STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155486	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middletown Nursing and Rehabilitation Center	131 S 10th St Middletown, IN 47356

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews, the facility failed to store, prepare, and distribute foods under safe sanitary conditions regarding the removal of dented cans of food and the cleaning of the stove hood. This deficiency had the potential to impact 14 of 14 residents residing in the facility.Findings include:During a kitchen observation, on 11/19/25 at 9:42 a.m., accompanied by the Dietary Manager, the following was observed:In the facility's dry storage area, each of five cans of Mandarin oranges were severely dented on the top seal of the cans. The cans had an intake date of 11/4/25. A can of butterscotch pudding was dented on the top seal with an intake date of 10/7/25. A can of sliced apples was dented on the top seal with an intake date of 3/25/25. A can of cream of mushroom soup had a dented top seal.The stove hood had a dish rag placed between the stove hood and the fire sprinkler pipe. The rag was covered in dark brown and black colored grease. The stove hood was marked as last serviced May 2025.The Dietary Manager indicated, at the time of observation, that staff members avoid the dented area when opening the cans. The food in the dented cans were still used. Staff members would open the cans halfway to avoid the dented area before serving the cans contents. She had been the Dietary Manager for a year. The stove hood should have been free of any debris.A current facility policy titled, Food Receiving and Storage, provided by the Administrator, on 11/24/25 at 10:17 a.m., indicated the following: .When food is delivered to the facility it will be inspected for safe transport and quality before being accepted 3.1-21(i)(1)(3)

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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to provide residents with dignified dining for 3 of 8 people reviewed for dining. (Residents 3, 4, and 11).Findings include:During a breakfast observation, on 11/20/25 at 8:25 a.m., the following was observed:CNA 7 was standing to the right side of Resident 3 while assisting her with eating. After offering Resident 3 a bite of food, CNA 7 walked over to Resident 4 and offered him a bite of food while standing on Resident 4's left side. CNA 7 walked back and forth between Resident 3 and 4 while offering the residents bites of food. CNA 7 did not sit down any time during the continuous meal service observation.CNA 6 walked over and stood to the right side of Resident 11 who was sitting at the table. CNA 6 offered Resident 11 a bite of oatmeal while she continued to stand next to Resident 11. After Resident 11 took a bite of oatmeal, CNA 6 then proceeded to walk around the dining room cueing semi-dependent residents to eat their meal.Resident 3's clinical record was reviewed on 11/20/25 at 1:33 p.m. Diagnoses included Alzheimer's disease, neurocognitive disorder, dementia and mood disturbance.A 10/1/25, significant change, Minimum Data Set (MDS) assessment indicated Resident 3 was dependent on staff with meals.Resident 11's clinical record was reviewed on 11/20/25 at 2:11 p.m. Diagnoses included history of a stroke, age related physical disability, and cognitive decline.An 11/12/25, quarterly, Minimum Data Set (MDS) assessment indicated Resident 11 needed touching assistance with meals.Resident 4's clinical record was reviewed on 11/21/25 at 10:05 a.m. Diagnosis included weakness, lack of coordination, and contracture of left hand.A 10/29/25, quarterly, MDS assessment indicated Resident 4 was a partial staff assist with meals.During an interview, on 11/20/25 at 2:42 p.m., CNA 7 indicated she was standing while assisting residents with their meals. There wasn't enough room to feed all the dependent residents at the same table. They would still need to walk between the residents so everyone could be fed without their food getting cold.During an interview, on 11/20/25 at 3:10 p.m., CNA 6 indicated she sometimes stood during breakfast meal service. They didn't have enough help assisting the residents with meals, so they stood to go back and forth between the residents.During an interview, on 11/21/25 at 3:35 p.m., the DON indicated, when assisting residents with meals, staff members should be sitting down, eye level with the residents. Usually, the staff members sat between two residents to assist them with meal service.A current facility policy, titled Assistance with Meals, provided by the Activity Director on 12/1/22 at 11:44 a.m., indicated the following: .3. Residents Requiring Full Assistance: B. Residents who cannot fed themselves will be fed by the nursing staff with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals.3.1-3(t)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that residents prescribed antipsychotic medications received appropriate gradual dose reduction (GDR) attempts and failed to provide documented clinical justification for the continued use of the antipsychotic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident 3 and Resident 9) Findings include: 1. During an observation, on 11/19/25 at 3:32 p.m., Resident 3 quietly lay in bed with her eyes closed. During an observation, on 11/20/25 at 8:33 a.m., Resident 3 sat quietly in a Broda (high-backed wheeled reclining) chair in the dining room as she was assisted with eating. During an observation, on 11/20/25 at 12:02 p.m., Resident 3 sat quietly in a Broda chair in the dining room at a table with other residents. During an observation, on 11/21/25 at 11:59 a.m., Resident 3 sat quietly in her Broda chair as CNA 10 propelled her to the dining room. During an observation, on 11/24/25 at 10:20 p.m., Resident 3 quietly lay in bed with her eyes closed. Resident 3's clinical record was reviewed on 11/20/25 at 1:33 p.m. Diagnoses included Alzheimer's disease, neurocognitive disorder with Lewy Bodies, anxiety disorder, major depressive disorder, recurrent, severe with psychotic symptoms, nontraumatic intracerebral hemorrhage in cerebellum, and dementia, unspecified severity, with mood disturbances. Current orders included Abilify (antipsychotic) 2 mg every evening (11/15/24), vilazodone (antidepressant) 40 mg daily (6/21/22), and risperidone (antipsychotic) 1 mg twice a day (11/15/24). A significant change Minimum Data Set (MDS) assessment, dated 10/1/25, indicated the resident was rarely or never understood. She had short- and long-term memory problems. She had severely impaired cognitive skills for daily decision making. She did not exhibit hallucinations or delusions during the assessment period. She did not exhibit physical symptoms directed towards others, verbal symptoms directed toward others, nor behavioral symptoms not directed towards others during the assessment period. She was not resistive to care during the assessment period. She was dependent on staff assistance for her activities of daily living. She received antipsychotic and antidepressant classes of medication. A GDR was clinically contraindicated on 9/5/25. A care plan, initiated and revised on 5/9/23, indicated the resident had the potential to be physically aggressive related to Alzheimer's dementia and neurocognitive disorder with Lewy Bodies as exhibited by hitting, kicking, pushing, and fighting during care. Interventions included the following: Administer medications as ordered. Monitor/document for side effects and effectiveness (5/29/23); Assess and anticipate resident's needs; food, thirst, toileting needs, comfort level, body positioning, pain, etc. (5/9/23); and Communication: provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of the source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of a staff member when agitated (5/9/23). A care plan, initiated and revised on 5/10/23, indicated the resident had a history of behavior problems related to the neurocognitive disorder with Lewy Bodies as exhibited by physical aggression, visual hallucinations, and bizarre behavior, specifically playing in and eating feces. Interventions included the following: Administer psychotropic medications as ordered. Monitor/document for side effects and effectiveness (5/10/23); Anticipate and meet resident's needs (5/10/23); and Explain all procedures to the resident before starting and allow the resident three to five minutes or more if needed to adjust to changes (5/10/23). A care plan, initiated and revised 5/5/23, indicated the resident used psychotropic medications (risperidone and Abilify) related to behavior management with diagnoses of major depressive disorder, recurrent, severe with psychotic symptoms as exhibited by visual hallucinations, physical aggression, and bizarre behaviors such as playing in and eating stool. Interventions included the following: Administer psychotropic medication as ordered by physician. Monitor for side effects and effectiveness every shift (5/5/23); Consult with the pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly (5/5/23); and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitor/record occurrence of target behavior symptoms (wandering, disrobing, playing in and eating stool, violence/aggression towards staff/others, visual hallucinations) and document per facility protocol (5/5/23). A care plan, initiated 5/5/23 and revised 5/8/23, indicated the resident used an antidepressant medication. Interventions included administer antidepressant medications as ordered by the physician and monitor/document side effects and effectiveness every shift (5/5/23). A psychosocial note, dated 7/16/25 at 3:15 p.m., indicated the resident's mood appeared stable with no obvious depressive feelings. She had no behaviors which included no hallucinations, no delusional thinking, no obvious signs of anxiety episodes or other mood issues. The resident received Abilify, risperidone, and vilazodone for symptoms related to major depressive disorder, recurrent, severe with psychotic symptoms. The resident's representative refused the facility's efforts to attempt GDR's of any of the resident's psychoactive medication and do not allow the in-house physician to treat the resident. The resident's family physician treats the resident and declines all recommendations to GDR the resident's psychoactive medications. A plan of care note, dated 8/22/25 at 12:46 p.m., indicated the resident had no reported behaviors. The SSD notified the resident representative of the black box warning for the psychoactive medications. The resident representative indicated the family physician wanted the resident to take these medications. The resident's representative was advised to request a GDR from the physician for the psychoactive medication. The resident no longer experienced symptoms, and the resident's disease process prevented her from performing previously demonstrated behavioral symptoms. An appointment with the family physician was scheduled for 9/5/25. A pharmacy consultation report, dated 8/28/25, provided by the DON on 11/24/25 at 10:45 a.m., indicated the pharmacist commented that the resident received two antipsychotics for major depressive disorder with psychotic symptoms, Abilify 2 mg every evening since 6/27/23 and risperidone 1 mg twice a day since 4/28/23. The pharmacist recommended the resident's Abilify and risperidone be reviewed for a GDR and questioned if the resident was a candidate for a trial dose reduction of either agent, with perhaps a trial off Ability, and if the resident was receiving the lowest effective dose. The physician response, in which he checked a box, indicated he declined the recommendations above because GDR was clinically contraindicated for the resident because continued use was in accordance with the current standard of practice and a GDR attempt at this time was likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. The form had blank lines below the checked statement and did not provide a rationale for the declination of a GDR of the Abilify and risperidone. The physician signed the form on 9/5/25. A physician progress note, dated 9/5/25, indicated the resident was seen for dementia, hypothyroidism, and hypercholesterolemia. The resident's medications were listed with no changes marked. The physician examined the resident. The assessment indicated that the resident's medication list was reconciled and updated, and they will continue to take the medications as listed other than as excepted. The progress note for the resident's physician visit lacked a rationale for declining the GDR for the Abilify and risperidone. A pharmacy consultation report, dated 10/29/25, provided by the DON on 11/25/25 at 10:45 a.m., indicated the pharmacist commented that the resident had received vilazodone 40 mg every day for the management of major depressive disorder since 4/28/23. The pharmacist recommended a GDR of the vilazodone to 20 mg every day. The physician response, in which he checked a box, indicated he declined the recommendations above because GDR was clinically contraindicated for the resident because continued use was in accordance with the current standard of practice and a GDR attempt at this time was likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. The form had blank lines below the checked statement and did not provide a rationale for the declination of a GDR of the vilazodone. The physician signed the form on 11/3/25. During an interview, on 11/21/25 at 11:54 a.m., the SSD indicated behaviors were documented on a behavior sheet. She did not have any behaviors documented for the resident. The resident had been mostly calm since she had admitted to (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. She had spoken to the resident's representative multiple times about the need to GDR the resident's antipsychotic medications. The resident's representative took the resident out of the facility to the family doctor. Even though the resident had no behaviors, the resident's representative did not want the resident's psychoactive medications reduced or discontinued. During an interview, on 11/21/25 at 11:59 a.m., RN 5 indicated she had spoken to the resident's representative in the past, and she had declined to allow a GDR of the resident's psychoactive medications. The resident was calm all the time. When the resident first arrived at the facility some time ago, she was occasionally tearful. But she had not been tearful for a while. During an interview, on 11/21/25 at 3:03, RN 8 indicated the resident was consistently calm. During an interview, on 11/24/25 at 2:12 p.m., CNA 7 indicated she had no problems at all with the resident having any behaviors. During an interview, on 11/24/25 at 2:35 p.m., the DON indicated she was aware the resident had no behavioral symptoms, but the resident representative and the physician declined to reduce and/or discontinue any of the resident's psychoactive medications. 2. During an observation, on 11/19/25 at 1:00 p.m., Resident 9 sat quietly in his wheelchair in the dining room and fed himself lunch. During an observation, on 11/19/25 at 3:51 p.m., Resident 9 lay quietly in his bed with the head of the bed elevated. His eyes were closed. During an observation, on 11/20/25 at 8:15 a.m., Resident 9 sat quietly in his wheelchair in the dining room and fed himself lunch. During an observation, on 11/20/25 at 10:24 a.m., Resident 9 sat in his room in his wheelchair and repeatedly stated, I need help. LPN 8 talked with resident, and he calmed. During an observation, on 11/20/25 at 12:02 p.m., Resident 9 sat in his wheelchair in the dining room and conversed with a visitor sitting at his table. During an observation, on 11/21/25 at 9:36 a.m., the SSD propelled Resident 9 in his wheelchair down the hall as he sat quietly and looked around. During an observation, on 11/24/25 at 9:57 a.m., Resident 9 sat quietly in his wheelchair at a table in the front lounge area with other residents. Resident 9's clinical record was reviewed on 11/21/25 at 9:16 a.m. Diagnoses included other specified depressive episodes and dementia, moderate, with agitation. Current orders included donepezil (for dementia) 10 mg daily at bedtime (8/4/25), escitalopram (antidepressant) 20 mg daily at bedtime (10/17/25), risperidone (antipsychotic) 1 mg daily at bedtime (10/23/25), quetiapine (antipsychotic) 25 mg twice a day (10/23/25), and tramadol-acetaminophen (for pain) 37.5/325 mg twice a day (8/16/25). A quarterly Minimum Data Set (MDS) assessment, dated 8/4/25, indicated the resident was moderately cognitively impaired. He did not exhibit hallucinations or delusions during the assessment period. He did not exhibit physical symptoms directed towards others, verbal symptoms directed toward others, nor behavioral symptoms not directed towards others during the assessment period. He was not resistive to care during the assessment period. He required supervision/touching assistance of staff with eating. With oral hygiene and rolling in bed, he required substantial/maximal staff assistance. He was dependent on staff assistance for toileting hygiene, showering/bathing, upper/lower body dressing, donning/doffing footwear, personal hygiene, and transfers. He required partial/moderate staff assistance with propelling his manual wheelchair for 50 to 150 feet. He received antipsychotic, antidepressant, and opioid classes of medication. The physician documented a GDR was clinically contraindicated on 11/6/25. A care plan, initiated and revised on 10/20/25, indicated the resident had a behavior problem related to dementia as exhibited by sexually inappropriate remarks, grasping, and agitation with verbal aggression. The interventions included the following: Administer medication as ordered. Monitor/document for side effects and effectiveness (10/20/25); Explain all procedures to the resident before starting and allow the resident time to adjust to changes (10/20/25); and Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed (10/20/25).A care plan, initiated and revised on 11/19/25, indicated the resident was physically aggressive on occasion including hitting, kicking staff related to dementia, moderate with agitation. The interventions included the following: The resident's triggers for physical aggression are during care specifically during nighttime hours. The resident's behaviors is de-escalated by waking resident gently, explaining (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure before attempting care (11/19/25); Assess and anticipate resident's needs - food, thirst, toileting needs, comfort level, body positioning, pain, etc. (11/19/25); Monitor/document/report as needed any signs or symptoms of resident posing a danger to himself and others (11/19/25); and When the resident becomes agitated: Intervene before agitation escalates. Guide resident away from source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later (11/19/25). A care plan, initiated 8/7/25 and revised 11/19/25, indicated the resident used psychotropic medications (quetiapine and risperidone) related to behavior management. The diagnosis was dementia, moderate with agitation, and included sexually inappropriate behaviors and combativeness during care. The interventions included the following: Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift (8/7/25); Consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly (8/7/25); and Monitor/record occurrence of target behavior symptoms (inappropriate sexual behavior and language, aggression towards staff/others, etc.) and document per facility protocol (8/7/25). A care plan, initiated and revised 8/7/25, indicated the resident used an antidepressant medication related to depressive disorder. The interventions included: Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift (8/7/25). A psychosocial progress note, dated 8/11/25 at 2:48 p.m., indicated the resident received quetiapine for signs and symptoms related to his dementia with behaviors including sexually inappropriate behaviors. He had a history of inappropriate behaviors prior to his stay in the facility. He had no behaviors, no hallucinations, no delusions, no anxiety and no other mood issues since admission to the facility. A psychosocial progress note, dated 9/2/25 at 10:45 a.m., indicated the SSD met with the resident's representative to discuss the resident's psychotropic medications and the black box warning for quetiapine. The resident's representative indicated the resident was prescribed the medication for inappropriate sexual behaviors at the previous facility. The resident representative declined to have a GDR of the quetiapine attempted because the resident was planned to return to the prior facility to live with his wife. A health status note, dated 9/3/25 at 11:32 a.m., indicated the resident was alert with periods of confusion. He had periods of combativeness which made care difficult at times. A health status note, dated 9/14/25 at 5:31 a.m., indicated the staff attempted to get the resident dressed and up for breakfast. He attempted to grab the CNA's bottom and made several inappropriate remarks. The CNA told the resident the remarks were inappropriate, and the resident said they were not. Then, the resident said he was going to break the CNA's hand. He tried to squeeze and twist the CNA's hand. The CNA removed her hand from the resident's hands and left the room to allow the resident to calm down. A health status note, dated 9/19/25 at 6:25 a.m., indicated the staff performed morning care when the resident threatened to knock out the staff's teeth. He drew his fist back and yelled for the staff to put some clothes on him. The staff were attempting to put clothing on him. A psychosocial note, dated 9/29/25 at 3:27 p.m., indicated a care plan meeting was held with the resident's representatives. The resident was no longer progressing in therapy and continued to require a mechanical lift for transfers. The consensus of the resident's representatives, therapy, and nursing was that resident would be unable to return to an assisted living facility. A health status note, dated 10/12/25 at 6:03 p.m., indicated the resident was agitated throughout much of the day, which was out of character for him. He was confused and yelled out throughout the day. A health status note, dated 10/14/25 at 6:03 a.m., indicated the resident became combative with staff during morning care. He attempted to hit and kick staff. A psychosocial note, dated 10/15/25 at 4:07 p.m., indicated the resident was to remain in the facility with no discharge plans. A health status note, dated 10/16/25 at 11:59 p.m., indicated the physician increased the resident's escitalopram medication from 10 mg to 20 mg daily. A behavior note, dated 10/17/25 at 6:32 a.m., indicated the resident was on his roommate's side of the room. The resident threatened to knock the roommate's head off. He had his fist drawn back and refused to leave. The staff assisted the resident from the room. A psychosocial note, dated 10/17/25 at 11:02 (continued on next page)

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Middletown Nursing and Rehabilitation Center	131 S 10th St Middletown, IN 47356

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problems providing care for the resident. He was very sweet. During an interview, on 11/21/25 at 2:59 p.m., RN 8 indicated the resident got mad and yelled if incontinence care was not done fast enough. The resident gradually started swinging at the staff, and it was not consistent behavior. The yelling though was common. He had improved since his family member had recently moved to the facility. During an interview, on 11/24/25 at 2:12 p.m., CNA 7 indicated she had no difficulties providing the resident's care. She just had to give him a few minutes to wake up and tell him what she was going to do then he was fine. During an interview, on 11/24/25 at 2:26 p.m., the DON indicated she had not seen the resident's behaviors but heard he grabbed and pushed at the staff. She was uncertain if the behaviors were psychotic behaviors or dementia behaviors, but his behaviors had improved since the medications had been changed. During an interview on 11/24/25 at 3:27 p.m., the SSD indicated she had received no additional behavioral referrals for Resident 9 other than the three she had provided. The black box warning for risperidone was retrieved on 11/24/25 from the FDA website at www.accessdata.fda.gov/drugsatfda_docs/label/2009/020272s056,020588s044,021346s033,021444s03lbl.pd The guidance indicated .WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS .Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. The indications for use for risperidone include the following: schizophrenia, bipolar mania, and irritability associated with autistic disorder in children and adolescents aged 5 to [AGE] years old. The black box warning for quetiapine was retrieved on 11/24/25 from the FDA website at www.accessdata.fda.gov/drugsatfda_docs/label/2020/020639s069lbl.pdf. The guidance indicated .WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS .Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. The indications for use for quetiapine included schizophrenia, bipolar I disorder manic episodes, and bipolar disorder, depressive episodes. A current facility policy, dated 12/31/24, titled Tapering Medications and Gradual Drug Dose Reduction, provided by the DON on 11/24/25 at 3:00 p.m., indicated the following: .Residents who use antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.For any individual who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be considered clinically contraindicated if: a. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and b. The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. A current facility policy, dated 12/31/24, titled Antipsychotic Medication Use, provided by the DON on 11/24/25 at 3:00 p.m., indicated the following: .Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.Antipsychotic medication shall generally be used only for the following conditions/diagnoses as documented in the record consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g. bipolar disorder, depression with psychotic features, and treatment refractory major depression); f. Psychosis in the absence or presence of dementia: g. Medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania (e.g., high-dose steroids); h. Tourette's Disorder; i. Huntington Disease; j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy.Diagnoses alone do not warrant the use of antipsychotic medications. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident and others; AND; (1) The symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or (2) Behavioral interventions have been attempted and included in the plan of care, except in an emergency.The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155486	A. Building B. Wing	11/24/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. 3.1-48(a)(4)3.1-48(b)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, the facility failed to ensure residents were offered up to date information on current vaccinations available for 2 of 5 residents reviewed for immunizations. (Resident 4 and Resident 6) Findings include:1. Resident 4's clinical record was reviewed on 11/21/25 at 10:05 a.m. Diagnoses included type 2 diabetes mellitus with hyperglycemia, dyspnea, unspecified, presence of coronary angioplasty implant and graft, and chronic kidney disease, stage 4. Resident 4 received the pneumococcal polysaccharide vaccine (PPSV) 23 on 11/30/2007 and the pneumococcal conjugate vaccine (PCV) 13 on 9/14/15. The clinical record lacked offering for consent or declination for the PCV 20 or the PCV 21. 2. Resident 6's clinical record was reviewed on 11/21/25 at 10:31 a.m. Diagnoses included chronic diastolic (congestive) heart failure, presence of coronary angioplasty implant and graft, and atherosclerotic heart disease of native coronary artery without angina pectoris. Resident 6 received the PCV 13 on 6/24/15 and the PPSV 23 on 11/27/19. The clinical record lacked offering for consent or declination for the PCV 20 or the PCV 21. During an interview, on 11/24/25 at 1:57 p.m., the DON indicated she was unable to locate documentation that the PCV 20 or 21 was offered to Resident 4 or Resident 6. During an interview, on 11/24/25 at 2:14 p.m., the DON indicated both residents should have been offered the PCV 20. According the CDC website, retrieved on 11/25/25 at www.cdc.gov/pneumococcal/vaccines/adults.html#cdc_vaccine_recommendations_section_3-older-adults-wh adults 65 years or older who have received the PCV 13 and PPSV 23 (at or after the age of 65 years) have the option to get the PCV20 or the PCV 21, or to not get additional pneumococcal vaccines based on shared clinical decision making between the adult and the vaccine provider. A current facility policy, dated 12/31/24, titled Pneumococcal Vaccine, provided by the Administrator on 11/24/25 at 2:25 p.m., indicated the following: .Administration of the pneumococcal vaccine or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. 3.1-13(a)