STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155387	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caroleton Healthcare Center	2500 Iowa Ave Connersville, IN 47331

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have complete and accurate documentation for the use of an antibiotic and failed to accurately document a resident's refusal of wearing heel boots and refusal of fingernail care for 3 of 34 residents reviewed for complete and accurate documentation (Resident 1, Resident 3 and Resident 32). Findings include:1. Review of the record for Resident 1 on 04/22/2026 at 12:21 p.m., indicated the resident's diagnosis included, but was not limited to, pneumonia (infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus). The physician's order for Resident 1, dated 1/20/26, indicated the resident was ordered ceftaiaxone (antibiotic) 1 gram intravenously every 24 hours for pneumonia. The infection surveillance criteria report for Resident 1, dated 1/20/26 at 11:13 a.m., indicated for pneumonia all three criteria 1a, 1b, and 1c must be met. Resident 1 was marked for 1a - for chest x-ray demonstrate probable pneumonia, 2a - new or worsening cough, new or increased sputum production and new or changed lung exam abnormalities and 1c- was not marked for any of the symptoms. The significant change Minimum Data (MDS) assessment for Resident 1, dated 3/5/26, indicated the resident had an acute short hospital stay. The resident was severely impaired for daily decision making. During an interview with the infection control nurse on 04/23/2026 at 1:08 p.m., she indicated the facility utilized the McGeer criteria (standardized surveillance to identify and monitor for infections) for the use of antibiotics. The infection control nurse indicated she would look for the documentation that Resident 1 met the criteria for antibiotic use on 1/20/26. During an interview with the infection control nurse on 4/23/26 at 2:23 p.m., she indicated she forgot to document 1c for mental status change and decline in Activities of daily living for Resident 1 on the 1/20/26 infection control criteria report. 2. The clinical record for Resident 3 was reviewed on 4/24/2026 at 12:48 PM. The medical diagnoses included, but were not limited to, partial traumatic amputation of two or more toes and damage to the nerves from complications of diabetes. The admission MDS Assessment, dated 3/10/2026, indicated Resident 3 was cognitively impaired and did not reject care. Resident 3 was dependent on staff for hygiene needs, turning, and transferring. Resident 3 had a non-removable dressing, surgical wounds, and dressings to areas other than feet. (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 3/11/2026, indicated Resident 3 had delirium and confusion. The interventions included, but were not limited to, observing behaviors including types of behaviors, frequency, and interventions utilized to help manage behaviors.A care plan, dated 3/11/2026, indicated Resident 3 had skin impairments. The interventions included, but were not limited to, to utilize pressure reducing heel boots while in bed.During an observation, on 4/23/2026 at 1:50 p.m., Licensed Practical nurse (LPN) 5 offered Resident 3 to put on his heel boots while in bed. Resident 3 refused to use heel boots and requested to float his heels with a pillow instead. Behavior monitoring documentation for 4/23/2026 (after the observation of the resident's refusal) indicated Resident 3 did not have any refusals of care. 3. The clinical record for Resident 32 was reviewed on 04/22/2026 at 12:37 PM. The medical diagnoses included, but were not limited to, stroke and alcohol induced dementia. An annual MDS, dated [DATE], indicated Resident 32 was cognitively impaired, did not refuse care, and was dependent on staff for grooming and hygiene needs. A care plan, initiated on 10/24/2020 and revised on 2/18/2026, indicated Resident 32 was at risk for skin alterations. The interventions included, but were not limited to, keeping Resident 32's fingernails short. A care plan, dated 7/29/2021 and revised on 2/18/2026, indicated Resident 32 had a mood disorder. The interventions included, but were not limited to, observing behaviors including types of behaviors, frequency, and interventions utilized to help manage behaviors.Review of the behavior management log for Resident 32, completed on 4/21/2026, indicated Resident 32 had one episode of refusals of care for 4/1/2026 through 4/21/2026. During an observation on 4/21/2026 at 10:56 AM, Resident 32 was sitting in the dining room. Resident 32's fingernails were long, jagged, and cracked on both hands.During an interview and observation, on 4/22/2026 at 12:05 PM, Resident 32's care was observed with Certified Nursing Assistant (CNA) 4. Resident 32 had long, jagged nails on both hands with brown debris underneath the fingernails on the left hand. CNA 4 touched Resident 32's hand and he immediately swatted at her. CNA 4 indicated Resident 32 refused nail care on almost every shower day, including every time CNA 4 gave Resident 32 a bed bath that month. When Resident 32 refused, CNA 4 would pass it on in report so staff could reapproach. During an interview, on 4/22/2026 at 2:00 PM, Director of Nursing (DON) indicated Resident 32 refused care, including nail care, often.During an interview, on 4/23/2026 at 2:20 PM, Assistant Director of Nursing (ADON) indicated resident behaviors should be documented on their behavior management logs within the electronic medical record. A policy entitled, Behavior Management, was provided by the DON, on 4/23/2026 at 1:57 PM. The policy indicated to document behaviors within the clinical record. 410 IAC (Indiana Administrative Code) 16.2-3.1.50(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1.50(a)(2)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to follow the physician's order for the correct size indwelling catheter (a tube that is inserted into the bladder, allowing urine to drain freely) for 1 of 35 residents reviewed to receive care and services that meet professional standards (Resident 4). Findings include:1. During an observation on 4/22/26 at 12:34 p.m., Qualified Medication Aide (QMA) 3 and Certified Nursing Assistant (CNA) 7 provided Resident 4 with catheter care. Resident 4 had a size 22 French catheter in place (a large-diameter medical tube measuring approximately 7.33 millimeters in external diameter). During an interview with Licensed Practical Nurse (LPN) 6 on 4/22/2026 at 12:50 p.m., the LPN indicated the nurse was responsible to ensure Resident 4 had the correct catheter size in place. LPN 6 reviewed Resident 4's physician order and indicated he was supposed to have a size 20 French catheter in place (medium to large diameter medical tube measuring approximately 6.66 millimeters in external diameter). LPN 6 indicated Resident 4's catheter was last changed on 4/19/26. During an interview with LPN 6 on 4/22/2026 at 1:11 p.m., the LPN indicated she was unable to find a size 20 French catheter in the facility's medical supplies. Review of the record for Resident 4 on 4/22/26 at 1:15 p.m., indicated the resident's diagnoses included, but were not limited to, urinary tract infection and urinary retention (inability to fully or partially empty the bladder, causing urine to accumulate). The plan of care for Resident 4, dated 1/6/26, indicated the resident was at risk for urinary complications related to urinary retention and an indwelling catheter. The interventions included, but were not limited to, change the indwelling catheter as ordered by the physician. The physician's order for Resident 4, dated 4/15/26, indicated the resident was to have a catheter size 20 with continuous drain. The quarterly Minimum Data Set (MDS) assessment for Resident 4, dated 1/6/26, indicated the resident was cognitively intact for daily decision making. The resident had an indwelling catheter. According to the American Urology Association 2024, Catheters come in sizes that measure the outside circumference in millimeters (mm), which is called the French (Fr) size. The larger the French size, the greater the catheter circumference. The French size as well as the recommended filling volume of the catheter's retention balloon (in cc or mL) is listed on the plastic cuff of the cathetersidearm (the arm of the Foley where the balloon is inflated). Make sure you have the right type and size Foley catheter kit, then open it up. 410 IAC (Indiana Administrative Code) 3.1-35(g)(1)

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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 assist a dependent resident with fingernail care and facial hair removal for 1 of 2 residents reviewed for Activities of Daily Living (ADL) (Resident 47). Findings include:During an observation and interview with Resident 47 on 4/21/2026 at 12:38 p.m., the resident had a full beard and long fingernails with black substance underneath on both hands. Resident 47 indicated he did not prefer to have a beard and liked to be clean shaven. The resident indicated no staff had offered to shave him since he was admitted to the facility. Resident 47 indicated when he was at home, he used an electric razor to trim his facial hair and then a disposable razor to cut his facial hair. The staff did trim his fingernails sometimes. During an observation on 4/22/26 at10:25 a.m., Resident 47 was sitting in the front lobby by the nursing station in a wheelchair. The resident had moderately long fingernails on both hands, with black substances and had a full long beard. During an observation on 4/22/2026 at 12:10 p.m., Resident 47 was eating lunch in the main dining room. The resident had moderately long fingernails on both hands, with black substances under the nails and had a full long beard. During an observation on 4/23/2026 10:24 a.m., Resident 47 was sitting in his wheelchair by the dining room. The resident had moderately long fingernails on both hands, with black substances and had a full long beard. Review of the record for Resident 47 on 4/23/2026 at 10:26 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinson disease (a chronic, progressive neurological disorder that occurs when nerve cells in the brain die or become impaired), muscle weakness, and need for assistance with personal care. The admission Minimum Data Set (MDS) assessment for Resident 47, dated 3/20/26, indicated the resident was cognitively intact for daily decision making. Resident 47 had no behaviors of rejecting care. The resident required substantial to maximal staff assistance with personal hygiene. The plan of care for Resident 47, dated 4/7/26, indicated the resident required assistance with ADL Self Care Performance related to weakness, pain to left knee with activity tolerance limitations, and Parkinson's disease process. The interventions included, but were not limited to, the resident required substantial to maximal staff assistance with personal hygiene. During an interview with the Director of Nursing (DON) on 04/23/2026 at 1:55 p.m., the DON indicated it was the responsibility of the Certified Nursing Assistant's (CNA's) to ensure Resident 47's fingernails were trimmed and cleaned and his facial hair was shaven. The routine resident care policy, provided by the DON on 4/23/26 at 1:57 p.m., indicated resident care was not necessarily medically or clinically based but was necessary for quality of life to promote dignity. The facility would promote resident centered care by attending to the total medical, nursing, physical, emotional, mental and social needs and honor resident lifestyle preferences while in the care of the facility. The routine care provided by the CNA would provide assistance with personal care. 410 IAC (Indiana Administrative Code) 3.1-38(a)(3)(D)410 IAC (Indiana Administrative Code) 3.1-38(a)(3)(E)

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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 observation, interview, and record review, the facility failed to implement tubular (tubi) compression bandage on both arms as ordered by the physician for a resident who was experiencing arm edema (swelling) for 1 of 2 residents reviewed for general skin condition (Resident 4). Findings include:During an observation and interview with Resident 4 on 4/21/2026 at 11:00 a.m., the resident had edema (swelling caused by excess fluid trapped in the body's tissues) of the lower arms of both arms. The resident indicated he did not know what caused his arms to swell. During an observation and interview with Resident 4 on 4/22/2026 at 12:15 p.m., the resident had tubular sleeves on both arms. Resident 4 indicated staff were supposed to take the tubular sleeves off at night and put them on in the morning. During an observation and interview with Resident 4 on 4/23/2026 at 10:21 a.m., the resident's tubular sleeves were not in place on either arm. Resident 4 indicated he had never refused to wear the tubular sleeves and the tubular sleeves gave him some relief from his arms swelling. Resident 4's bilateral lower arms were swollen (abnormally enlarged, rounded, or puffed up due to fluid accumulation). During an observation on 4/23/26 at 11:45 a.m., Resident 4 was eating lunch in his room. Resident 4 did not have his tubular sleeves in place; the resident's lower bilateral arms were swollen. Review of the record for Resident 4 on 4/22/26 at 1:15 p.m., indicated the resident's diagnosis included, but were not limited to, bilateral arm edema. The physician recapitulation for Resident 4, dated April 2026, indicated the resident was ordered tubi grip to bilateral arms every day and evening shift for edema to be applied in the morning and off at bedtime (original order date 1/21/26). The quarterly Minimum Data Set assessment (MDS) for Resident 4, dated 1/6/26, indicated the resident was cognitively intact for daily decision making. The resident had no behavior of refusal of care. The resident required substantial to maximal staff assistance with upper body dressing. The plan of care for Resident 4, dated 1/22/26, indicated the resident was to have tubi grip to bilateral arms every day and evening shift for edema, to be applied in the morning and off at bedtime. During an interview with the Director of Nursing (DON) on 4/23/26 at 1:56 p.m., the DON indicated the nurse was responsible for applying Resident 4's tubular sleeves. The physician order policy provided by the DON on 4/23/26 at 12:17 p.m., indicated the facility would provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident. The licensed nurse would accurately document physician and provider orders as determined by the licensee's scope of practice. The nurse would be responsible for executing the physician's order. 410 IAC (Indiana Administrative Code) 3.1-37(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to implement interventions of heel boots and follow physician orders for treatment of a pressure area for 1 of 3 residents reviewed for pressure ulcers. (Resident 3)Findings include:The clinical record for Resident 3 was reviewed on 4/24/2026 at 12:48 PM. The medical diagnoses included, but were not limited to, partial traumatic amputation (sudden, unexpected [NAME] of a body part) of two or more toes, damage to the nerves from complications of diabetes (nerve damage caused by chronically high blood sugar levels), and abnormalities of mobility and gait.The admission Minimum Data Set (MDS) Assessment, dated 3/10/2026, indicated Resident 3 was cognitively impaired. the resident was dependent on staff for his hygiene needs, turning, and transferring. Resident 3 had a non-removable dressing, surgical wounds and dressings to areas other than feet.A pressure care plan, dated 3/9/2026 and reviewed 4/17/2026, indicated Resident 3 had pressure ulcers. An intervention, dated 3/17/2026, indicated for Resident 3 to utilize heel boots to bilateral feet while in bed.Hospital discharge orders, dated 3/8/2026, indicated Resident 3 to receive betadine to the left heel twice daily and to alleviate pressure at all times to bilateral heels with heel suspension boots.The nursing assessment for Resident 3's admission to the facility, dated 3/8/2026, did not indicate any skin impairment to the left heel but did indicate non-removable dressing to bilateral feet. A physician's order for Resident 3, dated 3/9/2026, indicated staff were to use betadine (broad-spectrum antiseptic used to treat and prevent infections) to the resident's left heel twice a day. A physician's order for Resident 3, dated 3/11/2026, indicated staff were to use bilateral heel boots for the resident while in bed. The March 2026 treatment administration record for Resident 3 indicated betadine had been applied to the resident's left heel twice a day from 3/9/2026 to 3/11/2026.The March 2026 treatment administration record and care plan for Resident 3 did not reflect the use of heel boots between 3/8/2026 and 3/11/2026.A wound care report, dated 3/25/2026, indicated Resident 3 had an unstageable pressure injury to the left heel. The measurements for Resident 3's pressure injury to the left heel were 2 centimeters (cm) by 5 cm with no depth. These were the first measurements of the resident's wound to the left heel. A wound care progress note, dated 3/25/2026, indicated the left heel pressure injury was discovered after removal of a non-removal dressing. Additional wounds to the bilateral feet were discovered at this time, including diabetic foot ulcers, a deep tissue injury to left lateral foot, and a Stage 1 pressure to the right lateral foot.During an interview, on 4/23/2026 at 3:00 PM, Assistant Director of Nursing (ADON) indicated Resident 3 admitted for rehabilitation, nursing services, and wound care after surgical intervention. Resident 3 admitted with a surgical wound to the left lateral knee and bilateral feet. At admission Resident 3 had non-removable dressing to bilateral feet covering the toes up to the mid-shin to knee on both legs. Due to the non-removable dressing, Resident 3's heels were not visible when admitted to the facility. The left heel was not visible until 3/25/2026 at the first dressing change.During an interview, on 4/24/2026 at 11:00 AM, ADON indicated staff would not have been able to apply betadine to Resident 3's left heel as signed on the treatment record between 3/9/2026 through 3/11/2026. Direct floor staff were responsible for providing care to Resident 3's wounds and implementing intervention, including the use of bilateral heel boots. It was the expectation of the facility to follow physicians order unless contraindicated. A policy entitled, Wound Care, was provided by the DON, on 4/23/2026 at 1:57 PM. The policy indicated residents will receive treatment as indicated for management and prevention of skin integrity issues.410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to perform hand hygiene and change gloves when providing catheter (a tube that is inserted into the bladder, allowing urine to drain freely) care for 1 of 2 residents reviewed for catheter (Resident 4). Findings include:During an observation and interview with Resident 4 on 4/21/2026 at 10:56 a.m., Resident 4 indicated he had his catheter before being admitted to the facility. Resident 4 indicated he had been diagnosed with a urinary tract infection a few times since being at the facility. The resident had an indwelling catheter bag (a sterile, closed-drainage container connected to an indwelling catheter) hanging on the side of his bed. During an observation and interview on 4/22/26 at 12:34 p.m., Qualified Medication Aide (QMA) 3 and Certified Nursing Assistant (CNA) 7 went into Resident 4's room and applied gloves. There was no hand hygiene prior to the staff putting on their gloves. QMA 3 obtained a wash basin and wash clothes, lowered the head of the resident's bed down and raised the bed up with the bed remote control and removed Resident 4's incontinent brief that had a small amount of red substance on it. QMA 3 exposed the resident's genital area and used a wet soapy washcloth to clean the area and then rinsed and dried the area. QMA 3 then took the soapy washcloth and cleaned the catheter tubing. QMA 3 and CNA 7 applied a clean incontinent brief and incontinent pad. CNA 7 took off her gloves and took the soiled linen in a plastic bag out of the room. QMA 3 removed her gloves and donned another pair of gloves on and drained the resident's catheter bag into a urinal without preforming hand hygiene. QMA 3 and CNA 7 indicated they normally would complete hand hygiene and change their gloves during catheter care, but they were nervous and did not do it. Review of the record for Resident 4 on 4/22/26 at 1:15 p.m., indicated the resident's diagnoses included, but were not limited to, urinary tract infection (UTI) and urinary retention (the inability to fully or partially empty the bladder, causing urine to remain in the bladder even when one feels the need to urinate). The quarterly Minimum Data Set (MDS) assessment for Resident 4, dated 1/6/26, indicated the resident was cognitively intact for daily decision making. The resident had an indwelling catheter. The physician's order for Resident 4, dated 4/21/26, indicated the resident was ordered Sulfamethoxazole-Trimethoprim (antibiotic) 1 tablet by mouth every 12 hours for a UTI for 10 days. The catheter care policy provided by the Director of Nursing (DON) on 4/23/26 at 12:17 p.m., indicated catheter associated urinary tract infections was the most common adverse event associated with indwelling urinary catheters. The risk of bacteremia in residents with indwelling catheters was 3 to 36 times more likely that residents without an indwelling catheter. Catheter care at the bedside was performed to promote cleanliness and dignity. Catheter care included, but were not limited to, raise the residents bed to waist level before providing care, perform hand hygiene and apply gloves. Remove your gloves and perform hand hygiene. 410 IAC (Indiana Administrative Code) 3.1-4(a)(2)

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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. Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) while providing catheter care and during a pressure ulcer treatment for 2 of 5 residents reviewed for infection control (Resident 4 and Resident 3). Findings include:1. During an observation and interview with Resident 4 on 4/21/2026 at 10:56 a.m., the resident indicated he had his catheter prior to coming to the facility. Resident 4 indicated staff did not wear a gown when providing catheter care but did wear gloves. The resident was observed to have an EBP sign at the doorway and EBP equipment hanging on the door (gowns and gloves). During an observation and interview on 4/22/26 at 12:34 p.m., Qualified Medication Aide (QMA) 3 and Certified Nursing Assistant (CNA) 7 came into Resident 4's room and applied gloves. There was no hand hygiene prior to the staff putting on their gloves. QMA 3 and CNA 7 did not put on a gown during care. QMA 3 obtained a wash basin and washcloths, lowered the head of the resident's bed down and raised the bed up with the bed remote control, removed Resident 4's incontinent brief and used a wet soapy washcloth to clean the resident. QMA 3 then took the soapy washcloth and cleaned the resident's catheter tubing. CNA 7 took off her gloves and took the soiled linen in a plastic bag out of the room. QMA 3 removed her gloves and applied another pair of gloves on and drained the resident's catheter bag into a urinal without performing hand hygiene. QMA 3 and CNA 7 indicated they kind of remembered the facility training them on wearing gown during care of a catheter. QMA 3 indicated she would normally wear a gown when providing catheter care but did not this time. Review of the record for Resident 4 on 4/22/26 at 1:15 p.m., indicated the resident's diagnosis included, but was not limited to, urinary tract infection (UTI). The plan of care for Resident 4, dated 1/7/26, indicated the resident required EBP for indwelling medical device of a foley catheter. The interventions were appropriate Protective Personal Equipment (PPE) would be utilized during high contact care such as providing personal hygiene, changing a brief and related to catheter care. 2. During an observation, on 4/23/2026 at 1:50 PM, Licensed Practical Nurse (LPN) 5 completed wound care for Resident 3's multiple wounds. When changing the dressings to Resident 3's left knee wound, LPN 5 had the Assistant Director of Nursing (ADON) remove scissors from LPN 5's pocket. The scissors were not cleaned prior to being used to cut the xeroform (a non-adhering primary wound dressing). LPN 5 removed the soiled dressing to Resident 3's left knee. LPN 5 was observed not changing her gloves or perform hand hygiene between removing and cleaning the resident's left knee wound and re-applied a clean dressing. LPN 5 then addressed the resident's pressure area to the left heel. LPN 5 removed the resident's soiled dressing and cleaned the resident's wound. LPN 5 did not perform hand hygiene when she changed her gloves and then re-applied a new dressing to Resident 3's left heel. The clinical record for Resident 3 was reviewed on 4/24/2026 at 12:48 PM. The medical diagnoses included, but were not limited to, partial traumatic amputation of two or more toes and damage to the nerves from complications of diabetes. The admission MDS Assessment, dated 3/10/2026, indicated Resident 3 was cognitively impaired. A pressure care plan, dated 3/9/2026 and reviewed 4/17/2026, indicated Resident 3 had pressure ulcers. An intervention, dated 3/25/2026, indicated for Resident 3 to provide wound care as (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated.A wound care report, dated 4/22/2026, indicated Resident 3 had a blister to the left knee, one diabetic foot ulcer on the left foot, three diabetic foot ulcers on the right foot, and pressure injuries to the left heel, left lateral foot, and right lateral foot. During an interview, on 4/23/2026 at 2:20 PM, ADON indicated she would expect hand hygiene to be performed before the procedure, each time LPN changed her gloves, and after the procedure. ADON expected scissors to be cleaned before being used on a clean dressing procedure. A policy entitled, Standard Precautions, was provided by the DON, on 4/23/2026 at 1:57 PM. The policy indicated hand hygiene should be performed after glove removal and after contact with residents' wound dressings. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(a) 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155387	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caroleton Healthcare Center	2500 Iowa Ave Connersville, IN 47331

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post the results of the most recent survey of the facility in a place readily accessible to residents, family members, and legal representatives of residents for 46 of 46 residents in the facility.A resident council meeting was held on 4/22/26 at 9:45 a.m. The following residents were present at the meeting: Residents 17, 18, 21, 36, 37, 41, 43, and 44. During the meeting the council indicated they were unaware of the location of the most recent survey results. On 4/22/26 at 10:14 a.m., an observation of the facility survey binder was made. The binder was located in a bin attached to the wall by the entrance to the facility. There was a sign, informing survey results availability posted above the survey binder. Neither the binder nor the sign were at wheelchair level. On 4/22/26 at 12:40 p.m., an observation of the survey binder and posting were made with Resident 18, the co-president of resident council, and the Executive Director (ED). The ED assisted Resident 18 in her wheelchair to the location of the survey binder. Resident 18 was unable to reach the binder without assistance and indicated she could not read the posting above it. An interview was conducted with the ED on 4/22/26 at 12:40 a.m., immediately after the above observation. She indicated she would have maintenance staff to move the survey binder and posting to a location more accessible to the residents. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(b)(1)