STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155542	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cloverleaf of Knightsville	9325 N Crawford St Knightsville, IN 47857

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure safe administration of peritoneal dialysis (a home-based treatment for kidney failure that uses the lining of the abdomen to filter waste and extra fluid from the blood) by staff trained and qualified to administer peritoneal dialysis for 1 of 1 resident reviewed for peritoneal dialysis (Resident 2). Findings include:During an interview, on 2/10/26 at 10:41 a.m., Resident 2 indicated he was on peritoneal dialysis and staff would place him on the dialysis in the evening and would remove it around 8 to 8:30 a.m. the next morning. Resident 2's record was reviewed on 2/12/26 at 3:09 p.m. The profile indicated the resident's diagnoses included, but were not limited to, end stage renal disease (the final permanent stage of chronic kidney disease where kidneys function less than 15% of normal capacity, requiring dialysis or transplant for survival) and dependence on renal dialysis (indicates a chronic, life-sustaining need for mechanical blood filtration). Facility census information indicated Resident 2 was admitted to the facility on [DATE]. A physician order, dated 11/19/25, indicated to administer peritoneal dialysis two 6 liters (L) bags total over 12 hours per machine. Start at bedtime (HS) remove when completed daily. A care plan, dated 11/20/25, indicated the resident had a diagnosis of end stage renal disease and was at risk for complications with dialysis treatment. Interventions included, but were not limited to, complete peritoneal dialysis daily, medications as ordered, observe for pain at site and notify physician if pain is present, and weights as ordered. A quarterly Minimum Data Set (MDS) assessment, dated 11/27/25, indicated the resident was cognitively intact and was on dialysis. Resident 2's Medication Administration Record (MAR) was reviewed since his admission on [DATE], until present February 2026. The following was documented by staff as administering the peritoneal dialysis to Resident 2:1. November 2025 MAR:a. Registered Nurse (RN)16 had documented she administered peritoneal dialysis 5 times since his admission. The record lacked in-service documentation that RN 16 had been trained by the dialysis center to be able administer peritoneal dialysis to Resident 2.b. Licensed Practical Nurse (LPN) 17 had documented he administered peritoneal dialysis one time since the resident's admission. The record lacked in-service documentation that LPN 17 had been trained by the dialysis center to be able to administer peritoneal dialysis to Resident 2.2. December 2025 MAR:a. RN 15 had documented she administered peritoneal dialysis 2 times during the month of December. The record lacked in-service documented that RN 15 had been trained by the dialysis center to be able to administer peritoneal dialysis to Resident 2.b. RN 16 had documented she administered peritoneal dialysis 15 times during the month of December. The record lacked in-service documented that RN 16 had been trained by the dialysis center to be able to administer peritoneal dialysis to Resident 2.3. January 2026 MAR:a. RN 15 had documented that she administered peritoneal dialysis 2 times during the month of January 2026. The record lacked in-service documented that RN 15 had been trained by the dialysis center to be able to administer peritoneal dialysis to Resident 2.b. RN 16 had documented she administered peritoneal dialysis 15 times during the month of December. The record lacked in-service documented that RN 16 had been trained by the dialysis center to be able to administer peritoneal dialysis to Resident 2.4. February 2026 MAR:a. RN 15 had documented that she administered peritoneal dialysis one time from February 1st through the 12th. The record lacked (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-service documented that RN 15 had been trained by the dialysis center to be able to administer peritoneal dialysis to Resident 2.b. RN 16 had documented that she administered peritoneal dialysis 5 times from February 1st through the 12th. The record lacked in-service documented that RN 15 had been trained by the dialysis center to be able to administer peritoneal dialysis to Resident 2.c. LPN 17 had documented that he administered the peritoneal dialysis one time from February 1st through the 12th. The record lacked in-service documented that LPN 17 had been trained by the dialysis center to be able to administer peritoneal dialysis to Resident 2. During a phone interview, on 2/13/26 at 9:49 a.m., a Contracted Dialysis Center Administrator indicated that only trained and qualified staff were to administer peritoneal dialysis to residents in a long-term care facility. It was the expectation that the long-term care facility would notify the dialysis center of any new resident that was admitted to their facility and required peritoneal dialysis. The facility staff had to be trained for each specific resident that was admitted to the facility. The dialysis center would be the ones who trained staff on peritoneal dialysis for each specific resident. The Contracted Dialysis Center Administrator indicated RN 15, RN 16, and LPN 17 had not been trained on peritoneal dialysis for Resident 2. She was unable to provide documentation that they had attended an in-service training on 11/18/25. During an interview, on 2/13/26 at 10:03 a.m., the Director of Nursing (DON) indicated the dialysis center usually did training once a year at the facility. The DON indicated the staff called the contracted dialysis center when a new admission came to the long-term facility and was on dialysis. She was not sure why RN 15, RN 16, and LPN 17 had not been trained, she was unable to provide documentation that they had been trained on peritoneal dialysis administration for Resident 2. On 2/13/26 at 10:07 a.m., the DON provided a document with a revised date of October 2010, titled, Peritoneal Dialysis (Continuous Ambulatory), and indicated it was the current policy being used by the facility. The policy indicated, . The purpose of this procedure is to provide continuous ambulatory peritoneal dialysis that is safe and consistent with physician orders and instructions from the contracted dialysis facility. 1. This procedure must be performed by a nurse who has been specifically trained in peritoneal dialysis procedures, complications, and infection control for dialysis. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure dementia (a decline in mental ability such as memory, reasoning, and communication) residents' person-centered specific care needs were communicated to facility staff for 2 of 5 residents reviewed for dementia care (Residents 45 and 8). Findings include:1. Resident 45's record was reviewed on 2/10/26 at 2:12 p.m. The profile indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease with late onset (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform daily tasks, with symptoms worsening over time) and dementia with mood disturbance (the emotional changes and behavioral shifts that occur in people with dementia, often resulting from brain damage). A quarterly Minimum Data Set (MDS) assessment, dated 1/28/26, indicated the resident had severe cognitive deficit. A care plan, dated 5/31/25 and revised on 1/16/26, indicated the resident had a diagnosis of Alzheimer's disease and severe dementia with mood disturbance. Interventions included, but were not limited to, the resident liked to reminisce using photos of family and friends. The care plan lacked any further documentation of person-centered interventions. An activity evaluation, dated 5/19/25, indicated information of a personal level about the resident's past, favorite things, and preferences. During an interview, on 2/11/26 at 9:00 a.m., the Director of Nursing (DON) indicated the Activity Director completed the personal information about the resident on the assessment at admission and would update the information periodically and as needed. The Activity Director had been working on a plan to inform the floor staff of the person-centered information for each resident. To her knowledge this had not yet been set in place. During an interview, on 2/11/26 at 9:12 a.m., Certified Nursing Assistant (CNA) 8 indicated she did not know where she could immediately access the person-centered information on the residents. She would likely just go to the nurse and ask. During an interview, on 2/11/26 at 9:17 a.m., CNA 9 indicated he learned the person-centered information from the resident or through word of mouth. He had an assignment sheet but there was not any person-centered information on the document about the resident that he was aware of. He did not know where he could look to find the information. During an interview, on 2/11/26 at 9:26 a.m., Registered Nurse (RN) 6 indicated that the person-centered information about the residents would be somewhere in the resident's electronic medical record (EMR). She was unsure where the information could be found. On 2/11/26 at 10:48 a.m., the DON provided an assignment sheet for Resident 45 which included person-centered information on the resident. At the same time, she indicated the document had just been updated on 2/11/26 to include some residents' person-centered information. During an interview, on 2/11/26 at 2:00 p.m., the DON provided an education sign-in sheet, dated (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/6/25, and indicated it was the sheet when the staff was educated on use of the Kardex (a manual or electronic, cheat sheet used by nurses to quickly reference and update a patient's key information). The sign-in sheet lacked documentation that CNA 8, CNA 9, or RN 6, had participated in the education. During an interview, on 2/11/26 at 2:50 p.m., CNA 9 indicated he had been educated on how to access the Kardex about an hour after his initial interview, earlier on this date. He could not remember any education on the use of the Kardex, prior to what he had received on this date. 2. On 2/11/26 the medical record of Resident 8 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to Parkinsons disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), HTN (high blood pressure). A quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident was severely cognitively impaired and was dependent upon the staff for all daily care needs. Resident 8's record lacked evidence of a specific care plan for dementia care and interventions. An activity evaluation, dated 11/10/25, and completed by the Activity Director indicated the residents likes and dislikes, personal preferences and alternate activities to help to reduce anxiety. On 2/11/26 at 9:18 a.m., during an interview the Activity Director indicated they communicate with the staff regarding alternate activities to use if the resident was having behaviors and things to do to reduce anxiety. She indicated she was updating the assignment sheet and care plans to add this information for the staff. She indicated currently the information was not written down for the staff. On 2/11/26 at 9:20 a.m., during an interview Certified Nurse Aide (CNA) 4 indicated they received information in report and record it on their CNA report sheets. She indicated there was nothing written for them to review for interventions, but they passed the information on in their reports and given to the next CNA as well. On 2/11/26 at 1:30 p.m., during an interview the Director of Nursing (DON) indicated the staff had been educated to review the Kardex for guidance on interventions for behaviors. She indicated after she discussed the concern with the survey team, they reminded the staff about reviewing the Kardex (a specialized, concise, and frequently updated nursing documentation system used to summarize essential patient information). On 2/12/26 at 9:27 a.m., the Director of Nursing provided a document titled, Dementia – Clinical Protocol, dated November 2018, and indicated it was the policy currently being used by the facility. The policy indicated, .Treatment management 1. For the individual with confirmed dementia, the IDT will identify a resident centered care plan to maximize remaining function and quality of life. 2. Nursing assistants will receive initial training in the care of residents with dementia and related behaviors, In-services will be conducted at least annually thereafter.5.a. Resident needs will be communicated to direct care staff. through written documentation.Monitoring and follow-up.2. The IDT will adjust interventions and the overall plan depending on the individuals responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors.

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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. A. Based on observation and interview, the facility failed to maintain separation between clean and soiled cleaning mops and cleaning linens for 1 of 1 observation of the laundry room. This practice had the potential to affect 83 of 83 residents residing at the facility. B. Based on observation, interview, and record review, the facility staff failed to ensure they wore gloves during an injection administration and failed to ensure proper hand hygiene was performed during medication administration for 2 of 5 residents reviewed for medication administration (Resident 61 and 26). Findings include:A. On 2/13/26 at 2:00 p.m., during initial observation of the laundry area with the Infection Prevention (IP) nurse and the Director of Nursing (DON), observed clean mopheads and cleaning linens stored on a shelf in the soiled laundry room next to the washing machine. In addition, cleaning linen items were stored on top of a plastic crate with cans of chemicals inside of crate next to the washer. On 2/13/26 at 2:05 p.m., during an interview the IP nurse indicated she had not noticed the clean linens were within the soiled laundry area. On 2/13/26 at 2:05 p.m., the DON indicated the cleaning linens had always been stored there but they would re-wash the items and find an alternate place for them in the clean linen storage area. On 2/9/26 at 11:30 a.m., the Administrator provided a document, titled, Surveillance for infections a revision date of July 2017, and indicated it was the infection control policy currently being used by the facility. The policy indicated, .3. Infections that will be included in routine surveillance include those with, a. Evidence of transmissibility in healthcare environment.9. If transmission based precautions or other preventive measures are implemented to slow or stop the spread of infection. B. During the medication administration pass the following was observed: 1. On 2/11/26 at 8:59 a.m., Registered Nurse (RN) 6 prepared insulin for Resident 61. She entered the resident's room with the insulin pen, needle, oral medications, and medication (med) pass drink (fortified nutrition shake is a calorie and protein dense beverage). RN 6 administered the resident's insulin without wearing gloves into the resident's right upper arm. She then handed the resident his oral pills in a medicine cup and the med pass drink to aid in swallowing the medications. No hand hygiene was performed before or after leaving the resident's room. 2. On 2/11/26 at 9:09 a.m., RN 6 prepared medication at the medication cart for Resident 26. She entered Resident 26's room with 9 oral pills to administer. Resident 26 swallowed the medication and RN 6 did not perform hand hygiene before or after the medication administration. During an interview, on 2/11/26 at 9:24 a.m., RN 7 indicated staff should wear gloves when administering an insulin injection. She further indicated staff should perform hand hygiene in between residents when administering their medications to them. During an interview, on 2/11/26 at 9:29 am., the Director of Nursing (DON) indicated staff should wear gloves when administering insulin injections and should use hand sanitizer in between residents during medication administration pass. On 2/11/26 at 10:49 a.m., the DON provided a document with a revised date of April 2019, titled, Administering Medications, and indicated it was the current policy being used by the facility. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy indicated, .25. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. On 2/11/26 at 1:30 p.m., the DON provided a document with a revised date of April 2019, titled, Insulin Administration, and indicated it was the current policy being used by the facility. The policy indicated, .17. Wash hands. [NAME] clean gloves.23. Remove gloves, Wash hands. 3.1-18(b)