STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers received necessary treatment for 1 of 2 residents reviewed for pressure ulcers. Wound assessments were incomplete and treatment orders were not followed. (Resident 3)Findings include:On 5/20/26 at 8:17 A.M., Resident 3 was observed sitting in the common area by the nurse's station in her wheelchair wearing a specialized orthopedic shoe on her right foot. On 5/18/26 at 9:59 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors and pressure ulcer on right heel.The most recent quarterly Minimum Data Set (MDS) assessment, dated 3/11/26, indicated Resident 3's cognition was severely impaired, had 1 or more unhealed, unstageable pressure ulcer that was facility acquired, used a wheelchair, and substantial to maximum assist of staff (staff performs half the effort) for sit to stand transfers.Physician's Orders included, but were not limited to, the following:Dietary Supplement: LiquaCel, 30 milliliters (mL), for wound healing daily, ordered 10/15/25Darco shoe to right lower extremity (RLE) with steady for transfers, ordered 12/22/25Off loading boots to bilateral lower extremities (BLE) at all times except for transfers, ordered 12/22/25Betadine to right heel every shift. Apply soft non-adherent foam every 5 days. Special Instructions: Place appropriate documentation if wound opens. Ordered 10/15/25 and discontinued 2/23/26Cleanse area to right heel, paint with betadine, cover with soft non-adherent foam, secure with gauze wrap daily and PRN for soilage/dislodgement. Once A Day. Ordered 2/23/26 and discontinued 3/4/26Cleanse area to right heel, pat dry, collagen, dry dressing, secure with gauze wrap daily and PRN for soilage/dislodgement. Once A Day. Ordered 3/4/26 and discontinued 3/9/26Cleanse area to right heel, pat dry, skin prep peri-wound, apply Santyl to wound bed, cover with foam and secure with Kerlix. Once A Day. Ordered 3/9/26 and discontinued 3/23/26Give med pass 120 ml three times a day for weight loss and wound healing, ordered 3/12/26Cleanse area to right heel, pat dry, skin prep peri-wound, apply Santyl to wound bed, apply calcium alginate, cover with super absorbent dressing and wrap with gauze. Once A Day. Ordered 3/23/26 and discontinued 4/20/26Cleanse area to right heel, pat dry, skin prep peri-wound, apply collagen, cover with super absorbent and wrap with gauze once daily and as needed (PRN), ordered 4/21/26 The current care plan for Deep Tissue Injury (DTI) to Right Heel was initiated 9/23/25 and last reviewed 3/31/26 included, but was not limited to the following interventions all initiated 9/23/25:Assess and record the condition of the skin surrounding the pressure ulcerObserve and report signs of infection (e.g., localized pain, redness, swelling, tenderness, drainage, odor, and fever)Treatment per Medical Doctor (MD) order. Notify MD if treatment not effectiveWeekly skin assessment, measurement, and observation of the pressure ulcer and recordThe current Risk for Skin Breakdown Care Plan, initiated 4/5/24 and last reviewed 3/31/26 included but was not limited to, the following interventions:Darco shoe to RLE, initiated 12/22/25Z-flo boots (Fluidized heel boot for offloading pressure on the heel) to BLE at all times except for transfers, 12/22/25A Braden Skin Assessment (clinical tool used to predict a patient's risk of developing pressure injuries) on an admission assessment, dated 9/4/25, indicated the resident was at low to moderate risk of developing pressure ulcers.A Braden Skin Assessment on an admission assessment, dated 10/15/25, indicated the resident was at high risk of developing (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcers. Progress notes, Wound Zoom (electronic wound monitoring record), and wound management notes were reviewed from 9/1/25 to present and indicated the following:Progress Note on 9/22/25, indicated during care a 5 centimeter (cm) length x (by) 3 cm width blackish area was noted to right (Rt) heel. No drainage but redness noted. Area was firm to touch. No complaints of discomfort with palpation. MD and family notified with orders obtained. Betadine applied to area and Z-flo boot applied to right foot.On 9/22/25, an Interdisciplinary Team (IDT)/Wound note indicated the nurse noted a blackish area noted to right heel. Betadine ordered to be applied every shift and offloading boot applied to right foot to be worn at all times. Deep Tissue Pressure Injury (DTPI-serious type of pressure ulcer where the soft tissue under the skin is severely damaged, even though the skin itself may still look completely intact) evaluated in Wound Zoom. Will follow weekly.The clinical record lacked consistent weekly documentation of wound measurements, tissue description, drainage, pain, and periwound description.The clinical record indicated weekly skin assessments were completed, but no details of the assessment were recorded. They were only checked on the Medication Administration Record/Treatment Administration Record (MAR/TAR) that they were completed.The February 2026 MAR/TAR was reviewed and indicated the resident's dressing was not assessed or treated on 2/22/26 due to Resident Unavailable.The March 2026 MAR/TAR was reviewed and indicated liquacel 30 mL was not given on 3/25/26, 3/26/26, 3/27/26, 3/28/26, 3/29/26 because it was not available.The April 2026 MAR/TAR was reviewed and indicated liquacel 30 mL was not given on 4/23/26 and 4/27/26 because it was not available.On 5/18/26 at 1:56 P.M., during an observation of wound care and dressing change to the right heel pressure ulcer, Licensed Practical Nurse (LPN) 5 indicated the alginate pad removed from the wound was not the one ordered and she did not apply the collagen as ordered when she did the treatment. An eight and ten second lather for handwashing was also observed during that time.During an interview on 5/18/26 at 2:10 P.M., LPN 5 indicated the MD and/or Nurse Practitioner (NP) only look at the wound if the nurses ask them to. If they contacted them, it should be documented in the clinical record with new orders. She indicated the dressing was changed daily and indicated the alginate pad that was removed from the wound prior to care was supposed to be a collagen pad. She indicated she did not use a collagen pad when she did the treatment because she did not have one with her. LPN 5 indicated the documentation now went into wound management system. Prior to that, they used Wound Zoom and they took pictures of the wound. The system would measure it for them so it was not always accurate. She should document any changes noted, drainage, measurements, pain, and surrounding tissue characteristics in the clinical record.During an interview on 5/21/26 at 10:07 A.M., the Director of Nursing (DON) indicated the nurses check mark on the TAR that the wound dressing was changed and if something was abnormal, they would put in a progress note. In the clinical record, it should be documented what the wound looks like, size, signs and symptoms of infection, and pain. She indicated there was not a shortage of the supplements so she was not sure why it was marked unavailable. During an interview on 5/22/26 at 9:20 A.M., the Executive Director indicated they did not have a policy for following orders or accurate documentation but it would be expected as normal nursing standard.On 5/22/26 at 9:21 A.M., LPN 5 indicated during hand washing, staff were expected to lather their hands with soap for 20 seconds.During an interview on 5/21/26 at 11:20 A.M., the Regional Consultant indicated at least, the nursing staff should be documenting the measurements of the wound, drainage, and tissue type. She indicated the pictures were the documentation to show those things for Wound Zoom. The facility switched from using Wound Zoom to Wound Management because they were seeing problems with the documentation in Wound Zoom not coming over and not being completed. On 5/22/26 at 8:53 A.M., a non dated current Guidelines for General Wound and Skin Care Policy was provided by the Executive Director and indicated, To provide measures that will promote and maintain good skin integrity . guidelines should be followed for all residents with potential and/or actual impairment in skin integrity 14. Perform the wound treatment . 20. Document type of wound, location, stage (if applicable), length, width, depth in centimeters, base, drainage, periwound tissue, and treatment of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wound weekly using the wound/skin treatment flow sheet . 410 Indiana Administrative Code (IAC) 16.2-3.1-40(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure a resident with weight loss was provided ordered nutritional supplements and monitored for weight loss for 1 of 1 residents reviewed for weight loss. Phyisican orders were not followed and meals and supplements were documented as given and were not. (Resident 48)Finding includes:On 5/19/26 at 2:29 P.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors and malnutrition.The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/30/26, indicated Resident 48's cognition was severely impaired, set up assistance from staff for eating, had weight loss and was not on a weight loss regimen. Physician's Orders included, but were not limited to, the following:Fortified Foods -Special Instructions: Offer double portions at breakfast. Magic cup with lunch and dinner. Sandwich at bedtime (HS), ordered 4/29/25Dietary Supplement: Sandwich HS & food of choice HS snack at Bedtime (7:00 P.M. - 11:30 P.M.), ordered 1/27/25Dietary Supplement: MedPass 2.0, 120 milliliters (mL)- May substitute if unavailable, Once A Day, ordered 12/19/25 and discontinued 1/30/26Dietary Supplement: MedPass 2.0, 240 mL- May substitute if unavailable, Once A Day, ordered 1/30/26 and discontinued 3/12/26Dietary Supplement: MedPass 2.0, 120 mL three times a day (TID)- May substitute if unavailable, ordered 3/12/26Dietary Supplement: Magic Cup. May substitute if unavailable. Twice A Day 11:30 A.M. - 1:00 P.M., 5:00 P.M. - 10:00 P.M., ordered 1/27/25 The clinical record lacked an order for increased weight monitoring.A current Significant Weight Loss Care Plan, last reviewed 5/1/26, included but was not limited to, the following interventions:Provide diet, supplements, medications, adaptive equipment, and snacks as ordered, ordered 12/11/25Offer encouragement and assistance with eating as needed, ordered 12/11/25Weigh as ordered, ordered 12/11/25Weights from 1/1/26 to present included the following and indicated a 10.08 % weight loss:11/3/25 at 10:00 A.M., weight: 119.0 lbs12/1/25 at 10:26 A.M., weight: 112.4 lbs1/1/26 at 4:51 P.M., weight: 106.0 lbs2/3/26 at 6:48 A.M., weight: 103.6 lbs3/2/26 at 12:12 P.M., weight: 108.8 lbs4/5/26 at 1:19 A.M., weight: 106.0 lbs5/4/26 at 12:29 P.M., weight: 107.0 lbsAn Interdisciplinary Team (IDT) Progress Note, dated 3/12/26 indicated they reviewed the weight event. Resident noted to have significant weight loss. Current weights reviewed with Nurse Practitioner (NP) at the facility. New order to increase MedPass to 120 ml TID and monitor weights weekly. Medical Doctor (MD), Power of Attorney (POA), resident, and Registered Dietician (RD) were active in plan.Resident 48's meal, snack, and supplement consumption record in the Point of Care task and April 2026 Medication Administration Record/Treatment Administration Record (MAR/TAR) from 4/19/26 to present were reviewed. The following meal and/or snacks were recorded before served and supplements were documented as given but were not:4/19/26 2:47 P.M., Dinner 76-100 %4/19/26 2:43 P.M., bedtime snack none4/20/26 6:33 PM bedtime snack none4/21/26 5:41 PM bedtime snack none4/25/26 4:46 P.M. bedtime snack none4/28/26 4:06 P.M. bedtime snack none4/28/26 4:06 P.M. Dinner 76-100%4/29/26 4:35 P.M. bedtime snack none4/30/26 5:49 P.M. bedtime snack 76-100%5/8/26 no dinner recorded5/10/26 2:43 P.M. bedtime snack none5/14/26 lunch magic cup consumption documented as 76-100% but was observed not given5/16/26 3:36 P.M. bedtime snack none5/17/26 5:22 P.M. bedtime snack none5/19/26 at 1:37 P.M. lunch 76-100%5/19/26 lunch-magic cup consumption documented as 76-100% but was observed not given5/20/26 11:00 A.M. to 1:30 P.M. MedPass was documented that the resident consumed 76-100% but was observed not givenOn 5/14/26 at 1:01 P.M., Resident 48 was observed in her room, sitting in wheelchair with lunch tray on bedside table. Eyes were closed. Meal ticket indicated a magic cup with lunch and dinner. The tray did not include a magic cup.Observation on 5/19/26 at 1:36 P.M., Resident 48 was asleep in bed. The resident's lunch tray was on the bedside table against the wall under the TV. Meal ticket indicated a magic cup with lunch and dinner. The tray was covered with cellophane and food was untouched. It did not include a magic cup.Observation on 5/20/26 at 10:51 A.M., Resident 48 was eating breakfast at her bedside table. Certified Nurse Aide (CNA) 8 transferred the resident from her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair to the chair scale. The resident asked if she should take off her sweater and the CNA indicated it didn't matter. A note on the chair scale indicated to push reweigh once the resident was stable and sitting. It was not pushed by the CNA. CNA indicated weight was 108.0 lbs.Observation on 5/20/26 at 11:12 A.M., Qualified Medication Aide (QMA) 16 passed Resident 48 her medications. The resident did not have MedPass in her room at the time and was not given MedPass with medications.Interview on 5/20/26 at 8:16 A.M., Licensed Practical Nurse (LPN) 15 indicated they would try to weigh her after breakfast. At that time, she indicated it didn't matter when they weighed her.Interview on 5/20/26 at 10:55 A.M., CNA 8 indicated the resident was not on a special weight list. She indicated nurses would tell the aide if they needed to get a resident's weight. The aide would tell the nurse what it was or put it on a report form and the nurse would document it in the clinical record.Interview on 5/21/26 at 10:07 A.M., the Director of Nursing (DON) indicated Resident 48 ate on her own, MedPass came from nursing staff on the unit when the resident got their medications, and the magic cup came from the kitchen with their trays. Staff should be offering bedtime snacks around 8:00 P.M. and some like them at 10:00 P.M. Resident 48 sometimes wanted cookies and sometimes a sandwich, but aides should be charting the consumption amount in the Point of Care (POC) task and the nurse should be documenting in the Medication Administration Record (MAR) that the snack was given to the resident if there was a specific order to do so. Staff should only document after meals, snacks, and supplements have been given and eaten. She was unsure why the resident's order was not updated to weigh the resident weekly. She indicated they should try to weigh residents that were being monitored closely for weights first thing in the morning before breakfast. The chair scale was calibrated even if staff don't push the reweigh button after the resident is settled in the chair.On 5/22/26 at 8:53 A.M., a current non dated Guidelines for Weight Tracking Policy was provided by the Executive Director and indicated, Purpose: To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration . unless otherwise indicated or ordered by the physician the resident will have their weight taken and recorded monthly . On 5/22/26 at 8:53 A.M., a current non dated Nutritional Supplement Policy was provided by the Executive Director and indicated, Purpose: to explain that nutritional supplements are provided as needed to complement an individual's nutrient intake to ensure acceptable parameters of nutritional status are achieved and/or maintained . 410 Indiana Administration Code (IAC) 16.2-3.1-46(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 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 observation, interview, and record review, the facility failed to ensure the clinical record included accurate documentation for 1 of 1 resident reviewed for nutrition and 2 of 2 resident reviewed for pressure ulcers. Documentation showed resident was getting supplements but was not and meal/snack consumption was documented before the resident had them. Resident's wound documentation lacked complete wound assessments. (Resident 48, Resident 2, Resident 3)Findings include:1. On 5/19/26 at 2:29 P.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors.The most recent quarterly Minimum Data Set (MDS) assessment, dated 4/30/26, indicated Resident 48's cognition was severely impaired, set up assistance from staff for eating, had weight loss and was not on a weight loss regimen. Physician's Orders included, but were not limited to, the following:Fortified Foods -Special Instructions: Offer double portions at breakfast. Magic cup with lunch and dinner. Sandwich at bedtime (HS), ordered 4/29/25Dietary Supplement: Sandwich HS & food of choice HS snack at Bedtime (7:00 P.M. - 11:30 P.M.), ordered 1/27/25Dietary Supplement: MedPass 2.0, 120 mL three times a day (TID)- May substitute if unavailable, ordered 3/12/26Dietary Supplement: Magic Cup. May substitute if unavailable. Twice A Day 11:30 A.M. - 1:00 P.M., 5:00 P.M. - 10:00 P.M., ordered 1/27/25 Resident 48's meal, snack, and supplement consumption record in the Point of Care task and April 2026 Medication Administration Record/Treatment Administration Record (MAR/TAR) from 4/19/26 to present were reviewed. The following meal and/or snacks were recorded before served and supplements were documented as given but were not:4/19/26 2:47 P.M., Dinner 76-100 %4/19/26 2:43 P.M., bedtime snack none4/20/26 6:33 PM bedtime snack none4/21/26 5:41 PM bedtime snack none4/25/26 4:46 P.M. bedtime snack none4/28/26 4:06 P.M. bedtime snack none4/28/26 4:06 P.M. Dinner 76-100%4/29/26 4:35 P.M. bedtime snack none4/30/26 5:49 P.M. bedtime snack 76-100%5/8/26 no dinner recorded5/10/26 2:43 P.M. bedtime snack none5/14/26 lunch magic cup consumption documented as 76-100% but was observed not given5/16/26 3:36 P.M. bedtime snack none5/17/26 5:22 P.M. bedtime snack none5/19/26 at 1:37 P.M. lunch 76-100%5/19/26 lunch-magic cup consumption documented as 76-100% but was observed not given5/20/26 11:00 A.M. to 1:30 P.M. MedPass was documented that the resident consumed 76-100% but was observed not givenObservation on 5/14/26 at 1:01 P.M., Resident 48 was in her room, sitting in wheelchair with lunch tray on bedside table. Eyes were closed. Meal ticket indicated a magic cup with lunch and dinner. The tray did not include a magic cup.Observation on 5/19/26 at 1:36 P.M., Resident 48 was asleep in bed. The resident's lunch tray was on the bedside table against the wall under the TV. Meal ticket indicated a magic cup with lunch and dinner. The tray was covered with cellophane and food was untouched. It did not include a magic cup.Observation on 5/20/26 at 11:12 A.M., Qualified Medication Aide (QMA) 16 passed Resident 48 her medications. The resident did not have MedPass in her room at the time and was not given MedPass with medications.During an interview on 5/21/26 at 10:07 A.M., the Director of Nursing (DON) indicated Resident 48 ate on her own, MedPass came from nursing staff on the unit when the resident got their medications, and the magic cup came from the kitchen with their trays. Staff should be offering bedtime snacks around 8:00 P.M. and some like them at 10:00 P.M. Resident 48 sometimes wanted cookies and sometimes a sandwich, but aides should be charting the consumption amount in the Point of Care (POC) task and the nurse should be documenting in the Medication Administration Record (MAR) that the snack was given to the resident if there was a specific order to do so. Staff should only document after meals, snacks, and supplements have been given and eaten. 2. Observation on 5/20/26 at 8:17 A.M., Resident 3 was sitting in the common area by the nurse's station in her wheelchair wearing a specialized orthopedic shoe on her right foot. On 5/18/26 at 9:59 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors and pressure ulcer on right heel.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
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	most recent quarterly Minimum Data Set (MDS) assessment, dated 3/11/26, indicated Resident 3's cognition was severely impaired, had 1 or more unhealed unstageable pressure ulcer, used a wheelchair, and substantial to maximum assist of staff (staff performs half the effort) for sit to stand transfers.A current Deep Tissue Injury (DTI) to Right Heel Care Plans, initiated 9/23/25 and last reviewed 3/31/26 included, but was not limited to the following interventions all initiated 9/23/25:Assess and record the condition of the skin surrounding the pressure ulcerObserve and report signs of infection (e.g., localized pain, redness, swelling, tenderness, drainage, odor, and fever)Treatment per Medical Doctor (MD) order. Notify MD if treatment not effectiveWeekly skin assessment and record measurement and observation of the pressure ulcerProgress notes, wound zoom, and wound management notes were reviewed from 9/1/26 to present and indicated the following:The clinical record lacked consistent weekly documentation of wound measurements, tissue description, drainage, pain, and periwound description.The clinical record indicated weekly skin assessments were completed, but no details of the assessment were recorded. They were only checked on the Medication Administration Record/Treatment Administration Record (MAR/TAR) that they were completed.Resident 3's May 2026 Treatment Administration Record (TAR) was reviewed and indicated the order to apply collagen to the wound bed daily was completed but was not.During an interview on 5/18/26 at 2:10 P.M., LPN 5 indicated the dressing was changed daily on Resident 3 and indicated the alginate pad that was removed from the wound prior to care was supposted to be a collagen pad. She indicated she did not use a collagen pad when she did the treatment because she did not have one with her. 3. On 5/14/26 at 1:37 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but was not limited to, Lewy Body Dementia and a Stage 4 pressure ulcer of sacral region, present on admission.The most recent quarterly Minimum Data Set (MDS) assessment , dated 3/24/26, indicated Resident 2's cognition was severely impaired, totally dependent on staff for bed mobility, transfers, toileting, and showering, and had a stage 4 pressure ulcer that was present upon admission.A current Pressure Ulcer Care Plan, last reviewed 3/25/26, included, but were not limited to the following interventions initiated 11/4/25:Assess and record the condition of the skin surrounding the pressure ulcerObserve and report signs of infection (e.g., localized pain, redness, swelling, tenderness, drainage, odor, and fever)Weekly skin assessment and record measurement and observation of the pressure ulcer, Wound Zoom notes, progress notes, and MAR/TAR from 1/7/26 to present were reviewed and indicated the clinical record lacked complete wound assessment documentation on the following dates:1/7/261/28/262/9/262/16/262/23/263/2/263/9/263/16/263/23/264/20/26The clinical record indicated weekly skin assessments were completed, but there was no information about it. Staff only checked on the Medication Administration Record/Treatment Administration Record (MAR/TAR) that it was completed.On 5/20/26 at 10:00 A.M., wound care of Resident 2's sacral pressure ulcer performed by Licensed Practical Nurse (LPN) 10 and LPN 26 was observed. LPN 10 indicated the wound had macerated edges and slough observed from 12-2 o'clock and 6-9 o'clock. That slough sometimes would keep the wound from healing and it probably needed to be debrided. She indicated the facility used Wound Zoom for documenting but only leadership had privileges to document there. She would notify LPN 5 who was over wounds now about the slough and macerated edges that she saw when she changed the dressing. LPN 10 indicated the documentation she would do was to put in TAR that daily dressing change was completed.The clinical record lacked documentation about LPN 10 notifying LPN 5 or anyone else of Resident 2's sacral pressure wound conditions and changes.During an interview on 5/18/26 at 2:10 P.M., LPN 5 indicated the MD and/or Nurse Practitioner (NP) only look at the wound if the nurses ask them to. If they contacted them, it should be documented in the clinical record with new orders. LPN 5 indicated the documentation now went into wound management system and the TAR. Prior to that, they used Wound Zoom and they took pictures of the wound. The system would measure it for them so it was not always accurate. She should document any changes noted, drainage, measurements, pain, and surrounding tissue (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	characteristics in the clinical record.During an interview on 5/21/26 at 10:07 A.M., the DON indicated the nurses check mark on the TAR that the wound dressing was changed and weekly skin assessments were completed. If something was abnormal, they would put in a progress note. In the clinical record, it should be documented what the wound looks like, size, signs and symptoms of infection, and pain. During an interview on 5/21/26 at 11:20 A.M., the Regional Consultant indicated at least, the nursing staff should be documenting the measurements of the wound, drainage, and tissue type. She indicated the pictures were the documentation to show those things for Wound Zoom.During an interview on 5/22/26 at 9:20 A.M., the Executive Director indicated they did not have a policy for following orders or accurate documentation, but it would be expected as normal nursing standard.410 Indiana Administration Code (IAC) 16.2-3.1-50(a)(1)410 IAC 16.2-3.1-50(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to provide sanitary care for 1 of 2 observations of incontinence care and 2 of 2 observations of wound care. The nursing staff failed to lather hands with soap for 20-30 seconds during handwashing, change gloves after touching multiple items in the bathroom during incontinence care, staff left an incontinence pad on after a resident urinated in it, and hands were not sanitized and gloves were not changed between dirty and clean tasks. (Resident 37, Resident 2, Resident 3)Findings include: 1. On 5/18/26 at 1:56 P.M., wound care on Resident 3's right heel pressure ulcer performed by Licensed Practical Nurse (LPN) 5 was observed. Resident 3 was laying on her back with her right foot elevated and a towel under it. The nurse removed the dressing. She removed her gloves and washed her hands with a ten second lather. LPN 5 put gloves back on and cleaned the wound with gauze and wound cleanser, applied skin prep to sorrounding tissue, and took the wound measurements. LPN 5 removed her gloves and washed her hands with an eight second lather. LPN 5 put gloves back on and completed the wound care. 2. On 5/20/26 at 10:00 A.M., wound care on Resident 2's sacral pressure ulcer performed by Licensed Practical Nurse (LPN) 10 and assisted by LPN 26 was observed. Upon entering the room, LPN 10 washed her hands with an eight second lather and put on gloves. LPN 26 pulled out the pillows from around the resident, pulled the blanket down, pulled down Resident 2's pants and incontinence pad. LPN 26 and LPN 10 assisted the resident to lay on her left side and put a disposable drape down under the resident's hip. LPN 26 removed her gloves and washed her hands with an 11 second lather. LPN 10 and LPN 26 then proceeded with the rest of the wound care. Interview on 5/22/26 at 9:21 A.M., LPN 5 indicated during hand washing, staff were expected to lather their hands with soap for 20 seconds. 3. On 5/20/26 at 10:00 A.M., Certified Nurse Aide (CNA) 3 provided incontinence care on Resident 37 in the bathroom . CNA 3 used her gloved hands and pulled down Resident 37's pants and soiled incontinence pad after he stood up. CNA 3 failed to change gloves before she grabbed a clean incontinence pad and placed it on Resident 37. CNA 3 then touched the back of the wheelchair with her soiled gloves, wiped Resident 37's front side with a wipe, touched the back of the wheelchair and Resident 37's arm, removed another wipe and wiped Resident 37's buttocks, and then pulled up his incontinence pad and pants. At that time, Resident 37 indicated he was not finished toileting and would like to try again. CNA 3 pulled down his pants and incontinence pad, and he sat on the toilet. CNA 3 removed gloves, performed hand hygiene, and then Resident 37 stood up. CNA 3 wiped the front of Resident 37 and then proceeded to wipe his buttocks while Resident 37 had a large amount of urination that dribbled into the incontinence pad. CNA 3 failed to wipe Resident 37 and change the soiled incontinence pad before she pulled up Resident 37's incontinence pad and pants. CNA 3 then assisted Resident 37 to his wheelchair and pushed him out into the hallway. Interview on 5/22/26 at 9:21 A.M., the Infection Preventionist (IP) indicated if staff touched items with their gloved hands, they should change gloves and perform hand hygiene prior to touching the resident, and staff should change gloves between dirty and clean tasks. At that time, the IP further indicated that if a resident urinated in an incontinence pad that staff should sit the resident back down and remove the soiled incontinence pad. On 5/22/26 at 8:43 A.M., the Administrator provided a current Guideline for Handwashing/Hand (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 - Few	Hygiene policy revised 2/9/17 that indicated, .Health Care Workers (HCW) shall use hand hygiene at times such as.toileting.Before/after having physical contact with residents.After removing gloves, worn per Standard Precautions for direct contact with excretions. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(l) 410 IAC (Indiana Administrative Code) 16.2-3.1-18b(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Hills at the Monastery	710 Sunrise Drive Ferdinand, IN 47532

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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure waste was properly contained in dumpsters for 2 of 2 random observations. A full garbage bag was observed hanging out of the dumpster, debris was scattered throughout the grounds, and a worn recliner sat behind the dumpsters.Findings include:On 5/21/26 at 9:20 A.M., during a random observation, the dumpsters on the side of the building were observed with a full bag of trash on the ground next to the dumpsters and another full bag of trash hung out of a dumpster. Cardboard, multiple soiled gloves, empty clear cups, and other debris was scattered throughout the grass by the dumpsters, and a worn, brown recliner sat behind the dumpsters with foot rest opened.On 5/22/26 at 8:35 A.M., during a random observation, the dumpsters were observed to have a full bag of trash that hung out of a dumpster. Multiple soiled gloves, empty clear cups, and other debris was scattered throughout the grass by the dumpsters, and a worn, brown recliner sat behind the dumpsters with foot rest opened.Interview on 5/22/26 at 8:45 A.M., the Maintenance Director indicated kitchen staff was in charge of the dumpsters.Interview on 5/22/26 at 9:15 A.M., the Administrator indicated the Maintenance Director was in charge of the dumpsters.Interview on 5/22/26 at 9:22 A.M., the Maintenance Director indicated the dumpsters were emptied before 9:00 A.M., and all staff members were responsible for picking up trash around the dumpsters and making sure the bags were in the dumpster. He further indicated the recliner needed to be hauled off by staff at the facility.On 5/22/26 at 9:50 A.M., the Administrator provided a current Garbage and Refuse policy revised, 7/9/25 that indicated, .The dumpster area will be maintained in sanitary condition, clear of trash. 410 IAC (Indiana Administrative Code) 16.2-3.1-21 (i)(5)