STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Creek at Sunset	1109 S Indiana Street Greencastle, IN 46135

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 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. Based on record review and interview, the facility failed to inform a resident and/or their representative of the benefits, risks, and alternatives for a medication prior to initiating a psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (Resident 3). Findings include:Resident 3's record was reviewed on 11/18/25 at 1:45 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 10/22/25, indicated the resident was cognitively intact and received an antidepressant during the look back period. A physician's order, dated 9/11/25, indicated to administer 1 tablet of mirtazapine (antidepressant) 15 milligrams (mg) by mouth at bedtime for weight loss. The medical record lacked documentation of an Interdisciplinary (IDT) Psychotropic New/Increase Order Observation, or other documentation the resident was notified of the benefits, risks, alternatives, and the black box warning associated with the medication, was completed prior to the initiation of the mirtazapine. An event report, dated 9/10/25, indicated the resident's representative was notified of the order for mirtazapine for depression and decreased appetite. The event lacked documentation the resident and/or the resident's representative were notified of the benefits, risks, alternatives, and the black box warning associated with mirtazapine, prior to the initiation of the medication. On 11/20/25 at 10:59 a.m., the Director of Nursing (DON) provided a nutrition at risk (NAR) IDT note, dated 9/11/25, and indicated it was documentation consent was obtained from the resident for the mirtazapine. The note indicated, .Summary of Root Cause for Weight Change/Nutrition Concern: Resident often has poor meal intake, reports she is just eating how she was at home. New recommendations/interventions: Appetite stimulant as ordered. Friend and resident happy with the initiation of Remeron [mirtazapine] as it also helps with depression and thing [sic] this medication would be beneficial to resident. The note lacked documentation the resident and her friend were notified of the benefits, risks, alternatives, and the black box warning associated with mirtazapine, prior to the initiation of the medication. An article titled, Atypical antidepressants, dated 10/4/19, was accessed at https://www.mayoclinic.org/diseases-conditions/depression/in-depth/atypical-antidepressants/art-20048208, on 11/24/25. The article indicated, .Suicide risk and antidepressants. Most antidepressants are generally safe, but the FDA requires that all antidepressants carry black box warnings, the strictest warnings for prescriptions. In some cases, children, teenagers and young adults under 25 may have an increase in suicidal thoughts or behavior when taking antidepressants, especially in the first few weeks after starting or when the dose is changed. Anyone taking an antidepressant should be watched closely for worsening depression or unusual behavior. If you or someone you know has suicidal thoughts when taking an antidepressant, immediately contact your doctor or get emergency help. Keep in mind that antidepressants are more likely to reduce suicide risk in the long run by improving mood. A second record review was completed on 11/20/25 at 9:49 a.m. An IDT Psychotropic Medication New/Change Order Review was opened and completed on 11/19/25. The observation was backdated to 9/12/25. During an interview, on 11/20/25 at 10:23 a.m., the Executive Director (ED) indicated they normally reviewed informed consent and medications during the residents' care plan meetings. They were not aware consent had to be obtained prior to initiating or increasing a psychotropic medication. The ED was not able to find documentation the resident or her (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative was notified of the benefits, risks, alternatives, and black box warning associated with mirtazapine prior to the initiation of the medication. On 11/20/25 at 11:09 a.m., the DON provided a document titled, Psychotropic Management, last revised in July 2025. The policy indicated, .Definition: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories.Anti-depressant.Procedure.2.The IDT Psychotropic New/Increase Order observation in Matrix should be used for increases or initiation of psychotropic medications. 3.1-3(n)(2)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the code status of a resident was clear and concise and was the desire of the resident for 1 of 24 resident code status reviewed (Resident 17). Findings include:Resident 17's record was reviewed on [DATE] at 10:46 a.m. The profile indicated the resident's diagnoses included, but were not limited to, dementia with anxiety (a common complication where a person experiences a loss of cognitive function alongside feelings of excessive worry, restlessness, and being on edge) and major depressive disorder (a mood disorder characterized by persistent feelings of sadness and loss of interest that interfere with daily life). A POST form (Physician Orders for Life Sustaining Treatment-a medical order form that documents a patient's treatment preferences in the event of an emergency), dated [DATE], indicated the resident desired to have CPR (Cardiopulmonary Resuscitation) attempted if she had no pulse and was not breathing. At the same time, the POST form indicated the resident desired to allow natural death if the resident had a pulse and was not breathing. An admission Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident had moderate cognitive deficit, had mild depression, and no documented behaviors. A care plan, dated [DATE], indicated the resident had experienced emotional abuse trauma related to being abandoned by her husband and was at risk for experiencing traumatization, feeling unsafe/untrusting, and/or distressed. During an interview, on [DATE] at 11:24 a.m., the resident indicated she did not wish to have CPR performed. She did not feel as if the facility had explained the situation well enough for her at the time of her admission. She was so rattled at that time that she would have likely just signed anything that they placed in front of her. During an interview, on [DATE] at 11:39 a.m., Certified Nursing Assistant, (CNA) 8 indicated she was not aware of what the code status of the resident was, but it would be on her assignment sheet, or she could have the nurse look it up. During an interview, on [DATE] at 11:43 a.m., Licensed Practical Nurse (LPN) 9 indicated the code status would be in the resident's electronic record and a copy of the POST form would be in the code status manual. The resident's POST form indicated both CPR to be done and allow natural death. The LPN indicated the status contradicted each other. On [DATE] at 11:47 a.m., observation of the code status manual indicated the manual lacked documentation of the resident's POST form. During an interview, on [DATE] at 11:50 a.m., the Unit Manager indicated she had noticed the resident's POST form had conflicting information on it. She believed that someone had gone back to the resident to get clarification as to the resident's code status wishes. At the same time, the Unit Manager was unable to locate a copy of the residents' POST form in the code status manual. During an interview, on [DATE] at 1:26 p.m., the Director of Nursing Services (DNS) indicated the resident's admission was a very unusual circumstance. They worked very hard and quickly to get the resident into the facility. She was unsure who would have reviewed the POST information with the resident. It could have been the admitting nurse, the admissions person, or the unit manager. She understood that the POST form was confusing to understand. On [DATE] at 11:50 a.m., the DNS provided a document, with a revision date of 5/19, titled, Physician's Order for Scope of Treatment (POST), and indicated it was the policy currently being used by the facility. The policy indicated, .The POST should reflect the resident's current treatment preferences.Initiating a POST form: .3. The physician, advanced practice nurse.should discuss the benefits, burdens, efficacy, and appropriateness of treatment and medical interventions with the resident/legally recognized health care decision maker. A health care provider such as a nurse or social worker can explain the POST form to the resident/legally recognized health care decision maker; however, the physician, advanced practice nurse.is responsible for discussing treatment options with the resident/legally recognized health care decision maker. 3.1-4(a)3.1-4(A)(ii)3.1-53.1-7

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's Minimum Data Set (MDS) assessment was coded accurately for 1 of 19 residents' MDS assessments reviewed (Resident 3). Findings include:Resident 3's record was reviewed on 11/18/25 at 1:45 p.m. An admission MDS assessment, dated 7/21/25, indicated the resident had an intellectual disability (ID) or developmental disability (DD), with no organic (physical) condition. The resident's diagnosis list lacked documentation the resident had a diagnosis of an ID or DD. During an interview, on 11/20/25 at 1:20 p.m., the MDS Coordinator indicated the resident's assessment was coded in error, and the resident did not have an ID or DD. The facility used the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) manual as their policy for MDS coding. The CMS RAI manual version 3.0, dated October 2025, indicated, .A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status.Item Rationale: To document conditions associated with intellectual or developmental disabilities.Coding Instructions: Check all conditions related to ID/DD status that were present before age [AGE].Code Z: if ID/DD condition is not present. 3.1-31(b)(3)

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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 observation, record review, and interviews, the facility failed to complete accurate skin assessments and obtain treatments for 2 of 2 residents reviewed for quality of care (Residents 28 and 49). Findings include: 1. On 11/17/2025 at 12:10 p.m., during an observation and interview of Resident 28, observed a bandage on the lower right abdominal fold of the resident. The bandage was dated 11/12/25. The resident indicated the bandage was applied when she was recently in the hospital for an open wound that would not heal. A large purple bruise was observed on the top of the right upper thigh. The resident indicated it had occurred while in the hospital. On 11/18/25 at 10:00 a.m., during an interview the resident indicated the abdominal dressing had not been changed but the wound nurse told her she would come in and change it. On 11/18/25 at 2:30 p.m., the medical record of Resident 28 was reviewed. The resident was re-admitted to the facility on [DATE]. admission diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems) and type 2. A care plan, dated 9/11/23, indicated the resident was at risk for skin breakdown. Interventions included, but were not limited to, assess and document skin condition weekly and as needed, notify MD of abnormal findings, and apply preventative treatment as ordered. A care plan, dated 2/2/24, indicated the resident was at risk for bleeding/bruising related to use of antiplatelet medication. Interventions included, but was not limited to, document abnormal findings and notify MD (medical doctor). A Minimum Data Set (MDS) admission assessment, dated 9/11/25, indicated the resident had mild cognition deficit and required moderate assistance with daily care needs. An admission skin assessment, dated 11/15/25, indicated an abrasion to the lower right abdomen with measurements of the wound indicating 1.0 centimeters (cm) by (x) 1.4 cm. On 11/20/25 at 9:42 a.m., during an interview Licensed Practical Nurse (LPN) 10 indicated she had assessed the area on the abdomen of Resident 28 with the Nurse Practitioner (NP) on 11/19/25 and had obtained treatment orders at that time. She did not recall the dressing being dated 11/12/25. LPN 10 indicated upon admission and re-admission to the facility the nurse would complete a head to toe assessment of the resident and would notify the physician of any wounds and request treatment orders. On 11/20/25 at 9:48 a.m., during an interview Certified Nurse Aide (CNA) 8 indicated she would notify the nurse of dressings dated several days after admission and she would check the resident's skin for abnormalities and notify the nurse. On 11/20/25 at 10:55 a.m., during an interview the Director of Nursing (DON) indicated the nurse on the unit probably lifted the dressing, dated 11/12/25, observed the wound, measured the wound and then re-applied the soiled dressing, dated 11/12/25, because the nurses know the wound nurse liked to do her own dressings. She indicated she would have to look at the assessment to determine why the bruise on the upper right leg was not identified upon admission. She did not know why the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician had not been notified upon re-admission regarding the abdominal wound. A Physician order, dated 11/19/25, indicated to apply a pea size amount of Mupirocin ointment 2% topically once a day. Special instructions were to cleanse the abrasion located on the right lower quadrant with normal saline water, pat dry, apply mupirocin ointment, and cover with dry dressing. On 11/20/25 at 2:30 p.m., review of wound documentation indicated the abdominal wound measurements obtained on 11/19/25 indicated abdominal wound was 1 cm x 1 cm. The medical record indicated the abdominal wound was measured on 11/17/25. The wound measurements were 12 cm x 12 cm. On 11/20/25 at 2:35 p.m., during an interview the DON indicated the measurements for 11/17/25 were incorrect. On 11/20/25 at 11:30 a.m., the DON provided a document, titled, Skin Management Program, dated 5/22, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure for alterations in skin integrity pressure and non-pressure 1. Alterations in skin integrity will be reported to the MD/NP, the resident and or resident representative as well as to the direct care staff.2. Treatment order will be obtained from MD/NP.3. All alterations in skin integrity will be documented on the admission observation in the medical record in the admission observation (new admitted and re-admitted residents). On 11/20/25 at 11:30 a.m., the DON provided a document, titled, Resident change in condition policy, dated 11/2018, and indicated it was the policy currently being used by the facility. The policy indicated, .3. Non urgent medical change.a. All symptoms and unusual signs will be documented it the medical record and communicated to the attending physician promptly. 2. Resident 49's record was reviewed on 11/19/25 at 9:23 a.m. The profile indicated the resident diagnoses included, but were not limited to, rhabdomyolysis (a serious medical condition where damaged skeletal muscles breaks down, releasing harmful substances like myoglobin [an iron and oxygen binding protein in muscle tissue] into the bloodstream that can cause kidney damage and failure), chronic obstructive pulmonary disease (COPD – a progressive lung disease that causes restricted airflow and breathing problems), and hypertension (elevated blood pressure). The facility census indicated Resident 49 admitted to the facility on [DATE]. A care plan, dated 9/4/24, indicated Resident 49 was at risk for skin breakdown due to history of pressure wound, very limited mobility, and limited sensory perception. Interventions included, but were not limited to, assess and document skin condition weekly and as needed, turn and reposition at least every 2 hours, and encourage the resident to eat at least 75% of meals. A care plan, dated 9/5/24, indicated Resident 49 required assistance with toileting due to repeated falls. Interventions included, but were not limited to, assess and document skin condition weekly and as needed, and document any abnormal findings to doctor. A quarterly Minimum Data Set (MDS) assessment, dated 10/24/25, indicated Resident 49 had no cognitive impairment and required substantial assistance with toileting, bathing, and dressing. During an interview, on 11/17/25 at 11:38 a.m., Resident 49 indicated he had a fall at the facility in the last couple of weeks, but he wasn't sure of the exact day. He pulled up the pant leg that was to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his right lower extremity, a healing bruise was noted to cover his entire knee cap. The bruise was yellow, green, and purple in color and there was a scab noted on the top side of his knee cap. The resident indicated it was tender to the touch, but he didn't think he had broken anything when he fell. Review of fall event documentation, dated 11/5/25 at 10:10 a.m., indicated Resident 49 had a fall that was witnessed walking briskly to the dining room. The documentation indicated he fell on his bottom and had no injuries. Review of IDT (interdisciplinary team) note, dated 11/5/25 at 10:12 a.m., indicated Resident 49 had a fall at the facility on 11/4/25 at 1:10 p.m. The note indicated the resident fell onto his buttocks when he was walking briskly with his walker to the dining room. No injuries were noted, no x rays were obtained, and the resident wasn't sent to the emergency room. Review of weekly skin assessment note, dated 10/31/25 at 2:04 p.m., indicated Resident 49 had no areas of concern related to skin integrity alteration. The skin assessment didn't identify a bruise to his right knee. Review of a weekly skin assessment note, observation date of 11/6/25 at 4:10 p.m. with a completion date of 11/12/25 at 4:11 p.m., indicated Resident 49 had no areas of concern related to skin integrity alteration. The skin assessment didn't identify a bruise to his right knee. Review of weekly skin assessment note, dated 11/15/25 at 12:07 p.m., indicated Resident 49 had no areas of concern related to skin integrity alteration. The skin assessment didn't identify a bruise to his right knee. Review of wound management documentation, dated 11/19/25 at 10:13 a.m., indicated Resident 49 had no wounds. During an interview, on 11/19/25 at 9:40 a.m., Licensed Practical Nurse (LPN) 4 indicated the nurses had a schedule they went by for the weekly skin assessments. The skin assessments should be head to toe and any or all skin imperfections were documented under observations in the computer system. During an interview, on 11/19/25 at 10:10 a.m., Director of Nursing Services (DNS) indicated she was not aware that Resident 49 had a bruise to his right knee, she was not sure if it occurred when he had his last fall. During an interview, on 11/19/25 at 10:39 a.m., Certified Nurse's Aide (CNA) 6 indicated she would report any skin imperfections that a resident may have to the nurse. She indicated that during showers, she would sometimes see a new skin area, and she would document it on the shower sheet, and the nurse would be made aware of it as well. During an interview, on 11/19/25 at 10:42 a.m., Registered Nurse (RN) 7 indicated weekly skin assessments were completed Tuesday through Sunday by a schedule. The skin assessments were documented under the observation tab in the computer, and the nurses should be completing a head-to-toe assessment of the resident's skin. If the nurse noted a new skin imperfection, then a skin event should be opened in the computer system, and the wound nurse would be notified. During an interview, on 11/19/25 at 10:45 a.m., CNA 5 indicated if she noted a new skin area to a resident, she would place it on the shower sheet and notify the nurse. She had not noticed a bruise on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 49's knee recently. She indicated Resident 49 did require assistance with his showers from staff. During an interview, on 11/19/25 at 11:35 a.m., the DNS indicated she was not sure whether the bruise to Resident 49's right knee was from his fall or not, but the nursing staff should have noted the bruise on the weekly skin assessments and a skin event should have been documented as well. The article, What do the Colors of a Bruise Mean, dated 1/18/24, was retrieved on 11/24/25 from the Medical News Today website at https://www.medicalnewstoday.com. The guidance included: Bruises typically change color as they heal, at first appearing red, purple, or darker surrounding skin. They may progress to blue, black, or green before fading.After 10-14 days the bruise may turn yellowish-brown to light brown. On 11/19/25 at 11:20 a.m., the DNS provided a document with a revised date of 8/25, titled, Documentation Guidelines for Nursing, and indicated it was the policy currently being used by the facility. The policy indicated, .Weekly skin and vital sign assessment observation (All new skin areas must be reported to the wound nurse with new skin event completed) .8. New Skin Event, initiate for any newly identified skin conditions (except for new admissions or readmissions) .IDT initial wound review: after any new facility acquired wound/skin injury is found. 3.1-37

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was safely transported in the wheelchair resulting in a fall for 1 of 2 residents reviewed for accidents (Resident 1). Findings include:Resident 1's record was reviewed on 11/19/25 at 10:20 a.m. Census information indicated the resident was hospitalized from [DATE] to 10/2/25. Diagnoses on the resident's profile included, but were not limited to, Parkinson's disease (a progressive movement disorder of the nervous system), neurocognitive disorder with Lewy bodies (a decline in thinking ability, especially in the areas of attention, visual perception, and planning and organization), and repeated falls. A physician's order, dated 2/14/24, indicated anti-roll backs (device to keep the wheelchair from rolling backwards if a resident stood up without locking the wheels) to the resident's wheelchair. A physician's order, dated 1/3/25, indicated the resident may use cushion with pommel-type (designed to promote proper positioning by preventing patients from sliding forward in their wheelchair seats) wedge in wheelchair. An annual Minimum Data Set (MDS) assessment, dated 9/8/25, indicated the resident had a severe cognitive impairment and required supervision/touching assistance with eating, substantial/maximal assistance with oral hygiene, and was dependent with toileting hygiene, showering/bathing, chair/bed transfers, toilet transfers, and tub/shower transfers. An Occupational Therapy (OT) evaluation was dated 9/22/25. The evaluation indicated the resident had repeated falls and generalized muscle weakness. The resident fell on 9/14/25 and 9/16/25 and was referred to OT. The resident used a manual wheelchair with a pommel cushion, anti-rollbacks, and a foot board under the wheelchair (board to keep the resident's feet from getting caught under the chair). The resident required supervision with eating and maximal assistance with personal hygiene, lower body dressing, putting on/taking off footwear, showering/bathing, and toileting hygiene, and minimal assistance with upper body dressing. The resident exhibited difficulty propelling himself in the wheelchair. The resident required skilled OT to address deficits including safety awareness, repeated falls, muscle weakness, and decreased activity tolerance. A charting event, dated 9/28/25, indicated the resident had a decline in condition. A progress note, dated 9/28/25, indicated the resident was not acting normally at dinner. The resident was reaching out ahead of himself, had a blank stare, and was not wheeling himself in his wheelchair. When the staff attempted to communicate with the resident, he was minimally responsive. The resident's oxygen saturation (oxygen level in the blood, normally between 96 and 100 percent) was 80 percent. Oxygen was provided at three liters (l), and the resident's oxygen saturation rose to 90 percent. The resident remained minimally responsive. The physician ordered the resident to be sent to the hospital for further evaluation. The hospital Discharge summary, dated [DATE], indicated a final diagnosis included acute metabolic encephalopathy (when the brain has trouble working because of a chemical, or metabolic, problem in the body) and despite hydration and treatment of infection his encephalopathy at baseline must be really bad with severe underlying dementia and Parkinson's disease, he is barely able to open eyes spontaneously, nonverbal. A final diagnosis of Parkinson's disease indicated, despite medications, the resident exhibited a lot of rigidity. A progress note, dated 10/2/25, indicated the resident returned to the facility. The resident was a nothing by mouth (NPO) status, and a gastrostomy tube (g-tube) (tube inserted into the abdomen for artificial nutrition) had been placed. All medications were to be administered through the g-tube. A progress note, dated 10/3/25, indicated the resident was readmitted to the facility yesterday. The resident was lethargic with very swollen lower arms and hands. The continuous tube feedings continued. The physician was notified of the resident's current condition. A progress note, dated 10/5/25, indicated the resident was responsive but was not behaving at baseline. The resident was still lethargic. The resident had signs and symptoms of pain with hygiene and toileting. The resident was checked on routinely. An OT therapy evaluation was (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 10/6/25. The evaluation indicated the resident's primary diagnosis was metabolic encephalopathy, and he exhibited generalized muscle weakness, abnormal posture, and pain in the joints of both hands. The resident was referred due to a recent hospitalization and was having pain, especially in the hands. The goal was to keep the resident comfortable. The resident's prior level of functioning was up daily in manual wheelchair, self-propelled at a slow pace, required assist of one staff with toileting and dressing. The evaluation indicated the resident was totally dependent with ADLs. The resident required skilled OT to address impairments and deficits including abnormal posture, pain, decline in self-care, edema (swelling), and positioning. The resident's prior level of functioning was a manual wheelchair, but the resident was currently bed bound and would be placed in a Broda (equipped with advanced tilt and recline features) chair. The resident's therapy goal was to decrease pain. A progress note, dated 10/7/25, indicated the resident attempted to climb out of bed, was assisted up into the wheelchair, and was one on one supervision with staff. An OT note, dated 10/9/25, indicated the resident was up in the Broda chair with the leg/foot rest extended for comfort. The CNA and nurse reported the resident was able to stand and transfer to the Broda chair. The resident was active, moving in the Broda chair, and OT would follow-up with positioning. An admission MDS assessment was completed upon the resident's hospital return and was dated 10/9/25. The assessment indicated the resident had a severe cognitive impairment. Activities of daily living (ADLs) indicated eating, chair/bed transfers, and toilet transfers were not attempted, and the resident was dependent for oral hygiene, toileting hygiene, showering/bathing, putting on and taking off footwear, and personal hygiene. A fall event, dated 10/11/25, indicated the resident fell out of the wheelchair while being pushed, hit his head, and abrasions were noted. The Certified Nurse Aide (CNA) was pushing the resident in the wheelchair, the resident put his feet down, and he fell out of the wheelchair on his face. The intervention was to place foot pedals on the wheelchair and ensure the resident's feet were on the foot pedals before pushing him in the wheelchair. A progress note, dated 10/11/25, indicated the CNA was pushing the resident in the wheelchair, the resident put his feet down, fell out of the wheelchair, and hit the front of his forehead. There was a scraped area on the resident's forehead. The resident was more alert that day and talked at times. The note lacked documentation if the resident's ability to be safely pushed in a wheelchair had changed related to his decline in condition. An IDT note, dated 10/11/25, indicated the resident was being propelled in the wheelchair and put his feet down, which caused him to fall. There was an abrasion to the center of his forehead. The determined root cause of the fall was weakness to bilateral lower extremities. The intervention put in place to address the root cause was foot pedals when up in wheelchair related to being able to propel the wheelchair with his hands successfully. The record lacked documentation of OT or nursing notes, between 10/10/25 and 10/11/25, which indicated the resident was safe to be placed back in the manual wheelchair, instead of the Broda chair or the resident was safe to be pushed in the wheelchair without foot pedals considering his increased muscle weakness and change in condition. A current care plan indicated the resident was at risk for falls due to a history of falls, advanced age, incontinence, high-risk medication use, Parkinson's disease, neurocognitive disorder with Lewy bodies, requires assistance with transfers and ADLs, altered awareness of surroundings, impulsiveness, lack of understanding of physical limitations, and experiencing decline in ability to mobilize his wheelchair. An intervention, dated 10/13/25, indicated foot pedals when up in wheelchair. During an interview, on 11/19/25 at 2:16 p.m., the Executive Director (ED) indicated when the resident planted his feet while being pushed in the wheelchair and fell. The foot pedals were placed as an intervention for the fall. The resident had a decline in condition when he returned to the hospital, but he did return to his baseline. During an interview, on 11/19/25 at 2:41 p.m., CNA 5 indicated when the resident returned from the hospital, they tried to put him in a Broda chair, but it had not worked out. The resident had a decline in condition when he returned from the hospital and was not able to do as much. Therapy decided which residents required foot pedals and placed them in the resident's rooms if they needed them. The staff was not able to obtain foot pedals for wheelchairs (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on their own or in response to a change in the resident's ability to hold their feet up while being pushed in the wheelchair. During an interview, on 11/20/25 at 8:55 a.m., Certified Occupational Therapy Assistant (COTA) 16 requested the DON be present during interview regarding the resident's wheelchair. During the interview the DON answered the questions, and COTA 16 did not answer. The DON indicated the resident was in a Broda chair when he returned from the hospital. The resident had a lot of swelling and not much energy upon his return. The resident started to climb out of the Broda, so they put him in the wheelchair to see what happened. There were no foot pedals put on because he was able to propel himself. She thought the resident tried to stand up while being pushed in the wheelchair, and that was why he fell. Foot pedals were in the shed, and she thought staff could access them if needed. CNAs should have pushed residents at normal speed and watched to ensure their feet were raised. On 11/20/25 at 9:06 a.m., the DON provided a document titled, Fall Management Policy, last revised in June 2025. The policy indicated, .Policy: It is the policy.to ensure residents residing within the community have adequate assistance to prevent injury related to falls.Procedure: Fall Risk.5. The resident specific care requirements will be communicated to the assigned caregiver utilizing the resident profile or CNA assignment sheet. 3.1-45(a)(2)

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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. Based on observation and interview, the facility failed to provide the open date of medication stored in 1 of 2 medication administration carts. Findings include: On 11/20/25 at 9:55 a.m., during the observation of the North Hall medication administration cart, an opened un-dated Aspart 100 unit insulin pen (an injection device that you can use to deliver preloaded insulin into your subcutaneous tissue, the innermost layer of skin in your body) prescribed for Resident 5 was observed. On 11/20/25 at 10:00 a.m., during an interview Licensed Practical Nurse (LPN) 11 indicated the insulin pen had been opened on 11/19/25 in the evening. She acknowledged the pens should be dated when opened. On11/20/25 at 11:30 a.m., the Director of Nursing (DON) provided a document titled, Storage and Expiration Dating of Medications and Biologicals, dated 06/30/25, and indicated it was the policy currently being used by the facility. The policy indicated, .11. Once any medications or biologicals package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler)when the medication has a shortened expiration date once opened.11. 3 If a multidose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. 3.1-25(j)3.1-25(m)3.1-25(n)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's medical record was accurate when the resident's physician's orders were not updated to reflect their selections on the Physician's Orders for Scope of Treatment (POST) form (documentation of the resident's wishes at the end of life) for 1 of 24 residents' code statuses reviewed (Resident 1). Findings include: Resident 1's record was reviewed on 11/19/25 at 10:20 a.m. Census information indicated the resident was hospitalized from [DATE] to 10/2/25. Diagnoses on the resident's profile included, but were not limited to, nontraumatic intracranial hemorrhage (bleeding within the skull) and Parkinson's disease (a progressive movement disorder of the nervous system). An admission Minimum Data Set (MDS) assessment, dated 10/9/25, indicated the resident had a severe cognitive impairment and a feeding tube (inserted into the abdomen for artificial nutrition). The resident's current physician's orders included the following orders related to code status. -A physician's order, dated 2/5/24, indicated, POST For Orders: Section A: CARDIOPULMONARY RESUSCITATION (CPR) [emergency lifesaving procedure performed when the heart stops beating]: Patient has no pulse AND is not breathing. Special Instructions: Attempt Resuscitation/CPR. When not in cardiopulmonary arrest, follow orders B, C, and D. -A physician's order, dated 2/5/24, indicated, POST Form Orders: Section B: MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing. Special Instructions: Full intervention: Treatment goal: Full interventions including life support measures in the intensive care unit. -A physician's order, dated 2/5/24, indicated, POST Form Orders: Section C: ANTIBIOTICS: Special Instructions: Use antibiotics consistent with treatment goals. -A physician's order, dated 2/5/24, indicated, POST Form Orders: Section D: ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluids by mouth if feasible. Special Instructions: No artificial nutrition. An updated POST form was signed on 10/10/25, after the resident returned from the hospital stay. The form indicated Section A: do not attempt CPR, Section B: Comfort measures, allow natural death, Section C: Use antibiotics consistent with treatment goals, Section D: long-term artificial nutrition. The record lacked documentation the physician's orders were updated with the new POST form. During an interview, on 11/19/25 at 11:50 a.m., the Director of Nursing (DON) indicated she was not sure why the physician's orders were not updated in October when the resident's POST form preferences were changed. On 11/19/25 at 11:50 a.m., the DON provided a document titled, Physician's Order for Scope of Treatment (POST), last revised in May 2019. The policy indicated, .Policy: It is the policy of the facility that Physician's Orders for Scope of Treatment (POST) forms will be honored and executed per the following guidelines as residents and/or legally recognized health care decision maker's desire.5. Ensure that physician's orders indicating the decisions made on the POST for are added to the resident's orders (i.e. CPR Medical Interventions, Antibiotics, Artificially Administered Nutrition). 3.1-50(a)(2)