STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155374	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poplar Care Strategies	313 Poplar St Loogootee, IN 47553

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure resident privacy for 4 of 4 random observations. Staff did not knock on doors prior to entering, and doors and curtains were not closed during a wound dressing change. (Resident 21, Resident 3, Resident 9, Resident 10)Findings include:1. On 1/6/26 at 3:19 A.M., Licensed Practical Nurse (LPN) 17 and Certified Nurse Aide (CNA) 18 were observed to enter Resident 21's room without knocking. Resident 21 was in the room at that time. 2. On 1/5/26 at 10:09 A.M., Certified Nurse Aide (CNA) 25 was observed to enter Resident 21's room without knocking. Resident 21 was in the room at the time. On 1/7/26 at 9:23 A.M., Registered Nurse (RN) 21 was observed to enter Resident 21's room without knocking. Resident 21 was in the room at the time. On 1/7/26 at 9:35 A.M., the Maintenance Assistant was observed to enter Resident 21's room without knocking. Resident 21 was in the room at the time. 3. On 1/6/26 at 3:18 A.M., Licensed Practical Nurse (LPN) 7 was observed to enter Resident 10's room without knocking. Resident 10 was in the room at the time. 4. On 1/7/26 at 9:45 A.M., RN 21 was observed to enter Resident 9's room without knocking. Resident 9 was in the room at the time. 5. On 1/5/26 at 10:09 A.M., CNA 25 and CNA 9 were observed to enter Resident 3's room without knocking to assist her out of bed. On 1/6/26 at 9:35 A.M., RN 21 and RN 5 were observed during a dressing change for Resident 3. The door nor the curtain were closed. During the dressing change, two staff members were observed to walk past the room, one stopping to speak with RN 5. On 1/7/26 at 9:52 A.M., CNA 25 indicated staff should provide resident privacy by knocking on doors prior to entering their room, pulling curtains, and shutting blinds prior to providing care. On 1/7/26 at 2:30 P.M., the Administrator provided a current Resident Care and Dignity policy, last revised 1/2024, that indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . privacy and confidentiality 3.1-3(o)

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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review, the facility failed to ensure the Activity Director was certified for 1 of 1 Activity Director reviewed. (Activity Director)Finding includes: During an interview on 1/5/26 at 1:30 P.M, the Administrator indicated the Activities Director had recently resigned, and the Activities Assistant was currently overseeing the activities.During an interview on 1/5/26 at 2:00 P.M., the Activities Assistant indicated she was not certified, and the facility currently lacked an Activities Director.During an interview on 1/7/26 at 10:03 A.M., the Administrator indicated 12/12/25 was the previous Activity's Director last day she worked. The facility had not utilized a consultant after she resigned.On 1/8/26 at 10:53 A.M., employee records were reviewed and lacked a current Activity Director.On 1/8/26 at 11:53 A.M., the Administrator provided a current, undated Nursing Home Activities: Resident Rights and the Role of Activities Staff policy that indicated, .The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who - i. Is licensed or registered, if applicable, by the state in which practicing; and ii. Is: a. Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or b. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program; or c. Is a qualified occupational therapist or occupational therapy assistant; or d. Has completed a training course approved by the state.3.1-33 (e)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure an infection control program to help prevent the development and transmission of communicable diseases and infections for 4 of 5 residents observed for incontinence care, and 1 of 2 residents observed for a wound dressing change. Staff did not sanitize hands between glove changes, did not wear required Personal Protective Equipment (PPE), and placed a resident's open wound on bed linen. (Resident 25, Resident 3, Resident 21, Resident 27)Findings include:1. On 1/5/26 at 10:19 A.M., Certified Nurse Aide (CNA) 25 was observed to assist Resident 3 out of bed and to the toilet. The room was observed with EBP signs just outside the doorway, and a cart with PPE. CNA 25 did not wear a gown during care. Resident 3 was assisted to the bathroom and onto the toilet. CNA 25 removed a soiled brief while the resident was sat on the toilet. While putting on the clean brief, CNA 25 scraped the inside and outside of the clean brief on the floor prior to placing it over the resident's feet. The clean brief was then pulled up onto the resident. On 1/6/26 at 9:35 A.M., Registered Nurse (RN) 21 and RN 5 were observed to change a dressing on Resident 3's heel. The soiled dressing was removed from the right foot, and the heel wound was placed on the bedding. A drape was then placed under the foot and the wound cleaned. RN 21 then removed the drape, and placed the heel wound back on the bedding. RN 5 placed a clean drape under the foot and finished the wound dressing. On 1/6/26 at 3:53 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, viral hepatitis, dementia, and seizure disorder. The most recent significant change Minimum Data Set (MDS) assessment, dated 10/2/25, indicated no cognitive impairment, and dependent on staff for toileting. Current physician orders included, but were not limited to: Enhanced Barrier Precautions (EBP) every shift for Wounds, dated 9/26/25. 2. On 1/5/26 at 10:00 A.M., Certified Nurse Aide (CNA) 25, CNA 9, and Licensed Practical Nurse (LPN) 15 were observed to assist Resident 21 with incontinence and colostomy care. The room was observed with EBP signs just outside the doorway, and a cart with PPE. CNA 25, CNA 9, and LPN 15 did not wear a gown during care. Prior to care, CNA 9 washed hands for 12 seconds. LPN 15 emptied the resident's colostomy bag, removed her gloves, and washed hands with a 6 second lather. After assisting the resident with care and into a wheelchair, CNA 9 washed hands for 14 seconds. On 1/6/26 at 6:00 A.M., Resident 21's clinical record was reviewed. Diagnoses included, but was not limited to, sacral pressure ulcer. The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated a sacral pressure ulcer, and dependent on staff for toileting. Current physician orders included, but were not limited to: Enhanced Barrier Precautions every shift for wounds to coccyx and colostomy, dated 3/6/25. 3. On 1/6/26 at 10:38 A.M., Certified Nurse Aide (CNA) 25 was observed to assist Resident 25 with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	toileting. CNA 25 put gloves on, locked the brakes on the wheelchair, and pulled the resident's pants down. Without changing gloves, CNA 25 cleaned the resident after a bowel movement. CNA 25 then removed the gloves, and put on another pair of gloves without sanitizing hands between glove changes. 4. During an observation on 1/6/26 at 3:19 A.M., Licensed Practical Nurse (LPN) 17 and Certified Nurse Aide (CNA) 18 performed incontinence care on Resident 21. CNA 18 completed a 4 second hand lather prior to donning gloves. LPN 17 and CNA 18 removed the soiled brief and failed to perform hand hygiene after they removed their soiled gloves. LPN 17 and CNA 18 donned gloves, fastened the new brief, and then pulled up Resident 21's covers with the same gloves. LPN 17 removed gloves and performed a 12 second hand lather. 5. On 1/6/26 at 3:09 P.M., CNA 25 and Qualified Medication Aide (QMA) 32 were observed toileting Resident 27. When QMA 32 was putting a clean pull up incontinence pad back on Resident 27 who was seated on the toilet, she brushed the inside of the pull up against the resident's soiled socks. During an interview on 1/6/26 at 10:07 A.M., the Infection Preventionist (IP) indicated hand hygiene should be performed between dirty and clean tasks, and hands should be lathered for at least 20 seconds. A resident's pull up incontinence pad should not touch the floor, socks, or shoes when putting it on the resident. During an interview on 1/7/26 at 9:52 A.M., CNA 25 indicated staff should wash hands with a 20 second lather. She also indicated if gloves were soiled or the resident had a bowel movement, staff should sanitize between glove changes. She indicated when a resident was on EBP, staff should wear a gown for direct contact. On 1/8/26 at 11:47 A.M., the Administrator provided a current Enhanced Barrier Precautions policy, dated 4/2024, that indicated If resident is on enhanced barrier precautions or contact precautions, wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient On 1/8/26 at 11:47 A.M., the Administrator provided a current non-dated Hand Hygiene policy that indicated Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of20 [sic] seconds (or longer) . 3.1-18(b)(2) 3.1-18(l)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, functional, sanitary, and a homelike environment for residents, staff, and visitors for 6 of 10 rooms observed. (Room A1, Room A4, Room B2, Room B3, Room B6, Room F2)Findings include:1. On 1/5/26 at 10:19 A.M., Room A1 (shared by 3 residents) was observed with a strong odor of urine, brown substance smeared on raised toilet seat with handles at 2, 7, and 9 o' clock, and down the front of the toilet, 2 unlabeled bottles of moisturizing shampoo and body wash, an open tube of over the counter lotion and another unlabeled rash ointment on the back of the toilet, dust caked on the exhaust fan, the call light string was brown, and there were blue splatters on the wall to left of toilet and down the front of the toilet, and the tiles around the base of the toilet were brown. On 1/6/25 at 3:09 P.M., Room A1 was observed with a strong odor of urine, dust caked on the exhaust fan, the call light string was brown, and the tiles around the base of the toilet were brown. 2. On 1/5/26 at 1:49 P.M., Room A4 (private) was observed with a strong urine odor, dust caked on the exhaust fan, the call light string was brown, and the tiles around the base of the toilet were brown. On 1/8/26 at 9:17 A.M., the same was observed. urine odor. 3. During an observation on 1/5/26 at 10:03 A.M., the faucet handles and base in Room F2 were green. On 1/8/26 at 9:08 A.M., the same was observed in Room F2. 4. On 1/5/26 at 10:29 A.M., Room B2 was observed with a rolled up towel on the floor in front of the air conditioning unit. The bathroom was observed with a toilet seat riser with chipped paint on the legs where the resident's legs would sit. On 1/7/26 at 9:35 A.M., the same was observed. At that time, the Maintenance Assistant picked up the towel in front of the air conditioning unit, checked the unit, indicated he did not see any problems with the unit, and did not know why the towel was there. The towel was observed to have a yellowed stain on it. During an observation with the Maintenance Supervisor on 1/8/26 from 9:20 A.M. until 9:40 A.M., the same was observed on the toilet seat riser. The Maintenance Supervisor indicated he was unaware of the issue and would need to replace it. 5. On 1/5/26 at 10:49 A.M., the bathroom in Room B6 was observed with 1 of 2 lights on and working. On 1/8/26 at 9:06 A.M., the same was observed. During an observation with the Maintenance Supervisor on 1/8/26 from 9:20 A.M. until 9:40 A.M., the same was observed. He indicated he was unaware that the light was out. 6. On 1/5/26 at 10:53 A.M., the bathroom in Room B3 was observed with 1 of 2 lights on and working. On 1/8/26 at 9:05 A.M., the same was observed. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation with the Maintenance Supervisor on 1/8/26 from 9:20 A.M. until 9:40 A.M., the same was observed. He indicated he was unaware that the light was out. On 1/8/26 at 9:40 A.M., the Maintenance Supervisor indicated he had scheduled monthly maintenance checks on certain issues around the facility, but most had to do with life safety. He indicated any other issues, he was dependent on staff to let him know. He indicated there were forms at the two nurses stations that staff could fill out and submit to him. They could either put in a box by his office, or clip to the door. He indicated he was unsure of any policy related to preventative maintenance, but did follow the scheduled maintenance as a sort of policy. A preventative maintenance policy was requested and not provided. 3.1-19(f)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity when being spoken to. During 1 of 1 random interview, a resident indicated staff spoke harshly to residents during care, were short with residents, and cursed. These actions led the resident to feel angry. (Resident B)Findings include:On 1/7/26 at 10:13 A.M., Resident B indicated concern that a few un-named staff members had spoken harshly with residents. She indicated she had not directly observed the treatment, but had heard it from her room and from the hallway. She indicated Certified Nurse Aides (CNAs) had been overheard telling residents to shut your mouth and forcing residents to go to bed when they did not want to. She indicated the CNAs could be heard being hateful and speaking bad to other residents, often cursing and being short with them. She indicated the behavior had been going on for several months, and although grievances had been filed regarding the situation, as well as being brought up in resident council meetings, the behavior had continued. She indicated the behavior angered her as she was worried about the other residents it was happening to. On 1/7/26 at 10:45 A.M., the Activities Assistant indicated she attended resident council meetings with the residents. She indicated during the meetings, residents had indicated that staff were cursing, griping, and had been snippy with residents at times. She indicated when the allegations were made, she filled out grievance forms and gave them to the Administrator. At that time, she indicated she could remember filling out at least two grievances related to staff behavior. On 1/7/26 at 11:03 A.M., the Administrator indicated she was aware of the complaints about staff behavior and acknowledged the grievances. She indicated education had been done to address the situation with in-services related to resident rights, professionalism, phone use, and watching tone. She indicated she had been made aware of the situation through reviewing resident council minutes and following through on the grievances. At that time, she indicated there was not a current plan in place to monitor staff behavior or ensure appropriate resident treatment, but that her door was always open for residents to speak with her, as well as the Director of Nursing (DON) and Social Services Director (SSD). She indicated negative behavior by staff was not encouraged and had written up staff, in-serviced staff, and counselled staff in regards to foul language and professionalism. On 1/8/26 at 1:30 P.M., resident council minutes were reviewed and indicated, but were not limited to, the following:8/5/25 New business: wants help to be nicer - they are mean, say they are tired, the way they talk, the F Word, being on phones, need more patience. Concern with CNAs being nicer.10/6/25 Concern with a CNA being abrasive.11/3/25 Concern with nursing: [nurse name] is a smart---. Staff getting snippy.1/5/26 Concern with gripey nursing staff.On 1/8/26 at 1:40 P.M., grievances were reviewed and indicated, but were not limited to, the following:10/6/25 Grievance came from resident council that a CNA was abrasive and tone was short. The CNA was educated to be mindful of tone.10/9/25 A resident indicated staff had been short with him. The CNA was educated on customer service.1/5/26 Grievance came from resident council that a CNA was gripey. The resident and CNA were spoken to.On 1/8/25 at 2:00 P.M., the Administrator provided in-services and counselling forms that included the following:April 2025 in-services on conduct behavior and telephone usage were given.10/21/25 in-services on conduct behavior and telephone usage were given.An undated in-service was given on resident privacy and respectful communication.A counselling form, dated 8/18/25, indicated a CNA was given verbal counselling on conduct, customer service, and cell phone use after resident complaints about the CNA being in a rush and being short and rude to them. The CNA was getting the residents up in the morning before they wanted to, and language was unprofessional. The form was signed by the CNA and DON.Another counselling form, dated 8/18/25, indicated a different CNA was given verbal counselling on conduct, customer service, and cell phone use for the same reasons. The form was signed by the CNA and DON.On 1/7/26 at 2:30 P.M., the Administrator provided a current Resident Care and Dignity policy, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last revised 1/2024, that indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . be treated with respect, kindness, and dignityThis citation relates to Intake 2686980.3.1-3(a)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 1 of 2 residents reviewed for respiratory care. (Resident 32)Findings include: On 1/5/26 at 10:10 A.M., Resident 32 was observed sitting in his wheelchair with oxygen on via nasal cannula. At that time, a nasal spray (fluticasone propionate 50 micrograms (mcg) per spray) was observed on the bedside table. Resident 32 indicated he used the nasal spray whenever he needed to.On 1/6/26 at 8:08 A.M., Resident 32's clinical record was reviewed. Diagnosis included, but was not limited to, asthma.The most recent admission Minimum Data Set (MDS) assessment, dated 11/26/25, indicated Resident 32 was cognitively intact.Resident 32's clinical record lacked a current order for fluticasone propionate.Resident 32's clinical record lacked a care plan related to self-administering medications.Resident 32's clinical record lacked a self-administration assessment.During an interview on 1/8/26 at 9:15 A.M., Registered Nurse (RN) 3 indicated Resident 32 used the nasal spray in his room, and the clinical record lacked a current order to keep the nasal spray at bedside.On 1/8/26 at 11:47 A.M., the Administrator provided a current, undated Medication Administration policy that indicated, Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe.3.1-11(a)

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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 observation, interview, and record review, the facility failed to ensure a resident that was dependent on staff for Activities of Daily Living (ADLs) received necessary care to maintain their personal hygiene for 1 of 1 resident reviewed for ADL care. A dependent resident with Moisture Associated Skin Damage (MASD) was not offered or toileted every two hours as ordered. (Resident 27)Finding includes: On 1/7/26 at 9:09 A.M., Resident 27's clinical record was reviewed. Diagnoses included, but were not limited to, osteoarthritis and dementia without behaviors.The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/26/25, indicated Resident 27's cognition was severely impaired, she was substantial/maximum assistance of staff (staff performs over half of the effort) for toileting, transfers, always incontinent of bowel and bladder, no behaviors of rejecting care, and had MASD skin conditions.Current physician's orders included, but were not limited to, the following:Offer to assist resident with toileting needs every two hours and as needed every day and night shift, ordered 12/8/22Mary's Magic Butt Cream as needed for redness every day and night shift for preventative measure, ordered 6/3/24Nystatin Powder 100,000 Unit/Gram Apply to groin topically every day and night shift for yeast, ordered 7/5/24Cleanse perineal (peri) area and between bilateral buttocks with gentle soap and water, rinse, and pat dry. Apply Mary's Magic Butt Cream to red and opened areas every day and night, ordered 12/23/25A current Skin Impairment Care Plan, last revised 12/12/25, indicated the resident had impairment to skin integrity related to weakness, impaired mobility, yeast to groin area, incontinence, chronic excoriation to buttocks, and included, but was not limited to, the following interventions:Follow facility protocols for treatment of injury, initiated 12/23/21Medications and treatments as ordered, initiated 12/23/21Progress notes from 8/1/25 to present were reviewed and indicated:On 8/6/25 Skin Issues Note: 1. Location: Intergluteal cleft (vertical groove seperating buttocks). Issue type: MASD. Skin issue Wound acquired in-house. 2. Location: Medial coccyx (tailbone). Issue type: Excoriated MASD. Wound acquired in-house. 3. Location: Buttocks - generalized. Issue type: MASD. Wound acquired in-house.On 8/11/25, a skin/wound note indicated Inner buttocks and labia were red and excoriated.On 8/13/25, a nurse's note indicated the resident had increased redness to vaginal area and was complaining of itching and burning in the vaginal area. Nurse Practitioner (NP) ordered Diflucan 150 milligram (mg), give one by mouth daily for three consecutive days for fungal infection.On 8/15/25, a nurse's note indicated the resident continued to complain of itching (in vaginal area). On 8/21/25, a skin issues note indicated areas on bottom and peri area were improving.On 8/27/25, a skin issues note indicated the resident presented with erythema (redness) and some skin breakdown on the buttocks.On 9/17/25, a skin issue note indicated MASD of intergluteal cleft, coccyx, and buttocks. Stable: previously deteriorating wound characteristics plateaued.On 12/23/25, a skin/wound note indicated the resident had scratched open areas on her pubic bone, all around the labia and in the perineum.The clinical record lacked documentation of the resident being encouraged and toileted every 2 hours as ordered.On 1/6/25 at 3:09 P.M., Certified Nurse Aide (CNA) 25 and Qualified Medication Aide (QMA) 32 were observed toileting Resident 27. CNA 25 and QMA 32 assisted the resident onto the toilet. QMA 32 removed a saturated incontinence pad and saturated pants from the resident. The resident was noted to have redness to her buttocks.During a continuous observation on 1/7/25 from 10:20 A.M. to 1:49 P.M., Resident 27 was observed in the dining room until 12:15 P.M. when the resident left the dining room propelling self in wheelchair to the hallway by the entrance to the facility. At 12:38 P.M., two CNAs walked past the resident but did not address the resident and returned with other residents from the dining room. At 1:49 P.M., the Activities Assistant asked the resident if she wanted to go to the activity and she was pushed in her wheelchair to the activity area.During an interview on 1/8/26 at 11:00 A.M., Licensed Practical Nurse (LPN) 16 indicated Resident 27 needed staff assistance to be toileted and have thorough personal hygiene care. She was constantly wet and should be encouraged to do toileting every 2 hours at least because if not, her bottom would get galled and excoriated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quickly. She indicated they don't document the specific times that they offer the resident or toilet the resident because it didn't automatically pop up as a task every two hours to do. It's up to each CNA to keep track. They will usually do it upon arrival for shift, before breakfast, around 10:00 A.M., after lunch, and thereafter. The resident did not usually refuse care.During an interview on 1/8/26 at 12:26 P.M., the DON indicated she expected the resident to be offered and toileted every two hours as ordered. She expected the nurses checking off the task in the clinical record to make certain that it was being done. She was not aware that the order was not being followed.On 1/8/26 at 2:11 P.M., a current ADL policy was requested but not provided during the survey period.On 1/8/26 at 4:16 P.M., a current Comprehensive Care Plan Policy, dated 1/1/22, was provided by the Administrator and indicated, . It is our purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable and based on resident needs. A resident's care should have the appropriate intervention and provide a means of interdisciplinary communication to ensure continuity in resident care . The services provided or arranged by the facility, as outlined by the comprehensive care plan, will meet professional standards of quality . 3.1-38(a)(2)(C)3.1-38(a)(3)(A)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident received care, consistent with professional standards of practice, to prevent and treat a facility acquired pressure ulcer for 1 of 2 residents reviewed for pressure ulcers. Skin assessments were not completed and a resident's plan of care was not followed and revised to monitor and assess the resident's right ankle pressure ulcer. (Resident 7)Finding includes:On 1/6/26 at 9:53 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, polyneuropathy, and Stage II (Partial thickness loss of skin, which may present as a blister or shallow open sore) pressure ulcer. The stage of pressure listed was an inaccurate diagnosis. The resident had a Stage III (full-thickness loss of skin occurs, potentially exposing fat tissue. The ulcer may appear as a deep crater) pressure ulcer/injury.The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, indicated the resident was cognitively intact, dependent on staff assistance for showering, transfers, toileting, at risk for pressure ulcers, had one Stage III pressure ulcer, no pressure reducing device for chair or bed, no turning/repositioning program, on nutrition interventions to manage skin problems, receiving pressure ulcer care and had behavior of rejecting care one to three days out of the seven day look back period.Current physician's orders included, but were not limited to, the following:Regular diet, regular texture, thin consistency, give double portions of protein with meals, initiated 1/21/25 Protein powder, mix one scoop of protein powder in liquid of choice by mouth twice daily with meals, ordered 10/6/25 Enhanced Barrier Precautions (EBP-infection control measure requiring gown and gloves to be worn for high-contact care) every day and night shift related to Stage II pressure ulcer of right ankle, ordered 11/12/25 Magic Cup (nutrition supplement) with meals for weight loss and to promote wound healing. Staff to document the amount consumed, ordered 12/3/25 Cleanse the right ankle wound with wound cleanser and gently pat dry. Apply Calmoseptine (ointment used as a moisture barrier form a protective layer, keeping skin dry while its active ingredients promote healing by preventing moisture and irritants from further damaging the skin) to irritated skin around the outside of the wound. Hydrofera blue (foam wound dressings containing the antibacterial pigments methylene blue and gentian violet, designed to manage bacteria, control exudate, maintain moisture, and promote healing for various complex wounds) to wound bed only (cut to fit size), apply abdominal pad (ABD-a highly absorbent, thick dressing used to manage fluid, protect the wound, and promote healing by wicking moisture away from the skin.) and wrap with bulky kerlix gauze for additional protection every day shift Monday, Wednesday and Friday and as needed (PRN) if soiled or dislodged related to Stage II pressure ulcer on right ankle, ordered 12/10/25Appt on 1/14/26 with (name of wound care clinic), facility to transport one time related to Stage II pressure ulcer of right ankle, ordered 12/30/25Gently cleanse the wound and surrounding skin and pat dry. Apply a thick layer of LMX-4 (topical cream used to numb the skin for pain relief for minor procedures) and wrap loosely with a dressing and allow to set for 30 to 60 minutes prior to wound care of the right ankle. Cleanse numbing agent off of skin prior to completing treatment, every Monday, Wednesday, and Friday related to Stage II pressure ulcer of right ankle, ordered 1/7/26 A current Stage III pressure ulcer care plan, last revised on 9/10/25, included, but was not limited to, the following interventions:If the resident refuses treatment, confer with the resident, Interdisciplinary Team (IDT), and family to determine why and try alternative methods to gain compliance, initiated 3/19/25 Assess/record/monitor wound healing weekly and PRN. Measure length, width, and depth where possible. Assess and document the status of the wound perimeter, wound bed, and healing progress. Report improvements and declines to the Medical Doctor (MD), initiated 3/19/25Follow facility policies/protocols for the prevention/treatment of skin breakdown, initiated 3/19/25Follow up with the wound clinic as per orders, initiated 7/2/25Monitor nutritional status. Serve diet as ordered, monitor intake, and record. Initiated 3/19/25Braden Scale skin risk assessments (a standardized tool used in healthcare to assess a patient's risk of developing pressure (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries/ ulcers based on various risk factors), dated 10/11/24 and 3/19/25, indicated the resident was at mild risk. The clinical record lacked documentation of quarterly skin assessments between them.Skin and wound assessments, progress notes, wound clinic care notes, and medication and treatment administration records (MAR/TAR) from 3/19/25 to present were reviewed and indicated the following:On 3/19/25 at 6:08 P.M., the resident complained of right ankle pain, and upon examination, an area of 0.1 centimeters (cm) length x 0.1 cm width on the outer right ankle was present. The area was red and warm to the touch, skin intact. Progress notes and skin/wound assessments indicated the wound was progressively worsening from a Stage I (skin is intact but shows a localized area of non-blanching redness that didn't fade after pressure was removed) pressure ulcer to a Stage III pressure ulcer. The resident started an antibiotic for an infection of the wound on 5/6/25, 5/18/25, and 6/17/25. The Nurse Practitioner (NP) ordered a referral to a wound care clinic for evaluation on 6/27/25 and started an antibiotic and probiotic for the infection of the right lateral ankle pressure ulcer. The resident's pain was controlled with Tylenol 650 milligrams (mg) every six hours as needed, and then Tramadol 50 mg twice daily was added eventually for better pain control. An appointment with the wound clinic was scheduled for 7/21/25.The initial wound clinic evaluation note, dated 7/21/25, indicated the Stage III pressure injury measured 1.6 cm (length) x 1.6 cm (width) x 0.1 cm (depth). The wound was open with 15% granulation tissue (the new, pinkish-red, moist connective tissue with new blood vessels formed on the surface of a healing wound, acting as a foundation to fill it in, protect against infection, and support the growth of new skin (epithelialization). A crucial sign a wound was progressing from inflammation to the proliferative (rebuilding stage) and 85% slough (a layer of yellowish, soft, stringy, or cheesy dead tissue that would build up on the wound bed, acting as a barrier to healing and a breeding ground for bacteria. It was a sign that a wound was stuck in the inflammatory healing stage and must typically be removed or debrided for healthy tissue to grow and for the wound to close properly, noted in the wound bed. Small amount of serosanguinous drainage (thin, pinkish-red or light red fluid from a wound, common in early healing). Peri wound clean, moist, and blanchable erythema (redness). Wound edges attached and well defined. Treatment plan: Cleanse with normal saline, cover with Iodoflex (a dressing that released iodine to fight a broad spectrum of microbes, managed exudate, the fluid that seeps from a wound, and absorbed slough to promote healing and reduce infection risk) and an ABD pad, secured with cast padding and kerlix gauze daily and prn.A wound clinic note, dated 7/29/25, indicated the wound was debrided (the medical removal of dead, damaged, or infected tissue). Measurements prior to debridement were 1.2 cm x 1 cm x 0.1 cm. Post-debridement measurements were the same. Treatment plan: Cleanse wound with normal saline, Collagenase Santyl ointment (used for enzymatic debridement) to be applied nickel thickness to the wound base only, avoiding healthy tissue surrounding the wound. Cover with ABD pad and kerlix gauze. Change dressing daily. Follow-up appointment on 8/12/25.A wound clinic note, dated 8/12/25, indicated the wound was debrided again. Pre debridement measurements were 1.3 cm x 0.8 cm with scant serous drainage (a thin, watery, clear to pale yellow fluid that helped clean the wound and keep it moist for cell repair) and 100 % wound bed eschar (a thick, black or brown, leathery layer of dead, dry tissue that formed over a severe wound, hindering healing and creating a breeding ground for infection). Wound looks really good at this point. All the pressure has been relieved, and there is no erythema and no bogginess to the eschar. At this point, I think just keeping the pressure off is going to allow this to epithelialized. Treatment plan: Cleanse wound with normal saline and cover wound with ABD pad and kerlix gauze daily and PRN if soiled or dislodged. Follow-up appointment on 9/9/25.A wound clinic note, dated 9/9/25, indicated the resident arrived without any protective dressing in place on the right ankle pressure wound. The fat layer was exposed, and ulceration showed signs of regression with mild clinical signs of secondary infection of erythema, edema (swelling), and purulent drainage (a thick, often milky or yellowish fluid draining from a wound indicating a bacterial infection). Measurements of the wound were 1.3 cm x 1.3 cm x 0.1 cm. The wound bed had 60% granulation and 40% slough with attached well-defined edges. Treatment plan: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Antibiotic ordered for wound cellulitis. Patient to keep the heel lift boots on at all times when in a wheelchair or in bed. Cleanse the right ankle wound with normal saline, cover ulcer with adaptic calcium alginate dressing (a petrolatum-coated, non-adhering, highly absorbent dressing) and ABD pad. Secure with kerlix gauze daily and PRN if soiled or dislodged. Follow up appointment on 9/18/25.A wound Care note, dated 9/18/25, indicated the fat layer exposed ulceration was stable with minimal improvement. No signs of secondary infection. Further discussion was held about the patient not leaving the offloading protective boot in place due to her dementia. Change to adhered felt with offloading dressing and dress the wound Monday, Wednesday, and Fridays. Follow-up appointment scheduled.A wound clinic note, dated 10/2/25, indicated the fat layer exposed ulceration was stable with no signs of infection. The wound subcutaneous tissue was debrided of biofilm (a slimy, protective layer of microorganisms, like bacteria, fungi, algae, that stick to the surface in a moist environment). Post debridement measurements were 1 cm x 1 cm x 0.1 cm. Noted that the potential to heal was poor. Follow-up appointment scheduled. No new orders. Follow-up appointment scheduled 10/9/25.The wound clinic note from 10/9/25 was not available from the clinical record.A nursing note, dated 10/9/25, indicated facility and family were not happy with the care provided when the resident returned from her wound clinic visit on 10/9/25. The family requested a referral to a different wound clinic. An appointment was made for 10/15/25 at a different clinic.A wound clinic note, dated 10/15/25, indicated it was the initial visit for wound care to a Stage III pressure injury to the right ankle. Measurements of the wound were 2 cm x 2 cm x 0.1 cm. Fat layer exposed. A small amount of serosanguineous drainage was noted. Wound bed had no granulation, eschar, or epithelization, but did have slough. Edges of the wound were attached. Peri wound skin was erythematous, but temperature was normal, and no signs of infection. Local pulse was felt. Potential to heal was fair. Treatment plan: Apply Prisma dressing (collagen-based wound dressing that helped heal chronic wounds by turning into a gel, absorbing excess fluid, protecting against infection with silver, and creating a moist environment for new tissue growth), dampened with normal saline. Cover with a border foam. Change dressing on Mondays and Fridays. Off load ankle area with a pillow or an offloading boot. See back 10/22/25.A wound clinic note, dated 10/22/25, indicated measurements of the wound were 2.2 cm x 2.5 cm x 0.1 cm. A small amount of serosanguineous drainage was observed, and it had bright red, pink, firm granulation and slough, but no eschar or epithelialization. The patient might benefit from debridement, but the patient would not tolerate it. Continue current treatment, but change dressing changes to Monday, Wednesday, and Friday. Return in 2 weeks.A wound clinic note, dated 11/5/25, indicated measurements of the wound were 2 cm x 2 cm x 0.1 cm. Redness present. A small amount of serosanguineous, creamy yellow drainage present. Drainage sent for culture and sensitivity. Wound bed was bright red, pink, firm, with granulation and slough present but no eschar or epithelization. Treatment plan: Keflex 500 mg, give one by mouth three times a day for seven days for the infection of the right lateral ankle pressure ulcer. Change dressing to Aquacel Ag dressing (antimicrobial wound dressing). Next visit 11/12/25.A wound clinic note, dated 11/12/25, indicated measurements of the wound were 2 cm x 2.5 cm x 0.1 cm. A small amount of creamy, yellow serosanguineous drainage present. Wound bed with slough, granulation, firm, bright red, and pink. No eschar or epithelization. Treatment Plan: Apply Calmoseptine ointment to irritated skin around the outside of the wound. Prisma dressing to wound bed. Cover with an absorbent dressing. Change the outer dressing on Mondays, Wednesdays, and Fridays. Due to the patient's pain with wound dressing changes, apply dry Prisma applied in layers. Should leave primary dressing of Prisma in place as long as possible (weekly) to prevent irritation from dressing changes on the wound. Hopefully, Prisma will keep the wound covered almost like a scab and keep the wound from getting infected, as well as prevent irritation. Reviewed drainage cultures growing protease and Methicillin-Resistant Staphylococcus Aureus (MRSA, a type of staph infection caused by bacteria resistant to many common antibiotics). Keflex 500 mg, give one by mouth three times a day, continued for five more days. Follow up on 12/3/25.A Nurse's note, dated 12/3/25, indicated the NP was in the facility to see (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wednesdays. She indicated there was not an order and the care plan did not indicate how often. At that time, she indicated skin assessments were to be done weekly and the nurse should get measurements at that time or with wound dressing changes. She would not document measurements, wound characteristics, or about the wound care when provided in the clinical record; she would just mark that it was completed on the MAR/TAR. She indicated the kitchen would put the protein powder in the resident's tea at meals. She was unaware why the order indicated it was to be provided twice daily with meals, because the MAR/TAR indicated it to be given at three meals and that was how it was documented it was given. The nursing staff should be checking the resident's meals because they were the ones documenting how much of the magic cup, protein powder, and meal was consumed. If the resident had been refusing the magic cup, protein powder, or double portions, then the dietary staff should bring that to the attention of the nurse and/or DON so they can notify the MD and try something else. The orders should be followed as written.During an interview on 1/8/25 at 11:24 A.M., the Dietary Manager indicated Resident 7 was on a regular diet, protein powder was put in food, and got double meat at breakfast and lunch. The resident was not receiving the magic cup ordered on 12/3/25. She got the protein powder in her food because she would not consume the magic cups. During an interview on 1/8/26 at 11:57 A.M., the DON indicated that, depending on how the wound looked, the resident was seeing wound care 1-2 times a week. She indicated the facility was not allowed to take pictures of the wound, so staff relied on skin assessments to compare progress. She was aware that the skin assessments of the facility as a whole were not consistently being completed, and signs and symptoms of infection and wound characteristics were not being documented. The resident's last wound assessment in-house was done on 12/8/25. She indicated they definitely need to follow up on measurements and documentation needed to be better so wounds could be better tracked. There was no other documentation with wound care provided other than marking it completed in the MAR/TAR. The weekly skin assessments were where they should do that, but depending on the nurse, they may document that and may not. She indicated she was not aware that the resident was more cooperative in the early morning for wound care, and that would be something they would check into changing. She indicated the kitchen would be giving the resident the magic cup, putting protein powder in liquid, and giving double portions of protein. She was not aware that the resident was not getting these, and there was confusion from staff about them. The protein powder should be taken at all meals, she indicated the order for twice daily (BID) was put in erroneously. She indicated the orders should be followed as written, and if the resident was non-compliant, it should be brought to the attention of her and the MD. She indicated the MDS coordinator would be the one to revise the care plan for the resident, and it should be resident-specific.On 1/8/26 at 2:05 P.M., a current Pressure Ulcer Prevention Policy, last revised April 2020, was provided by the administrator and indicated, . Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. evaluate, report, and document potential changes in the skin . Review the interventions and strategies for effectiveness on an ongoing basis . On 1/8/26 at 4:16 P.M., a current Skin Assessment and Documentation Policy, dated 12/1/21, was provided by the administrator and indicated, Braden scale for predicting pressure sore risk assessment is to be completed . quarterly . To complete the care plan correctly, it must include the interventions to prevent skin breakdown and interventions to treat actual breakdown when indicated . the care plan should be updated . as the resident's needs or condition changes . when completing a head to toe skin assessment you need to initiate appropriate skin grids, for each skin impairment identified, and document all of this on the skin assessment located in [electronic health recording system] . a weekly skin assessment must be completed by the nurse . weekly wound report for each pressure area. Once a new pressure area is identified, take the following steps: Measure each area once a week and PRN for any changes in the wound. Record the measurements and description on the wound report for the appropriate wound . Any changes in skin conditions should be reported to the nurse and physician for follow-up . a facility wound report: to be completed each week (continued on next page)

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	155374	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poplar Care Strategies	313 Poplar St Loogootee, IN 47553

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by a designated nurse in the facility, the director of nursing is responsible to see that this report is completed and accurate. Gather information and measurements from the resident skin assessments that are completed each week. Collect this data at a time that provides the most recent measurements to the Risk Management Team. This data will be used to review wound healing and evaluate the treatment plan for each resident with skin problems . On 1/8/26 at 4:16 P.M., a current Wound Care Policy, revised October 2010, was provided by the administrator and indicated, . The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data . notify the supervisor if the resident refuses the wound care. Report other information in accordance with facility policy and professional standards of practice . On 1/8/26 at 4:16 P.M., a current Food and Nutrition Services Policy, revised October 2017, was provided by the Administrator and indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs . meals and/or nutritional supplements will be provided . Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident . 3.1-40(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent falls for 1 of 1 residents reviewed for accidents. Fall interventions were not in place for a resident with multiple falls, a fall assessment was not completed after a fall, and an interdisciplinary note was not completed after a fall. (Resident 23)Findings include:During an observation on 1/05/2026 10:07 AM Resident 23 was observed in the common area with a staff member. She had fall socks on and a fall alarm attached to her wheelchair.On 1/5/26 at 3:21 P.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limit to, fracture of the right pubis, dementia, abnormalities of gait and mobility, and unsteadiness on feet.The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/18/25, indicated Resident 23 had severe cognitive impairment and was dependent on staff for transfers and toileting.Resident 23's Physician's Orders included, but was not limited to, resident should not be left in the wheelchair unsupervised while in her room or in the lounge for safety, dated 10/14/25.Resident 23's care plan included, but was not limited to, The resident is at an increased risk for falls r/t [related to] having Confusion , Gait/balance problems, bowel and bladder incontinence, Psychoactive drug use , being unaware of her safety needs and having a history of recurrent falls, dated 9/29/25. Current interventions included, but were not limited to, resident should not be left in the lounge unsupervised while in her wheelchair, dated 10/22/25.On 11/13/25 at 3:56 P.M., a nurses note written by Registered Nurse (RN) 3 indicated the following, Heard pressure alarm sounding in TV [television] lounge at 1515 [3:15 P.M.]. Resident found laying flat on her back on the floor in front of TV [television].Resident 23's clinical record lacked a fall assessment after the fall on 11/13/25.Resident 23's clinical record lacked an interdisciplinary team (IDT) note after the fall on 11/13/25.During an interview on 1/6/26 at 7:33 A.M., RN 3 indicated that Resident 23 was in the lounge by herself when she fell on [DATE].During an interview on 1/6/26 at 7:41 A.M., the Director of Nursing (DON) indicated that Resident 23 was supposed to be supervised at all times when she was in the lounge. At that time, she further indicated she did not see a fall assessment or IDT note after the 11/13/25 fall, but she would expect a fall assessment and IDT note to be completed after every fall.On 1/8/26 at 11:47 A.M., the Administrator provided a current Falls-Clinical Protocol policy, revised March 2018 that indicated, .the staff and physician will identify pertinent interventions to try and prevent subsequent falls.3.1-45(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure a resident's plan of care for nutrition was followed for 1 of 1 residents reviewed for nutrition. A resident with weight loss was not receiving the diet and supplements ordered, the resident was not being weighed weekly as ordered, and the care plan was not revised. (Resident 7)Finding includes:On 1/6/26 at 9:53 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, polyneuropathy, and pressure ulcer.The most recent quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, indicated the resident was cognitively intact, supervision of staff for eating, dependent on staff assistance for showering, transfers, toileting, 137 pounds (lbs), 64 inches tall, had weight loss (not on prescribed regimen), no swallowing disorder, and not on a therapeutic diet.Current physician's orders included, but were not limited to, the following:Regular diet, regular texture, thin consistency, give double portions of protein with meals, initiated 1/21/25 Protein powder, mix one scoop of protein powder in liquid of choice by mouth twice daily with meals, ordered 10/6/25 Magic Cup (nutrition supplement) with meals for weight loss and to promote wound healing. Staff to document amount consumed, ordered 12/3/25 The clinical record lacked an order for weekly weights on Resident 7.A current Nutrition Care Plan, last revised 10/17/24, included, but was not limited to, the following interventions:Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage resident to comply. Explain consequences of refusal, obesity/malnutrition risk factors, initiated 10/17/24Provide and serve supplements as ordered, initiated 10/17/24Provide and serve diet as ordered. Monitor intake and record every meal, initiated 10/17/24Regular diet/regular texture/thin consistency, initiated 10/17/24Resident 7's documented weights since 11/1/25 to present included the following:On 11/1/25 at 9:55 A.M., 148.0 lbs (Mechanical Lift)On 12/2/25 at 8:27 A.M., 136.5 lbs (Wheelchair)On 1/5/26 at 7:43 A.M., 146.0 lbs (Wheelchair)The resident had a weight loss from 11/1/25 to 12/2/25 of -7.77%.Progress notes included, but were not limited to, the following:A weight change note, dated 12/3/25 at 3:13 P.M., indicated Interdisciplinary Team (IDT) reviewed significant weight loss. Resident's current weight is 136.5#. This is a 11.5 lbs (7.8%) loss in 30 days. She is on a regular diet and consumes all meals in the main dining room with set up assistance only. Appetite varied. On average she consumed 25-50% of all meals served. She was noted to snack throughout the day with items her family provides. She is currently getting a magic cup PO with her supper meal daily, protein powder by mouth, one scoop with meals to promote wound healing and a multi-vitamin with minerals by mouth daily. She has a chronic wound on her right ankle and is seen at Good Samaritan Wound Clinic weekly for this. She can be non-compliant at times with MD orders. Weight loss discussed with Nurse Practitioner (NP). New order given to increase current Magic Cup order from once daily with supper to with each meal. New order also given for weekly weights. Resident and POA aware.A nutrition/dietary note, dated 12/27/25 at 7:43 P.M., indicated Registered Dietitian (RD) Reviewed the clinical record due to weight loss of 7.8% in 30 days. BMI: 23.4. Diet: Regular diet w/ double protein portions. Supplements: magic cup w/ meals. One scoop protein powder with each meal. Intake: 25-75% of meals, accepts approximately 50% of magic cups. Magic cup at meals added on 12/3 due to weight loss. Recommendation: Continue current plan of care. RD to monitor weight and trends and follow up in January 2026.The Medication Administration Record/Treatment Administration Record (MAR/TAR) and indicated the resident was receiving the supplements and diet as ordered.On 1/7/26 from 10:20 A.M. to 12:00 P.M., Resident 7 was observed sitting in her wheelchair in the main dining room for a continuous observation. Her lunch was served without double portion of protein, a magic cup was not offered, and the protein powder was not visible in the resident's tea, which was the only liquid she was served at that time. The resident, sitting in her wheelchair, propelled herself out of the dining room with her feet after she completed her meal to the front hallway by the entrance of the building.During an interview on 1/7/26 at 9:35 A.M., Certified Nurse Aide (CNA) 25 indicated there (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be an order for weights on residents that comes up on the CNA tasks to do. They weigh the resident and write it down for the nurse and they put it into the resident's clinical record. If a resident refuses, the nurse was notified and they would document that because the CNAs do not have access to charting on the residents. During an interview on 1/8/25 at 10:51 A.M., Licensed Practical Nurse (LPN) 16 indicated Resident 7 was on monthly weights, so there would not be a separate order for her because that's the standard. In regards to the weight entered on 12/2/25, if she would have entered that weight and noticed that much of a discrepancy, she would have had the resident reweighed and documented that. She was unsure why that was not done and why the order for the weekly weight from 12/3/25 was not entered. She indicated the resident was not likely to refuse being weighed because they can either do it by the mechanical lift or while she sat in the wheelchair. She indicated the kitchen would put the protein powder in the resident's tea at meals. She was unaware why the order indicated it was to be provided twice daily with meals because the MAR/TAR indicated it to be given at three meals and that was how it was documented it was given. The nursing staff should be checking the resident's meals because they were the ones documenting how much of the magic cup, protein powder, and meal were consumed. If the resident had been refusing the magic cup, protein powder, or double portions then the dietary staff should bring that to the attention of the nurse and/or Director of Nursing (DON) so they can notify the Medical Doctor (MD) and try something else. The orders should be followed as written.During an interview on 1/8/25 at 11:24 A.M., the Dietary Manager indicated Resident 7 was on a regular diet, protein powder was put in food, and got double meat at breakfast and lunch. Resident was not on a magic cup. She got the protein powder in her food because she would not drink the magic cups. During an interview on 1/8/26 at 11:57 A.M., the DON indicated she would have expected a reweight to be done before going to the Nurse Practitioner (NP) to see if it was true weight loss, but since it was not done, and the NP gave new orders, she had to expect it was a true weight loss on the resident. She indicated the kitchen would be giving the resident the magic cup, putting protein powder in liquid, and giving double portions of protein. She was not aware that the resident was not getting these and there was confusion from staff about them. The protein powder should be at all meals, she indicated the order for twice daily (BID) was put in erroneously. She indicated the orders should be followed as written and if the resident was non compliant, it should be brought to the attention of her and the MD. She indicated the MDS coordinator would be the one to revise the care plan for the resident and they should be resident specific.On 1/8/26 at 4:16 P.M., a current Food and Nutrition Services Policy, revised October 2017, was provided by the Administrator and indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs . meals and/or nutritional supplements will be provided . Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident . On 1/8/26 at 4:16 P.M., a current Comprehensive Care Plan Policy, dated 1/1/22, was provided by the Administrator and indicated, . It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident . On 1/8/26 at 4:16 P.M., a current Weight and Measurement Policy, revised March 2011, was provided by the Administrator and indicated, . The purposes of this procedure are to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident . 3.1-46(a)(2)