STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Parkwood	1001 N Grant St Lebanon, IN 46052

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observation, interview, and record review, the facility failed to ensure the physician's order to obtain weekly weights were followed for 2 of 3 residents reviewed for quality of care. (Resident B and J)Findings include:1. During an observation, on 3/1/26 at 2:44 p.m., Resident B was asleep in her recliner with her legs elevated. Resident B's brown pants were cut from the bottom hem up to the calf area bilaterally (both sides) and the bottom of the pants around the lower calf area appeared wet. Edema (swelling) was noted to both of Resident B's lower legs.During an observation, on 3/2/26 at 11:00 a.m., Resident B was asleep in her recliner with her legs elevated. Resident B was wearing brown pants with the bottom of the pants cut and wet. Lower leg edema was noted bilaterally. A pair of light tan pants were lying on Resident B's bed which were also cut to the calf area.During an observation, on 3/3/26 at 9:51 a.m., Resident B was asleep in her recliner with her feet elevated. Resident B was wearing blue pants which had also been cut from the bottom hem to the calf area. Lower leg edema was noted bilaterally.The clinical record for Resident B was reviewed on 3/4/26 at 1:56 p.m. The diagnoses included, but were not limited to, chronic diastolic congestive heart failure (CHF), lymphedema, and edema.A care plan, with a start date of 11/17/22, indicated Resident B received diuretic medication related to CHF and to obtain and document weights as ordered.A care plan, dated as last revised 6/10/25, indicated Resident B had a potential for nutritional risk related to CHF and edema with diuretic use and to obtain and document weights per order.A physician's order, dated 12/19/25, indicated to obtain weekly weights, once a morning, on Tuesdays and included, Task(s) to Record: Temperature.A review of Resident B's medication administration record (MAR) for the weekly weights indicated the staff had been obtaining and documenting a weekly temperature and not the physician's ordered weekly weight.A review of the vitals tab in the electronic health record (EHR), where weights were also documented, did not include documentation of the physician's ordered weekly weights. During an interview, on 3/5/26 at 12:02 p.m., the QMA/Scheduler who was also in charge of obtaining weights had reviewed the MAR and indicated temperatures were documented instead of Resident B's weights. She was responsible for ensuring weights were completed in a timely manner and a re-weight was obtained if a resident was flagged for a significant weight change. She indicated new orders were reviewed during the Interdisciplinary Team (IDT) meetings on Thursdays.During an interview, on 3/5/26 at 12:14 p.m., Licensed Practical Nurse (LPN) 4 reviewed the MAR and the physician's order and indicated the order was for weekly weights but temperatures were documented in the MAR. LPN 4 indicated whoever entered the order into the EHR had entered it incorrectly.During an interview, on 3/5/26 at 1:51 p.m., the Clinical Support Nurse indicated Resident B's order was placed into the EHR with a task attached to it and the task was set as temperature instead of weight. The IDT reviewed weights by printing out a report of all weights recorded in the facility and looked for significant changes. When reviewing the facility weights, IDT did not review the actual orders, but all the weights which were obtained and documented into the EHR. The physician who ordered the weekly weights would (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Parkwood	1001 N Grant St Lebanon, IN 46052

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review the weights for trends.During an interview, on 3/5/26 at 2:07 p.m., the Executive Director (ED) indicated a nurse should have caught an entry error in the physician's weight order when they were completing the task.During an interview, on 3/5/26 at 2:24 p.m., Nurse Practitioner (NP) 5 indicated it was difficult to monitor weights in the facility because the weights were not always documented in the same location within the electronic health record. The physicians relied on the nurses to monitor weights and to notify the physician of changes or issues. Weights documented in the vital tab within the EHR were the weights she would review and would only review an order if the nurses or the facility informed her of an issue with the order. Resident B's edema was stable, but the resident needed to be weighed weekly related to CHF and diuretic use.2. During an observation, on 3/1/25 at 10:57 a.m., Resident J was in the lounge watching T.V., a midline (intravenous line for medication administration) was present in the right upper arm.During an observation and interview, on 3/2/26 at 8:51 a.m., Resident J was sitting in his wheelchair in the hallway, a midline was present in his right upper arm and edema to his lower legs, ankles, and feet was noted bilaterally. Resident J indicated he had gained weight from swelling, and the midline was placed to receive IV (intravenous) medication for the swelling. He was not sure how much weight he had gained because he was not weighed very often.During an observation, on 3/3/25 at 9:49 a.m., an empty IV medication bag, dated 3/2/26, hung on an IV pole. The pharmacy label on the medication bag indicated Furosemide (a diuretic medication for edema or fluid buildup) 80 mg (milligram); intravenous.During an observation, on 3/5/26 at 1:46 p.m., Resident J was sitting in his wheelchair by the nurse's station, the midline had been removed, and edema was still noted bilaterally to his lower legs, ankles, and feet.The clinical record for Resident J was reviewed on 3/2/26 at 2:47 p.m. The diagnoses included, but were not limited to, congestive heart failure, edema, and lymphedema.A care plan, with a start date of 1/24/23, indicated Resident J had a potential risk for nutritional risk and to obtain and document Resident J's weight per the order.A physician's visit note, dated 1/28/26, indicated the plan for Resident J's edema, lymphedema, and congestive heart failure included, but was not limited to, monitoring weekly weights.Documentation of weekly weights or a physician's order for weekly weights was not found in the EHR.A change in condition document, dated 2/20/26, indicated Resident J had experienced an increase in edema and shortness of breath. A physician's order was placed for IV Furosemide 80 mg and a 1 Liter fluid restriction from 2/25/26 to 3/2/26.The change in condition document did not include weight monitoring.A progress note, dated 2/25/26 at 12:30 p.m., indicated the Director of Nursing (DON) contacted the Medical Director (MD) to review Resident J's case and to confirm orders. The order for IV Lasix 80 mg was confirmed, and Resident J was placed on daily weights.Documentation of daily weights or a physician's order for daily weights was not found in the EHR.During an interview, on 3/5/26 at 3:34 p.m., the DON indicated she had spoken with the MD about Resident J and had placed the orders given by the MD. The DON indicated she could not recall if the MD had ordered daily weights or if she had intended to put the resident on routine weight checks as a nursing measure but would contact the MD to confirm.During an observation and interview, on 3/5/26 at 3:34 p.m., the MD reply, via text message, to the DON, indicated Resident J was supposed to be a weekly weight. The DON indicated she unfortunately did not place an order for weekly weights in the EHR.A current facility policy, titled Physicians Orders, dated as last revised 1/30/26 and received from the Clinical Support Nurse on 3/5/26 at 2:00 p.m., indicated .It is the standard of this facility that physician orders are followed, reviewed to ensure delivery of applicable care, being alert for changes in condition related to new orders, and need to notify the physician for.potential order changes as needed.Each resident will have physician's orders to guide the facility in caring for and treating each resident.Licensed Nurses (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Parkwood	1001 N Grant St Lebanon, IN 46052

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Medication Aides are expected to follow physician's orders.Licensed Nurses are expected to notify the physician with any concerns related to new physician orders or potential need for changes in orders.During physician visits and or rounding, physician's orders will be discussed with the physician and licensed staff for need for changes, such as new orders, discontinuing orders, or changing current orders.This citation relates to Intake 2743347.410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)