STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155611	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hoosier Health & Living Community	621 S Sugar St Brownstown, IN 47220

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 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 Based on observation, interview, and record review, the facility failed to store food safely related to unlabeled and outdated foods, and failed to ensure proper sanitization of dishware related to dishwasher rinse temperatures and monitoring logs for 3 of 3 kitchen observations. This deficient practice had the potential to effect 85 of 85 residents that resided in the facility.Findings include:1. During the initial tour of the kitchen on 08/07/25 at 10:51 A.M., the following items were observed in the refrigerators: - a gallon sized plastic bag contained an open package of unsliced turkey. There was no label to indicate when the turkey was opened,- a small metal pan with several cooked slices of bacon laying on top of a thin layer of solid bacon grease. The pan was covered with plastic wrap and dated 07/27, and - two large, undated metal pans of bread pudding, covered with plastic wrap. During an interview, on 08/07/25 at 10:55 A.M., the Kitchen Manager (KM) indicated they sliced the turkey meat and used it for sandwiches; it should have been labeled when it was opened. The bacon was used for sandwiches and to season green beans when cooking them and was good for 10 days after it was cooked. The bread pudding was prepared the previous evening and should have been labeled. 2. During an interview, on 08/13/25 at 11:10 A.M., the KM indicated there was not a full load of dishes to wash as the staff were caught up on dishes and wouldn't be washing items again until after lunch was served, but she could run the empty rack through a cycle for observational purposes. She placed a rack in the dishwasher and turned it on. The label on the dishwasher indicated the wash cycle temperature needed to reach 150 degrees Fahrenheit (F) and the rinse cycle temperature needed to reach 180 degrees. The KM ran the dishwasher a few times, but the rinse temperature did not get higher than 174 degrees. The KM indicated it sometimes took a few cycles for the dishwasher to get to the appropriate temperature, and it would be better to come back and observe the dishwasher when dishes were washed after lunch. 3. On 08/13/2025 at 1:10 P.M., the dishwasher was observed. A single load of dishes needed to be ran through the dishwasher multiple times before the rinse cycle temperature reached 180 degrees. The dishwasher temperature log for the current month was in a binder near the dishwashing area and was reviewed with the KM at that time. The dishwasher ran three times a day. There were several days, some with multiple times in the same day, that the documented rinse temperature was below 180 degrees. A notice at the bottom of the log sheet indicated staff were to .Notify Dietary Manager Immediately if Temperatures DO NOT Meet Manufacturers Recommended Temperatures.On 08/13/25 at 2:15 P.M., the KM provided the Dish Machine Temperature Log for June and July. Each log was separated into Breakfast, Lunch, and Dinner sections with a Begin Wash, Begin Rinse, End Wash, and End Rinse temperature documented for each section. The June log was complete, but the rinse temperature never reached 180 degrees when the breakfast dishes were washed, only reached 180 degrees one time when the lunch dishes were washed, and only half the time when the dinner dishes were washed. The July log was incomplete, with half of the days of the month blank. Of the days the dishwasher temps were documented, the rinse temperature only reached 180 twice. During an interview, on 08/13/25 at 1:15 P.M., the KM indicated if the dishwasher rinse temperature did not reach 180 degrees, staff were to hand wash the dishes. She did not think the kitchen staff were documenting the temperatures in the (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	logs correctly. During an interview, on 08/13/25 at 3:37 P.M., the Administrator indicated there had been no outbreak of food borne illness in facility.The current INDIANA DEPARTMENT OF HEALTH Retail Food Establishment Sanitation Requirements Title 410 IAC 7-26, effective April 16, 2025, was reviewed on 08/13/25 at 3:00 P.M. The requirements indicated, . refrigerated .food prepared on-premises must be consumed on the premises, sold, or discarded when held at a temperature of not more than forty-one (41) degrees Fahrenheit, five (5) degrees Celsius for a maximum of seven (7) days. The day of preparation is counted as day one (1) . The current facility policy, titled Food and Non-Food Storage, revised in 2012, was provided by the Social Services Director (SSD) on 08/13/25 at 2:15 P.M. The policy indicated, .Foods that have been removed from their original containers are clearly marked with contents, dated and wrapped.The current facility policy, titled Environmental Sanitation/Infection Control, dated 2012, was provided by the SSD on 08/13/25 at 2:15 P.M. The policy indicated, .The dish machine is operated following standards for temperatures.Rinse cycle 180 F.Wash and rinse cycles of the dish machine are recorded after each meal.Unusual temperatures or sanitizer levels are circled for follow up with corrective action and a supervisor is notified.3.1-21(i)(2)3.1-21(i)(3)

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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 observation, interview, and record review, the facility failed to complete Minimum Data Set (MDS) assessments accurately related to falls for 2 of 19 resident records reviewed. (Residents 8 and 83) Findings included:Based on observation, interview, and record review, the facility failed to complete Minimum Data Set (MDS) assessments accurately related to falls for 2 of 19 resident records reviewed. (Residents 8 and 83) During an observation and interview, on 08/11/2025 at 9:42 A.M., Resident 8 was sitting in a chair in her room. The resident's walker was sitting nearby. She was alert and oriented and indicated she had recently fallen near the outside entrance to the facility while getting into a family member's vehicle to go to a doctor's appointment. She twisted her ankle when she fell. During an interview, on 08/11/2025 at 1:58 P.M., the Social Services Director (SSD) indicated the resident had fallen while getting into a family members vehicle who was taking the resident to an appointment. The family was educated to have staff assist the resident into and out of the vehicle from now on. During an interview, on 08/13/2025 at 10:47 A.M., the Assistant Director of Nursing (ADON) indicated the resident had a fall while getting into a vehicle with a family member to go to an appointment. The fall was witnessed by the family member. The family normally took the resident to take her appointments. The nurse assessed the resident following the fall, talked with the family member, and educated the family on having a staff member assist the resident when getting into the vehicle. The resident had some bruising and swelling to an ankle. They x-rayed the ankle, and it was negative for a fracture. During an interview, on 08/13/2025 at 2:13 P.M., the ADON indicated Resident 8 had only one fall since she had been recently admitted to the facility. The clinical record was reviewed on 08/11/2025 at 10:34 A.M. An Annual MDS assessment, dated 01/17/25, indicated the resident was cognitively intact, was independent with sit to stand, transfers from bed to chair, and to toilet, and walking 150 feet. A Discharge MDS assessment indicated the resident discharged to the hospital on [DATE], and returning to the facility was anticipated. An Entry tracking MDS assessment, dated 07/21/25, indicated the resident returned to the facility on [DATE]. Section J, of a Quarterly MDS assessment, dated 08/12/25, was provided by the ADON on 08/13/25 at 2:00 P.M. The record indicated the section was completed on 08/01/25, and the resident had one fall with no injury since the last assessment. A Post Fall Assessment Event Report, dated 07/29/25 at 8:44 A.M., indicated the resident had a fall outside of the building on the facility grounds. A Progress Note on the report indicated the resident's right ankle was swollen with bruising. 2. During an interview, on 08/13/2025 at 10:59 A.M., the ADON indicated Resident 83 came to the facility after she was unable to take care of herself. Her dementia had progressed. On admission, the resident was up and walking freely about the unit. She had poor safety awareness. The resident was admitted on [DATE] and had several falls since admission. The clinical record for Resident 83 was reviewed on 08/12/2025 at 11:04 A.M. A Quarterly MDS assessment, dated 05/16/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, hypertension, anxiety, and depression. The resident required Supervision or touching assistance with going from sitting to standing and with chair to bed transfers. The resident had one fall with no injury since the prior assessment, an admission assessment, dated 03/15/25. The admission MDS assessment, dated 03/15/25, indicated the resident was severely cognitively impaired. Post Fall Assessment Event Reports, dated between 03/15/25 and 05/16/25, were provided by the ADON on 08/13/25 at 1:40 P.M., and included the following: 04/26/25 at 10:33 A.M., unwitnessed, the resident acquired a skin tear to her right elbow. 04/27/25 at 8:30 P.M., unwitnessed, the resident had no injury, 05/02/25 at 11:50 A.M., unwitnessed, the resident hit her head and had swelling and a hematoma to the back of her head, 05/02/25 at 12:45 P.M., witnessed, the resident hit the back of her head again, and her right pupil was sluggish, 05/04/25 at 6:10 P.M., unwitnessed, in the dining room, the resident had broken teeth and received four sutures to her chin, and 05/13/25 at 2:45 P.M., witnessed, the resident had no (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury. The facility failed to document the correct number of falls in the resident's MDS assessment, dated 05/16/25. During an interview, on 08/13/2025 at 11:50 A.M., MDS Coordinator 2 indicated the falls were documented on Section J of the MDS assessments. On the 05/16/25 assessment, the documentation indicated the resident had one fall. She obtained her information about falls from the Matrix (software type) Electronic Health Record for each resident. On the Matrix they look for the falls since the last assessment. There should have been more falls documented on the 05/16/25 Quarterly MDS assessment. They did not have a policy on completing the MDS assessments, they followed the RAI (Resident Assessment Instrument) manual. 3.1-(d)(3)

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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	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review, interview, and observation, the facility failed to administer As Needed (PRN) medications related to blood pressure values; and identify and address a resident's skin impairment for 2 of 19 residents reviewed for Quality of Care. (Residents 3 and 7)Findings include:1.The clinical record for Resident 3 was reviewed on 08/11/2025 at 2:22 P.M. An Annual Minimum Data Set (MDS) assessment, dated 08/03/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, bipolar disorder, depression, stroke, and dementia. The physician's orders included, but were not limited to, the following: - - With a start date of 04/26/25 and a discontinued date of 07/31/25, the resident's blood pressure was to be assessed, twice a day. Staff were to assessed the resident's blood pressure upon rising, 6:00 A.M. to 10:00 A.M., and Before Bedtime, 7:00 P.M. to 11:00 P.M. If the resident's Systolic Blood Pressure (SBP), the top number, was equal to or greater than 160, staff were to administer a PRN clonidine. - - With a start date of 06/01/25 and a discontinued date of 07/31/25, the resident was to receive Clonidine, 0.1 milligrams, every 12 hours as needed for SBP greater than 160. The Electronic Medication Administration Record (EMAR) for July 2025 was provided by the Director of Nursing (DON), on 08/13/25 at 3:50 P.M. The record indicated the resident did not receive the prescribed Clonidine medication for high blood pressure values on the following dates and times: On 07/03/25, upon rising, when the resident's blood pressure was 166/76. On 07/03/25, before bedtime, when the resident's blood pressure was 167/67. On 07/07/25, upon rising, when the resident's blood pressure was 185/78. On 07/09/25, before bedtime, when the resident's blood pressure was 170/68. On 07/10/25, upon rising, when the resident's blood pressure was 190/81. On 07/14/25, upon rising, when the resident's blood pressure was 176/71. On 07/20/25, at bedtime, when the resident's blood pressure was 174/88. On 07/21/25, at bedtime, when the resident's blood pressure was 167/68. During an interview, on 08/13/2025 at 1:56 P.M., RN 4 indicated when documenting on the EMAR, if a medication was held/not given, there was a button on the EMAR to choose, it would prompt you with a box to put a note in to say why the medication was held. If it was given, it would have the initials of the staff member who administered the medication. During an interview on 08/13/25 at 1:39 P.M., the DON indicated the facility lacked a policy for following physician's orders, they just followed standard nursing practices. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview and observation, on 08/08/2025 at 10:49 A.M., Resident 7 indicated she had bumped her arm on the mechanical lift that day when staff had gotten her up. There was a silver dollar sized bruise with a dry L-shaped scab in the middle of the bruise on her lower left arm. During an observation, on 08/12/25 at 9:42 A.M., Certified Nurse Aide (CNA) 6 and 7 assisted the resident out of bed and into her chair using the mechanical lift. The resident was wearing a short-sleeved T-shirt. The resident had a silver dollar sized bruise with a dry L-shaped scab in the middle of the bruise on her lower left arm. During an observation, on 08/13/25 at 9:35 A.M., the resident was sitting in her room in her wheelchair. She had a short-sleeved T-shirt on and had a silver dollar sized bruise with a dry L-shaped scab in the middle of the bruise on her lower left arm. The clinical record for Resident 7 was reviewed on 08/12/2025 at 10:00 A.M. An Annual MDS assessment, dated 06/05/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, diabetes, anemia, hypertension, and depression. The resident was dependent on staff for all transfers. The clinical record lacked documentation that the resident had a skin impairment to the left lower arm. During an interview, on 08/13/25 at 9:41 A.M., LPN 8 indicated if a resident had a new skin tear or bruise the staff should alert the nurse. The area would be assessed, and the physician would be notified. A treatment would be initiated, if need be, and the nurse would open an event in the resident's clinical record. Within the event a progress note would be made about the skin impairment. During an interview, on 8/13/2025 at 10:51 A.M., the DON indicated if a resident had a new skin tear or bruise then there would be monitoring in the EMAR. The nurse would open an event, notify the physician, and get treatment orders. During an interview, on 08/13/25 at 10:53 A.M., the Facility Wound Nurse indicated she was unaware of Resident 7 having skin impairments. During an interview, on 08/13/25 at 10:55 A.M., the DON indicated the staff should have started an event and let someone know that the resident had an area to the left arm. The current facility policy titled, Skin Assessment, dated February 1, 2019, was provided by the DON on 08/13/25 at 1:39 P.M. The policy indicated, .ensuring the completion of thorough skin assessments on admission and throughout the residents' stay.If a new skin condition is identified.the nurse will open the appropriate Skin Integrity Event.Notify the MD, obtain and enter a treatment order.apply the initial treatment.Notify family.Document. 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's wound was identified prior to the resident developing an unstageable pressure ulcer for 1 of 3 residents reviewed for pressure ulcers. (Resident 4) Findings include:The Clinical record for Resident 4 was reviewed on 08/11/25 at 11:19 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/28/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, coronary artery disease, diabetes, hypertension, and stage 3 chronic kidney disease. The resident required staff assistance for all Activities of Daily Living (ADLs) except for eating. A mechanical lift was used for transfers. The resident had a specialty mattress for his bed and cushion for his chair. A Wound Management note, dated 07/29/25 at 10:42 A.M., indicated the resident had an Unstageable (a type of wound where the depth of tissue damage cannot be determined due to the presence of slough [dead tissue] or echar [a black layer of dead tissue]) - Deep Tissue Injury (DTI) (a type of pressure injury that develops under intact skin appearing as purple or maroon discoloration) pressure ulcer measuring 1.7 centimeters (cm) by 0.7 cm by 0.1 cm deep on his sacrum. The wound was covered with 100% slough (a moist non-viable tissue). A wound physician's note, dated 07/29/25, indicated the resident had an Unstageable - DTI measuring 1.7 cm by 0.7 cm by 0.1 cm. on his sacrum estimated time to heal 2 to 4 months. treatment plan was to apply calcium alginate and cover with a foam border dressing daily and as needed for 30 days. A Wound Management note, dated 08/05/25 at 7:21 A.M., indicated the resident had an Unstageable - DTI pressure ulcer measuring 1.5 cm by 0.7 cm by 0.1cm on his sacrum. The wound was covered with 100% slough. A wound physician's note, dated 08/05/25, indicated the resident had an Unstageable - DTI measuring 1.7 cm by 0.7 cm by 0.1 cm. on his sacrum. The wound underwent a treatment with non-contact, non-thermal, low frequency ultrasound instead of sharp debridement. A wound physician's note, dated 08/12/25, indicated the resident had an Unstageable - DTI pressure wound was healed. The clinical record lacked documentation the resident had been absent from the facility for any services for an extended period of time during the month of July.During an interview, on 08/12/2025 at 3:07 P.M., Certified Nurse Aide (CNA) 5 indicated Resident 4 required assistance with everything except eating. A mechanical lift was used to transfer him. He was incontinent of both bowel and bladder. When he was changed or given a shower, the resident's skin was observed. If a new skin issue was discovered, the nurse would be notified. The resident was turned and repositioned every two hours when in bed or sitting in his chair. The resident was compliant with care. They did not have paper shower sheets for documentation. During an observation and interview, on 08/13/2025 at 10:29 A.M., Resident 4 was in bed laying on his back. CNA 7 and CNA 9 rolled the resident on to his right side. The resident had no wound on his sacrum. The Director of Nursing (DON) indicated the wound doctor had been in the facility yesterday and had said the wound was healed. During an interview, on 08/13/2025 at 1:13 P.M., the facility wound nurse indicated the floor nurses saw residents' wounds at least twice a day when treatments were done. She would see the wounds weekly and more often if a skin issue was brought to her attention. On 07/29/25, she visualized and documented the wound on Resident 4's sacrum. When the resident's wound was first identified it was an Unstageable wound. She indicated an Unstageable pressure ulcer was a wound where the depth couldn't be measured because it would be covered with slough or eschar (a black layer of dead tissue). The current facility policy, titled WOUND MANAGEMENT POLICY, dated February 1, 2019, was provided by the DON on 08/13/25 at 2:00 P.M. The policy indicated, .[NAME] and Associates, Inc. is committed to providing quality care to our residents by implementing clinical guidance and best practices for the management of wounds and other skin conditions throughout a residents' stay in our [NAME] communities . 3.1-49(a)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to provide physician prescribed medications for 1 of 5 residents reviewed for pharmacy services. (Resident 3)Findings include:The clinical record for Resident 3 was reviewed on 08/11/2025 at 2:22 P.M. An Annual Minimum Data Set (MDS) assessment, dated 08/03/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, bipolar disorder, depression, stroke, and dementia. The resident's current physician's orders included, but were not limited to, dapagliflozin propanediol (Farxiga) tablet, 10 milligrams by mouth, once daily upon rising, with a start date of 05/20/25. The medication was documented as Not Administered on the following dates: - 05/27/25, Waiting on delivery from pharmacy,- 05/28/25, Waiting on delivery from pharmacy,- 05/30/25, Waiting on delivery from pharmacy,- 05/31/25, Drug/Item Unavailable,- 06/01/25, Drug/Item Unavailable,- 06/02/25, Drug/Item Unavailable,- 06/06/25, Drug/Item Unavailable, and- 06/10/25, Drug/Item Unavailable. During an interview, on 08/13/2025 at 1:56 P.M., RN 4 indicated nurses and QMAs (Qualified Medication Aides) were allowed to order medications for the residents. For a resident who was already receiving a medication, the facility received rolls of packaged medications every Monday, that were for the week. If a resident received a new physician's order, the nursing staff updated the family, called the pharmacy, and faxed the pharmacy the order. The facility would have the medication on the same day they placed the order. If there was a medication the resident needed right away, they could use the Emergency Drug Kit (EDK) located in the building, or they could use a local pharmacy. When documenting on the Electronic Medication Administration Record (EMAR), if a medication was held/not given, there was a button on the EMAR to choose, it would prompt you with a box to put a note in to say why the medication was held. If it was given, it would just have the giver's initials. The current undated PHARMACEUTICAL SERVICES AGREEMENT policy was provided by the Director of Nursing on 08/13/25 at 3:50 P.M. The policy indicated, .Pharmaceutical services are to be available to all residents at this facility for prescription and nonprescription drugs.Provide routine and timely pharmacy service seven days per week and emergency pharmacy service 24 hours per day, seven days per week. 3.1-25(a)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to obtain a uranalysis and start treatment in a timely manner for 1 of 19 residents reviewed for laboratory services. (Resident 81)Findings include:The clinical record for Resident 81 was reviewed on 08/12/2025 at 10:36 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/19/25, indicated the resident was moderately cognitively impaired. The residents' diagnoses included, but were not limited to, hypertension, non-Alzheimer's dementia, anxiety, depression, major depressive disorder, anxiety, and vascular dementia.A Progress Note, dated 06/25/25 at 9:05 P.M., indicated the nurses had received a call from the resident's physician's office. They had received the resident's urine dipstick results. They wanted a sample sent to the laboratory (lab) for a urinalysis (UA) culture and sensitivity (C&S). The nurse completed the paperwork and was waiting for the sample to send it to the lab.A Progress Note, dated 06/26/25 at 8:38 A.M., indicated the resident had hematuria and increased frequency of bladder incontinence with increased urination. The resident also had increased confusion with night sweating.A Progress Note, dated 06/27/25, at 5:10 A.M., indicated the resident's UA results were received and showed 4+ bacteria. The C&S of the urine was pending.A Progress Note, dated 06/28/25 at 12:26 P.M., indicated the nurse had received the C&S results. The results were faxed to the resident's primary care physician.A Progress Note, dated 06/30/25 at 4:04 A.M., indicated the facility was awaiting a reply from the physician about the C&S results.A Progress Note, dated 06/30/25 at 12:55 P.M., indicated the nurse had received a call from the physician's office with a new order for Macrobid 100 milligrams, twice a day, for 7 days for a Urinary Tract Infection (UTI). The family was updated.The June Electronic Medication Administration Record (EMAR) indicated the residents received the first dose of the antibiotic on 06/30/25 from 7:00 P.M. to 11:00 P.M.During an interview, on 08/13/25 at 9:41 A.M., Licensed Practical Nurse (LPN) 8 indicated if a resident had a new order for a UA C&S the lab would come every day of the week to pick it up. Once the results were ready, the lab would fax them to the facility. Once the results were received, the nurse would need to notify the physician. If the resident needed an antibiotic, then she would call the physician to get them started on it immediately. If the resident was seen by an outside physician and it was a weekend, then they always had an on-call provider that could be notified.During an interview, on 08/13/25 at 10:48 A.M., the Director of Nursing (DON) indicated when a UA C&S was obtained and sent to the lab, the lab would send the results back. If the lab showed the residents had a UTI, then the physician would be notified to start them on an antibiotic. If the results came back to the facility on the weekend, then there was an on-call provider that would be notified.During an interview on 08/13/25 at 1:39 P.M., the DON indicated the facility lacked a policy for lab services and they just followed standard nursing practice.3.1-49(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155611	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hoosier Health & Living Community	621 S Sugar St Brownstown, IN 47220

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident's record accurately reflected current nursing measures or interventions for 1 of 18 residents reviewed. (Resident 68)Findings include:On 08/08/25 at 11:34 A.M., Resident 68 was observed in her room in her bed. The left side of the bed was against the wall. The bed was in a low position with a mat in place on the floor on the right side of the bed.On 08/11/25 at 3:25 P.M., the resident was observed in her room in bed. The bed was in a low position with a floor mat on the right side of the resident's bed. On 08/13/25 at 1:36 P.M., the resident was observed in her room in bed. The bed was in a low position with a floor mat on the right side of the resident's bed. During an interview, on 08/13/25 at 1:38 P.M., Certified Nurse Aide (CNA) 3 indicated she was familiar with the resident. The resident had the floor mat because she had fallen. Once she fell, they put her bed in the lowest position and placed the mat on the floor for safety. The floor mat had been in place since she was most recently readmitted to the facility from a psychiatric hospital.During an interview, on 08/13/25 at 1:42 P.M., RN 4 reviewed the resident's care plan for falls and indicated a floor mat was not listed as an intervention. RN 4 indicated if the resident had a floor mat in place it should be on their care plan. The resident's record was reviewed on 08/13/25 at 1:57 P.M. A Significant Change Minimum Data Set assessment, dated 07/03/25, indicated the resident was readmitted to the facility on [DATE]. The resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, dementia and diabetes. The resident used a wheelchair. The resident required partial to moderate staff assistance with rolling left to right and sitting to laying. The resident required substantial staff assistance with sit to stand transferring and chair to bed transferring. The resident did not attempt to walk during the assessment review period.A Progress Note, dated 05/09/25 at 4:45 P.M., indicated the resident experienced a witnessed fall. The resident injured her lip and had abrasions on her elbows, knees, and the palms of her hands.A Progress Note, dated 05/28/25 at 11:50 A.M., indicated the resident experienced a fall in the hallway. The resident hit her head on the handrail and re-injured the skin on her elbow. The resident was discharged from the facility on 05/28/25 and readmitted on [DATE].A Progress Note, dated 06/28/25 at 8:48 A.M., indicated the resident was found lying on the floor in her room. The resident indicated she slid out of her wheelchair and onto the floor and hit her head in the process.The resident's Electronic Health Record was reviewed and lacked documentation of any kind for the use of a floor mat.During an interview with the Director of Nursing (DON) and the Social Services Director (SSD), on 08/13/25 at 2:18 P.M., the DON indicated the floor mat was not a fall intervention, so it was not required to be in the resident's Fall Care Plan. The floormat was a nursing measure, a comfort measure. The SSD indicated if a resident was fidgety or restless, they could use a floor mat. The facility did not have a policy for updating care plans, they referred to the Resident Assessment Instrument (RAI) manual.The resident's record, including her complete care plan, lacked documentation that indicated the resident was frequently restless or that the resident preferred to spend time laying on the floor.The resident's current physician's orders were provided by Corporate Clinical Support Staff on 08/13/25 at 3:18 P.M. The physician's orders lacked an order for the use of a floor mat.The resident's current care plan for falls was provided by Corporate Clinical Support Staff on 08/13/25 at 3:18 P.M. The care plan interventions included, but were not limited to, a current intervention, with a start date of 04/25/25, to maintain a clear pathway in the room, free of obstacles.3.1-50(a)(2)