STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Health & Rehabilitation Center	353 Tyler St Gary, IN 46402

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interview, the facility failed to maintain a sanitary kitchen related to a low temperature chemical dishwasher not sanitizing properly. This had the potential to affect all 70 residents who received meals prepared in the kitchen. (Main Kitchen)Finding includes:On 9/15/25 at 9:00 a.m. the initial kitchen tour was completed with the Dietary Manager (DM). The DM indicated they used a chemical dishwasher, but it was not working properly at the time, and the company was coming out to service it on Friday. He obtained a test strip and dipped it into the dishwasher water. It did not register any parts per million of sanitizing solution. Dietary Aide 1 indicated she had put bleach in a bucket of water in the sink to sanitize the dishes. The DM indicated that was not the correct way to sanitize dishes. During an interview on 9/16/25 at 10:29 a.m., the DM indicated he had educated the kitchen staff to use sanitizing solution in the sink to sanitize the dishes until the dishwasher was fixed. The current policy, Warewashing, indicated, All dishware, serviceware and utensils will be cleaned and sanitized after each use. 1. The Dining Service staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware 3.1-21(i)(3)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review and interview, the facility failed to ensure pureed food was prepared correctly. This had the potential to affect all 8 residents who received pureed food from the kitchen. (Main Kitchen)Finding includes: On 9/18/25 at 11:30 a.m., the [NAME] was observed preparing pureed food for lunch. He indicated there were eight residents who received pureed food, and he was preparing ten servings so there would be extra. He scooped out 4 large serving spoons of turkey pot pie and placed it in the blender and started to puree. He had a 4-quart pitcher of hot water to which he added a scoop of chicken stock and mixed in. He then poured approximately a quart of the chicken broth into the blender. He indicated he added about a cup of broth. He then added 10 scoops of food thickener, another one half to one quart of chicken broth, then another 5 scoops of thickener. The recipe for pureed turkey pot was on the counter next to the blender. The recipe indicated to make 10 servings as follows:10 servings each 3 oz protein 1 1/4 cup chicken brothDuring an interview with the [NAME] at that time, he indicated he added extra broth to extend the recipe in case they wanted seconds.During an interview on 9/18/25 at 11:50 a.m., the Dietary Manager indicated he would re-educate the [NAME] on how to make pureed food. 3.1-21(a)(3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred walls and doors, dirty and discolored floor tiles, missing baseboards, stained ceiling tiles, and missing hooks from privacy curtains for 2 of 4 units throughout the facility. (Units 4 and 5) Findings include: During the environmental tour with the Director of Nursing and the Corporate Nurse Consultant on 9/22/25 at 1:35 p.m., the following was observed: 1. Unit 4a. The entry door to room [ROOM NUMBER] had chipped paint and was marred at the base. The cove base located next to bed A was missing along the side of the wall. The privacy curtains for both beds A and B had hooks missing. Two residents resided in the room. 2. Unit 5 a. The walls located next to the bed and the foot of the bed in room [ROOM NUMBER] were scratched and marred. One resident resided in the room. b. The wall next to bed B in room [ROOM NUMBER] was scratched and marred. The ceiling tile located above the heat register was discolored and bulging, and the tile floor throughout the room was scuffed and marred. Two residents resided in the room. c. The wall next to the head of bed B in room [ROOM NUMBER] was scratched and marred. The floor tile in the bathroom had an accumulation of dirt along the baseboard. Two residents resided in the room and four residents shared the bathroom. During an interview at that time, the Director of Nursing indicated she would relay the above concerns to the Maintenance Director. 3.1-19(f)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and interview, the facility failed to maintain a resident's dignity related to wearing a hospital gown during the day and leaving a resident exposed for 1 of 1 resident reviewed for dignity. (Resident 64)Finding includes:During a random observation on 9/16/25 at 10:29 a.m., CNA 2 and CNA 3 were observed bathing Resident 64. The resident was left undressed and exposed throughout the bath.During random observations at the following times, the resident was observed wearing a hospital gown: 9/16/25 at 10:30 a.m., 9/17/2025 at 9:01 a.m., 9/18/25 at 9:39 a.m. and 2:34 p.m., and 9/19/25 at 10:50 a.m.The record for Resident 64 was reviewed on 9/18/2025 at 12:52 p.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage, hemiplegia (paralysis on one side of the body) following a stroke, and gastrostomy status.The 7/14/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, and was dependent for activities of daily living (ADLs) and transfers. The record lacked a care plan for the resident wearing a hospital gown during the day.During an interview on 9/19/25 at 2:30 p.m., the Director of Nursing (DON) and Corporate Nurse 1 indicated the aides should have kept the resident covered during the bath, only uncovering what was being washed. When informed of the resident wearing a hospital gown during the day without a care plan indicating it was her preference, no additional information was received.A policy titled, Dignity, received as current from the DON on 8/19/25 at 2:58 p.m. indicated, .When assisting with care, residents are supported in exercising their rights. For example, residents are: . encouraged to dress in clothing that they prefer .Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care .3.1-3(t)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was fully informed of risks and benefits of a psychotropic medication prior to initiating the medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 11)Finding includes:Resident 11's record was reviewed on 9/17/25 at 1:26 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, renal disease, generalized anxiety disorder and major depression. The admission Minimum Data Set assessment, dated 7/28/25, indicated the resident had severe cognitive deficits and was dependent for bed mobility, transfers and toileting. Physician's Orders, dated 7/22/25, indicated to give alprazolam (an antianxiety medication) 0.5 milligrams (mgs) three times daily for anxiety and quetiapine fumarate (an antipsychotic) 25 mgs, two tablets twice daily for psychotic disorder with delusions. A Nursing Progress Note, dated 7/25/25, indicated the psychiatric Nurse Practitioner had ordered sertraline (an antidepressant) 50 mgs daily.A Psychotropic Consent assessment was completed on 8/13/25 for alprazolam, quetiapine and sertraline and signed by the Social Service Director. It was not signed by the resident or his representative. There was no documentation in the resident's record indicating the resident or representative had been informed about the medication's risks and benefits.During an interview on 9/22/25 at 1:59 p.m., the Director of Nursing indicated she was aware the consent had not been signed by the resident representative. There was no additional information provided. 3.1-3(n)(2)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a resident was assessed to self-administer medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 24)Finding includes: During a random observation on 9/15/25 at 11:36 a.m., an Albuterol inhaler was observed at Resident 24's bedside. During an interview at that time, the resident indicated he used the inhaler as needed (PRN) and at times he did his own nebulizer treatments. During random observations on 9/16/25 at 9:26 a.m. and 9/17/25 at 8:54 a.m., the inhaler was observed on the resident's bedside table. The resident shared the room with two other residents. The record for Resident 24 was reviewed on 9/17/25 at 2:25 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and hypertension. The 8/31/25 Medicare 5-Day Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 6/7/24 and identified as current, indicated the resident chooses to administer his inhaler. Interventions included, but were not limited to, educate the resident on the order for inhaler use, time and dosage, along with proper storage of the medication, lock box in resident's room for storage of the inhaler, and routine self-administration evaluation.Physician's Orders, dated 8/24/25, indicated the resident was to receive the Albuterol Sulfate 108 (90 base) microgram (mcg) inhaler, 2 puffs every 4 hours as needed PRN for COPD and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) 3 ml inhale orally every 6 hours via nebulizer while awake for COPD. There was no order to self-administer either medication. A Self-Administration of Medication assessment, dated 6/7/24, indicated the resident could administer his Breztri inhaler and the medication had to be kept in the lock box in the resident's room. There was no current Self-Administration of Medication assessment available for review. During an interview on 9/17/25 at 8:58 a.m., LPN 1 indicated the resident administered his inhaler by himself. During an interview on 9/17/25 at 2:00 p.m., the Director of Nursing indicated she was not sure how often the self-administration of medication assessment was to be completed and she would check the facility's policy. The current facility policy titled Self-Administration of Medications and Treatments was provided by the Director of Nursing on 9/18/25 at 8:56 a.m. The policy indicated a physician's order would be obtained specifying the resident's ability to self-administer medications and/or treatments and, if necessary, listing which medications and treatments would be included in the self administration plan, storage of self-administered medications or treatments would comply with state and federal regulations. All bedside medications would be maintained in a secure location in the resident's room. The resident would also be assessed for continued self-administration of medications and/or treatments quarterly and with any significant change of condition. 3.1-11(a)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician was notified timely of residents not receiving medications as ordered for 2 of 6 residents reviewed for unnecessary medications. (Residents C and B)Findings include:1. The closed record for Resident C was reviewed on 9/17/25 at 10:55 a.m. Diagnoses included, but were not limited to, left below the knee amputation (BKA), diabetes, hypertension, pressure ulcers of the hip and buttock, and heart failure.The 7/29/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and was dependent for activities of daily living (ADLs) and transfers.The resident was admitted to the facility on [DATE] following a hospitalization related to the left BKA surgery. At that time, the resident had a unstageable pressure ulcers to the right thigh and buttock as well as a dehisced (reopened surgical incision) wound to the left leg stump. An 8/5/25 Skin/Wound Note indicated the wound to the right thigh was odorous and had purulent (pus) drainage. An 8/8/25 Progress Note indicated the wound doctor assessed the resident's pressure ulcers and ordered Flagyl (an antibiotic) 500 mg intravenously (IV) every 8 hours for 7 days for the wound infection.An 8/9/25 Nurse's Note indicated the Flagyl was not available, and they were awaiting its delivery from the pharmacy.The August 2025 Medication Administration Record (MAR) indicated the resident did not receive any doses of the Flagyl. The record lacked documentation that the physician was notified that the resident did not receive the Flagyl as ordered.During an interview on 9/18/25 at 10:25 a.m., the Infection Preventionist indicated if an antibiotic was not started as ordered, the nurse should have notified the physician and documented it, but she did not see that had been done.During an interview on 9/19/25 at 10:40 a.m., the wound doctor indicated he would expect the IV antibiotic to be started the day it was ordered, and that he was not informed that the resident did not receive the Flagyl until after 8/14/25.During an interview on 9/19/25 at 2:30 p.m., the DON and Corporate Nurse 1 were informed of the findings. Both indicated they did not know why the Flagyl was not administered to the resident. No further information was received. 2. The record for Resident B was reviewed on 9/19/25 at 9:04 a.m. Diagnoses included, but were not limited to, Alzheimer's, diabetes, and COVID-19.The 8/8/25 Annual Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, required substantial assistance with Activities of Daily Living (ADLs), and was independent with transfers.The Physician's Order Summary indicated a Covid test and stat chest x-ray were ordered on 8/6/25 at 10:30 a.m. for shortness of breath. On 8/6/25 at 12:40 p.m., the resident tested positive for Covid.A Nurse's Note, dated 8/7/25 at 2:12 p.m., indicated the resident had wheezing and shortness of breath on exertion. New orders were received including Paxlovid (an oral antiviral medication for treating Covid-19 in patients who are at high risk of the disease progressing to a more severe illness) twice a day for 5 days.The August Medication Administration Record (MAR) indicated the resident only received 3 of the 10 scheduled doses of Paxlovid. A Nurse's Note, dated 8/10/25 at 6:43 p.m., indicated the Paxlovid had not yet arrived, and the nurse manager was made aware. The record lacked documentation that the physician was notified that the resident did not receive the Paxlovid as ordered.During an interview on 9/19/25 at 2:30 p.m., the DON and Corporate Nurse 1 indicated the nurse should have notified the physician that the resident did not receive the medication as prescribed and documented the notification in the resident's record.A policy titled, Notification of Changes, received as current from the DON on 8/19/25 at 2:58 p.m. indicated, . The facility must . consult the resident's physician . when there is a change requiring such notification . Circumstances requiring notification include: . a need to alter a treatment.3.1-5(a)(3)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to ensure professional standards of quality were maintained related to CNAs stopping and starting tube feedings for 1 of 5 residents reviewed for tube feedings. (Resident 64)Finding includes:During a random observation on 9/16/25 at 10:29 a.m., CNA 2 and CNA 3 were observed bathing Resident 64. The resident had a gastrostomy tube (a feeding tube inserted through the abdomen), connected to a tube feeding pump. The feeding pump was paused while the resident was lying flat. When the feeding pump started beeping, CNA 3 pushed buttons on the pump. When the bath was completed and the head of the bed was elevated, CNA 3 started the tube feeding pump.During an interview at that time, CNA 2 and CNA 3 indicated they had stopped the tube feeding before lying the resident flat, and re-started it after the head of the bed was elevated. CNA 3 demonstrated which buttons they pushed to stop and start the feedings. The record for Resident 64 was reviewed on 9/18/2025 at 12:52 p.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage, hemiplegia (paralysis on one side of the body) following a stroke, and gastrostomy status.The 7/14/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment and was dependent for activities of daily living (ADLs) and transfers. A 9/1/25 Physician's Order indicated enteral feeding (tube feeding) of Jevity 1.2 (a tube feeding forumla) at 50ml/hr (milliliters per hour) for 20 hours; on at 5:00 p.m., off at 1:00 p.m.During an interview on 9/19/25 at 2:30 p.m., the Director of Nursing (DON) indicated the CNAs should not stop or start the tube feedings, but should be getting a nurse to do it. The Indiana State Department of Health Nurse Aide Curriculum, created July 1998 and revised November 19, 2015, indicated, . The resident with a feeding infusing should not lie flat. The head of the bed should be elevated at least 30 . Some procedures will need to be changed slightly for the resident with a feeding tube. For example, an occupied bed cannot be flattened to change the linen or to provide incontinence care with the feeding infusing. If the bed must be flattened, seek the nurse's assistance to turn off the pump prior to the procedure and turn the pump back on after the procedure. Your major responsibility concerning the resident with a feeding tube is to make regular observations and promptly report any problem .3.1-35(g)(1)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, record review and interview, the facility failed to provide ongoing activities for dependent residents for 3 of 3 residents reviewed for activities. (Residents 14, 35 and 44)Findings include: 1. Resident 14 was observed in her bed on 9/15/25 at 11:45 a.m. and 3:00 p.m., 9/16/25 at 10:36 a.m., 1:55 p.m. and 3:49 p.m., and on 9/17/25 at 9:13 a.m., 1:21 p.m. and 3:24 p.m. There was no radio or television on in the room. On 9/18/25 at 9:26 a.m., the resident was up in her chair yelling out nonsensically, there was no radio or television on in the room. At 9:57 a.m. a staff member was in the resident's room attempting to calm her and had turned the radio on. The resident's record was reviewed on 9/18/25 at 9:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, severe protein calorie malnutrition and adult failure to thrive. The Annual Minimum Data Set (MDS) assessment, dated 8/8/25, indicated the resident had severe cognitive impairment and was dependent for bed mobility, toileting and transfers. An Activity Care Plan, dated 12/11/24, indicated, [Resident's name] enjoys television, may require an optimal amount of sensory as well as cognitive stimulation . During an interview on 9/18/25 at 9:50 a.m., the Activity Director indicated an activity aide would visit the resident three times a week for a one-on-one visit that normally lasted about 15 minutes. She indicated the radio or television should be on for the resident and that normally the nursing staff did that. 2. Resident 35 was observed in her bed on 9/15/25 at 11:45 a.m. and 3:00 p.m., 9/16/25 at 10:36 a.m., 1:55 p.m. and 3:49 p.m., and 9/17/25 at 9:13 a.m., 1:21 p.m. and 3:24 p.m. There was no radio or television on in the room. On 9/18/25 at 9:26 a.m. the resident's roommate was yelling loudly next to her, there was no television or radio on in the room. The resident's record was reviewed on 9/18/25 at 9:45 a.m. Diagnoses included, but were not limited to, cerebral palsy, epilepsy and visual loss. The Annual MDS assessment, dated 7/24/25, indicated the resident had severe cognitive impairment and was dependent for bed mobility, toileting and transfers. A Care Plan, dated 7/10/24, indicated the resident cannot express her care needs and requires assistance with daily needs. Interventions were to provide one-on-one activities, talk/read to her and provide music. During an interview on 9/18/25 at 9:50 a.m., the Activity Director indicated an activity aide would visit the resident three times a week for a one-on-one visit that normally lasted about 15 minutes. She indicated the radio, or television should be on for the resident and that normally the nursing staff did that. During an interview on 9/18/25 at 11:11 a.m., the Director of Nursing was made aware of the lack of activities or sensory stimulation for Residents 14 and 35, there was no additional information provided. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During the following random observations, Resident 44 was observed lying in bed, awake, without television, music, or staff interaction: 9/15/25 at 11:36 a.m., 9/16/25 at 9:34 and 10:25 a.m., 9/17/25 at 8:56 a.m. and 1:50 p.m., and 9/18/25 at 9:31 a.m. The resident's record was reviewed on 9/17/25 at 3:04 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) following a stroke affecting the left side, seizures, and dementia. The 7/31/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment and was dependent in activities of daily living (ADLs) and transfers. The 4/3/25 Quarterly / Annual Activities Participation Review indicated the resident enjoyed self-directed leisure time activities, participated in sensory stimulation activities, and would listen to music. An Activities Care Plan, identified as current, indicated the resident was on a one-to-one sensory stimulation goal for activities through the next review date. A review of the one-to-one visits report form indicated the resident did not receive 3 one-to-one visits for the week of 9/7/25 to 9/13/25. During an interview on 9/18/25 at 2:17 p.m., the Activities Director indicated the resident should get one-on-one visits three times a week and she was looking into getting more televisions and radios for stimulation. 3.1-33(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure blood pressure medications were administered and/or held per parameters as ordered. The facility also failed to ensure medications were administered as ordered and laboratory tests were obtained for 3 of 7 residents reviewed for unnecessary medications. (Residents F, E, and D)Findings include: 1. The record for Resident F was reviewed on 9/18/25 at 11:42 a.m. Diagnoses included, but were not limited to, end stage renal disease, hypotension (low blood pressure), and hypertension. The 8/27/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and he was receiving dialysis while a resident of the facility. A Care Plan, reviewed on 8/22/25, indicated the resident had hypotension with episodes of syncope (fainting) related to dialysis. Interventions included, but were not limited to, administer medications per physician's order. A Physician's Order, dated 8/21/25, indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) 5 milligrams three times a day. The medication was to be held for systolic blood pressure (top number) less/greater than 110 or heart rate less than 60. The August 2025 Medication Administration Record (MAR), indicated the resident received the Midodrine on the following dates and times: 8/23/25 at 9:00 a.m. blood pressure 136/92 8/23/25 at 2:00 p.m. blood pressure 117/78 8/27/25 at 2:00 p.m. blood pressure 127/76 8/21/25 at 9:00 p.m. blood pressure 122/68 8/24/25 at 9:00 p.m. blood pressure 132/68 8/25/25 at 9:00 p.m. blood pressure 115/68 8/26/25 at 9:00 p.m. blood pressure 132/68 8/31/25 at 9:00 p.m. blood pressure 141/71 The September 2025 MAR, indicated the resident received the Midodrine on the following dates and times: 9/12/25 at 9:00 a.m. blood pressure 117/68 9/18/25 at 9:00 a.m. blood pressure 92/62 (the medication was held) 9/4/25 at 2:00 p.m. blood pressure 139/93 (continued on next page)

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South Shore Health & Rehabilitation Center	353 Tyler St Gary, IN 46402

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/4/25 at 9:00 p.m. blood pressure 131/79 9/6/25 at 9:00 p.m. blood pressure 135/78 9/9/25 at 9:00 p.m. blood pressure 121/72 9/10/25 at 9:00 p.m. blood pressure 148/80 9/14/25 at 9:00 p.m. blood pressure 119/76 9/16/25 at 9:00 p.m. blood pressure 119/70 9/17/25 at 9:00 p.m. blood pressure 115/65 9/18/25 at 9:00 p.m. blood pressure 121/71 During an interview on 9/19/25 at 2:40 p.m., the Director of Nursing indicated the medication order needed to be clarified. 2. The record for Resident E was reviewed on 9/17/25 at 9:49 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, hypertensive heart disease, and hypotension (low blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 7/31/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. A Physician's Order, dated 6/7/24 and listed as current on the September 2025 Physician's Order Summary (POS), indicated the resident was to receive Lisinopril (a blood pressure medication) 10 milligrams (mg) one time daily. The medication was to be held if the resident's blood pressure was less than 100/60. The July 2025 Medication Administration Record (MAR) indicated the resident received the Lisinopril on the following dates and time when her blood pressure was less than 100/60: 7/5/25 at 9:00 a.m. blood pressure 110/59 7/7/25 at 9:00 a.m., blood pressure 110/56 7/10/25 at 9:00 a.m. blood pressure 100/56 7/11/25 at 9:00 a.m. blood pressure 100/56 7/14/25 at 9:00 a.m. blood pressure 108/56 The August 2025 MAR indicated the resident received the Lisinopril on the following dates and time when her blood pressure was less than 100/60: 8/11/25 at 9:00 a.m. blood pressure 89/46 The September 2025 MAR indicated the resident received the Lisinopril on the following dates and (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time when her blood pressure was less than 100/60: 9/10/25 at 9:00 a.m. blood pressure 103/58 9/12/25 at 9:00 a.m. blood pressure 107/54 A Physician's Order, dated 8/5/24 and listed as current on the September 2025 POS, indicated the resident was to receive Midodrine HCl (a medication for low blood pressure) 10 milligrams (mg) every 8 hours as needed (PRN) for hypotension. Give when systolic blood pressure (top number) was less than 90. The July, August, and September 2025 Medication Administration Records (MARs) indicated the resident's blood pressure was monitored once a day rather than every 8 hours. The July 2025 MAR indicated on 7/30/25 at 9:00 a.m., the resident's blood pressure was 79/55. The resident did not receive the PRN Midodrine. The August 2025 MAR indicated on 8/20/25 at 9:00 a.m., the resident's blood pressure was 83/60. The resident did not receive the PRN Midodrine. During an interview on 9/19/25 at 2:40 p.m., the Director of Nursing indicated the resident should have received the Midodrine as ordered and a clarification order for the Lisinopril should have been obtained. 3. Resident D's record was reviewed on 9/18/25 at 3:07 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction, diabetes mellitus, and atrial fibrillation. The Quarterly MDS, dated [DATE], indicated the resident had moderate cognitive impairment and was dependent for toileting and transfers. A complete blood count (CBC) and comprehensive metabolic panel (CMP) lab tests were completed on 4/28/25. There were handwritten orders at the bottom of the lab results that indicated to repeat the labs in one week and to give potassium 40 milliequivalents x 1. There were no orders for the repeat lab or the potassium entered into the electronic record. There was no indication the repeat lab had been completed in one week or the potassium had been given as ordered. During an interview on 9/22/25 at 1:59 p.m., the Director of Nursing indicated the repeat lab had not been done and the potassium had not been given. This citation relates to Intake 2597285. 3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for 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. Based on record review and interview, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase or prevent further decrease in range of motion for 2 of 4 residents reviewed for mobility. (Residents 44 and B)Findings include:1. During a random observation on 9/16/25 at 9:05 a.m., Resident 44 was observed lying in bed. He did not move his left arm or leg. His left knee appeared contracted. There was no visible intervention in place for the immobile limbs. The resident's record was reviewed on 9/17/25 at 3:04 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) following a stroke affecting the left side, seizures, and dementia.The 7/31/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment and was dependent in activities of daily living (ADLs) and transfers.A 6/14/23 Physician's Order indicated the resident was to participate in the restorative care program.A Restorative Care Plan, updated 7/31/25, indicated the resident required assistance with bed mobility and had range of motion (ROM) limitations. Interventions included a splint program to prevent further contracture of the left knee, and passive range of motion exercises.A 7/31/25 Restorative Nursing Note (the last restorative note in the record) indicated the resident's goals were not met, and they would continue the restorative program.The record lacked documentation of ROM exercises or a brace program being implemented since 7/31/25.During an interview on 9/22/25, LPN 2 indicated there had not been a restorative program for a couple of months because they could not staff it. During an interview on 9/22/25, at 2:30 p.m., the DON indicated they planned to resume the restorative care program when they could get enough staff hired and trained.2. During a random observation on 9/15/25 at 3:28 p.m., Resident B was observed sitting in his wheelchair. He did not move his right arm, and he had a carrot splint in his right hand. The record for Resident B was reviewed on 9/19/25 at 9:04 a.m. Diagnoses included, but were not limited to, fractures of the left tibia (shinbone) and left clavicle (collarbone), Alzheimer's, and repeated falls. The 8/8/25 Annual Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, required substantial assistance with Activities of Daily Living (ADLs).A 3/3/25 Physician's Order indicated the resident was to participate in the restorative care program.A Restorative Care Plan, updated 5/21/25, indicated the resident required active ROM exercises 5 days a week and participation in a walking program.A 5/21/25 Restorative Nursing Note (the last restorative note in the record) indicated the active ROM and walking programs were recommended to continue. The record lacked documentation of active ROM exercises or a walking program implemented since 5/21/25.During an interview on 9/22/25, LPN 2 indicated there had not been a restorative program for a couple of months because they could not staff it. During an interview on 9/22/25, at 2:30 p.m., the DON indicated they planned to resume the restorative care program when they could get enough staff hired and trained.3.1-42(a)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review and interview, the facility failed to ensure tube feedings were infusing at the correct times and/or the head of the bed was elevated while tube feeding was infusing for 3 of 5 residents reviewed for tube feeding. (Residents 14, 9 and 64)Findings include:1. Resident 14 was observed in bed on 9/16/25 at 10:36 a.m., there was no tube feeding hanging or infusing at that time. On 9/18/25 at 9:26 a.m. and 11:04 a.m., the resident was observed in her chair in her room, there was no tube feeding hanging or infusing. The resident's record was reviewed on 9/18/25 at 9:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, severe protein calorie malnutrition and adult failure to thrive. The Annual Minimum Data Set (MDS) assessment, dated 8/8/25, indicated the resident had severe cognitive impairment and was dependent for bed mobility, toileting and transfers. The Physician's Order indicated to give Jevity 1.2 (a type of tube feeding) continuously at 50 milliliters per hour for 18 hours a day. The September 2025 Medication Administration Record indicated the tube feeding was to be turned on at 6:00 p.m. daily and turned off at 1 p.m. During an interview on 9/18/25 at 11:06 a.m., RN 2 indicated the tube feeding should be on until 1 p.m. The previous nurse had taken it off early, she did not know why, and she had not restarted it. During an interview o 9/18/25 at 11:11 a.m., the Director of Nursing was made aware the tube feeding was not infusing as ordered. There was no additional information provided. 2. During a random observation on 9/15/25 at 10:15 a.m., Resident 9 was observed lying in bed. The head of the bed was up less than 30 degrees. A tube feeding was infusing via a pump. At 10:28 a.m., CNA 1 entered the room, put the head of the bed flat, and proceeded to clean the resident and change his disposable brief. The tube feeding continued to infuse. When asked, CNA 1 indicated sometimes she stopped the feeding pump before lying the resident flat and sometimes she did not. The head of the bed was immediately raised and the nurse brought in to assess the resident with no issues noted. The resident's record was reviewed on 9/16/25 at 2:12 PM. Diagnoses included, but were not limited to, dementia, Alzheimer's, and dysphagia (difficulty swallowing). The 8/15/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, was dependent in ADLs, and required maximal assistance with transfers. An 8/11/25 Physician's Order indicated to elevate the head of the bed 30 to 45 degrees at all times with tube feeding, every shift. On 9/15/25 at 10:40 a.m., RN 1 indicated the head of the bed should be up 45 degrees while the tube feeding was infusing and should be stopped when the resident was flat for turning or repositioning. During an interview on 9/17/25 at 2:00 p.m., the Director of Nursing (DON) indicated the CNAs should (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get a nurse to stop the tube feeding when they need to put the head of the bed down. 3. During random observations on 9/18/25 at 9:39 a.m. and 12:00 p.m., there was no tube feeding hanging or infusing for Resident 64. The record for Resident 64 was reviewed on 9/18/2025 at 12:52 p.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage, hemiplegia (paralysis on one side of the body) following a stroke, and gastrostomy status. The 7/14/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment and was dependent in activities of daily living (ADLs) and transfers. A 9/1/25 Physician's Orders indicated enteral feeding (tube feeding) of Jevity 1.2 (a tube feeding forumla) at 50ml/hr (milliliters per hour) for 20 hours; on at 5:00 p.m., off at 1:00 p.m. A 3/20/25 Care Plan indicated the resident had a nutritional problem related to requiring enteral nutrition (tube feeding). Interventions included to provide enteral nutrition formula, rate and fluid flushes as ordered. During an interview on 9/18/25 at 12:00 p.m., RN 2 indicated the tube feeding should have been infusing, but the midnight nurse must have taken the feeding down too early. During an interview on 9/18/25 at 2:30 p.m, the Director of Nursing (DON) indicated the tube feeding should have been infusing as per order. 3.1-44(a)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate for 2 of 3 residents reviewed for respiratory care. (Residents 12 and 24)Findings include:1. During a random observation on 9/15/25 at 2:34 p.m., Resident 12 was observed in his room in bed. The resident had oxygen by the way of a nasal cannula in use. The oxygen concentrator was set at 8 liters. On 9/16/25 at 9:15 a.m., 11:50 a.m., 2:04 p.m., and 3:45 p.m., the resident was observed in his room in bed. Oxygen via nasal cannula was in use and the oxygen concentrator was set at 8 liters. The record for Resident 12 was reviewed on 9/18/25 at 3:32 p.m. Diagnoses included, but were not limited to, pleural effusion (a collection of fluid around the lungs), heart failure, and anxiety. The 5 day Medicare Minimum Data Set (MDS) assessment, dated 9/5/25, indicated the resident was cognitively intact and received oxygen while a resident of the facility. A Care Plan, dated 7/24/25, indicated the resident received oxygen therapy related to congestive heart failure, history of pneumonia, pulmonary embolism (blood clot), pulmonary edema, and respiratory failure. Interventions included, but were not limited to, administer oxygen per physician's order. A Physician's Order, dated 9/12/25, indicated the resident was to receive oxygen at 4 liters continuously every shift.During an interview on 9/18/25 at 8:50 a.m., the Director of Nursing indicated the resident's oxygen concentrator should have been set at the correct flow rate. 2. During a random observation on 9/15/25 at 11:35 a.m., Resident 24 was observed with oxygen by the way of a nasal cannula in use. The resident's oxygen concentrator was set at 3 liters. On 9/16/25 at 8:52 a.m., the resident's oxygen was in use and the oxygen concentrator was set at 2 liters. At 9:27 a.m., the oxygen concentrator was set at 3 liters. On 9/17/25 at 8:54 a.m., the resident's oxygen was in use and the oxygen concentrator was set at 3 liters. The record for Resident 24 was reviewed on 9/17/25 at 2:25 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and hypertension. The 8/31/25 Medicare 5-Day Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was not receiving oxygen while a resident of the facility. A current Care Plan indicated the resident had oxygen therapy as needed related to COPD and a history of pneumonia to help relieve hypoxia (low levels of oxygen in body tissue). Interventions included, but were not limited to, administer oxygen per physician's order. Physician's Orders, dated 8/27/25, indicated the resident was to receive 2 liters of oxygen per nasal cannula as needed (PRN) to keep his oxygen saturation above 92% every shift. The resident's oxygen saturation was to be monitored every shift.The September 2025 Medication Administration Record (MAR) indicated the oxygen was signed out as being in use each shift for the month except for the evening of 9/13/25. During an interview on 9/17/25 at 8:58 a.m., LPN 1 indicated the resident's oxygen concentrator was always set at 3 liters. During an interview on 9/17/25 at 2:00 p.m., the Director of Nursing was informed of the incorrect flow rate. No further information was provided.3.1-47(a)(6)

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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. Based on record review and interview, the facility failed to ensure a Pharmacy recommendation was completed as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident D)Finding includes:Resident D's record was reviewed on 9/18/25 at 3:07 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction, diabetes mellitus, and atrial fibrillation. The Quarterly Minimum Data Set (MDS) assessment, dated 8/8/25, indicated the resident had moderate cognitive impairment and was dependent for toileting and transfers. A pharmacy review was completed on 5/11/25. A recommendation was made to the Physician to consider scheduling a complete blood count (CBC), comprehensive metabolic panel (CMP), A1c (test to measure sugar in the blood), Vitamin D level and lipids at the next convenient lab. The Physician agreed and signed the recommendation on 5/15/25. A CBC and CMP were completed on 5/29/25. The A1c, Vitamin D and lipid test had not been completed. During an interview on 9/22/25 at 9:18 a.m., the Director of Nursing indicated she normally reviews the pharmacy recommendations then gives them to the Physician or Nurse Practitioner. She did not know why the pharmacy recommendation had not been completed. The policy, Medication Regimen Review and Address Irregularities, dated 6/12/23, indicated, .e. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities 3.1-25(i)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were free of significant medication errors related to medications not administered as ordered for infections for 2 of 6 residents reviewed for unnecessary medications. (Residents C and B)Findings include: 1. The closed record for Resident C was reviewed on [DATE] at 10:55 a.m. Diagnoses included, but were not limited to, left below the knee amputation (BKA), diabetes, hypertension, pressure ulcers of the hip and buttock, and heart failure.The [DATE] Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and was dependent for activities of daily living (ADLs) and transfers.The resident was admitted to the facility on [DATE] following a hospitalization related to the left BKA surgery. At that time, the resident had a unstageable pressure ulcers to the right thigh and buttock as well as a dehisced (reopened surgical incision) wound to the left leg stump. A Physician's Order, dated [DATE], indicated Tigecycline (an intravenous antibiotic) 100 milligrams two times a day, related to infection of the skin and subcutaneous tissue, for 28 days.A Skin/Wound Note, dated [DATE], indicated the wound to the right thigh was odorous and had purulent (pus) drainage. On [DATE], a culture was sent of the right thigh wound.A Progress Note, dated [DATE], indicated the wound doctor assessed the resident's pressure ulcers and ordered Flagyl (an antibiotic) 500 mg intravenously (IV) every 8 hours for 7 days for the wound infection.A Nurse's Note, dated [DATE], indicated the Flagyl was not available, and they were awaiting its delivery from the pharmacy.The [DATE] Medication Administration Record (MAR) indicated the resident did not receive any doses of the Flagyl. A Skin/Wound Nurse's Note, dated [DATE] at 11:54 a.m., indicated the wound doctor was informed of the wound culture results. New orders were received to discontinue the Flagyl and start Levaquin (an antibiotic) for pseudomonas (a bacteria that can be resistant to many antibiotics). An Acute Care Note, dated [DATE] at 1:20 p.m., indicated the resident was found altered mentally and verbally unresponsive and was being sent to the hospital emergency department (ED) for evaluation. An ED physician's note, dated [DATE], indicated, Pt [patient] in septic shock; source of infection is not known.During an interview on [DATE] at 10:25 a.m., the Infection Preventionist indicated the right hip wound was infected, the wound doctor ordered Flagyl and wanted it started right away. It happened over the weekend, and when she came back Monday, she saw the Flagyl had not been started. At that time, she received the culture results and the antibiotic order was changed. She indicated if an antibiotic was not started as ordered, the nurse should have notified the physician and documented it.During an interview on [DATE] at 10:40 a.m., the wound doctor indicated the right hip wound was the only infected wound he observed, and the resident had no other infectious process he was aware of. He would expect the IV antibiotic to be started the day it was ordered, and that he was not informed that the resident did not receive the Flagyl until after she expired in the hospital on [DATE]. He indicated he could not determine if the resident's outcome would have been different if she had received the Flagyl as prescribed. During an interview on [DATE] at 2:30 p.m., the DON and Corporate Nurse 1 were informed of the findings. Both indicated they did not know why the Flagyl was not administered to the resident. No further information was received. 2. The record for Resident B was reviewed on [DATE] at 9:04 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, diabetes, and COVID-19.The [DATE] Annual Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, required substantial assistance with Activities of Daily Living (ADLs), and was independent with transfers.The current Physician's Order Summary indicated a Covid test and stat chest x-ray were ordered on [DATE] at 10:30 a.m. for shortness of breath. On [DATE] at 12:40 p.m., the resident tested positive for Covid.A Nurse's Note, dated [DATE] at 2:12 p.m., indicated the resident had wheezing and shortness of breath on exertion. New orders were received including Paxlovid (an oral antiviral medication for treating Covid-19 in patients who are at high risk of the disease progressing to a more severe illness) twice a day for 5 days.A Nurse's Note, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE] at 6:43 p.m., indicated the Paxlovid had not yet arrived and the nurse manager was made aware. The [DATE] Medication Administration Record (MAR) indicated the resident only received 3 of the 10 scheduled doses of Paxlovid. The record lacked documentation as to why the resident did not receive the medication as ordered. During an interview on [DATE] at 2:30 p.m., the DON and Corporate Nurse 1 indicated the medication came as one unit from the pharmacy, and should have been available for the resident to receive as ordered. They did not know why the resident did not receive the medication as it was prescribed. The manufacturer prescriber administration instructions for Paxlovid indicated to alert the patient of the importance of completing the full 5-day treatment course and to continuing isolation in accordance with public health recommendations to maximize viral clearance and minimize transmission of SARS-CoV-2. If the patient misses a dose of Paxlovid within 8 hours of the time it is usually taken, the patient should take it as soon as possible and resume the normal dosing schedule. This citation relates to Intake 2597285.3.1-48(c)(2)

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	155530	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Health & Rehabilitation Center	353 Tyler St Gary, IN 46402

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, record review, and interview, the facility failed to ensure infection control practices were in place and implemented related to not donning personal protective equipment (PPE) for residents in enhanced barrier precautions (EBP) for two random resident care observations. (Residents 9 and 64)Findings include:1. During a random observation on 9/15/25 at 10:28 a.m., CNA 1 was observed providing a partial bath with incontinence care for Resident 9, who had a gastrostomy tube (a feeding tube inserted through the abdomen). CNA 1 did not wear a gown when providing direct care for the resident. The resident's record was reviewed on 9/16/25 at 2:12 p.m. Diagnoses included, but were not limited to, dementia, Alzheimer's, and dysphagia (difficulty swallowing).The 8/15/25 Significant Change Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment and was dependent in activities of daily living (ADLs), and required maximal assistance with transfers.A Physician's Order, dated 9/16/25, indicated the resident required enhanced barrier precautions (EBP) and that all staff must don gown and gloves for all high contact resident care activities.A Care Plan, dated 9/17/25, indicated the resident required enhanced barrier precautions (EBP) during high-contact care including bathing, dressing, hygiene, changing linens and changing briefs.During an interview on 9/17/25 at 2:00 p.m., the Director of Nursing (DON) indicated staff should wear a gown and gloves with any direct contact with a resident on EBP. 2. During a random observation on 9/16/25 at 10:29 a.m., CNA 2 and CNA 3 were observed bathing Resident 64, who had a gastrostomy tube. At that time, neither CNA 2 nor CNA 3 were wearing a gown.On 9/17/25 at 9:07 a.m., CNA 1 was observed pulling Resident 64's legs apart and adjusting her disposable brief. At that time, CNA 1 was not wearing a gown or gloves. The record for Resident 64 was reviewed on 9/18/2025 at 12:52 p.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage, hemiplegia (paralysis on one side of the body) following a stroke, and gastrostomy status.The 7/14/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment and was dependent in activities of daily living (ADLs) and transfers. A Physician's Order, dated 6/4/25, indicated the resident was on enhanced barrier precautions (EBP), and that all staff must don a gown and gloves for all high-contact activities, including bathing, dressing, hygiene, changing linens and changing briefs.A Care Plan, dated 12/3/24, indicated the resident required EBP during high-contact care related to the presence of a feeding tube.During an interview on 9/17/25 at 2:00 p.m., the Director of Nursing (DON) indicated staff should wear a gown and gloves with any direct contact with a resident on EBP. A policy titled, Enhanced Barrier Precautions, received as current from the Director of Nursing on 9/18/25 at 9:07 a.m. indicated, . EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities . High-contact resident care activities include . bathing . providing hygiene . changing briefs or assisting with toileting . The policy indicated EBP should be implemented for residents with a wound or indwelling medical device. 3.1-18(b)