill with the numbers EP1271 bottle of Baby Aspirin with [Resident 25] name with no label1 bottle of Fiber with [Resident 25] name with no label On 4/13/26 at 9:25 A.M., the following loose pills were found in the East Back Medication Cart:1 round peach pill with H392 small white oval pills1 round medium white pill with the number 551 brown pill with 8.61/2 large white pill1 round oval peach pill with the number UL 125 During an interview on 4/13/26 at 9:30 A.M., Licensed Practical Nurse (LPN) 5 indicated there should be no loose pills in the carts and that she destroys the pills in a drug buster solution. During an interview on 4/15/26 at 3:00 P.M., the Director of Nursing (DON) indicated the bottles of supplements should have label and have a physician's order. On 4/17/26 at 10:36 A.M., the Administrator provided a current policy Medication Storage dated 2/26. The policy indicated .medications: discontinued, outdated, defective, or deteriorated .are destroyed . " 410 Indiana Administrative Code (IAC) 16.2-3.1-25(j)410 Indiana Administrative Code (IAC) 16.2-3.1-25(o)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 store food under sanitary conditions and monitor equipment for proper sanitization levels for 1 of 1 kitchens observed. Food was left open to air, expired food was not disposed of, and dishwasher chemical sanitization logs were not filled out. (Kitchen) Finding includes:During the initial tour on 4/13/26 at 9:05 A.M., the following was observed:The low-temperature chemical dishwasher April 2026 log was hanging on the wall across from the dishwasher. It was blank. At that time, the Dietary Manager indicated that staff should be filling it in each time they tested the dishwasher for sanitization levels. Staff tested the dishwasher for sanitization levels before each meal.In the walk-in dairy refrigerator: Sliced cheese open to air with no dateShredded cheese open to airIn the walk-in vegetable refrigerator:Coleslaw carton with a use by date of 4/9/26In the dry storage room:Bulk sugar container open to airBulk oatmeal container open to airOn 4/17/26 at 10:36 A.M., the Administrator provided a Mechanical Ware Washing (Dish Machine) policy, dated 2025, that indicated The proper cleaning and sanitizing of dishes in the dietary department is extremely important to the health and safety of residents . Record the PPM (parts per million), wash and rinse temperatures for the low temperature dish machine . The.PPM of the sanitizer (if a low-temperature machine) should be tested and logged before washing dishes from each meal to ensure the dish machine is properly sanitizing dishes . Dish machine logs should be posted and updated throughout the day.On 4/17/26 at 10:36 A.M., the Administrator provided a Storage Labeling and Dating policy, dated 2025, that indicated Product inventory must be stored, labeled, dated, rotated, and discarded properly according to federal and state guidelines . Containers for bulk items like flour and sugar should be leak-proof, non-absorbent, tight fitting, and NSF (National Science Foundation) approved . Items that have exceeded the manufacturer's expiration date or UB (use by) date should be discarded.On 4/17/26 at 10:47 A.M., the Administrator provided a Food Safety Requirements policy, dated 2/2026, that indicated Practices to maintain safe refrigerated storage include: .Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; and Keeping foods covered or in tight containers.410 Indiana Administrative Code (IAC) 16.2-3.1-21(i)(2)410 IAC 16.2-3.1-21(i)(3)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the provider of weight changes outside of order parameters for 1 of 2 residents reviewed for weight change. (Resident 5) Finding includes:On 4/14/26 at 9:58 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure and chronic kidney disease.The most current Discharge Minimum Data Set (MDS) Assessment, dated 3/10/26, indicated Resident 5's cognitive function was assessed by staff and the resident's memory was OK and he was independent in making decisions about his daily life. He required supervision of staff for transferring and partial to moderate assistance (staff does less than half the work) for toileting. He weighed 226 pounds (lbs) and had no weight loss.A nutritional risk care plan, initiated 12/18/25, included an intervention to monitor weights as ordered.A fluid overload care plan, initiated 12/14/25, included an intervention to weigh as scheduled.Physician orders included but were not limited to:Fax weekly weights to Nursing Home Triage (NHT) every Tuesday day shift related to congestive heart failure, dated 12/16/25Notify Nursing Home Triage (NHT) if weight gain of three pounds in 24 hours or five pounds in one week as needed related to congestive heart failure, dated 12/13/25The electronic Medication Administration Record (eMAR) for December 2025, January 2026, February 2026, March 2026, and April 2026 was reviewed. Weekly weights were not faxed to NHT on the following days:1/13/262/10/262/24/26The Weight Summary for 12/14/25 through 4/14/26 was reviewed. On 2/24/26, Resident 5 weighed 215.6 lbs. On 3/2/26, Resident 5 weighed 224.9 lbs, resulting in a 9.3 lb weight gain in a week.The clinical record lacked documentation to indicate the provider was notified that Resident 5 gain over five lbs in a week.During an interview on 4/16/26 at 12:40 P.M., the Director of Nursing (DON) indicated that weekly weights were not faxed on 1/13/26, 2/10/26, and 2/24/26, and a notification to the provider did not occur on 3/2/26 after the resident gained over five lbs in a week.On 4/17/26 at 10:36 A.M., the Administrator provided a current Notification of Changes policy, dated 2/2026, that indicated The facility must.consult with the resident's physician.when there is a change requiring such notification . Circumstances requiring notification include: .Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.On 4/17/26 at 11:17 A.M., the Administrator provided a current Weight Management policy, dated 2/2026, that indicated The physician should be informed of a significant change in weight.410 Indiana Administrative Code (IAC) 16.2-3.1-5(a)(2)

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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 interview and record review, the facility failed to ensure residents ordered an as needed (PRN) anti-anxiety medication had a specific duration, or stop date, for the medication prescribed for 2 of 2 residents reviewed for hospice and 1 of 2 residents reviewed for choices. (Resident 4, Resident 48, and Resident 7) Findings include: 1. On 4/15/26 at 9:13 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 3/24/26, indicated Resident 4 was rarely understood and was dependent on staff for eating, bathing, toileting, and transfers (staff do all of the work). Physician orders included, but were not limited to: Lorazepam (an antianxiety medication) oral tablet 0.5 MG (milligrams) Give one tablet by mouth every 30 minutes as needed for anxiety/restlessness; Start date 3/15/26 The order lacked a stop date for PRN lorazepam. Resident 4's electronic medication administration record (eMAR) from March 2026 through April 2026 was reviewed. As needed lorazepam was not received during that time. 2. On 4/14/26 at 8:43 A.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure. Resident 48 was admitted into hospice services on 4/18/24. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/9/26, indicated Resident 48 had severe cognitive impairment and received an antianxiety medication during the 7-day lookback period. Physician orders included but were not limited to: lorazepam (an antianxiety medication) 0.5 milligrams (mg) oral tablet - Give half of a tablet by mouth every two hours as needed (PRN) for anxiety/restlessness. May dissolve in water if unable to swallow - while receiving hospice services, dated 3/20/25. The order lacked a stop date for the medication. The electronic Medication Administration Record (eMAR) from November 2025 to April 2026 was reviewed. PRN lorazepam was not received during that time. 3. On 4/14/26 at 9:10 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, bipolar disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/11/26, indicated that Resident 7 was cognitively intact and did not receive an antianxiety medication during the 7-day lookback period. Physician orders included but were not limited to:hydroxyzine (an antianxiety medication) 10 milligrams (mg) oral tablet - Give one tablet by mouth every twelve hours as needed (PRN) for itching, dated 12/4/25. The order lacked a stop date for the medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The electronic Medication Administration Record (eMAR) from January 2026 to April 2026 was reviewed. Resident 7 received PRN hydroxyzine on the following days:1/18/26 at 12:13 A.M.2/15/26 at 3:41 P.M.2/16/26 at 4:24 P.M.3/5/26 at 4:25 A.M.3/7/26 at 3:51 P.M.3/9/26 at 7:06 P.M. During an interview on 4/16/26 at 8:59 A.M., the Director of Nursing (DON) indicated that if a resident was not receiving hospice services, medications should have a 14 day stop day. If a resident was receiving hospice services, the order should specify the duration of hospice. On 4/17/26 at 10:49 A.M., the Administrator provided a current Use of Psychotropic Medication(s) policy, dated 2/2026, that indicated PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. 410 Indiana Administrative Code (IAC) 16.2-3.1-48(a)(2)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, the facility failed to ensure comprehensive Minimum Data Set (MDS) Assessments were completed timely for 1 of 3 closed records reviewed and 1 of 3 residents reviewed for wounds. (Resident C and Resident 49) Findings include:1. On 4/14/26 at 1:20 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, cerebrovascular disease. Resident C was discharged from the facility to the hospital on 3/27/26 and did not return to the facility. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 3/4/26, indicated Resident C was not assessed for cognitive impairment and required substantial to maximal assistance (staff does more than half the work) for toileting. A Discharge MDS Assessment was not completed. During an interview on 4/16/26 at 2:20 P.M., the MDS Coordinator indicated that the previous MDS Coordinator did not complete Resident C's Discharge MDS Assessment. 2. On 4/14/26 at 1:58 P.M. Resident 49's clinical record was reviewed. Diagnosis included, but was not limited to, osteoarthritis. The most recent admission MDS Assessment, dated 3/19/26, indicated Resident 49 was cognitively intact and was dependent on staff (staff do all of the work) for toileting, bathing, and transfers. The admission MDS Assessment was completed on 4/13/26. During an interview on 4/16/26 at 2:21 P.M., the MDS Coordinator indicated the admission MDS Assessment was completed late. On 4/17/26 at 10:36 A.M., the Administrator provided a policy titled Conducting an Accurate Resident Assessment, dated 2/2026, that indicated Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument 410 Indiana Administrative Code (IAC) 16.2-3.1-31(d)(1)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed no less than once every 3 months for 1 of 1 residents reviewed for Resident Assessment. (Resident 6)Finding includes: On 4/6 at 11:26 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, disorder of the kidney and ureter and essential primary hypertensionThe most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] but was not completed until 4/10/26. During an interview on 4/17/26 at 10:35 A.M., the Social Services Director indicated care plan conferences needed to be done every 3 months.On 4/17/26 at 10:40 A.M., the Administrator provided a current policy Care Planning dated 2/2026. The policy indicated . The facility will discuss the care plan with the resident and/or representative at regularly scheduled care plan conferences, initially, at routine intervals, and after significant changes .410 Indiana Administrative Code 16.2-3.1-31(d)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement care plan interventions for 1 of 4 residents reviewed for accidents and 1 of 1 resident reviewed for restraints, and develop a care plan for 1 of 5 residents reviewed for unnecessary medications. Interventions for call lights to be within reach were not implemented and there was no care plan developed for antianxiety and antidepressant medications use. (Resident 3, Resident 2, and Resident 38)Findings include:1. During an observation on 4/13/26 at 11:22 A.M., CNA 2 and QMA 4 were observed using a sit to stand lift to transfers Resident 3 from the bathroom to the wheelchair. Resident 3's call light was under the bed and out of reach. During an observation on 4/15/26 10:20 A.M., Resident 3 was observed in bed and the call light was on the floor under the foot of the bed. During an observation on 4/16/26 at 8:52 A.M., Resident 3 was laying in bed; two wheelchairs were in the resident's within line of sight and the call light was hung over the foot of bed. On 4/14/26 at 10:40 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, and post traumatic stress disorder. The most recent Discharge MDS (Minimum Data Set) Assessment, dated 2/25/26, indicated Resident 3's cognition was not assessed, the resident required partial assistance for toileting (staff do at least half of the work) and was dependent on staff for transfers (staff do all of the work). The care plan included, but was not limited to: (Resident) at risk for falls due to: Confusion at times, dementia, gait/balance problems, pain, psychoactive drug use, use of assistive device; Date Initiated: 5/9/22 Interventions included, but were not limited to: Call system and bedside table in reach. Explain use of it upon admission and reinforce as needed; Date Initiated: 5/9/22 Wheelchair out of site (bathroom) when he goes to bed; Date Initiated: 10/7/25 2. During an observation on 4/13/26 at 11:22 A.M., Resident 2's call light was wrapped around the headboard post and the resident was in his wheelchair at end of bed. On 4/14/226 at 8:46 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but was not limited to, dysphagia. The most recent Annual MDS Assessment, dated 3/20/26, indicated the resident was moderately cognitively impaired and was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers. The care plan included, but was not limited to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident) is at risk for falls; Date Initiated: 6/23/22 Interventions included, but were not limited to: Call system and bedside table in reach. Explain use of it upon admission and reinforce as needed. Date Initiated: 6/23/22 3. On 4/15/26 at 9:45 A.M., the clinical record for Resident 38 was reviewed. Diagnoses included, but were not limited to, muscle weakness and chronic combined systolic (congestive) and diastolic (congestive) diastolic heart failure. The current Quarterly MDS assessment dated [DATE] indicated Resident 38 was cognitively intact. Resident 38 needed set up assistance for eating, needed substantial to maximum assistance for hygiene and dressing, and was dependent on transferring. During the 7-day look back period the use of antianxiety and antidepressant medications was indicated. Current physician orders included, but were not limited to:Sertraline HCl Oral Tablet (antidepressant) 100 Milligrams (MG), give 1 tablet by mouth in the morning dated 3/2/26. Klonopin Oral Table (antianxiety) 0.5 MG, give 0.5 tablet by mouth in the morning for anxiety 0.5 = 0.25mg dated 3/2/26. Clonazepam Oral Tablet (antianxiety) 0.5 MG, give 1 tablet by mouth at bedtime dated 9/16/25. There are no current care plans for antianxiety and antidepressant drugs. During an interview on 4/17/26 at 10:35 A.M., the Social Services Director indicated care plans are initiated upon admission, quarterly, and with a significant change. On 4/17/26 at 10:35 A.M., the Administrator provided a current policy Comprehensive Care Plans dated 2/2026. The policy indicated . the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment . 410 Indiana Administrative Code (IAC) 16.2-3.1-35(b)(1)410 Indiana Administrative Code (IAC) 16.2-3.1-35(b)(2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to ensure residents dependent on staff for ADLs (activities of daily living) were showered for 1 of 3 residents reviewed for ADL care. (Resident C) Finding includes:During an anonymous interview on 4/14/26 at 1:20 P.M., it was indicated that Resident C was transported to the hospital from the facility on 3/27/26. Upon arrival in the emergency room, Resident C appeared generally unkempt.On 4/14/26 at 1:25 P.M., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, cerebrovascular disease.The most current Quarterly Minimum Data Set (MDS) Assessment, dated 3/4/26, indicated Resident C was not assessed for cognitive impairment and required partial to moderate assistance of staff (staff does less than half the work) for bathing.A current assistance with self-care and mobility tasks care plan, dated 12/15/25, indicated Resident C required substantial to maximal assistance (staff does more than half the work) for bathing.On 4/16/26 at 12:30 P.M., Licensed Practical Nurse (LPN) 6 provided shower documentation for March 2026. Resident C did not receive or refuse a shower or complete bed bath on the following days in March 2026:3/10/263/14/263/17/263/24/26During an interview on 4/16/26 at 12:46 P.M., the Director of Nursing (DON) indicated that residents got showers at least twice a week.During an interview on 4/16/26 at 1:34 P.M., the DON indicated Resident C's assigned shower days were Tuesdays and Saturdays. On 4/17/26 at 10:36 A.M., the Administrator provided a current Resident Showers policy, dated 2/2026, that indicated Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety.This citation relates to Intake 2970173.410 Indiana Administrative Code (IAC) 16.2-3.1-38(b)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure a resident with signs and symptoms of fluid overload were monitored according to physician order for 1 of 2 residents reviewed for significant weight change. (Resident 5) Finding includes:On 4/14/26 at 9:58 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure and chronic kidney disease.The most current Discharge Minimum Data Set (MDS) Assessment, dated 3/10/26, indicated Resident 5's cognitive function was assessed by staff and the resident's memory was OK and he was independent in making decisions about his daily life. He required supervision of staff for transferring and partial to moderate assistance (staff does less than half the work) for toileting. He weighed 226 pounds (lbs) and had no weight loss.A nutritional risk care plan, initiated 12/18/25, included an intervention to monitor weights as ordered.A fluid overload care plan, initiated 12/14/25, included an intervention to weigh as scheduled. (Signs and symptoms of fluid overload include rapid weight game, edema, and shortness of breath.)Physician orders included but were not limited to:Obtain early morning daily weights in the morning related to congestive heart failure, dated 12/14/25A dietary note, dated 12/18/25 at 10:52 A.M., indicated that Resident 5 had edema and was anticipated to have weight fluctuations due to his diagnosis of congestive heart failure (CHF) and use of diuretic therapy. Daily weights were ordered to monitor for changes.A dietary note, dated 1/8/26 at 2:35 P.M., indicated Resident 5 had pitting edema and triggered for significant weight gain over 90 days.A dietary note, dated 1/15/26 at 10:31 A.M., indicated Resident 54 lost ten pounds in a week due to receiving extra doses of furosemide (a diuretic medication). A 1500 milliliters per day fluid restriction was initiated. Edema was improving.A dietary note, dated 1/22/26 at 10:06 A.M., indicated Resident 5 continued to have pitting edema and took furosemide daily.A dietary note, dated 2/26/26 at 2:41 P.M., indicated Resident 5 triggered for significant weight loss over six months. Weight fluctuations were anticipated due to his diagnoses of CHF, pitting edema, and use of diuretic therapy. Changes were monitored through daily weights.A dietary note, dated 4/2/26 at 12:06 P.M., indicated Resident 5 was readmitted to the facility from the hospital where he had a percutaneous endoscopic gastrostomy (PEG) tube placed. He triggered for significant weight gain over 30 days, but rapid weight fluctuations up and down have been common for resident due to fluids with CHF/edema and diuretic therapy. Daily weights are ordered to monitor changes.A weight change note, dated 4/9/26 at 3:30 P.M., indicated current weight is 209 lbs this week which is down from 236 lbs last week. Noted that rapid and large weight fluctuations have been common due to fluids from edema and diuretic therapy. Daily weights are ordered to monitor changes. The electronic Medication Administration Record (eMAR) for December 2025, January 2026, February 2026, March 2026, and April 2026 was reviewed. A daily morning weight was not obtained on the following days:12/16/2512/22/2512/26/251/17/261/21/261/22/262/3/262/17/262/18/262/20/262/21/262/25/263/4/263/5/2 an interview on 4/16/26 at 12:40 P.M., the Director of Nursing (DON) indicated that daily weights were not obtained on the 18 days listed and were either just not done or the resident was marked asleep. At that time, the DON indicated that staff were expected to try again or pass it along to the next shift if a resident needed to be weighed and was asleep.On 4/17/26 at 11:03 A.M., the Administrator provided a Weight Monitoring policy, dated 2/2026, that indicated Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise . Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status . Weights should be recorded at the time obtained . If clinically indicated - monitor weight daily.410 Indiana Administrative Code (IAC) 16.2-3.1-37(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmacist medication recommendations were reviewed and acted upon by the physician for 1 of 5 residents reviewed for unnecessary medications. (Resident 8) Finding includes: On 4/14/26 at 9:19 A.M., Resident 8's clinical record was reviewed. Resident 8 was admitted on [DATE]. Diagnosis included, but was not limited to, pulmonary embolism.The most recent Significant Change MDS, dated [DATE], indicated Resident 8's cognition was not assessed, the resident required partial assistance for toileting, substantial assistance from staff for bathing, and received anticoagulant medication during the lookback period. Physician orders included, but were not limited to:Eliquis (an anticoagulant medication) oral tablet 2.5 MG (milligrams) Give one tablet by mouth in the morning related to pulmonary embolism; Start date 3/13/26On 4/15/26 at 12:13 P.M., the Administrator provided a pharmacy document titled New admission Review, dated 3/13/26. The document indicated the pharmacist recommended Resident 8's Eliquis be evaluated due to it being outside the typical dose. The clinical record lacked approval or rationale for denying the pharmacist recommendation. During an interview on 4/17/26 at 9:04 A.M., the Director of Nursing indicated the physician reviewed the pharmacy recommendation on 4/16/26 and accepted the pharmacist recommendation. On 4/17/26 at 10:36 A.M., the Administrator provided a policy titled Medication Regimen Review, dated 2/2026, that indicated The pharmacist shall communicate any irregularities to the facility in the following ways: a. Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. b. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities410 Indiana Administrative Code (IAC) 16.2-3.1-25(i)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions were implemented during 1 of 2 random observation of care and infection control practices were not implemented during 1 of 2 insulin administrations. Findings include: 1. During an observation on 4/13/26 at 11:22 A.M., CNA 2 and QMA 4 entered Resident 3's bathroom. Resident 3 was cleaned up and assisted off of the toilet and on to the sit to stand lift. Resident 3 was moved from the bathroom to the wheelchair in the bedroom. Resident 3 was not offered to wash his hands; CNA 2 and QMA 4 wore gloves but did not wear gowns during the care and transfer of Resident 4. On 4/14/26 at 10:40 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbances, anxiety, and post traumatic stress disorder. The most recent Discharge MDS, dated [DATE], indicated Resident 3's cognition was not assessed, the resident required partial assistance for toileting (staff do at least half of the work) and was dependent on staff for transfers (staff do all of the work). Physician orders included, but were not limited to: Enhanced Barrier Precaution due to wounds; Start date 10/22/25 During an interview on 4/17/26 at 9:00 A.M., the Infection Preventionist indicated staff should use Enhanced Barrier Protection (EBP) when a resident has a wound, catheter, feeding tube or as otherwise indicated per protocol. 2. On 4/15/26 at 7:15 A.M., during a medication pass, Licensed Practical Nurse (LPN) 7 was observed not using an alcohol swab to prepare the rubber injectable port of a Lantus and lispro insulin pen prior to placing the needle to administer insulin to Resident 10. During an interview on 4/15/26 at 7:30 A.M., LPN 7 indicated she should have prepped the pen stopper with alcohol prior to placing the needle. During an interview on 4/17/26 at 9:29 A.M., the Director of Nursing indicated that the nurse should have cleaned the rubber injectable port before the needle is placed prior to administering the medications. On 4/17/26 at 10:36 A.M., the Lispro Kwik Pen insert was reviewed and indicated the rubber seal should be wiped with an alcohol swab. On 4/17/26 at 10:36 A.M., the Administrator provided a policy titled Enhanced Barrier Precautions, dated 2/2026, that indicated PPE for enhanced barrier precautions is only necessary when performing high-contact care activities 4. High-contact resident care activities include: a. Dressing, b. Bathing, c. Transferring, d. Providing hygiene, f. Changing briefs or assisting with toileting 410 Indiana Administrative Code (IAC) 16.2-3.1-18(b)(1)