STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hutsonwood at Brazil	501 S Murphy Ave Brazil, IN 47834

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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 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide range of motion or appropriate interventions for 2 of 2 residents reviewed for range of motion (Residents 69 and 12) resulting in actual harm when a cognitively impaired dependent resident developed contractures of the left hand and arm (Resident 69). Findings include:1. On 1/5/26 at 10:00 a.m., during initial observation, Resident 69 was sitting in a high back wheelchair in the lounge area. Observed the left arm bent upwards at the elbow and the left hand contracted. Nails were pressed into the palm of her hand. No anticontracture devices observed on hand or arm. On 1/6/26 at 10:29 a.m., resident observed sitting in wheelchair in lounge area and noted to have contracture of the left hand and lower left arm. No anticontracture device observed in place. On 1/6/26 at 9:34 a.m., during an interview Licensed Practical Nurse (LPN) (10) indicated Resident 69 walked with therapy for a time but acted like she was afraid and they discontinued therapy. She indicated physical therapy did not continue providing services for long. She indicated the facility did not provide any type of restorative program in the memory care unit. On 1/12/26 at 10:00 a.m., during follow-up observation noted Resident 69, sitting in a high backed wheelchair. She was slumping very low in the chair with both legs extended over the foot petals. The resident was leaning over the left side of the chair with the left arm hanging over with no support under the arm and shoulder to aide in positioning. A loosely rolled washcloth was loose in the residents left hand. Nails on the left hand were long and jagged. On 1/9/26 at 11:45 a.m., during an interview, the Physical Therapy Director indicated they did not have a restorative aide. On 1/9/26 at 1:27 p.m., during an interview, Licensed Practical Nurse (LPN) 16 indicated the Certified Nurse Aides (CNA) provided range of motion (ROM) with the residents as needed. She indicated they did not have any orders for ROM for Resident 69 and acknowledged she had noticed the resident's hand was very contracted and nails were pressing into her palm. She did not know when the contracture had started. She indicated they should be using some type of anticontracture device in her hand. On 1/9/26 at 1:39 p.m., during an interview, Certified Nurse Aide 15 indicated she did range of motion when moving and dressing the residents only. She indicated she did not do active (moving a body part using the individuals own muscles) or passive (when someone else or a machine moves the limbs and joints of the body) ROM. On 1/9/26 at 2:52 p.m., the medical record of Resident 69 was reviewed. The record indicated the resident was admitted to the facility on [DATE]. Admitting diagnosis included but were not limited to neurocognitive disorder with Lewy bodies (a progressive brain disorder caused by abnormal protein clumps or Lewy bodies damaging brain cells, leading to thinking problems (similar to Alzheimer's, plus slowed movement, rigidity, tremor), type 2 diabetes mellitus with diabetic neuropathy (a disease that occurs when your blood glucose, also called blood sugar, is too high, neuropathy is nerve damage caused by high blood sugar from diabetes). The most recent quarterly Minimum Data Set (MDS) assessment, dated 9/30/25, indicated the resident was cognitively impaired and was dependent upon the staff for mobility and positioning. The MDS lacked documentation of contractures. Review of the resident's care plans lacked documentation of contractures and preventive measures. The record lacked documentation of preventive measures or (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

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F 0688 Level of Harm - Actual harm Residents Affected - Few	interventions including treatments and ROM to joints prior to survey. The resident's record lacked documentation of orders for range of motion or interventions to prevent or treat contractures. On 1/12/26 at 10:05 a.m., during an interview, Licensed Practical Nurse LPN 11 indicated Resident 69 would not sit up in chair and would not allow the staff to reposition her. She indicated when the staff repositioned the resident she moved back into the low position. She indicated the resident would not allow the staff to move the fingers of the left hand or arm but would allow the staff to trim her fingernails. She indicated the resident was not receiving a specific range of motion (ROM) program to prevent contractures. She acknowledged the medical record lacked documentation of exercises to the hands, fingers or arm and acknowledged the medical record lacked documentation of contracture of the left arm and hand. On 1/12/26 at 10:15 a.m., during an interview, Certified Nurse Aide 9 indicated they attempted to provide ROM for Resident 69, but it was difficult. She indicated they had placed hand rolls in her left hand, but she removed them. The CNA was not sure when the contracture started. On 1/12/26 at 1:40 p.m., during an interview, the therapy manager indicated she had not been informed the resident had developed a contracture of the left arm and hand till 1/9/26. She indicated she was in the memory care unit daily where the resident resides, and staff would usually inform her of any changes in residents conditions including changes in ROM and contractures. She did not know when the contracture started. She indicated when she was informed of a change, therapy would assess the resident for therapy services. The therapy manager indicated they used anticontracture devices to help prevent contractures and to prevent increased contractures in residents limbs and hands. 2. On 1/5/26 at 2:15 p.m., during a phone interview, the Power of Attorney for Resident 12 indicated the resident was walking and had received physical therapy while at the hospital. She indicated when the resident returned to the facility, she did not receive much therapy and had declined rapidly since returning. She indicated the resident was no longer walking though she was ambulatory prior to falls. She indicated she was concerned about her general decline and concerned she was not receiving preventive care. On 1/5/26 at 2:00 p.m., during an initial observation, Resident12 was observed sleeping in bed. The resident was lying on her back with her head hyperextended. The bed was in the low position. A padded mat was on the floor next to the left side of the bed. The call light was lying on the foot of the bed. On 1/9/26 at 10:00 a.m., the medical record of Resident 12 was reviewed. The most recent admission to the facility was on 9/25/25. admission diagnosis included, but was not limited to, fracture of right femur (bone fracture of the right hip), pain in right hip, and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A significant change Minimum Data Set (MDS) assessment, dated 10/1/25, indicated the resident was cognitively impaired and was dependent upon staff for all daily care needs including transferring and ambulation. A care plan, dated 10/8/25, indicated, ADLs Functional Rehabilitation Potential Intervention included, but was not limited to, approaches of independent transfer with start date of 4/25/23 and independent bed mobility with start date of 4/25/23. The care plan lacked documentation of updated specific interventions to prevent decline in ADL. On 1/6/26 at 9:34 a.m., during an interview, Licensed Practical Nurse (LPN) 10 indicated Resident 12 walked with therapy for a time but acted like she was afraid and they discontinued therapy. She indicated the facility did not provide any type of restorative program in the memory care unit where Resident 12 resided. On 1/9/26 at 11:45 a.m., during an interview the Physical Therapy Director indicated Resident 12 could ambulate 200 to 250 feet in the hall, but she had come to the place when she resisted the therapy staff and refused. She indicated the resident was discharged because it was causing her more distress, but the resident was able to ambulate after she had fractured her hip in a fall. She indicated no one had looked at the hyperextension of the resident's neck and the staff were educated on exercises to bring her chin forward and range of motion (ROM) exercises. She indicated therapy would be picking her back up again next week. She did not have specific documentation reflecting staff education regarding ROM and decline in mobility. On 1/9/26 at 1:27 p.m., during an interview, Licensed Practical Nurse (LPN) (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	16 indicated the Certified Nurse Aide (CNA) provided range of motion (ROM) (how far and in what direction a joint can move, from bending to stretching representing the joint's flexibility and movement potential without pain) for the residents as needed. She indicated they did not have any orders for ROM for Resident 12. She indicated Physical Therapy (PT) advised them to walk Resident 12, but she did not recall any instruction from therapy regarding range of motion (ROM). She indicated the staff walked Resident 12 to the bathroom at times but due to rigidity she was not able to walk as much. On 1/9/26 at 1:39 p.m., during an interview, Certified Nurse Aide 15 indicated she did range of motion when moving and dressing the residents. She indicated she remembered therapy providing education regarding ROM. She indicated Resident 12 did not want to walk, and prior to falls Resident 12 was very ambulatory. On 1/9/26 at 2:05 p.m., during an interview, the Director of Nursing (DON) acknowledged the staff should follow therapy with ROM as needed to keep the residents mobile. She acknowledged the staff had not been providing ROM as recommended by physical therapy. On 1/9/26 at 2:33 p.m., the DON provided a document, titled, prevention of decline in Range of Motion, dated 1/1/25, and indicated it was the policy currently being used by the facility. The policy indicated, .3. b. The facility will provide treatment and care in accordance with professional standards of practice. c. Care plan interventions will be developed and delivered through the facilities restorative program.4. Preventive care a. Staff will be educated on the risk factors for decline in range of motion. These include but are not limited to: 1. Limbs or digits immobilized because of injury or surgical procedures. 3.1-38(a)(1) 3.1-42(a)(1)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, record review, and interview, the facility failed to ensure the dietary staff were trained and competent in infection control measures to prevent food borne illness during 4 observations of the dietary department. The deficient practice had the potential to affect 77 of 77 residents who received food and/or drinks from the kitchen. Findings include: On 1/5/26 at 10:45 a.m., during a kitchen observation with the Dietary Manager, the dishwasher temperature was not within the recommended range for sanitation. Review of the temperature logs indicated the logs were incorrect. The Dietary Manager confirmed the documentation had been recorded inaccurately by the employee. On 1/5/26 at 11:00 a.m., observed the Dietary Manager wash her hands and dried hands on rolled damp paper towels that were on top of the counter in the food prep area. She indicated the dispenser batteries were low, and the paper towel dispenser was not working. The Dietary Manager acknowledged the paper towels were not sanitary. On 1/5/26 at 12:38 p.m., during a follow up in the dietary department observed the Dietary Manager wash her hands and dried her hands on the roll of damp paper towels that were placed on a counter in the food perp area. She indicated the paper towel dispenser was still not working. On 1/7/26 at 11:05 a.m., during an interview the Dietary Manager asked if she should use disposable plates due to the dishwasher temperature not reaching recommended levels to sanitize dishes. She then indicated she would use disposable utensils and plates for meal service. She did not know if the service provider had been to the facility to repair the dishwasher. On 1/7/26 at 11:10 a.m. during an interview the Assistant Dietary Manager indicated she did not know what the risks were if food was served on dishes that had not been sanitized. She indicated if the dishwasher was not working at the required temperature she would notify the Administrator. On 1/7/26 at 11:15 a.m., during an interview the Dietary [NAME] indicated if dishes were not sanitized it could cause illness to the residents including stomach issues. On 1/7/25 at 10:48 a.m., observed the Dietary Manager and Dietary Aide 7, wash their hands in the designated handwashing sink in the kitchen both employees dried their hands on damp rolled paper towel that had been placed on a counter in the food prep area. The Dietary Manager indicated it was their handwashing sink and indicated the paper towel dispenser was not working. Cross reference F812 On 1/7/26 at 11:21 a.m., the Director of Nursing provided a document, titled, Hand Hygiene, dated, 1/1/25 and indicated it was the policy currently being used by the facility. The policy indicated, .5. Hand hygiene technique when using soap and water.e. Dry thoroughly with a single use paper towel. f. Use clean towel to turn off the faucet. On 1/7/26 at 11:21 a.m., the Director of Nursing provided a document, titled, Dishwasher Temperature, dated 1/1/25, and indicated it was the policy currently being used by the facility. The policy indicated, .1. All items cleaned in the dishwasher will be washed in water that is sufficient to sanitize any and all items.3. A The wash temperature shall be 150 - 165 degrees Fahrenheit.b. The final rinse temperature shall be 180 degrees Fahrenheit or above but not to exceed 194 degrees Fahrenheit. 3.1-20(h)3.1-35(c)(2)(C)

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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. A. Based on observations, record review, and interview, the facility failed to ensure frozen foods were dated prior to use and failed to ensure dishwasher was sanitizing dishes and utensils at the recommended temperatures for sanitation during 6 dietary observations. This deficient practice had the potential to affect 77 of 77 residents who receive food and drinks from the kitchen. B. Based on observation, interview, and record review, the facility failed to ensure ice was distributed in a safe and sanitary manner during 1 of 1 lunch meal service observations. This deficient practice had the potential to affect all residents that were being served in the main dining room on 1/5/26. Findings include: A. On 1/5/26 at 10:45 a.m., during a kitchen observation with the Dietary Manager the following was noted. The wash temperature of the dishwasher reached 140 degrees. The rinse temperature reached 162 degrees. The Dietary manager indicated the dishwasher was not at the appropriate temperature. Review of the temperature logs for breakfast on 1/5/26 indicated the temperature had been recorded as 150 degrees for the wash cycle and 190 degrees for the rinse cycle. The dietary manager confirmed this was inaccurate documentation. Review of the temperature logs from 1/1/26 to 1/7/26 indicated temperatures were recorded as wash 150 degrees and rinse 190 degrees for breakfast, lunch and dinner every day. The record from 12/1/25 to 12/31/25 indicated the same readings for all three meals. During an observation of the freezer the following frozen foods were not dated. Frozen eggs, frozen chicken, and frozen angel food cakes. On 1/5/26 at 11:00 a.m., observed the Dietary Manager washing her hands. She dried her hands with damp rolled paper towels that had been placed on top of a counter in the food prep area. She indicated the paper towel dispenser was not working because the dispenser batteries were low. On 1/5/26 at 12:38 p.m., during a follow up visit, the Dietary Manager washed her hands and dried her hands from damp rolled paper towels that had been placed on a counter in the food prep area. She indicated the paper towel dispenser was still not working. On 1/7/26 at 10:48 a.m., observed the Dietary Manager and Dietary Aide wash their hands in the designated handwashing sink in the kitchen. The paper towel dispenser was not working, and both employees dried their hands on rolled damp paper towel sitting on a counter in the food prep area. The Dietary Manager indicated this was their handwashing sink. On 1/7/26 at 11:00 a.m., observed the dishwasher temperature readings were at 140 degrees for the wash and 160 degrees for the rinse. During interview the Dietary Manager indicated she would use disposable utensils and plates for meal service. She indicated she had called the service provider on 1/5/26 and requested service for the dishwasher she did not know if they had been to the facility to repair it. On 1/7/26 at 11:10 a.m. during an interview the Assistant Dietary Manager indicated she did not know what risks were if food was served on dishes that had not been sanitized. She indicated if the dishwasher was not working at the required temperature, she would notify the administrator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/7/26 at 11:30 a.m., during an interview the Dietary Manager indicated she talked to the maintenance person, and he indicated he had spoken to the dishwasher service provider, and they were to send someone out to the facility first thing Tuesday 1/6/26. She indicated she was busy on one of the units on Tuesday and forgot about the dishwasher needing service. She indicated she did not realize they had not come in until 1/7/26. She indicated the staff had not cleaned the dishes in the three way sink and had continued to use the dishwasher. She indicated she had not reported the issue with the dishwasher to the Administrator. On 1/7/26 at 11:45 a.m., during an interview the Administrator indicated he had not been informed on 1/5/26 of the issues with the dishwasher temperature. On 1/7/26 at 12:00 p.m., during an interview with the Dietary Manager she indicated she had found out the service provider had come into the building on 1/6/26 and indicated he told someone it was an issue with the circuit board and they only had to flip the switch and the dishwasher would work. She was not sure what time the service provider came into the facility. She indicated the dishwasher was at the correct temperature for the remaining meals on 1/6/26. She acknowledged she could not confirm this and was going by the temperature log record. A Dietary Aide indicated she thought the service provider came in around 10:30 a.m., time of arrival and departure could not be confirmed. The Dietary Manager acknowledged the dishwasher was not indicating the correct temperatures on the morning on 1/7/26 up to 12:00 p.m. She acknowledged the documentation on the temperature log was incorrect. On 1/9/26 at 11:38 a.m., the Director of Nursing provided a document titled, Date Marking for Food Safety, dated 1/1/25, and indicated it was the policy currently being used by the facility. The policy indicated, .2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. On 1/7/26 at 11:21 a.m., the Director of Nursing provided a document, titled, Dishwasher Temperature, dated 1/1/25, and indicated it was the policy currently being used by the facility. The policy indicated, .1. All items cleaned in the dishwasher will be washed in water that is sufficient to sanitize any and all items.3. A The wash temperature shall be 150 – 165 degrees Fahrenheit.b. The final rinse temperature shall be 180 degrees Fahrenheit or above but not to exceed 194 degrees Fahrenheit. Cross reference F802. B. During lunchtime meal service in the main dining room on 1/5/26 at 11:47 a.m., the following was observed: Certified Nurses Aide (CNA) 3 was preparing a drink for a female resident. She obtained ice and placed it in a cup with an ice scoop; she placed the ice scoop back into the clear plastic container that contained the ice. The scoop and handle were in contact with the ice. She proceeded to serve the drink to the resident. At 11:49 a.m. CNA 3 took the ice scoop out of the ice container and placed ice in a cup for another female resident. The CNA placed the ice scoop back into the plastic container of ice and the scoop and handle was in contact with the ice. She served the cup of ice water to the resident. At 11:52 a.m. Qualified Medication Aide (QMA) 4 walked by the drink cart and noted the ice scoop was in the ice container she picked it up and placed it in an empty plastic container that was allocated for the scoop. The QMA did not sanitize the ice scoop before placing it back into the empty container. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, on 1/12/26 at 9:46 a.m., the Activity Director indicated that she would help with meal service and passing trays to the residents in the main dining room at times. She indicated the ice scoop should not be placed in the container with the ice and it had its own container it should be placed in when not in use. On 1/12/26 at 10:06 a.m., the Administrator provided a document with a revised date of 1/23/25, titled, Ice Machines and Portable Ice Carts, and indicated it was the current policy being used by the facility. The policy indicated .6. Ice scoops should be cleaned every 24 hours and placed in a clean container outside of the bin or the cart after every use. Do not store the ice scoop in the ice bin/cart. 3.1-21(i)(1) 3.1-21(i)(3)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure that resident personal information was protected from exposure, during 1 of 2 medication administration observations (Residents 34, 78, and 8). Findings include:During observation of medication administration with Licensed Practical Nurse (LPN) 8, on 1/8/26, the following was observed: a. On 1/8/26 at 8:28 a.m., LPN 8 set up the medications to administer to Resident 34. She was observed to use the desk computer to rectify the medications. At the same time, she indicated she was using the desk computer at the nurse's station because the laptop on the medication cart would not stay charged. She left the nurse's station to administer the medications and left the resident's personal information exposed on the computer screen without closing or covering the screen. b. On 1/8/26 at 8:41 a.m., LPN 8 set up the medications to administer to Resident 78. She was observed to use the desk computer to rectify the medications. She left the nurse's station to administer the medications and left the resident's personal information exposed on the computer screen without closing or covering the screen. c. On 1/8/26 at 8:59 a.m., LPN 8 set up the medications to administer to Resident 8. She was observed to use the desk computer to rectify the medications. She left the nurse's station to administer the medications and left the resident's personal information exposed on the computer screen without closing or covering the screen. During an interview, on 1/9/26 at 8:47 a.m. the Director of Nursing (DON) indicated the expectation was that the resident's personal information be covered when the nurse was away from the cart or desk. The nurse should have been using the computer on the cart if possible. On 1/9/26 at 10:46 a.m., the DON provided a document, dated 1/1/25, titled, Confidentiality of Personal and Medical Records, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Explanation and Compliance Guidelines: .8. Paper notes and/or electronic medical records or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons. 3.1-3(o)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to initiate or revise interventions to prevent falls for 1 of 1 residents reviewed for accidents (Resident 12). Findings include:On 1/5/26 at 2:00 p.m., during an initial observation, Resident 12 was observed sleeping in bed. The resident was lying on her back with her head hyperextended. The bed was in the low position. A padded mat was on the floor next to the left side of the bed. The call light was lying on the foot of the bed. On 1/9/26 at 10:00 a.m., the medical record of Resident 12 was reviewed. The most recent admission to the facility was on 9/25/25. admission diagnosis included, but was not limited to, fracture of right femur (bone fracture of the right hip), pain in right hip and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A significant change Minimum Data Set (MDS) assessment, dated 10/1/25, indicated the resident was cognitively impaired and was dependent upon staff for all daily care needs including transferring and ambulation. A care plan, dated 9/2/22 with the most recent edited date of 11/23/25, indicated the resident was at risk for falls related to weakness, gait and balance deficits, use of medications which may cause dizziness, and change in normal routine and environment. Care plan interventions included assist to transfer, footwear to prevent slipping, call light within reach, room well lit, pathways free of clutter, personal items and used items within reach, observe for medication side effects, prompt toileting assistance, therapy screen, obtain labs, medication review, redirect to dining room for meals, comfortable seating, and touch pad call light. Review of events in the medical record indicated on 2/1/25 at 7:30 p.m., the resident fell in her room. The record indicated the bed was in a low position and the resident was sitting on the floor next to the bed. The record lacked documentation if the resident had nonskid socks or shoes on at the time of the fall. The root cause indicated the resident had been ambulating. Interventions included nonskid footwear. The documentation lacked evidence of new interventions to prevent falls. On 2/14/25 at 8:20 a.m., the resident fell in the dining room area. The resident was found lying on the floor on her right side. The root cause indicated the resident had been ambulating. The record lacked documentation of resident wearing nonskid shoes. Interventions included monitor vital signs and medication review. The record lacked documentation of vital signs at the time of the fall, no new interventions were implemented to prevent falls, and the record lacked documentation of medication review results. On 9/22/25 at 5:00 p.m., the resident was found lying on the floor in the doorway of her room. Documentation indicated the resident was wearing nonskid shoes. Root cause indicated the resident had been ambulating. The resident was complaining of pain of the right hip. She was placed on one-to-one supervision and sent to the hospital for evaluation. The resident was admitted to the hospital with diagnosis of fracture of the right hip. On 9/25/25 the resident returned to the facility from hospital stay. The medical record lacked documentation of new interventions to prevent falls. On 10/9/25 at 5:30 p.m., the resident was in the main dining room area. She attempted to stand from the wheelchair and fell backwards onto the floor. The record indicated the resident had nonskid shoes on her feet. Interventions were monitoring vital signs and report to physician or nurse practitioner, wheelchair, activities and offer comfortable seating. The record lacked evidence of vital signs at the time of the fall and lacked evidence of new interventions specific to prevent falls. On 11/12/25 at 3:49 p.m., the resident stood from her bed and fell on the floor. The fall was witnessed by an employee. Documentation indicated the vital signs at the time of the fall were temperature 97.6, pulse 81, respirations 18, blood pressure 140/79. The resident sustained a skin tear to her hand and a 2 centimeter (cm) by 1cm laceration to the right side of her forehead. Intervention was to add touch pad call light. The record lacked documentation of new interventions to prevent falls. On 1/6/26 at 9:34 a.m., during an interview, Licensed Practical Nurse (LPN) (10) indicated Resident 12 walked with therapy for a time but acted like she was afraid and they discontinued therapy. She indicated physical therapy did not continue providing services for long (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the therapist would notify the physician to determine if the resident needed to continue with therapy. She indicated the facility did not provide any type of restorative program in the memory care unit where Resident 12 resided. She indicated preventive fall measures were to keep the resident in her wheelchair at the nurse's station to observe and to prevent falls. On 1/9/26 at 11:45 a.m., during an interview the Physical Therapy Director indicated therapy was a minimum of five days a week per discipline. Therapy may be provided on weekends as well. She indicated Resident (12) could ambulate 200 to 250 feet in the hall, but she had come to the place she resisted the therapy staff and refused. She indicated the resident was discharged because it was causing her more distress, but the resident was able to ambulate after she had fractured her hip in a fall. She indicated they did not have a restorative aide, but the staff was educated regarding walking the resident and they were instructed if she stood, they must try to walk her. She indicated no one had reviewed the hyperextension of the resident's neck, but the staff were educated on exercises to bring her chin forward including range of motion (ROM) exercises. She indicated therapy would be providing services again next week. On 1/9/26 at 1:25 p.m., during an interview the MDS nurse indicated she would update the care plan within 14 days if there was a significant change in the resident's condition. She indicated if a resident fell she would update the care plan the next day. She indicated she does not delete interventions because she may want to use them again. She did not enter care plans for therapy; they would enter their own. On 1/9/26 at 1:27 p.m., during an interview Licensed Practical Nurse (LPN) 16, indicated the Certified Nurse Aide (CNA) provides range of motion (ROM) (how far and in what direction a joint can move, from bending (flexion) to stretching (extension), representing the joint's flexibility and movement potential without pain) for the residents as needed. She indicated they did not have any orders for ROM for Resident 12. She indicated Physical Therapy (PT) advised them to walk Resident 12, but she did not recall any instruction from therapy regarding ROM. She indicated the staff walked Resident 12 to the bathroom at times but due to rigidity she could not walk as much. She indicated if a resident had a fall the interventions would be determined by the individual resident. She indicated Resident 12 no longer tried to get up on her own and she had a mat on the floor due to risk of falling out of bed. On 1/9/26 at 1:39 p.m., during an interview, Certified Nurse Aide 15 indicated she did passive (PROM) (when someone or something else (like a therapist or machine) moves a joint through its full range of movement, without the person using their own muscles), when moving and dressing the residents. She indicated she did not provide PROM to the residents, but she remembered therapy providing education regarding ROM. She indicated Resident 12 did not want to walk, and prior to her falls Resident 12 was very ambulatory. She indicated the resident liked her room quiet, so they kept her lights turned off when she was in the room. On 1/9/26 at 1:45 p.m., observed resident lying in bed in her room. The room was dark, the bed was in a low position, a padded mat was on floor on the left side of the bed, and the soft touch call light was lying on the foot of the bed. The medical record lacked documentation or interventions of low bed or mat to the floor. On 1/9/26 at 2:05 p.m., during an interview the Director of Nursing (DON) indicated if a resident fell, they would look at why the resident fell and enter specific interventions. The DON acknowledged the staff should follow therapy services with range of motion (ROM) as needed to keep the resident's mobile. On 1/12/26 at 1:22 p.m., the DON provided a document, titled, Fall prevention program, dated 1/1/25, and indicated it was the policy currently being used by the facility. The policy indicated, .3. The baseline care plan will include the identification of the fall risk score and interventions. 4.a. Interventions will be monitored for effectiveness.e. Review the resident's care plan and update as indicated.h. Fall events will be reviewed by the IDT to establish root cause and update interventions/treatment plans as needed in the resident's electronic health record. 3.1-45(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident had physician's order and a care plan for an indwelling urinary catheter (a thin, flexible tube left inside the bladder, typically through the urethra, to continuously drain urine into an external collection bag), failed to ensure the catheter's external urine collection bag (catheter bag) and tubing were prevented from contact with the floor, and failed to ensure the catheter bag was maintained in a dignified manner, for 1 of 1 resident observed for urinary catheter (Resident 21). Findings include: During an initial observation of Resident 21, on 1/6/26 at 9:14 a.m., the resident's catheter bag was observed in contact with the floor. The resident was sitting in her wheelchair next to her bed. During a random observation, on 1/7/26 at 9:04 a.m., the resident was observed in her room in her wheelchair. The resident's catheter tubing was in contact with the floor. During a random observation, on 1/7/26 at 1:06 p.m., the resident was sitting in her wheelchair in her room. The resident's catheter bag was facing the door to the hallway. The dignity bag (a covering that is placed over the urinary drainage bag to prevent the exposure of urine in the bag and provide dignity to the resident) was observed in a position as to leave the catheter bag with urine exposed. Resident 2's record was reviewed on 1/8/26 at 1:25 p.m. The profile indicated the resident had been admitted on [DATE], for diagnoses which included, but were not limited to, urinary tract infection (UTI-a common bacterial infection in any part of your urinary system) and overactive bladder (a sudden, strong, uncontrollable urge to urinate, even when the bladder isn't full). Review of the events indicated the resident had been admitted with a UTI on 11/17/25 and had other UTIs documented on 12/11/25 and 12/26/25. A quarterly Minimum Data Set (MDS) assessment, dated 12/17/25, indicated that the resident had no cognitive deficit, was dependent with toileting, was always incontinent of bladder, and lacked documentation of the resident having an indwelling urinary catheter. The record lacked documentation of a catheter care plan. A historical review of the resident's physician's orders lacked documentation of orders for a indwelling urinary catheter upon admission. A skilled nurse assessment, dated 11/18/25, indicated the resident had a UTI, but lacked documentation of any indwelling urinary catheter. A skilled nurse assessment, dated 12/2/25, lacked documentation of any indwelling urinary catheter. The census indicated that the resident had been hospitalized from [DATE] to 12/11/25, for change on mental status. The hospital history and physical report, dated 12/2/25, indicated the resident had a urinary tract infection. A post hospital Clinical Admission/re-admission document, dated 12/11/25 at 1:51 p.m., lacked documentation that the resident had an indwelling urinary catheter when returning from the hospital. A physician's order, dated 12/14/25, indicated to remove the catheter and start a voiding trial (a medical test to determine if a patient can urinate (void) normally and empty their bladder adequately after a urinary catheter has been removed) one time. A physician's order, dated 12/16/25, indicated to anchor a Foley (indwelling urinary catheter) if retaining urine over 200 milliliters (ml) and no voiding within 6 hours. The record lacked documentation of results of a voiding trail to justify the placement of a indwelling urinary catheter. Review of the resident's progress notes, dated 11/17/25 through 1/9/26, lacked documentation of an indwelling urinary catheter. On 1/12/26 at 9:42 a.m., the resident was observed in her room sitting in her wheelchair. At the same time the resident indicated that her indwelling urinary catheter had been removed 2 days prior.On 1/12/26 at 9:48 a.m., review of the resident's progress notes and physician's orders lacked documentation of any orders to remove the resident's indwelling urinary catheter or nurse's notes documenting the removal.During an interview, on 1/12/26 at 9:53 a.m., the Director of Nursing (DON) indicated she was not aware that there were no orders for the resident's catheter. She believed she came with a catheter on her original admission date. It was removed on 12/14/25, per MD order for a voiding trial. The voiding trial was successful. She was not sure when or why the resident had another catheter placed. She was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to find any documentation or orders for the new catheter or about the catheter being removed. The expectation was that a physician's order should have been in place in the resident's record any time there was an indwelling urinary catheter in place and before it was removed. The nurse should document the catheter in the progress notes to ensure it was being observed as expected. During an interview, on 1/7/26 at 3:26 p.m., the DON indicated there was not a policy specifically related to the catheter bag and/or tubing on the floor, but the facility would follow standards of nursing practice. The expectation was that catheter bags and/or tubing should never come in contact with the floor as it was an infection control risk. On 1/7/26 at 3:26 p.m., the DON provided a document, dated 2024, titled, Catheter Care, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Explanation: .2. Privacy bags will be available and catheter drainage bags will be covered at all times, while in use.On 1/12/26 at 11:00 a.m., the DON provided a document, dated 2024, titled, Consulting Physician/Practitioner Orders, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Explanation and Compliance Guidelines.2. For consulting physician/practitioner orders.the nurse in a timely manner will: a. Call the attending physician to verify the order. B. Follow facility procedures for.orders including: noting the order, submitting to pharmacy, and transcribing to.record.3.1-41(a)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain a resident's medications in a timely manner after their admission to the facility for 1 of 6 residents reviewed for pharmaceutical services (Resident B). Findings include:Resident B's record was reviewed on 1/9/26 at 10:14 a.m. Census information indicated the resident was admitted to the facility on [DATE]. A Medication Administration Record (MAR), dated December 2025, included the following information. -A physician's order, dated 12/19/25, indicated administer ascorbic acid (supplement) 250 milligrams (mg) by mouth daily for muscle wasting. The medication was not administered, on 12/19/25, related to pharmacy delivery tonight. The medication was not administered, on 12/27/25, 12/28/25, and 12/31/25, related to awaiting from pharmacy. The MAR lacked documentation the physician or the pharmacy were contacted regarding the missed administrations. -A physician's order, dated 12/19/25, administer enoxaparin (blood thinner) 30 mg/0.3 milliliters (ml) subcutaneously (SQ) once daily for sick sinus syndrome (group of heart rhythm disorders). The medication was not administered, on 12/19/25, related to pharmacy delivery tonight. The first administration of the medication was on 12/20/25. The MAR lacked documentation the physician or the pharmacy were contacted regarding the missed administration. -A physician's order, dated 12/19/25, indicated administer metoprolol succinate (blood pressure medication) extended release (ER) 50 mg by mouth daily for essential primary hypertension (high blood pressure). The medication was not administered, on 12/19/25, related to pharmacy delivery tonight. The first administration of the medication was on 12/20/25. The MAR lacked documentation the physician or the pharmacy were contacted regarding the missed administration. -A physician's order, dated 12/19/25, indicated administer metronidazole (antimicrobial medication) 500 mg by mouth twice daily. The medication was not administered on the morning of 12/19/25, related to pharmacy delivery tonight. The first administration of the medication was in the evening of 12/19/25. The MAR lacked documentation the physician or the pharmacy were contacted regarding the missed administration. -A physician's order, dated 12/19/25, indicated administer sodium bicarbonate (antacid) 650 mg by mouth twice daily for functional dyspepsia. The medication was not administered on the morning of 12/19/25, related to pharmacy delivery tonight. The first administration of the medication was in the evening of 12/19/25. The MAR lacked documentation the physician or the pharmacy were contacted regarding the missed administration. -A physician's order, dated 12/19/25, indicated administer venlafaxine (antidepressant) 75 mg by mouth daily for depression. The medication was not administered, on 12/19/25, related to pharmacy delivery tonight. The first administration of the medication was on 12/20/25. The MAR lacked documentation the physician or the pharmacy were contacted regarding the missed administration. A progress note, dated 12/18/25, indicated the resident was admitted to the facility at 10:00 p.m. The progress note lacked documentation the pharmacy was notified of the resident's admission or her medications were ordered from a back-up pharmacy. Progress notes, dated 12/19/25, lacked documentation the physician or the pharmacy were contacted regarding the resident's missed medication administrations. During an interview, on 1/9/26 at 1:42 p.m., the Assistant Director of Nursing (ADON) indicated when a resident was admitted to the facility orders were put in the electronic medical record, and a medication list should have been faxed to the pharmacy. The pharmacy should have filled the resident's medications based on this information. If a resident was admitted at 10:00 p.m., the nurse should have pulled available medications out of the emergency drug kit (EDK) and called the pharmacy to have the other medications sent from a back-up pharmacy on a stat (immediate) delivery. Medication orders had to be received by the pharmacy by 5:00 p.m., in order for the medications to be sent on the regularly scheduled pharmacy delivery. If medications were unavailable for administration the physician should have been notified. On 1/9/26 at 1:26 p.m., the Director of Nursing (DON) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided an untitled document, last revised on 3/8/22, and indicated it was the list of medications currently available in the facility's EDK. The list indicated metoprolol succinate and metronidazole were available in the EDK. The DON did not provide documentation either of the available medications were pulled from the EDK for the resident. On 1/9/26 at 2:24 p.m., the ADON provided a document titled, Medication Ordering and Receiving From Pharmacy, last revised in November 2018, and indicated it was the policy currently being used by the facility. The policy indicated, .Emergency Pharmacy Services and Emergency Kits. Policy: Emergency pharmacy services are available on 24-hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from [Pharmacy Name].II. To access medication from the emergency medication supply, secondary to a new order or when medication for which there is a current prescription is not readily available, the appropriate facility personnel should not take a medication from the e-box [EDK].without checking allergies on the medical record and possible drug-drug interactions. 1. The appropriate facility personnel confers with the prescriber to determine whether the order is a true emergency, i.e., order cannot be delayed until the scheduled pharmacy delivery. The appropriate facility personnel may alert the physician to the listing of medications that are readily available in the emergency supply.2. Only after verifying that the above communication has occurred, the pharmacy has received a complete prescription, and medication allergies, interactions, and other contraindications have been checked, the appropriate facility personnel may remove the required medication from the emergency medication supply. If the medication is not available in the emergency medication supply, the appropriate facility personnel contacts the pharmacy, using the after0hours emergency number(s) if necessary.5. Use of the emergency medication is noted on the resident's medication administration record. This citation relates to intake 2705536. 3.1-25(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure documented physician rationale for a declination of a pharmacy recommendation and failed to ensure a pharmacy recommendation was addressed in a timely manner for 2 of 5 residents reviewed for unnecessary medications (Residents 11 and 13). Findings include:1. Resident 11 record was reviewed on 1/6/26 at 3:46 p.m. The profile indicated the resident's diagnoses included, but were not limited to, diabetes mellitus (a group of metabolic diseases marked by consistently high blood sugar (glucose) due to the body's inability to produce or properly use insulin), overactive bladder (a common condition marked by a sudden, uncontrollable urge to urinate, often leading to frequent bathroom trips, and chronic kidney disease stage 3 (your kidneys have moderate damage, filtering blood less effectively, leading to waste buildup and potential complications like high blood pressure, anemia (low iron), and fatigue). Facility census information indicated Resident 11 was admitted to the facility on [DATE]. A significant change in status Minimum Data Set (MDS) assessment, dated 10/21/25, indicated the resident was cognitively intact. Review of pharmacy recommendation, dated 11/5/25, indicated Resident 11 received the urinary anesthetic medication phenazopyridine (relieves symptoms caused by irritation of the urinary tract, such as pain, burning, and passing frequent small amounts of urine) 100mg (milligrams) daily since return from the hospital on 10/15. Could this be discontinued? The recommendation was marked disagree by physician and was signed and dated by physician on 11/19/25. The recommendation lacked a rationale as to why the physician disagreed with the recommendation. The electronic health record lacked documentation of a physician rationale for a declination of the pharmacy recommendation. During an interview, on 1/7/26 at 11:01 a.m., the Director of Nursing (DON) indicated she was unsure if they had any documentation as to why the physician declined the pharmacy recommendation. She was new to the role of DON and was still learning all the regulations for pharmacy recommendations. During an interview, on 1/7/26 at 11:12 a.m., the DON indicated she was unable to find documentation of any rationale from the physician as to why he disagreed with the recommendation. During an interview, on 1/7/26 at 11:33 a.m., the DON indicated she was unable to find a specific policy related to pharmacy recommendations, but the facility should follow state and federal guidelines regarding pharmacy recommendations. On 1/7/26 at 11:21 a.m., the DON provided a document with a date of 1/1/25, titled, Medication Regimen Review, and indicated it was the policy currently being used by the facility. The policy indicated, .6. Written communications from the pharmacist shall become a permanent part of the resident's medical record.f. All pharmacy recommendations requiring a physician's action will be brought to the attention of the appropriate physician in a timely manner (within 7 business days). 2. On 1/7/26 at 10:40 a.m., the medical record of Resident 13 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included but was not limited to hemiplegia (a (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength) following cerebral infarction (stroke), dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), and pain. A physician order, dated 8/15/22, indicated to evaluate resident's pain level using either a verbal rating, FACES scale, or PAIN scale. Record pain rating and/or if resident says Yes or no to pain. Special Instructions: use medication note for pre pain score, post pain score, and non-pharm interventions every shift. A care plan, dated 12/19/24, indicated pain. Interventions included, but were not limited to, medications as ordered and observe routinely for effectiveness and notify physician of unmanaged pain, numeric scale to evaluate pain and treatment effectiveness and use interventions before pain becomes severe. A pharmacy review and recommendation, dated 8/9/25, indicated the resident had been receiving Norco 5/325 mg every 6 hours routinely since 10/20/24 and no symptoms of pain were noted on the most recent assessment. A recommendation was presented to change Norco to three times per day (TID). The attending physician agreed to the recommendation. The facility did not change the administration of the medication to TID as recommended. A Physician order, dated 9/10/25, indicated to administer hydrocodone-acetaminophen -Schedule II (narcotic) tablet 5-325 mg amt: 1 tablet by mouth four times a day for pain. An annual Minimum Data Set (MDS) assessment, dated 9/17/25, indicated the resident was cognitively impaired, required maximum assistance for daily care needs, and received opioid medications during the assessment period. On 1/8/26 at 10:10 a.m., the review of the vital signs record and Medication Administration Records for Resident 13, from 8/1/25 to 1/5/26, lacked documentation of pain assessment. On 1/8/26 at 10:30 a.m., during an interview the Director of Nurses indicated the nurse should enter a pain level into the medical record of each resident at least every shift. She acknowledged the medical record of Resident 13 lacked documentation of level of pain. She acknowledged if a resident was on a pain medication and was not experiencing pain the nurse should notify the physician and request reduction or discontinuance of routine pain medication. On 1/7/26 at 11:21 a.m., the DON provided a document with a date of 1/1/25, titled, Medication Regimen Review, and indicated it was the policy currently being used by the facility. The policy indicated, .6. Written communications from the pharmacist shall become a permanent part of the resident's medical record.f. All pharmacy recommendations requiring a physician's action will be brought to the attention of the appropriate physician in a timely manner (within 7 business days). 3.1-25(h)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to assess a resident for pain and administered narcotic medication without documentation of pain symptoms for 1 of 5 residents reviewed for unnecessary medications (Resident 13). Findings include:On 1/5/26 at 11:00 a.m., observed Resident 13 sleeping in bed. He was not restless and was sleeping soundly. No outward signs of pain observed. On 1/5/26 at 12:30 p.m., observed resident sitting in a high back wheelchair during the noon meal service. Resident was relaxed and no visual indicators of pain noted. The resident was relaxed and looked comfortable On 1/7/26 at 10:40 a.m., the medical record of Resident 13 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnosis included, but was not limited to, hemiplegia (a loss of strength in the arm, leg, and sometimes face on one side of the body) and hemiparesis (a relatively mild loss of strength) following cerebral infarction (stroke), dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), and pain. An annual Minimum Data Set (MDS) assessment, dated 9/17/25, indicated the resident was cognitively impaired, required maximum assistance for daily care needs, and received opioid medications during the assessment period. A care plan, dated 12/19/24, indicated pain. Interventions included, but were not limited to, medications as ordered and observe routinely for effectiveness and notify physician of unmanaged pain, numeric scale to evaluate pain and treatment effectiveness and use interventions before pain becomes severe. A physician order, dated 9/4/23, indicated to administer acetaminophen tablet 500 mg (milligram) 1 tablet by mouth every 6 hours as needed for pain. A Physician order, dated 9/10/25, indicated to administer hydrocodone-acetaminophen -Schedule II (narcotic) tablet 5-325 mg amt: 1 tablet by mouth four times a day for pain. A physician order, dated 8/15/22, indicated to evaluate resident's pain level using either a verbal rating, FACES scale, or PAIN scale. Record pain rating and/or if resident says yes or no to pain. Special Instructions: use medication note for pre pain score, post pain score, and non-pharm interventions every shift. A pharmacy review and recommendation, dated 8/9/25, indicated the resident had been receiving Norco 5/325 mg every 6 hours routinely since 10/20/24 and no symptoms of pain were noted on the most recent assessment. A recommendation was presented to change Norco to three times per day (TID). The attending physician agreed to the recommendation. The facility did not change the administration of the medication to TID as recommended. On 1/8/26 at 10:10 a.m., the review of the vital signs record and Medication Administration Records for Resident 13, from 8/1/25 to 1/5/26, lacked documentation of pain assessment. On 1/8/26 at 10:20 a.m., during an interview, Licensed Practical Nurse (LPN) 16 indicated the resident complained of pain occasionally. She indicated she would assess residents for pain at least every shift. She indicated some orders had pain scale in the order and some did not. She indicated if a resident was not complaining of pain and they were provided hospice services she would let hospice manage the pain medication. If the resident was not on hospice she would notify the physician. She indicated the pain scale can also be entered into the residents vital signs record. On 1/8/26 at 10:30 a.m., during an interview the Director of Nurses indicated the nurse should enter a pain level into the medical record of each resident at least every shift. She acknowledged the medical record of Resident 13 lacked documentation of level of pain. She acknowledged if a resident was on a pain medication and was not experiencing pain the nurse should notify the physician and request reduction or discontinuance of routine pain medication. On 1/7/26 at 11:21 a.m., the DON provided a document with a date of 1/1/25, titled, Medication Regimen Review, and indicated it was the policy currently being used by the facility. The policy indicated, .6. Written communications from the pharmacist shall become a permanent part of the resident's medical record.f. All pharmacy recommendations requiring a physician's action will be brought to the attention of the appropriate (continued on next page)

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	155503	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hutsonwood at Brazil	501 S Murphy Ave Brazil, IN 47834

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician in a timely manner (within 7 business days). 3.1-48(a)(1)3.1-48(a)(2)3.1-48(a)(3)3.1-48(a)(4)3.1-48(a)(5)3.1-48(a)(6)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 3 of 7 residents observed during the medication pass. There were 26 opportunities for errors observed with 3 medication errors, resulting in a medication error rate of 11.54 percent (Residents 34, 78, and 8). Findings include:1a. On 1/8/26 at 8:28 a.m., Licensed Practical Nurse (LPN) 8 administered medications to Resident 34. The medications included, but were not limited to, fluticasone propionate (Flonase) 50 micrograms (mcg) nasal spray (a corticosteroid medication used to relieve allergy symptoms) 1 spray to each nostril two times daily. The LPN shook the nasal spray container and placed the tip into the resident's left nostril and sprayed. She then placed the tip of the nasal spray into the resident's right nostril and sprayed it. The LPN failed to instruct the resident to pinch off his opposite nostril as she administered the nasal spray. An active physician's order, reconciled on 1/9/26 at 1:57 p.m., indicated to administer 1 spray of 50 mcg fluticasone propionate nasal spray to bilateral (both sides) nostrils, two times daily. On 1/9/26 at 2:48 p.m., Registered Pharmacist 20 indicated the manufacturer's guidelines for administering fluticasone propionate nasal spray, was to close the opposite nostril as the medication was administered. b. On 1/8/26 at 8:41 a.m., Licensed Practical Nurse (LPN) 8 administered medications to Resident 78. The medications included, but were not limited to, fluticasone propionate (Flonase) 50 micrograms (mcg) nasal spray (a corticosteroid medication used to relieve allergy symptoms) 2 sprays to each nostril two times daily. The LPN shook the nasal spray container and placed the tip into the resident's left nostril and sprayed. She then placed the tip of the nasal spray into the resident's right nostril and sprayed it 2 times. The LPN failed to instruct the resident to pinch off his opposite nostril as she administered the nasal spray. An active physician's order, reconciled on 1/9/26 at 2:06 p.m., indicated to administer 2 sprays of 50 mcg fluticasone propionate nasal spray to bilateral (both sides) nostrils, two times daily. During a telephone interview, on 1/9/26 at 2:48 p.m., Registered Pharmacist 20 indicated the manufacturer's guidelines for administering fluticasone propionate nasal spray, was to close the opposite nostril as the medication was administered. During an interview, on 1/9/26 at 8:47 a.m. the Director of Nursing (DON) indicated the expectation was that nasal sprays should be administered as per physician's order, facility policy, and acceptable standards of practice.On 1/9/26 at 10:46 a.m., the DON provided a document, dated 2024, titled, Nasal Spray Administration, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: Nasal spray medications are administered.in accordance with professional standards of practice. 2. On 1/8/26 at 8:59 a.m., Licensed Practical Nurse (LPN) 8 administered medications to Resident 8. The medications included, but were not limited to, tiotropium 0.018 milligram (mg) inhalation powder (Spiriva) (a prescription maintenance medication used once daily to manage chronic obstructive pulmonary disease [COPD-a progressive lung disease that blocks airflow, making it hard to breathe, caused by permanent damage to the airways and lung tissues] in adults), inhale 1 puff daily. Rinse mouth and spit after each administration. The LPN prepared the inhaler and handed it to the resident. The resident inhaled 1 puff and handed the inhaler back to LPN 8. The LPN left the resident's room and failed to have the resident rinse and spit after the inhaler was administered. An active physician's order, reconciled on 1/9/26 at 2:17 p.m., indicated to administer 1 puff of tiotropium 0.018 mg inhalation powder (Spiriva) daily. Rinse mouth and spit after administration. During an interview, on 1/9/26 at 8:47 a.m. the Director of Nursing (DON) indicated the expectation was that inhalers should be administered as per physician's order, facility policy, and acceptable standards of practice.On 1/9/26 at 10:46 a.m., the DON provided a document, dated 2024, titled, Administration of Metered Dose Inhaler, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Explanation and Compliance Guidelines.16.allow the resident to rinse and gargle with water.to remove medication from mouth and back of throat.3.1-4(c)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure multi-use vials of medication had open dates documented, for 1 of 3 medication carts reviewed. Findings include: On 1/9/26 at 10:46 a.m., an observation of medication cart 1 of the back hall indicated the following a. An open bottle of nasal spray for Resident 71 lacked documentation of an open date. Resident 71's record was reviewed on 1/9/26 at 11:15 a.m. The profile indicated the residents' diagnoses included, but were not limited to, nasal congestion (when the tissues lining the nasal passages are swollen and inflamed, making it hard to breathe through the nose, often accompanied by runny nose). A physician's order, dated 1/6/26, indicated to administer 2 sprays of Vicks [NAME] 12-hour non-aerosol nasal spray (a nasal decongestant that shrinks swollen blood vessels in your nose), 2 sprays in each nostril, two times a day. b. An open bottle of fluticasone propionate nasal spray (a type of medication used to treat and prevent inflammation in the nose caused by allergies or other conditions) for Resident 19 lacked documentation of an open date. Resident 19's record was reviewed on 1/9/26 at 11:19 a.m. The profile indicated the residents' diagnoses included, but were not limited to, nasal congestion (when the tissues lining the nasal passages are swollen and inflamed, making it hard to breathe through the nose, often accompanied by runny nose). A physician's order, dated,10/29/25, indicated to administer fluticasone propionate spray 50 micrograms (mcg) per actuation (spray), 1 spray in both nostrils, two times a day. During an interview, on 1/9/26 at 10:46 a.m., the Unit Manager indicated the medications would be dated when the bottles were opened. The bottles would be opened when the seal was broken. On 1/12/26 at 11:21 a.m., the Director of Nursing (DON) provided a document, dated 1/1/25, titled, Labeling of Medication and Biologicals, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy Explanation and Compliance Guidelines: .8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed. 3.1-25(j)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, and record review, the facility failed to ensure a resident's indwelling urinary catheter (a thin, flexible tube left inside the bladder, typically through the urethra, to continuously drain urine into an external collection bag), external urine collection bag (catheter bag) and tubing were prevented from contact with the floor, for 1 of 1 resident observed for urinary catheter (Resident 21). B. Based on observation, interview, and record review, the facility failed to ensure proper hand hygiene during medication administration for 1 of 2 medication administration observations. Findings include:A. During an initial observation of Resident 21, on 1/6/26 at 9:14 a.m., the resident's catheter bag was observed in contact with the floor. The resident was sitting in her wheelchair next to her bed. During a random observation, on 1/7/26 at 9:04 a.m., the resident was observed in her room in her wheelchair. The resident's catheter tubing was in contact with the floor. Resident 2's record was reviewed on 1/8/26 at 1:25 p.m. The profile indicated the resident had been admitted on [DATE], for diagnoses which included, but were not limited to, urinary tract infection (UTI-a common bacterial infection in any part of your urinary system) and overactive bladder (a sudden, strong, uncontrollable urge to urinate, even when the bladder isn't full). Review of the events indicated the resident had been admitted with a UTI on 11/17/25 and had other UTIs documented on 12/11/25 and 12/26/25. During an interview, on 1/7/26 at 3:26 p.m., the DON indicated there was not a policy specifically related to the catheter bag and/or tubing on the floor, but the facility would follow standards of nursing practice. The expectation was that catheter bags and/or tubing should never come in contact with the floor as it was an infection control risk. B. During the medication administration observation, on 1/8/26 at 8:15 a.m., Licensed Practical Nurse (LPN) 8 was observed to wash her hands prior to setting up her first administration. She performed the handwashing procedure appropriately. A visitor approached the LPN and requested a cup of ice. The LPN obtained the ice for the visitor, touching the outside of the ice bucket, the ice scoop, and the netting surrounding the ice cart, and then proceeded to set up and perform the initial medication pass without sanitizing her hands.During an interview, on 1/9/26 at 8:47 a.m. the Director of Nursing (DON) indicated hand washing and sanitation should always be completed prior to and after each medication pass for the residents. If the nurse touched anything prior to administration, she should have washed her hands again prior to starting the administration. On 1/12/26 at 12:06 p.m., the DON provided a document, dated 1/1/25, titled, Hand Hygiene Table, and indicated it was the policy currently being used by the facility. The policy indicated, .After handing contaminated objects.Before preparing or handling medications. 3.1-18(k)(1)