STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grove Village	1021 E Central Ave Greensburg, IN 47240

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a homelike environment related to hot water temperatures. This deficient practice had the potential to effect 75 of 75 residents residing in the facility. Findings include:During an observation, on 04/20/2026 at 9:51 A.M., in room [ROOM NUMBER] the bathroom sink water was tested for water temperature. The water in the residents bathroom sink was immediately too hot to place your hands under the water without discomfort or redness. During an observation, on 04/20/2026 at 9:54 A.M., in room [ROOM NUMBER] the bathroom sink water was tested for water temperature. The water in the residents bathroom sink was too hot to place your hands under the water without discomfort or redness.During an observation, on 04/20/2026 at 10:04 A.M., in room [ROOM NUMBER] and room [ROOM NUMBER] the shared a bathroom sink water was tested for water temperature. The water in the residents bathroom sink was too hot to place your hands under the water without discomfort or redness. During an observation, on 04/20/2026 at 10:06 A.M., in room [ROOM NUMBER] and room [ROOM NUMBER] the shared a bathroom sink water was tested for water temperature. The water in the residents bathroom sink was too hot to place your hands under the water without discomfort or redness. During an observation, on 04/20/2026 at 10:08 A.M., in room [ROOM NUMBER] and room [ROOM NUMBER] the shared a bathroom sink water was tested for water temperature. The water in the residents bathroom sink was too hot to place your hands under the water without discomfort or redness. During an observation, on 04/20/2026 at 10:09 A.M., in room [ROOM NUMBER] the bathroom sink water was tested for water temperature. The water in the residents bathroom sink was too hot to place your hands under the water without discomfort or redness. During an observation, with the Maintenance Director on 04/20/2026 from 10:13 A.M. through 10:34 A.M., the following was observed of water temperatures in the residents bathroom sinks:- At 10:13 A.M., in room [ROOM NUMBER] the hot water was turned on, and the hot water temperature was 132 degrees Fahrenheit, at 10:16 A.M. the water temperature was 110 degrees Fahrenheit, and at 10:17 A.M. the water was 117.3 degrees Fahrenheit, - At 10:20 A.M., room [ROOM NUMBER] the hot water was turned on, and the hot water temperature was 127 degrees Fahrenheit, at 10:23 A.M. the water temperature was 114.0 degrees Fahrenheit,- At 10:33 A.M., room [ROOM NUMBER] the hot water was turned on, and the water temperature was 123 degrees Fahrenheit, at 10:34 A.M., the water temperature was 120.9 degrees Fahrenheit. During an interview, on 04/20/2026 at 10:35 A.M., the Maintenance Director indicated he checked water temperatures once a week. He always let the water run for two to three minutes until the temperature was a steady temperature. The regulation range was 100 to 120 degrees Fahrenheit. At 10:45 A.M., the Maintenance Director indicated he was not sure why the water temperatures were fluctuating. He had to adjust them often and they had put in a new mixing valve recently. He was working with his boss but believed they need to be recalibrated. He had to keep a close watch on the temperatures. The temperature at the mixing valve was appropriate but it was hotter coming out of the lines and he was unsure why. During an interview, on 04/20/2026 at 10:53 A.M., the Administrator indicated no residents had been burned from hot water. She was not aware of residents knowing that they needed (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to let the water run for a few minutes before sticking their hands under the water. The staff assisted residents on the dementia unit with washing their hands, but they did have individual bathrooms in their rooms that they had access to. There were no signs hanging in the bathrooms alerting residents to wait a couple minutes before placing their hands in the water. The current facility policy tilted, Resident Rights, with a revision date of 08/2025, was provided by the Regional Director Clinical Services on 04/24/2026. The policy indicated, .Quality of Life and Safe Environment.A resident has a right to care in an environment that promotes maintenance or enhancement of each resident's quality of life. The resident has the right to be safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.410 IAC (Indiana Administrative Code) 16.2-3.1-19(r)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-19(r)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview, record review, and observation, the facility failed to educate a resident and follow appropriate infection control guidelines related to urinary care for 4 of 4 residents reviewed for Urinary Tract Infections (UTIs) and indwelling urinary catheters. (Residents 5, 4, 27, and 56)Findings include:1. During an interview, on 04/20/2026 at 11:31 A.M., Resident 5 indicated she had recently been on an antibiotic for a UTI. It currently burned when she urinated and her urine was milky yellow in color. During an interview, on 04/22/2026 at 10:52 A.M., Licensed Practical Nurse (LPN) 4 indicated the resident required stand-by assistance of one staff member for toileting. The resident preferred to be independent with toileting. The staff had educated her on wiping from front to back. The clinical record was reviewed on 04/21/2026 at 3:04 P.M. A Significant Change Minimum Data Set (MDS) assessment, dated 02/10/2026, indicated the resident was cognitively intact. The resident required substantial assistance from staff members for hygiene and was frequently incontinent of bowel and bladder. The resident's diagnoses included, but were not limited to, diabetes (a chronic condition causing high blood sugar because the body cannot make or properly use insulin) and morbid obesity (a chronic disease defined by a Body Mass Index (BMI) of 40 or higher, or 35 or higher with significant obesity-related health complications). The Infection Control Tracking and Trending for Antibiotic Stewardship Records were reviewed on 04/22/2026 at 10:39 A.M. The records indicated Resident 5 had the following UTI symptoms and treatments: -On 04/05/2026, altered mental status, the urinalysis tested positive for the bacteria E. coli, and the resident was started on the antibiotic Fosfomycin on 04/08/2026, and -On 03/18/2026, burning, frequency, and increased incontinence, the urinalysis tested positive for the bacteria E. coli and pseudomonas. The resident was started on the antibiotic Fosfomycin on 03/22/2026. The resident's complete Care Plan, Progress Notes, and Infection Events were reviewed. The clinical record lacked documentation the resident had been educated on appropriate toileting procedures. During an interview, on 04/24/2026 at 1:27 P.M., the Director of Nursing (DON) indicated they were currently testing the resident for a UTI due to her recent fall. The resident toileted herself. They had no record of the resident being educated on the appropriate toileting procedures. The Interdisciplinary Team did not do a root cause analysis for infections. It was dependent on the resident. She was unaware of the frequency in which the facility assessed residents for performing Activities of Daily Living (ADLS). The Interdisciplinary Team (IDT) Comprehensive Care Plan Policy, with a revised date of 10/2025, was provided by the Administrator on 04/23/2026 at 3:41 P.M. The policy indicated, .It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process. The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being . 2. During an interview, on 04/21/2026 at 9:42 A.M., Resident 4 indicated he had a lot of UTIs and his indwelling urinary catheter leaked at times. The indwelling urinary catheter care for Resident 4 was observed, on 04/23/2026 at 1:10 P.M., with CNA 3 and CNA 17. The staff took a towel and a clean pad in the room with them and donned a gown and gloves. CNA 17 prepared a clean plastic bag, wetted some washcloths, and placed them in the clean bag. CNA 3 touched the bed control device, assisted (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	the resident with their disposable water cup, handed the cup to CNA 17, who placed it on the over-bed table. CNA 17 placed the resident's phone on the over-bed table, touched the bed control device, then picked up the clean brief. The staff continued to provide care to the resident's private areas without changing their gloves. The clinical record for Resident 4 was reviewed on 04/22/2026 at 3:44 P.M. An admission MDS assessment, dated 04/08/2026, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, end stage renal disease (permanent, stage 5 chronic kidney failure, where kidneys function below 10–15% and cannot support life, requiring regular dialysis or a kidney transplant) and obstructive uropathy (a structural or functional blockage of urine flow, leading to urine backflow, potential kidney swelling (hydronephrosis), and kidney damage). The resident had an indwelling urinary catheter and was frequently incontinent of bowel. The SURVEILLANCE LOG OF RESIDENT INFECTIONS AND ANTIBIOTIC USE record, for April 2026, indicated the resident was treated with the antibiotic Levofloxacin/ Macrobid for a UTI from 04/11/2026 to 04/20/2026. 3. During an interview, on 04/21/2026 at 9:19 A.M., Resident 27 indicated she was currently on an antibiotic for a UTI. She had UTIs frequently. She received bed baths. She did not use a bed pan; she usually just went in her brief. The incontinence care was observed, on 04/22/2026 at 3:13 P.M., with Certified Nurse Aide (CNA) 6 and CNA 7. The resident was in her room in bed. The CNAs entered the resident's room, donned gloves, took a package of cleaning wipes, pulled the resident's covers down, and removed her brief from the front of her body. CNA 6 wiped down the center of the resident's private area, from front to back and back to front, with one wipe and did not turn the wipe. CNA 6 got a clean wipe and wiped the creases of the resident's legs around the private area. The CNAs rolled the resident to her side, wiped her backside, and changed her brief. The staff did not try to separate the resident's legs to see the folds of the labia or ensure cleanliness. Incontinence care was observed, on 04/23/2026 at 1:47 P.M., with CNA 3 and Nurse Aide in Training (NAT) 8. The two staff members donned gloves. CNA 3 filled a plastic basin with water, touching the faucet with her gloved hands, and took the basin to the bedside. The CNA got a plastic garbage bag out of her pocket for the soiled linens then threw a dirty tissue of the resident's in the trash. The CNA removed the resident's bed linens, touched the privacy curtain, then removed the resident's brief from the front. The CNA wetted wash clothes in the wash pan, added soap, wiped from front to back, turning the washcloth, and pulling the labia apart. The CNA followed with a rinse cloth and a towel, then continued with cleaning the backside of the resident, changed her gloves, and applied a fresh brief. During an interview, on 04/23/2026 at 1:59 P.M., CNA 3 indicated, when providing incontinence care, staff were to gather supplies, put warm water in the plastic basin, and don gloves. When cleaning, go down the middle, from front to back, fold the washcloth for every crevice after each wipe. You should do the same with a rinse cloth and a towel. Staff should change gloves if they touch inanimate objects in the residents' rooms. This resident was able to move her legs apart. The clinical record for Resident 27 was reviewed on 04/23/2026 at 3:13 P.M. An Annual MDS assessment, dated 03/04/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hemiplegia (the severe or complete paralysis of one side of the body, caused by brain damage (often opposite the affected side) or spinal cord injury, frequently stemming from strokes, tumors, or congenital conditions) and irritable bowel (a common, chronic functional disorder of the large intestine causing abdominal pain, cramping, bloating, and diarrhea or constipation). The resident was always incontinent of bladder and bowel. The resident required substantial/maximal assistance of staff members for toileting hygiene. The physician's orders indicated the resident had received the antibiotic Bactrim 800-160 milligrams (mg) twice a day from 04/18/2026 to 04/21/2026, for a UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The Perineal Care policy, with a reviewed date of 03/2023, was provided by the Regional Director of Clinical Services on 04/24/2026 at 10:19 A.M. The policy indicated, .Don gloves .fill wash basin with warm water .Assist resident to spread legs and lift knees .Wet and soap folded wash cloth .Separate labia and wash urethral area first .Wash between and outside labia in downward strokes .Alternate from side to side wipe from front to back and from center of perineum outward .Use a clean area of the washcloth with each wipe. Do not rewipe area unless using a clean area of the washcloth . 4. During an observation, on 04/21/2026 at 1:51 P.M., Resident 56 was sitting in his recliner in his room. The resident's urinary catheter drainage bag was hanging on a trash can to the right side of the resident's recliner. During an observation, on 04/21/2026 at 2:14 P.M., Resident 56 was sitting in his recliner in his room. The resident's urinary catheter drainage bag was hanging on a trash can to the right side of the resident's recliner. During an interview, on 04/21/2026 at 2:34 P.M., the Director of Nursing (DON) indicated the resident's urinary catheter drainage bag should not have been hanging on the trash can. She moved the catheter bag at that time. During an interview, on 04/21/2026 at 2:36 P.M., QMA 13 indicated the resident was an assist of one staff with care. The resident was able to walk to the bathroom, but the staff would hang his urinary catheter drainage bag where it needed to be. During an interview, on 04/22/2026 at 10:22 A.M., QMA 16 indicated the resident needed assistance with care. He had a cream for his penis and had an indwelling urinary catheter. His penis had a split in it from where he had pulled on the catheter. During an observation and interview, on 04/23/2026 at 1:14 P.M., Resident 56 indicated his penis was split down from the catheter. He never messed with his catheter; the staff always messed with it. The resident's urinary catheter drainage bag was hanging from a trash can beside the recliner. The catheter bag had a dignity cover on the sides of the bag but it was opened on the bottom and the urine collection bag was resting on the floor. During an observation, on 04/23/2026 at 1:29 P.M., CNA's 14 and 15 provided urinary catheter care for Resident 56. The resident's penis had a tear to the bottom of the penis. There were no open wounds. The resident's incontinence brief had a moderate amount of green drainage. The CNA's indicated the resident had a lot of drainage. After the urinary catheter care was completed, CNA 14 placed the urinary catheter drainage bag on the trash can beside the resident's recliner. During an interview, on 04/23/2026 at 1:45 P.M., CNA 14 indicated the resident has had the green drainage for a couple of days. It was worse at that time. She always hung the urinary catheter drainage bag on the trash can because that was where the resident liked it. During an interview, on 04/23/2026 at 9:08 A.M., RN 11 indicated the resident came to the facility with his urinary catheter. The resident had an inflatable pump in his penis. The resident always complained of penis pain, but it would fluctuate. The resident's penis was not flaccid and always stayed a little erect. The resident had a penile tear that has since healed but would never grow back. The tear was from his long-term urinary catheter use. The resident had gone to a urology consult recently and believed he was going to get a suprapubic catheter; he was going to go back for a follow (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	up appointment in a few days. The resident did have an infection recently and was on a couple of antibiotics. During an interview, on 04/23/2026 at 9:17 A.M., the Nurse Practitioner indicated if the resident had a tear to the penis, it was likely due to the catheter being pulled but she was unsure what had caused it. The clinical record for Resident 56 was reviewed on 04/22/2026 at 1:57 P.M. A Quarterly MDS assessment, dated 02/09/2026, indicated the resident was cognitively intact. The resident's diagnoses, included but were not limited to, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging tissue) and obstructive uropathy (a structural or functional blockage of urine flow, leading to urine backflow, potential kidney swelling (hydronephrosis), and kidney damage). A Hospital Discharge Record, dated 11/26/2025, indicated the resident would need to follow up with urology. The resident had no Urology Visit scheduled until April 2026. A Progress Note, dated 03/28/2026 at 3:53 P.M., indicated the resident had complaints of pain to the penis. Upon an assessment, the nurse noted there was increased edema to the shaft of the penis. The resident was noted with a tear to the penis related to the catheter. There was purulent (a thick, milky, or opaque fluid—often yellow, green, or brown—that oozes from a wound, signaling a potential bacterial infection) and bloody drainage noted to the brief. The drainage was malodorous (something having an unpleasant, foul, or offensive smell). The resident's catheter was replaced, the area was cleansed, and antibiotic ointment was applied. The physician was notified. A Progress Note, dated 03/28/2026 at 5:00 P.M., indicated a new order was received to culture the tear to the head of the penis. The staff were to cleanse the tear with soap and water, pat dry, and apply antibiotic ointment, everyday until the wound was healed. The resident was also to receive Keflex (an antibiotic) 500 milligrams (mg), twice a day, for seven days. A Progress Note, dated 04/02/2026 at 2:23 P.M., indicated the resident's culture results were received and indicated there was moderate growth of staph-aureus and heavy growth of proteus mirabilis. The physician was notified. A Progress Note, dated 04/03/2026 at 5:36 P.M., indicated a new physician's order was received for Clindamycin (an antibiotic) 300 mg, twice a day for seven days in addition to the Keflex. The EMAR indicated the resident was administered the medications per the physician orders. The Complete Care Plan was reviewed and included, but was not limited to, a care plan the resident required an indwelling urinary catheter related to Benign Prostatic Hyperplasia (a common condition in older men where the prostate gland becomes enlarged, causing uncomfortable urinary symptoms with lower urinary tract) and obstructive uropathy with a start date of 12/03/2025. The interventions included, but were not limited to the following: - the resident prefers to have catheter bag hanging on the trash can beside chair, with a start date of 04/21/2026 at 2:41 P.M., and- do not allow tubing or any part of the drainage system to touch the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	floor, with a start date of 12/03/2025. The Care Plan and clinical record lacked any indication the resident was educated on the risks of having the urinary catheter drainage bag hanging on the trash can or interventions related to the catheter drainage bag hanging on the trash can prior to the start of the survey. During an interview, on 04/23/2026 at 2:35 P.M., the Assistant Director of Nursing (ADON) indicated the resident admitted to the facility with a catheter. There was a weekend when the staff called her and indicated the resident had a laceration to his penis. It was a typical keratosis (a rare, benign (non-cancerous) skin growth appearing as tan, brown, or black waxy, stuck-on papules or plaques) the resident had for awhile that had become more inflamed. The resident would frequently adjust his urinary catheter himself. The staff should be monitoring the resident's skin while providing urinary catheter care completed every shift. The resident had his first urology visit last week. If the resident's hospital discharge paperwork indicated they needed to follow-up with urology, then they would call them within a week to get that scheduled. Urology was only for chronic catheter management and when a resident was discharging home from the hospital. During an interview, on 04/24/2026 at 3:07 P.M., the DON indicated the facility lacked a policy related to urinary catheter bags touching things. The resident was care planned for his urinary catheter bag to hang on the trash can. They added the intervention the day she saw the bag hanging on the trash can during the survey. The current facility policy titled, Infection Prevention and Control Program Policy, with a revision date of 05/2023, was provided by the Regional Director Clinical Services on 04/24/2026 at 10:19 A.M. The policy indicated, .The facility shall establish and maintain infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections. The IPCP is a comprehensive system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under contractual arrangement, is based on the facility assessment, and following accepted national standards. The IPCP includes Antibiotic Stewardship Program. 410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to assess a resident to self-administer medications for 2 of 19 residents reviewed for self-administration of medications. (Residents 34 and 73)Findings include:1. During an observation and interview, on 04/21/2026 at 9:07 A.M., Resident 34 was sitting in her chair, in her room. The resident had a medication cup full of medications sitting on her over the bed table. She indicated the medications were her morning medications. The staff would normally leave them on her table so she could take them with her breakfast or after she was done eating. During an observation and interview, on 04/23/2026 at 9:02 A.M., the resident was sitting in her chair in her room, there was a cup full of medication sitting on her over bed table. Licensed Practical Nurse (LPN) 9 indicated the resident's medications should not have been left at her bedside table. The resident should have had a physician's order for the medications and an assessment to self-administer medications. During an interview, on 04/23/2026 at 9:05 A.M., LPN 9 indicated the resident didn't have an order or an assessment to self-administer medications. The resident's medications should not have been sitting on her bedside table without a nurse in the room. The clinical record for Resident 34 was reviewed on 04/21/2026 at 2:11 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/17/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, dementia (an umbrella term for progressive cognitive decline—including memory loss, language issues, and behavioral changes), anemia (a common blood condition characterized by a lack of healthy red blood cells or hemoglobin, leading to reduced oxygen transport), hypertension (high blood pressure), diabetes (high blood sugar), anxiety (a common, often chronic, mental health condition characterized by excessive, persistent worry and fear that interferes with daily life, often causing physical symptoms like heart palpitations, trembling, and nausea), and depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, fatigue, and cognitive difficulties, lasting at least two weeks). The Electronic Medication Administration Record (EMAR) indicated the resident had the following physician orders for morning medications: - Alprazolam (an antianxiety medication) 0.5 milligrams (mg), - Aripiprazole (an antipsychotic medication) 5 mg, - Aspirin 81 mg, - Calcitriol (vitamin D) 0.25 micrograms (mcg),- Cetirizine (an antihistamine) 10 mg, - Vitamin D3 125 mcg, - Daily Vitamin 400 mcg, - Diltiazem (blood pressure medication) 240 mg, - Metformin (a high blood sugar medication) 500 mg, - Metoprolol (a blood pressure medication) 50 mg, - Omeprazole (a heartburn medication) 40 mg, - Calcium Carbonate 500 mg, - PreserVision (an eye vitamin), - Sertraline (an antidepressant medication) 150 mg, and - Tamsulosin (a bladder medication) 0.4 mg. 2. During an observation and interview, on 04/20/2026 at 9:51 A.M., Resident 73 was sitting in his bed, in his room. The resident had a medication cup with a brown substance that contained white and pale colored flecks in it, sitting on his bedside table next to his breakfast tray. He indicated the medications cup contained his morning medication and chocolate pudding. He would take them when he was finished eating. During an observation and interview, on 04/20/2026 at 10:28 A.M., Resident 73 was sitting in his bed, (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in his room. The medication cup with a brown substance that contained white and pale colored flecks in it and his breakfast tray were no longer sitting on the bedside table. The resident indicated he finished his breakfast and had taken his medications. During an interview on 04/20/2026 at 10:50 A.M., LPN 2 indicated Resident 73 would not interrupt his meal to take his medications. He took his medications crushed in pudding or applesauce and took them after he had finished his meal. Medications should not be left at bedside, and residents should be watched until all medications were taken. The clinical record for Resident 73 was reviewed on 04/24/2026 at 10:46 A.M. An annual MDS assessment, dated 02/17/2026, indicated the resident was cognitively intact. The Resident's diagnoses included, but were not limited to, a seizure disorder, high blood pressure, and dementia. The clinical record lacked order or an assessment to self-administer medications. The current facility policy, titled Self-Administration of Medications, revised on 01/2015, was provided by the Administrator on 04/23/2026 at 4:16 P.M. The policy indicated, .If a resident desires to participate in self-administration, the interdisciplinary team will assess the competence of the resident to participate by completing the Self-Administration of Medication Assessment observation. 410 IAC (Indiana Administrative Code) 16.2-3.1-11(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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs of a resident related to call light availability for a resident with frequent falls for 1 of 19 residents reviewed for accommodations of needs. (Resident 9) Findings include: During an observation, on 04/20/2026 at 9:43 A.M., Resident 9 was asleep in bed in her room. No call lights were available for the resident. A touch pad call light and a push button call light were on the floor under the turn-off system hanging on the wall. Neither call light would be reachable by the resident. During an observation and interview, on 04/21/2026 at 2:54 P.M., the resident's room door was closed. A therapy associate in the hallway indicated Resident 9's roommate liked the room door to stay closed. If staff members left the door open, the roommate would get up and close it. During an observation, on 04/22/2026 at 11:02 A.M., the resident was sitting in her recliner in her room. Her head was tilted back and her eyes were closed. Her wheelchair was sitting in front of the recliner, and her feet were propped up on the seat of the wheelchair. A push-button call light was laying in the middle of the resident's bed, several feet away from the resident. During an observation and interview, on 04/24/2026 at 10:46 A.M., the resident was lying in bed in her room. Her call light was on the floor under the edge of the bed out of the resident's reach. Certified Nurse Aide (CNA) 10 indicated the call light must have fallen. During an interview, on 04/23/2026 at 3:29 P.M., the Physical Therapist indicated the resident fell frequently. The hardest part for her was getting out of bed in the morning, she required a lot of assistance. When she first stood up and walked, she was unsteady. Staff usually stood with her when she first would get up and walked with her down to the dining room. Throughout the day, the resident was more awake and she would get up and ambulate on her own with stand-by assistance. During an interview, on 04/24/2026 at 10:48 A.M., the Infection Preventionist indicated to ensure call lights were in reach for residents the staff would give the call light to the resident when they laid them down or when they were in their chairs. The clinical record was reviewed on 04/21/2026 at 2:24 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/10/2026, indicated Resident 9 was rarely understood. The resident's diagnosis included, but was not limited to, dementia (a progressive, irreversible syndrome characterized by a decline in cognitive function, memory, language, and behavior, beyond normal aging, caused by damaged brain cells). The resident needed assistance with hygiene and was incontinent of bowel and bladder. The resident had two or more falls with no injury and two or more falls with minor injuries since the last assessment. The resident's Risk for Falls Care Plan included, but was not limited to, and intervention, with an approach start date of 05/30/2023, to keep the resident's call light in reach.The Interdisciplinary Team (IDT) Comprehensive Care Plan Policy, with a revised date of 10/2025, was provided by the Administrator on 04/23/2026 at 3:41 P.M. The policy indicated, .It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented.The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being .Purpose .Create an organized, resident-centered review on a routine basis .provided to maintain or restore health and well-being .410 IAC (Indiana Administrative Code) 16.2-3.1-3(v)(1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop or implement care planned interventions related to hearing aids and implanted medical devices for 2 of 21 residents reviewed for Care Plans. (Residents 48 and 56)Findings include:1. During an interview, on 04/21/2026 at 10:26 A.M., Resident 48 indicated she did have some hearing loss. She received hearing aids last year. She didn't wear them because she was not sure how to adjust them. On 04/22/2026 at 9:42 A.M., the resident was observed in bed in her room. She indicated she thought her hearing aids were on a shelf near her bed. The CNAs (Certified Nurse Aides) never asked her about them, she didn't think they even knew she had them. The resident's hearing aids were observed in a case on a shelf of the plastic storage unit. The case was plugged in and was covered in a thin layer of dust. During an interview, on 04/22/2026 at 9:48 A.M., CNA 3 indicated that if a resident had hearing aids, she would ask if they wanted to wear them as part of routine Activities of Daily Living (ADL) care. She would assist them with putting the hearing aids on and making sure they were in the correct ear and that they were functioning without issue. She routinely provided care for the resident. She had never assisted the resident with hearing aids; she didn't even know the resident had hearing aids. During an interview, on 04/22/2026 at 10:00 A.M., Licensed Practical Nurse (LPN) 19 indicated the resident didn't wear hearing aids. She thought she had her hearing tested recently, like in the last three or four months. The resident's clinical record was reviewed on 04/22/2026. A Quarterly Minimum Data Set (MDS) assessment, dated 04/01/2026, indicated the resident was cognitively intact. The resident had minimal hearing difficulty and did not wear hearing aids. A Progress Note, dated 08/22/2025 at 10:39 A.M., indicated the resident's hearing aids were delivered and adjusted for fit. A Progress Note, dated 01/07/2026 at 07:27 A.M., indicated the resident was seen by the audiologist on 01/06/2026. The hearing aids were to be cleaned after each use. The hearing aids should be kept on the charger when not in use. Please assist the resident by inserting the hearing aids in the morning and removing the hearing aids in the evening. Please charge the hearing aids for at least three hours every day before wearing. The resident was to wear the hearing aids daily. The resident's Communication Care Plan, with a start date of 03/17/2025, and a revision date of 04/07/2026, indicated the resident had hearing loss. The interventions included, but were not limited to: - An intervention, with a start date of 03/17/2025, indicated the staff were to check to ensure the resident's hearing aids are clean, functioning, and properly placed into both ears. During an interview, on 04/22/2026 at 9:48 A.M., CNA 3 indicated they had CNA papers that contained important information about each resident; things like how much assistance a resident would need when transferring, fall interventions, if they wore dentures or glasses, things like that. Everything on the CNA papers was part of the resident's Care Plan on the computer. The CNA paper for the resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated staff were to check that her hearing aid(s) were clean, functioning, and properly placed into both ear(s). They were to store the hearing aid(s) in the resident's room or in the nurse's cart. When the CNA opened the computer to review the resident's record, she did not see interventions related to the resident's hearing aids on the screen. She indicated everything on the CNA papers should be accessible on the computers the CNAs used to document care. During an interview, on 04/22/2026 at 10:30 A.M., CNA 3 indicated she was unaware that she could open a resident's Care Plan in the computer and review the resident specific interventions. 2. During an interview, on 04/23/2026 at 9:08 A.M., Registered Nurse (RN) 11 indicated the resident came to the facility with his urinary catheter. The resident had an inflatable pump in his penis. The resident always complained of penis pain, but it would fluctuate. The resident's penis was not flaccid and always stayed a little erect. The resident had a penile tear that has since healed but would never grow back. The tear was from his long-term urinary catheter use. The resident had gone to a urology consult recently and believed he was going to get a suprapubic catheter; he was going to go back for a follow up appointment in a few days. During an interview, on 04/23/2026 at 2:35 P.M., the Assisted Director of Nursing (ADON) indicated the resident admitted to the facility with a catheter. There was a weekend when the staff called her and indicated the resident had a laceration to his penis. It was a typical keratosis (a rare, benign [non-cancerous] skin growth appearing as tan, brown, or black waxy, stuck-on papules or plaques), that the resident always had that had become more inflamed. The resident would frequently adjust his urinary catheter himself. The staff should be monitoring the resident's skin while providing urinary catheter care that was completed every shift. The resident had his first urology visit last week. Historically the resident had a penile pump, but she had never seen it function. She believed it would have been documented on the admission assessment. The resident had told them about the implant on admission. She didn't think the facility had a policy to care plan a resident for a penile pump only for pacemakers and pain pumps. The clinical record for Resident 56 was reviewed on 04/22/2026 at 1:57 P.M. A Quarterly MDS assessment, dated 02/09/2026, indicated the resident was cognitively intact. The resident's diagnoses, included but were not limited to, vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, damaging tissue) and obstructive uropathy (a structural or functional blockage of urine flow, leading to urine backflow, potential kidney swelling (hydronephrosis), and kidney damage. The residents care plan lacked a care plan related to the penile pump. The current facility policy, titled IDT Comprehensive Care Plan Policy, revised on 10/2025, was provided by the Administrator on 04/23/2026 at 3:41 P.M. The policy indicated, .It is the policy of this facility that each resident will have an interdisciplinary care plan developed and implemented. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to update or revise residents' care plans related to hearing aids and preventative measures related to skin impairments for 2 of 21 residents reviewed for care plan revisions. (Residents 48 and 12)Findings include:1. During an interview, on 04/21/2026 at 10:26 A.M., Resident 48 indicated she did have some hearing loss. She got hearing aids last year. She didn't wear them because she was not sure how to adjust them.On 04/22/2026 at 9:42 A.M., the resident was observed in bed in her room. She indicated she thought her hearing aids were on a shelf near her bed. The CNAs (Certified Nurse Aides) never asked her about them, she didn't think they even knew she had them. The resident's hearing aids were observed in a case on a shelf of the plastic storage unit. The case was plugged in and was covered in a thin layer of dust. During an interview, on 04/22/2026 at 9:48 A.M., CNA 3 indicated that if a resident had hearing aids, she would ask if they wanted to wear them as part of routine Activities of Daily Living (ADL) care. She would assist them with putting the hearing aids on and making sure they were in the correct ear and that they were functioning without issue. If a resident refused to wear their hearing aids or was having a problem with their hearing aids, she would let the nurse know. She would not document anything about it but would tell the nurse and thought the nurse would document something in the resident's record. She routinely provided care for the resident. She had never assisted the resident with hearing aids; she didn't even know the resident had hearing aids. During an interview, on 04/22/2026 at 10:00 A.M., Licensed Practical Nurse (LPN) 19 indicated the resident didn't wear hearing aids. She thought she had her hearing tested recently, like in the last three or four months. If a resident had hearing aids and wasn't wearing them, she would document it in the resident's record. She would let the Social Services Director (SSD) know.The resident's record lacked documentation that she was not wearing her hearing aids.The resident's clinical record was reviewed on 04/22/2026. A Quarterly Minimum Data Set (MDS) assessment, dated 04/01/2026, indicated the resident was cognitively intact. The resident had minimal hearing difficulty and did not wear hearing aids.A Progress Note, dated 08/22/2025 at 10:39 A.M., indicated the resident's hearing aids were delivered and adjusted for fit.A Progress Note, dated 01/07/2026 at 07:27 A.M., indicated the resident was seen by the audiologist on 01/06/2026. The hearing aids were to be cleaned after each use. The hearing aids should be kept on the charger when not in use. Please assist the resident by inserting the hearing aids in the morning and removing the hearing aids in the evening. Please charge the hearing aids for at least 3 hours every day before wearing. The resident was to wear the hearing aids daily. An Audiologist Group Visit Note in the resident's Electronic Health Record (EHR) indicated a hearing aid check was performed on 01/06/2026. The progress notes section of the document indicated the hearing aids worked well. It was important to note that turning the volume up on one hearing aid would change the volume on both aids simultaneously. The hearing aids fit well and the resident was hearing well. The nurses were to insert and remove the hearing aids. The hearing aids were paired to the resident's cell phone so the resident could control the volume. The resident was very happy about that. The resident's Communication Care Plan, with a start date of 03/17/2025, and a revision date of 04/07/2026, indicated the resident had hearing loss. The interventions included, but were not limited to:- An intervention, with a start date of 03/17/2025, to check that hearing aids are clean, functioning, and properly placed into both ears, and- An intervention, with a start date of 03/17/2025, that if the resident refused to wear her hearing aids, explore the reason for refusal.During an interview, on 04/22/2026 at 10:09 A.M., the Social Service Director (SSD) indicated the resident had hearing aids. She was last seen by the audiologist on 07/16/2025. The resident never mentioned that she had any issues with the hearing aids. During an interview, on 04/22/2026 at 10:11 A.M., the Assistant Director of Nursing (ADON) indicated if a resident was refusing to wear their hearing aids they would look into it. They would open a Hot Charting Event in the resident's record (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	where they would monitor the situation. They would document what was going on, what they tried to do to address the issue, and if the resident continued to refuse to wear them. They would update the resident's care plan to reflect the interventions and the resident's refusal. The resident's care plan lacked documentation it was revised related to the resident's non-use of or refusal to wear their hearing aids.During an interview, on 04/22/2026 at 10:30 A.M., LPN 19 indicated she went to the resident's room and assisted the resident with putting in her hearing aids. The resident immediately indicated the hearing aids needed to be adjusted. The LPN thought there should be a Hot Charting Event opened in the resident's record. The audiologist should have told them they adjusted the resident's hearing aids and that the resident could adjust them with her cell phone when they came in to see her in January. 2. During an interview, on 04/21/2026 at 9:37 A.M., Resident 12's family member indicated they were concerned about how the resident kept injuring her lower legs. She had experienced bruising and skin tears on her lower legs.The resident's clinical record was reviewed on 04/23/2026 at 9:52 A.M. A Significant Change MDS assessment, dated 12/22/2025, indicated the resident was severely cognitively impaired. The resident's diagnosis included, but was not limited to, dementia (a decline in mental ability severe enough to interfere with daily life, caused by physical changes in the brain). The resident had no skin impairments. The resident used a manual wheelchair and was able to propel herself short distances independently.A Progress Note, dated 02/14/2026 at 12:00 A.M., indicated the resident was found to have bruising on her left lower leg. The bruising was noted to align with the resident's wheelchair pedal. Staff were educated to ensure the resident's wheelchair pedals and the resident's legs were in the appropriate place.An Interdisciplinary Team (IDT) Progress Note, dated 02/16/2026, indicated the resident had bruising to her left leg. The root cause was determined to be that the resident moved her feet off the wheelchair foot pedals at times to propel herself without moving the pedals to the side. The new intervention was to remove the pedals from the chair.A Wound Review IDT Note, dated 03/23/2026 at 11:02 A.M., indicated the resident had a skin tear to the back of her left leg. The root cause was determined to be related to the resident hitting her legs on her wheelchair foot pedals. The new intervention was to remove the wheelchair foot pedals when not in use. A Wound Review IDT Note, dated 04/11/20260 at 4:12 A.M., indicated the resident had a skin tear on the back of her right leg. The root cause was determined to be related to mechanical trauma from hitting her legs on the wheelchair foot pedals. The new intervention was to apply support bandages/stockings to the resident's legs to protect her skin. The resident's Care Plans that were in place on 03/23/2026 and 04/11/2026 were reviewed on 04/23/2026 at 10:04 A.M. The Care Plans lacked indication they were updated to include the interventions to remove the resident's foot pedals from her wheelchair to help prevent injury to her legs.During an interview, on 04/24/2026 at 10:17 A.M., the Director of Nursing indicated during that time she thought hospice had provided a smaller wheelchair for the resident and that wheelchair would have come with foot pedals. Recently, the resident received a new, high-backed wheelchair and no longer propelled herself. The resident's Care Plan should have been updated to indicate the foot pedals should have been removed from the wheelchair if that was an implemented intervention to prevent injuries to the resident's legs. The current facility policy, titled IDT Comprehensive Care Plan Policy, revised on 10/2025, was provided by the Administrator on 04/23/2026 at 3:41 P.M. The policy indicated, .It is the policy of this facility that each resident will have an interdisciplinary care plan developed and implemented.Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(2)410 IAC (Indiana Administrative Code) 16.2-3.1-35(d)(2)(B)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to have ongoing communication and collaboration with the dialysis center regarding a residents prescribed medications during dialysis care days for 1 of 1 resident reviewed for dialysis services. (Resident 4) Findings include:The clinical record for Resident 4 was reviewed on 04/22/2026 at 3:44 P.M. An admission Minimum Data Set (MDS) assessment, dated 04/08/2026, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, end stage renal disease (permanent, stage 5 chronic kidney failure, where kidneys function below 10 to 15% and cannot support life, requiring regular dialysis or a kidney transplant), hypertension (high blood pressure), hypokalemia (a condition characterized by low blood potassium levels, essential for nerve, muscle, and heart function), atrial fibrillation (a common heart rhythm disorder characterized by rapid, chaotic electrical signals causing the upper chambers (atria) to quiver instead of beating effectively, resulting in an irregular, fast heartbeat), and depression (a common, serious mood disorder characterized by persistent sadness, loss of interest in activities, fatigue, and cognitive difficulties, lasting at least two weeks). The resident received dialysis treatments while a resident.The April 2026 Electronic Medication Administration Record (EMAR) indicated the resident did not receive the following medications on the following dates and times: - Amiodarone tablet; 200 milligrams (mg) once a day for a diagnosis of Atrial Fibrillation was not administered, on 04/03/2026 from 7:00 A.M. to 11:00 A.M. and on 04/06/2026 from 7:00 A.M. to 11:00 A.M., due to the resident not being available. - Carvedilol tablet; 3.125 mg twice a day for a diagnosis of hypertension was not administered, on 04/03/2026 from 7:00 A.M. to 11:00 A.M. and on 04/06/2026 from 7:00 A.M. to 11:00 A.M., due to the resident not being available. - Eliquis (apixaban) tablet; 5 mg twice a day for a diagnosis of Atrial Fibrillation was not administered, on 04/03/2026 from 7:00 A.M. to 11:00 A.M. and on 04/06/2026 from 7:00 A.M. to 11:00 A.M., due to the resident not available. - Potassium chloride tablet extended release; 10 Milliequivalents once a day for a diagnosis of hypokalemia was not administered, on 04/03/2026 from 7:00 A.M. to 11:00 A.M. and on 04/06/2026 from 7:00 A.M. to 11:00 A.M., due to the resident not being available. - Sertraline tablet; 25 mg once a day for a diagnosis of depression was not administered, on 04/03/2026 from 7:00 A.M. to 11:00 A.M. and on 04/06/2026 from 7:00 A.M. to 11:00 A.M., due to the resident not being available. - Velphoro (sucroferric oxyhydroxide) tablet, chewable; 500 mg three times a day for a diagnosis of End Stage Renal Disease was not administered, on 04/03/2026 at 7:00 A.M. and on 04/06/2026 at 7:00 A.M., due to the resident not being available. During an interview, on 04/23/2026 at 10:42 A.M., Licensed Practical Nurse (LPN) 19 indicated Resident 4 went out for dialysis treatments on Monday, Wednesday, and Friday. The resident received some medications multiple times throughout the day. The resident could get his medications before he left for dialysis or when he returned, it just depended on the nurse on duty. During an interview, on 04/24/2026 at 10:52 A.M., LPN 18 indicated for residents who left the facility for dialysis treatments, the staff managed their medications. It depended on how the medication was ordered. They just followed the physicians' orders on the EMAR. During an interview, on 04/24/2026 at 1:07 P.M., the Director of Nursing indicated Resident 4 had not received his Amiodarone medication on April 3 and on April 6, the resident was unavailable. The Amiodarone was prescribed for his Atrial Fibrillation. The nurse on duty did not give the resident his medications because he was out of the facility at dialysis. The DON indicated the facility did not have a policy that said when residents were out of the building when they should give a resident their medications. The current Dialysis Care policy, with a reviewed date of 11/2017, provided by the Regional Director of Clinical Services on 04/24/2026 at 10:19 A.M. The policy indicated, .to ensure that residents requiring dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care, and the residents' goals and preferences. The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice .410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer medications appropriately and have medications available for 2 of 22 residents reviewed for pharmacy services. (Residents 82 and 77)Findings include:1. During an observation, on 04/23/2026 at 9:00 A.M., Registered Nurse (RN) 11 provided a treatment to Resident 82. After the treatment was complete, there was a medication cup observed on the resident's over the bed table that contained two pink tablets. RN 11 gave the medications to the resident. During an interview, on 04/23/2026 at 11:42 A.M., RN 11 indicated the tablets she gave the resident in her room were antacids. There was a nurse in training, Licensed Practical Nurse (LPN) 12, that had prepared the medications and took them to the resident before she went into the resident's room to complete the treatment. She asked the nurse to wait to give her the medications until after she was done with her treatment. Usually, the nurse who prepared the medication was the nurse that would administer the medication. The clinical record for Resident 82 was reviewed on 04/22/2026 at 1:17 P.M. The resident admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, stricture of artery (thick-walled, elastic blood vessel) and peripheral vascular disease (a slow, progressive circulation disorder involving narrowing, blockage, or spasms in blood vessels). The current facility policy titled, Medication Administration, with a revision date of 4/2025, was provided by the Administrator on 04/23/2026 at 4:16 P.M. The policy indicated, .Observe resident taking medications.2. The clinical record for Resident 77 was reviewed on 04/23/2026 at 9:57 A.M. A Significant Change Minimum Data Set (MDS) assessment, dated 03/15/2026, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited, Metabolic encephalopathy (a brain dysfunction caused by underlying systemic illnesses-such as liver failure, kidney failure, or diabetes-that disrupt normal metabolism, leading to altered brain chemistry) and adult failure to thrive. The February and March 2026 Electronic Medication Administration Record indicated the resident had not received the following medications due to them being unavailable:- Megestrol Suspension 400 mg, twice a day for adult failure to thrive. The resident did not receive the medications on 02/25/2026 from 7:00 P.M. to 11:00 P.M., 02/26/2026 from 7:00 A.M. to 11:00 A.M., and 02/26/2026 from 7:00 P.M. to 11:00 P.M., and - Sodium Chloride 1,000 mg, three times a day. The resident did not receive the medications on 03/02/2026 at 2:00 P.M., 03/02/2026 at 8:00 P.M., and 03/03/2026 at 8:00 A.M. The resident's clinical record lack physician notification related to the resident's medications not being available. During an interview, on 04/24/2026 at 10:34 A.M., RN 11 indicated if a resident's medication wasn't available in the medication cart, then she would check their emergency drug kit. If it was available from there then she would get it and administer it. If the medication was not available in the emergency drug kit, then she would get it STAT (immediately or without delay). If she ordered it STAT, then it would come within two to four hours. They would get medications delivered daily from 6:00 A.M. to 8:00 A.M. If resident's medications weren't available, then the physician should be notified. She would document in the EMAR or the progress notes that the medication was unavailable and that the physician was notified. The current facility policy titled, Medication Shortages/Unavailable Medications, with a revision date of 08/01/2024, was provided by the Regional Director Clinical Services on 04/24/2026. The policy indicated, .Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy.If the medication shortage is discovered at the time of medication administration, Facility staff should immediately notify the Pharmacy.410 IAC (Indiana Administrative Code) 16.2-3.1-25(a)410 IAC (Indiana Administrative Code) 16.2-3.1-25(b)(4)