STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa of Hobart	4410 W 49th Ave Hobart, IN 46342

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 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, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to staff failing to perform hand hygiene after glove removal and direct resident contact for 4 of 8 residents observed during medication administration. (Residents 93, J, 25, and 85)Findings include:The following was observed during medication administration with LPN 5 on 4/6/26:On 4/6/26 at 5:03 p.m., LPN 5 checked Resident 93's blood sugar level busing a glucometer. The LPN did not sanitize her hands prior to putting on her gloves or after she took them off. At 5:10 p.m., LPN 5 checked Resident J's blood sugar level using a glucometer. Again, the LPN did not sanitize her hands prior to putting on her gloves or after she took them off. At 5:20 p.m., LPN 5 proceeded to Resident 25's room to apply a Lidocaine 4% patch (a pain relief patch). The LPN donned a pair of gloves and applied the patch to the resident's left shoulder. The LPN removed her gloves and left the resident's room. She did not sanitize her hands prior to or after removing her gloves. At 5:35 p.m., LPN 5 was preparing Resident 85's medications. She dispensed two pills into the medication cup and proceeded into the resident's room. The LPN did not sanitize her hands prior to preparing the resident's medications. The LPN explained to the resident what medications he was receiving and handed him a glass of water. After the resident was done taking his medications, she took the plastic cup from him and some other things from his overbed table to throw in the garbage. She did not sanitize her hands after leaving the resident's room.During an interview on 4/7/26 at 11:30 a.m., the Administrator indicated the LPN should have sanitized her hands after glove removal and after direct resident contact. The facility Hand Hygiene policy was provided by the Administrator on 4/7/26 at 12:36 p.m., the policy indicated the following:Examples of When to Perform Hand Hygiene (Either Alcohol Based Hand Sanitizer orHandwashing):- Before and after having direct contact with a patient's intact skin (taking a pulse or bloodpressure, performing physical examinations, lifting the patient in bed)- After contact with inanimate objects (including medical equipment) in the immediatevicinity of the patient-After glove removal410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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, record review, and interview, the facility failed to ensure residents were assessed to self-administer medications and had Physician's Orders for the medication for 1 of 1 resident reviewed for accident hazards (Residents C)Finding includes:During random observations on 3/30/26 at 11:00 a.m., on 3/31/26 at 10:02 a.m., and 2:17 p.m., on 4/1/26 at 9:20 a.m., 11:24 a.m., 2:30 p.m., and 4:00 p.m., and on 4/2/26 at 2:10 p.m., there was a bubble pack of over the counter generic laxative medication and a Salonpas patch (a medicated patch used for pain) laying on Resident C's over bed table. During an interview on 3/30/26 at 11:00 a.m., Resident C indicated he used the laxative medication when he was constipated and he liked using those medicated pain patches better than what the facility had. The record for Resident C was reviewed on 4/2/26 at 10:39 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder, anxiety, quadriplegia, and hypotension (low blood pressure). The 1/23/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling Foley (urinary) catheter. There was no care plan for the resident to self-administer his own medications and there was no self-administration of medications assessment completed for the resident. There were no Physician's Orders for the Salonpas patch or an over the counter laxative tablet. A Nurses' Note, dated 3/4/26 at 10:55 a.m., indicated the resident refused the Lidoderm Patch 5 % as he had his own patch and refused what the facility offered. During an interview on 4/2/26 at 3:30 p.m., the Unit Manager indicated she was unaware the resident had his own medicated pain patches and the over counter laxative medication. During an interview on 4/2/26 at 3:30 p.m. the Director of Nursing indicated the resident needed to be assessed to self-administer his own medications. A policy titled, Self-Administration of Medications-Clinically Appropriate, received as current from the Director of Nursing on 4/2/26 at 3:16 p.m., indicated, . The resident has right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. When a resident requests to self-administer medication(s), it is the responsibility of the interdisciplinary team (IDT) to determine that it is safe before the resident exercises that right. A resident may only self-administer after the IDT has determined which medications may be self-administered. 410 IAC (Indiana Administrative Code) 16.2-3.1-11(a)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure a resident's Responsible Party was notified of a change in condition related to increased behaviors and being placed on one-to-one supervision for 1 of 1 resident reviewed for notification of change. (Resident D)Finding includes:The record for Resident D was reviewed on 3/31/26 at 3:29 p.m. Diagnoses included, but were not limited to, vascular dementia with mild agitation and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 12/27/25, indicated the resident was cognitively impaired for daily decision making.A Behavior Note, dated 2/6/26 at 8:50 p.m., indicated the resident was ambulating in the dining room and pushing on the doors. The resident was noted to set off the alarm for the back door. The staff were able to redirect the resident back to her wheelchair. The resident then proceeded to get up and go back to the door and begun to open the door, she indicated she was going down the street to get a pop. The resident became resistive and verbally aggressive with staff with redirection. A different staff member was able to redirect the resident back to her wheelchair. The resident was assisted to her room and she put herself to bed. One-to-one care was initiated. A Behavior Observation Form, dated 2/6/26 at 9:40 p.m., indicated the resident was exit-seeking and wanting to go to the store to get a pop. There was no date and time on the form when the physician was notified. The resident's name was listed as family or responsible party notified and there was no date and time documented. There was no documentation in the nurses' notes on 2/7/26 and 2/8/26 of the resident's family being notified of the behaviors and one to one care. A Behavior Note, dated 2/9/26 at 12:28 p.m., indicated the resident remained on 15 minute checks. No complaints of pain or signs and symptoms of distress were noted. The resident was observed attempting to rub toast on her legs during breakfast. The resident indicated she was trying to heal myself. The resident was easily redirected. The family and physician were made aware and a urinalysis was ordered due to the behaviors. During an interview on 4/6/26 at 4:30 p.m., the Bakersfield Unit Manager indicated the resident's family was not notified of the resident's behavior and being placed on 1:1's on 2/6/26. The facility policy titled, Change in Condition Process, was provided by the Administrator on 4/7/26 at 4:30 p.m. The purpose of the policy was to ensure the facility promptly informed the resident, consulted the resident's physician; and notified, consistent with his or her authority, the resident's representative when there was a change requiring notification. The facility must inform the resident, consult with the resident's physician and notify the resident's family member or legal representative when there was a change requiring such notification. Situations requiring notification include:A significant change in the resident's physical, mental, or psychosocial status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. This citation relates to Intake 2785036.410 IAC (Indiana Administrative Code) 16.2-3.1-5(a)(2)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, the facility failed to ensure allegations of abuse were promptly reported by staff for 1 of 2 residents reviewed for abuse. (Resident 28)The finding includes:During an interview on 3/30/26 at 10:37 a.m., Resident 28 indicated on 3/28/26, she had an interaction with LPN 1 that was very distressing. At approximately 4:00 p.m., she asked the CNA to ask her nurse for her medication. LPN 1 then came to her room, cursed and spoke to her in a rude and insulting manner. LPN 1 told the resident that she knew the previous nurse already told her when her medication was due, and now she had to waste her time by coming to talk to her. The resident indicated she was so upset by the way she was treated that she became physically ill and vomited in the garbage can. She shut down and was crying. CNA 2 came in to deliver her food tray, and asked the resident if she was OK. LPN 1 told CNA 2 that the resident was fine. A few minutes later, CNA 1 entered the resident's room, saw the resident was upset, and went to get LPN 2. The record for Resident 28 was reviewed on 4/1/26 at 9:51 a.m. Diagnoses included, but were not limited to, chronic pancreatitis, depression, and anxiety.The Quarterly Minimum Data Set (MDS) assessment, dated 12/20/25, indicated the resident was cognitively intact for daily decision making, and was dependent in ADLs.The record lacked any documentation about any staff / resident interactions on 3/28/26.During an interview on 4/2/26 at 3:37 p.m., CNA 2 indicated when he came in with the resident's dinner tray on 3/28/26, the resident was visibly upset and crying. He knew the resident was upset about something with her nurse and not getting medication, but he did not witness any interaction between LPN 1 and the resident. During an interview on 4/6/26 at 1:13 p.m., LPN 1 indicated that the resident was upset that she could not get her medication early, and the resident was acting like she always did. The nurse before her told her she already talked to the resident about when the medication was due. The resident told LPN 1 the other nurses always gave her medication early if she needed it. LPN 1 told her not to tell on the other nurses to her. LPN 1 indicated she did not see the resident get physically ill, but that she did tell LPN 1 she was rude and that she was going to report her. During an interview on 4/6/26 at 1:20 p.m., CNA 1 indicated when she entered the resident's room on 3/28/26 to feed her roommate, the resident was upset and crying. The resident told CNA 1 that LPN 1 was rude and did not give her the medication she needed. CNA 1 went and asked LPN 2 to come see the resident. During an interview on 4/6/26 at 3:10 p.m., LPN 2 indicated she was called to the resident's room by CNA 1. She could hear something was going on at the end of the hall, it was loud, but could not tell what exactly it was. When LPN 2 entered the room, the resident was very upset, sobbing, and indicated LPN 1 had yelled and cursed at her. LPN 2 indicated she would consider what the resident reported to her as abuse. She indicated she reported the incident verbally to RN 1 (oncoming midnight nurse) and the DON. LPN 2 indicated they did not really have a charge nurse on off shifts, and that she reported the incident to RN 1 because she was a seasoned nurse. During an interview on 4/6/26 at 4:01 p.m., the Administrator, DON, and Unit Manager indicated they were not aware of the allegations of verbal abuse. The DON indicated LPN 2 did not call her about the incident. During an interview on 4/6/26 at 4:34 p.m., the Administrator indicated she was the Abuse Coordinator, and staff had been educated to contact her directly, at any time, for any suspected abuse. She had not been informed of the interaction between Resident 28 and LPN 1. LPN 2 should have called her. A policy titled, Abuse Prevention and Reporting, received as current from the Administrator on 3/30/26 at 3:50 p.m., indicated, . Employees and volunteers are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, or to an immediate supervisor who must then immediately report it to the administrator . 410 IAC (Indiana Administrative Code) 16.2- 3.1-28(c)

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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, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to nail care for 2 of 7 residents reviewed for ADLs. (Residents 4 and 5) Findings include:1. During an interview on 3/30/26 at 3:24 p.m., Resident 4 indicated he would like his fingernails shorter and he guessed he would wait until next week when activity staff could take care of it. The resident's fingernails were observed to be long on both hands. On 3/31/26 at 2:47 p.m., the resident's fingernails remained long. On 4/1/26 at 9:25 a.m. and 3:30 p.m., the resident's fingernails remained long. On 4/2/26 at 10:01 a.m. and 2:30 p.m., the resident's fingernails remained long. The record for Resident 4 was reviewed on 4/2/26 at 1:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes and history of spinal fusion at the cervical region. A Care Plan, dated 2/19/26, indicated the resident required assistance with ADLs including bed mobility, eating, transfers, toileting, and bathing related to obstructive uropathy, sleep apnea, spinal stenosis, weakness, sepsis, and decreased mobility. Interventions included, but were not limited to, assist with personal hygiene including dressing and grooming as needed. Encourage self participation as able. The admission Minimum Data Set (MDS) assessment, dated 2/26/26, indicated the resident was cognitively intact and required supervision or touching assistance for personal hygiene. Documentation in the Task section of the resident's record indicated his shower days were on the day shift on Tuesday and Friday. The resident received a shower on 3/17, 3/24, and 3/31/26. The resident received a complete bed bath on 3/20/26 and a partial bed bath on 3/27/26. Nail care was documented as being provided on 3/17, 3/20, 3/24, and 3/31/26. During an interview on 4/2/26 at 3:31 p.m., the Director of Nursing indicated the resident's fingernails would be cut and he didn't have to wait for activity staff. 2. On 3/30/26 at 10:05 a.m., Resident 5 was seated in his wheelchair in his room. The fingernails on the resident's left hand and right thumb were extremely long. During an interview on 3/30/26 at 2:15 p.m., the resident nodded his head yes when asked if he would like his fingernails shorter. On 3/31/26 at 10:00 a.m. and 10:40 a.m., the resident was seated in the hallway in his wheelchair. The fingernails on his left hand and right thumb remained long. The record for Resident 5 was reviewed on 4/2/26 at 2:35 p.m. Diagnoses included, but were not limited to, type 2 diabetes, stroke, and aphasia (difficulty speaking). The Quarterly Minimum Data Set (MDS) assessment, dated 2/20/26, indicated the resident was cognitively impaired and was dependent on staff for personal hygiene. A Care Plan, reviewed on 2/20/26, indicated the resident required assistance with ADLs including bed mobility, eating, transfers, toileting, and bathing related to decreased mobility, weakness, anemia, gastric ulcer, aphasia following stroke, and aneurysm of other specified arteries. Interventions included, but were not limited to, assist with personal hygiene including dressing and grooming as needed. Encourage self participation as able. Documentation in the Task section of the resident's record indicated he received his shower on the day shift on Monday and Thursday. Documentation indicated the resident received a shower on 3/5, 3/9, 3/12, 3/19, 3/23, and 3/26/26. A complete bed bath on 3/16 and 3/30/26 and a partial bed bath on 4/2/26. Nail care was documented as being provided on 3/16/26. During an interview on 4/2/26 at 3:35 p.m., the Administrator indicated the resident had his fingernails cut the afternoon of 3/31/26. 410 IAC (Indiana Administrative Code) 16.2-3.1-38(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 record review and interview, the facility failed to ensure insulin was given as ordered for 1 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure documentation was completed after a change in condition related to elevated blood pressure for 1 of 1 resident reviewed for hospitalization and lack of follow up documentation regarding an anti-diarrheal medication for 1 of 1 resident reviewed for constipation and diarrhea. (Residents N, B, and M)Findings include: 1. The record for Resident N was reviewed on 4/6/26 at 11:41 a.m. Diagnoses included, but were not limited to, type 2 diabetes and bipolar disorder without psychotic features. A Physician's Order, dated 1/27/26, indicated the resident was to receive Insulin Aspart (a rapid acting insulin), five units subcutaneously (SQ) with meals for diabetes. The resident was also to receive Glargine Insulin (a long acting insulin) 22 units SQ at bedtime for diabetes. The admission Minimum Data Set (MDS) assessment, dated 2/2/26, indicated the resident was cognitively intact and she had received insulin injections during the assessment reference period. A Care Plan, dated 2/2/26, indicated the resident was at risk for complications related to the diagnosis of type 2 diabetes mellitus with hyperglycemia (high blood sugar). The resident did receive injectable insulin. Interventions included, but were not limited to, administer diabetes medications as ordered by the physician. Monitor and/or document for side effects and effectiveness. The March 2026 Medication Administration Record (MAR) indicated the resident did not receive the Aspart Insulin on the following dates and times because the resident's blood sugar was outside of the parameters: -8:00 a.m., 3/17 blood sugar 191, 3/18 blood sugar 102, 3/19 blood sugar 200, and 3/23/26 blood sugar 163. -12:00 p.m., 3/14 blood sugar 143, 3/17 blood sugar 178, 3/18 blood sugar 102, 3/21 blood sugar 93, 3/24 blood sugar 178, and 3/25/26 blood sugar 142. -6:00 p.m., 3/2 blood sugar 194, 3/7 blood sugar 185, 3/13 and 3/24 no blood sugar level documented but the insulin was held, 3/29 blood sugar 93, and 3/30/26 no documentation of blood sugar level but the insulin was held. There was no order to hold the Aspart Insulin based on blood sugar parameters. The 3/2026 MAR indicated the Glargine Insulin was held at bedtime due to the resident's blood sugar being outside of parameters on the following dates: 3/7, 3/8, 3/13, 3/21, 3/22, 3/28, 3/29, and 3/30/26. There were no blood sugar levels documented and there was no order to hold the insulin based on parameters. During an interview on 4/7/26 at 11:30 a.m., the Nurse Consultant indicated the standing insulin orders did not have orders for parameters and the insulin should have been given as ordered. 2. The record for Resident B was reviewed on 4/1/26 at 2:48 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), heart failure, dementia without behaviors, high blood pressure, and syncope. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/3/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. A Care Plan, revised on 12/16/25, indicated the resident had high blood pressure. The approaches were to administer anti-hypertensive medications as ordered and monitor for side effects and effectiveness. The resident's blood pressure was checked and recorded on 4/3/26 at 10:16 a.m. and was 191/78, and on 4/4/26 at 10:39 a.m. was 174/106. A Physician's Order, dated 5/28/25, indicated Isosorbide Mononitrate ER (a medication used to treat chest pain) Oral Tablet Extended Release 24 Hour 60 milligrams (mg) give one tablet by mouth one time a day. The medication was signed out as being administered on 4/3 and 4/4/26 during the morning. A Nurses' Note, dated 4/4/26 at 4:55 p.m., indicated the Emergency Medical System (EMS) had arrived to the facility to transport the resident to the hospital. There were no nursing progress notes documented on 4/3/26 and none prior to 4/4/26 at 4:55 p.m. There were no blood pressures documented or checked after 4/4/26 at 10:39 a.m. A Change in Condition Report, with an effective date of 4/4/26 at 5:00 p.m. and a created dated of 4/6/26, indicated the resident had neurological signs of a stroke. The vital signs at the time of the evaluation were blood pressure 174/106 at 10:39 a.m., pulse of 82 on 4/2/26 at 9:38 p.m., respirations were 18 on 4/2/26 at 9:38 p.m., and pulse oximetry was 91% on 4/4/26 at 10:32 a.m. The resident was not receiving an anticoagulant. A question indicating were these the most recent vital signs the answer was checked yes. The blood pressure of 174/106 on 4/4/26 at 10:39 a.m. A question indicating was the the diastolic (bottom number) blood pressure greater than 90 mmHg (millimeters of mercury) but less than 115 mmHg was not checked and none of the above was marked on the assessment. A Nurses' Note, dated 4/4/26 at 5:02 p.m., indicated the resident was observed sitting in her wheelchair, with left sided facial droop and slurred speech. The resident had no loss of consciousness and oxygen was already in use. The physician was notified of the change in condition and orders were received to transfer to hospital and 911 was called. A Nurses' Note, dated 4/4/26 at 9:30 p.m., indicated the resident was admitted to the hospital for signs of a stroke. There was no documentation the physician was notified of the high blood pressures, nor was there any documentation the blood pressures were rechecked. During an interview on 4/56/26 at 1:30 p.m., the Unit Manager indicated they think the resident had a stroke, and was sent out to the hospital over the weekend. During an interview on 4/7/26 at 2:00 p.m., Resident B's son indicated his mother was admitted to the hospital on Saturday 4/4/26 with high blood pressure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/7/26 at 2:50 p.m. the Director of Nursing indicated there was no follow up of an assessment after the high blood pressures on 4/3 and 4/4/26 or documentation the resident's blood pressure was rechecked. She was unsure if the physician had been notified of the high blood pressure. She was alerted at 4:42 p.m. that 911 was called on 4/4/26. 3. During a random observation on 4/1/26 at 2:20 p.m., Resident M was sitting in his wheelchair in his room. He was holding his head up with his hand, was slow to speak, and kept his eyes closed during conversation. He indicated he did not sleep well the night before due to diarrhea. He reported the diarrhea to staff, but did not receive medication for it. At that time, a staff member entered to take the resident to dialysis. He refused dialysis due to diarrhea. LPN 3 then entered the room, and spoke with the resident about refusing dialysis. She indicated she would contact the physician and ask about getting an anti-diarrheal medication. The record for Resident M was reviewed on 4/1/26 at 3:43 p.m. Diagnoses included, but were not limited to, heart disease, acute respiratory failure, dependence on dialysis, fluid overload, and anxiety. The admission Clinical Observation, dated 3/21/26, indicated the resident was cognitively intact for daily decision making. The clinical record indicated the resident had diarrhea/loose stool on 3/28/26, 4/1/26, and 4/2/26. The resident was incontinent of stool on three additional occurrences from 4/2/26 to 4/3/26, but the consistency of those stools was not documented. A Nurse's Note by LPN 3, dated 4/1/26, indicated, Pt [patient] was notified that dialysis services was ready for him. Pt told CNA he did not want to go to dialysis today d/t [due to] diarrhea, CNA reported to this nurse. Upon review of pt chart, pt does not currently have any active orders for an anti-diarrheal . Pt reports that wife plans to bring an anti-diarrheal that was prescribed during previous hospital stay. Educated the pt that medication and specific order would have to be cleared with PCP, so that we may enter the specific order in his chart, for documentation and safety purposes . PCP [primary care physician] notified and in agreement to continue medication once order is communicated to him. Floor staff for evening shift notified of interaction and pending arrival of medication from wife. Nursing management staff notified as well. There was no documentation of any follow up and no anti-diarrheal medication ordered. During an interview on 4/7/26 at 10:05 a.m., the DON indicated she attended a care conference with the resident's wife on 4/2/26, but she was not aware of the resident's untreated diarrhea and lack of follow-up on obtaining an order for an anti-diarrheal medication. This citation relates to Intake 2797209. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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 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, record review, and interview, the facility failed to ensure suprapubic catheter (urinary catheter inserted directly into the lower abdomen) care was completed and the catheter was changed as ordered by the physician for 1 of 1 resident reviewed for catheters. (Resident C)Finding includes:During an observation on 3/30/26 at 11:12 a.m., Resident C was observed in bed. At that time, he indicated staff do not provide catheter care every day and his catheter had not been changed for over a month. The resident lifted up the bed sheets, and his supra pubic catheter was observed. The stoma (insertion site opening) was scabbed over and there was a moderate amount of bloody drainage noted around the catheter. There was no bandage over the stoma site. During an observation on 4/1/26 at 2:30 p.m., the resident was observed in bed. At that time, he lifted the bed sheets and the catheter tubing had a moderate amount of dried drainage on it, and there was no bandage covering the stoma site. The resident indicated no one had done catheter care in the last couple of days. The record for Resident C was reviewed on 4/2/26 at 10:39 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder, anxiety, quadriplegia, and hypotension (low blood pressure). The 1/23/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had an indwelling foley (urinary) catheter. A Care Plan, dated 7/25/25, indicated the resident was risk for complications secondary to requiring a suprapubic catheter. A Physician's Order, dated 1/26/26, indicated suprapubic catheter, size 18 French, balloon size 30 cubic centimeters (cc), change every month and as needed for dislodgement, leaking, or blockage on the 8th of every month. The Treatment Administration Record (TAR) for the months 12/2025, 1/2026, and 2/2026, indicated the supra pubic catheter change was signed out as being done and completed by a QMA.The 3/2026 TAR, indicated on 3/8/26 a 9 was coded, indicating see progress notes. A Nurses' Note, dated 3/8/26 at 10:24 a.m., indicated Patient recently sent to ER (Emergency Room) for Suprapubic catheter change on 2/22/26.The suprapubic catheter had not been changed since 2/22/26. A Physician's Order, dated 7/16/25, indicated catheter care every shift.The TAR for the months of 1/2026, 2/2026 and 3/2026, and 4/2026, indicated the Wound Nurse provided catheter care for the resident every day shift and signed his initials as doing so. The catheter care was signed out as being completed every evening and midnight shift as well.During an interview on 4/2/26 2:10 p.m. the resident indicated the Wound Nurse had never performed catheter care for his suprapubic catheter. During an interview on 4/2/26 at 3:15 p.m., the Wound Nurse indicated he did sign out treatments if there were holes in the record. He had not completed catheter care for the resident, however, he did sign that he completed the catheter care. During an interview on 4/2/26 at 3:30 p.m., the Director of Nursing indicated QMAs were not able to change a suprapubic catheter. She indicated the Wound Nurse should not have signed out the catheter care if he did not complete it. This citation relates to Intake 2793463.410 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
	155469	A. Building B. Wing	04/07/2026

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, record review, and interview, the facility failed to ensure a resident received individualized services and other interventions related to dementia care while residing on a memory care unit for 1 of 5 residents reviewed for dementia care. (Resident 89)Finding includes:During a random observation on 4/1/26 at 10:55 a.m., Resident 89 was observed in a wheelchair at a table in the activity/dining room on the memory care unit. At that time, the resident turned her wheelchair away from the table, Activity Aide 2 got up from reading questions to the other residents, picked up her wheelchair from behind and moved her back in front of the table. The resident stated whoa and grimaced slightly. Activity Aide 2 said nothing to the resident, just moved her back and then went back over to the group and continued the activity. At 10:57 a.m., the resident stood up from the chair and Activity Aide 2 yelled from across the room Miss [name of resident] sit back down. She did not get up and try any interventions, just kept on reading to the other residents. During a random observation on 4/1/26 at 2:35 p.m., the resident was seated in her wheelchair at a table in the activity/dining room and was not participating in any activity. At 2:50 p.m., a CNA sitting across the room yelled out loud [resident name] sit down. The CNA did not get up to assist the resident with anything, just yelled at her from across the room.During a random observation on 4/2/26 at 10:05 a.m., Resident 89 was observed seated in a wheelchair at a table next to the Activity Aide 1, who was reading a bible story out loud to those residents seated near her. Resident 89 was anxious and mumbling under her breath, saying curse words and trying to grab at the book the aide was reading, The resident reached across the table and went to grab another book by Activity Aide 1. She picked up the book and quickly Activity Aide 1 stated no you cannot have that. I have to read that next. She removed the book from the resident's hands. The resident then became more anxious and started crying and rubbing her eyes, and begun swearing again, under her breath. She continued to have these swearing outbursts and attempted to stand up several times. The activity aide just simply stated stop cussing and sit down. The resident continued to stand up several times and Activity Aide 1 stated have a seat Miss [resident name]. Activity Aide 1 offered no other interventions for the resident, she offered no other activities for the resident. She continued to read the book to the other residents, while Resident 89 kept having the same behaviors. At 10:18 a.m., the resident banged her hand on the table, and started yelling out loud, a nurse entered the room and indicated she would take her out and stated she probably needs a change of scenery. The resident was wheeled out of the room. The record for Resident 89 was reviewed on 4/6/26 at 12:57 p.m. Diagnoses included, but were not limited to, repeated falls, high blood pressure, anxiety disorder, Alzheimer's disease, and stroke.The 3/5/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident had other behaviors towards others physical symptoms such as hitting or scratching. The resident received an antipsychotic and an antidepressant medication. There was no care plan for dementia care with individualized interventions or approaches in place for any of her behaviors.A 2/13/26 Quarterly Social Service Note indicated there was no change in status for speech, cognition, social interaction, mood status, behavioral status, or adjustment difficulties. The resident was not receiving any psychoactive medication, and was not currently receiving psychological/psychiatric services. A Physician's Order, dated 8/27/25, indicated Abilify (a antipsychotic medication) 2 milligrams (mg) one time a day. The resident currently received services from an outside behavioral center. The Nurse Practitioner saw the resident at least monthly and sometimes more often. During an interview on 4/6/26 at 1:30 p.m., the Unit Manager indicated there was no care plan regarding the resident's dementia with approaches or interventions when she had behaviors. The activity aide should have given the resident something else to have in her hands rather than just taking the book out of her hands. She also indicated staff should have gone over to the resident when she was standing up and tried to redirect her rather than just telling the resident to just (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sit down without any interventions. During an interview on 4/6/26 at 1:45 p.m., the Director of Nursing indicated they have been looking at the memory care unit, the behaviors and the structured activities over the last couple of weeks and determined there needed to be some changes with staff and how they help those residents with behaviors. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on record review and interview, the facility failed to ensure each resident received medically related social services related to the timeliness of vision and dental visits for 1 of 2 residents reviewed for vision and 1 of 1 resident reviewed for dental. (Resident B)Finding includes:The record for Resident B was reviewed on 4/1/26 at 2:48 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), heart failure, dementia without behaviors, high blood pressure, and syncope.The 12/1/25 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. The resident's vision was adequate with no corrective lens and staff were unable to examine the resident's mouth for dental. The 3/3/26 Quarterly MDS assessment indicated the resident was not cognitively intact for daily decision making. The resident's vision was adequate with corrective lenses and she had no oral problems. A History and Physical from the hospital, dated 11/13/24, indicated the resident was edentulous (no natural teeth). A Nursing admission Assessment, dated 11/23/24, indicated the resident had no issues with teeth.A readmission Nursing Assessment, dated 5/27/25, indicated the resident had no issues with teeth.A Care Conference, dated 5/12/25, indicated referrals were sent to the Dentist and Optometrist. A Care Conference, dated 10/8/25, indicated the family would like her to be put on the list to see the eye doctor.A Dental Exam Note, dated 11/5/25, indicated the resident had no teeth in both the upper and lower and right and left quads. This was the first time the resident had seen a dentist.An Optometrist Exam Note, dated 12/18/25, indicated the resident had hypermetropia (close objects were blurry) in the right eye and Myopia (difficulty seeing objects far away) in the left eye. The resident had cataract noted in both the right and left eyes. A new eye glasses prescription was left by the Optometrist. This was the first time the resident had seen an eye doctor. A Dental Exam Note, dated 3/6/26, indicated the resident had no teeth and was edentulous. There were no concerns at this time and honey ridges were non existent to facilitate upper or lower dentures. The patient's compliance was poor.An Optometrist Exam Note, dated 3/19/26, indicated staff requested glasses prescription. The exam was the same as 12/18/25.There was no documentation in Social Service Progress Notes regarding any of the visits and if the eyeglasses had been ordered, or if the family had been notified about the resident's dental exam. During an interview on 4/2/26 at 3:50 p.m., Social Service (SS) 1 indicated she had just started the position last year and was responsible for all of the ancillary services for the residents, like getting the referrals and setting up appointments for them. If the resident needed a consultation, nursing would do that. She was unsure why the resident was not seen by the dentist before 11/2025 and by the eye doctor before 12/2025 and was unaware a prescription for the eyeglasses was written on that visit. She would check into when the glasses were ordered as they came in today on 4/2/26. She also was not aware the resident had a cataract issue and what needed to be done by the facility. During an interview 4/6/26 at 10:04 a.m., SS 1 indicated she reached out to the eye doctor and they told her the glasses were ordered on 3/20/26 and they arrived on 4/2/26. The Optometrist indicated they were just watching the cataracts and surgery was not recommended at this time.During an interview on 4/6/26 at 11:30 a.m., SS 1 indicated during the care conference in February 2026, the resident's son indicated that his mom needed glasses. She indicated the eye doctor said they had the script for her glasses in 12/2025, however they reached out to the son for consent to order the glasses, and when he did not return the calls they did not order them. She said after the care plan conference she reached out to Optometrist and asked for them to resend the script so they could get the son's consent and order the glasses. The Optometrist was in the facility performing eye exams on 9/9/25, 11/21/25 and 12/18/25. She indicated the resident was not a candidate for dentures according to the last dental visit. The Dentist and Dental Hygienist were in the facility on the following days: Dentist on 7/11/25, 8/15/25, 9/10/25, 10/3/25, and 12/12/25, and the Hygienist on 7/18/25, 8/29/25, 9/26/25, 10/17/25, and 12/1/25.During an interview on 4/6/26 at (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:30 a.m., the Administrator indicated the facility identified a quality assurance issue with residents not receiving ancillary services in a timely manner and created a performance improvement plan (PIP), dated 5/2025 through 7/2025. She indicated this was created prior to her arrival at the facility. During an interview on 4/6/26 at 1:30 p.m., the Director of Nursing had no additional information to provide. This citation relates to Intake 2797209.410 IAC (Indiana Administrative Code) 16.2-3.1-34(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and interview, the facility failed to ensure prescription medications were properly labeled for 2 of 8 residents observed during medication administration. (Residents 104 and 12)Findings include:1. On 4/6/26 at 9:41 a.m., LPN 4 was observed preparing medications for Resident 104. LPN 4 dispensed one 75 milligram (mg) Pregabalin capsule (a medication for nerve pain) into the medication cup. The label on the medication card indicated the resident was to receive one capsule every 12 hours. The record for Resident 104 was reviewed on 4/6/26 at 10:15 a.m. Diagnoses included, but were not limited to, polyneuropathy (nerve damage in the hands and feet). A Physician's Order, dated 3/31/26, indicated the resident was to receive a Pregabalin capsule, 75 mg three times a day. The label on the medication did not match the medication order and there was no label on the medication card indicating the order had been changed. 2. On 4/6/26 at 9:56 a.m., LPN 4 was observed preparing medications for Resident 12. LPN 4 dispensed two 1 milligram (mg) tablets of Bumetanide (a diuretic) into the medication cup. The label on the medication card indicated the resident was to receive 1 mg daily. The record for Resident 12 was reviewed on 4/6/26 at 10:20 a.m. Diagnoses included, but were not limited to, edema. A Physician's Order, dated 3/26/26, indicated the resident was to receive Bumetanide 2 mg daily. The label on the medication did not match the medication order and there was no label on the medication card indicating the order had been changed. During an interview on 4/7/26 at 11:30 a.m., the Nurse Consultant indicated the pharmacy would be contacted regarding the labeling of the medications. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(j)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to dietary supplement consumption for 1 of 1 resident reviewed for nutrition and a dental assessment for 1 of 1 resident reviewed for dental. (Resident 20 and B)Findings include: 1. The record for Resident 20 was reviewed on 2/31/26 at 2:24 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, adjustment disorder, dementia with psychotic disturbance, vascular dementia, high blood pressure, atrial fibrillation, and chronic kidney disease. The 12/31/25 Modification of the Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and had no oral problems or weight loss. A Physician's Order, dated 3/5/26, indicated High-Calorie liquid Supplement two times a day for weight. The Medication Administration Records (MAR) for 3/2026 and 4/2026 indicated the high calorie liquid supplement was signed out as being administered, however, the amount consumed was not documented. During an interview on 4/7/26 at 10:15 a.m. the Director of Nursing indicated she would have to check to see if the consumption needed to be documented. During an interview on 4/6/26 at 11:45 a.m., the Director of Nursing indicated the amount consumed of the high calorie supplement should have been documented on the MAR. 2. The record for Resident B was reviewed on 4/1/26 at 2:48 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), heart failure, dementia without behaviors, high blood pressure, and syncope.The 12/1/25 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and staff were unable to examine the resident's mouth for dental. The 3/3/26 Quarterly MDS assessment indicated the resident was not cognitively intact for daily decision making. The resident had no oral problems. A History and Physical from the hospital, dated 11/13/24, indicated the resident was edentulous (no natural teeth). A Nursing admission Assessment, dated 11/23/24, indicated the resident had no issues with teeth.A readmission Nursing Assessment, dated 5/27/25, indicated the resident had no issues with teeth.A Dental Exam Note, dated 11/5/25, indicated the resident had no teeth in both the upper and lower right and left quads.During an interview on 4/6/26 at 1:30 p.m., the Director of Nursing indicated the nursing admission dental assessments were not accurate.During an interview on 4/7/26 at 2:00 p.m., Resident B's son indicated the resident's dentures were lost at the hospital and she had no natural teeth.410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(2)