STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Health Campus	6685 East 117th Avenue Crown Point, IN 46307

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure infection control measures were in place and implemented related to correct isolation precautions in place for a resident on contact isolation, contracted staff not following enhanced barrier precautions during care and staff not cleaning a shared blood pressure cuff between residents. (Resident 6, phlebotomist and RN 1)Findings include:1.Resident 6 was observed in her bed on 3/16/26 at 11:15 a.m. There was an enhanced barrier precaution sign on the door and a PPE (personal protective equipment) bin next to the door. The resident's record was reviewed on 3/16/26 at 2:45 p.m. Diagnoses included, but were not limited to, cholecystitis (inflammation of the gallbladder) and urinary tract infection. The resident had been readmitted to the facility on [DATE] following a hospital stay. A Physician's Order, dated 3/13/26, indicated the resident was on contact isolation related to Strep A/ blood culture (Group A streptococcal infection). Contact sign outside resident's room. Gown and glove for high contact resident care activities. Face shield should be used for any tasks that have a high potential of splash or spray. On 3/16/26 at 2:54 p.m., the resident was observed with the Director of Nursing. She was made aware there was an order for contact isolation, but the resident was placed on enhanced barrier precautions. She indicated she would look into the issue. No further information was provided. 2.On 3/16/26 at 2:30 p.m., a phlebotomist was observed walking in the hallway toward resident's rooms. She was wearing a face mask and a blue protective gown. She entered room K, which had an enhanced barrier precautions sign on the door. Moments later she exited the room, still wearing the blue gown and face mask, and approached another resident in the common area. The resident and phlebotomist went into room [ROOM NUMBER] and closed the door. During an interview on 3/16/26 at 2:41 p.m., the Director of Nursing was made aware of the observation. She indicated the phlebotomist should have changed her gown and mask and immediately went to room [ROOM NUMBER]. The Enhanced Barrier Precautions sign, posted on the door of room K, indicated, Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and gowns for the following high contact resident care activities Device care or use: central lines, urinary catheters, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. 3. On 3/19/26 9:09 a.m., RN 1 was observed preparing Resident 120's medications. Resident 120 had (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a sign on her door indicating that she was in enhanced barrier precautions. RN 1 obtained the blood pressure cuff from the top of the medication cart, entered the resident's room, and measured the resident's blood pressure. When the blood pressure reading was completed, she removed the blood pressure cuff and returned it to the top of the medication cart. RN 1 had not cleaned or disinfected the blood pressure cuff before or after use. RN 1 then continued on to prepare Resident 3's medications. Resident 3 had a sign on his door indicating that he was in enhanced barrier precautions. RN 1 obtained the blood pressure cuff from the top of the medication cart, entered the resident's room, and measured the resident's blood pressure. When the blood pressure reading was completed, she removed the blood pressure cuff and returned it to the top of the medication cart. RN 1 had not cleaned or disinfected the blood pressure cuff before or after use. RN 1 then continued on to prepare Resident 44's medications. Resident 44 had a sign on his door indicating that he was in enhanced barrier precautions. RN 1 obtained the blood pressure cuff from the top of the medication cart, entered the resident's room, and measured the resident's blood pressure. When the blood pressure reading was completed, she removed the blood pressure cuff and returned it to the top of the medication cart. RN 1 had not cleaned or disinfected the blood pressure cuff before or after use. During an interview on 3/19/26 at 10:27 a.m., the Administrator was made aware RN 1 had not cleaned the blood pressure cuff before or after use. A reuseable equipment cleaning policy was requested. A facility policy, titled Infection prevention and Control Program, indicated, .Cleaning and disinfection of environmental surfaces and reusable equipment: .b. The facility cleaning/disinfection policies include handling of equipment shared among residents [e.g. blood pressure cuffs, rehab therapy equipment etc.] c. Facility has policies and procedures to ensure that reusable medical devices are cleaned and reprocessed appropriately prior to use on another resident . 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to dirty fans, trash cans, floors, and baseboards for 1 of 1 kitchen. (The Main Kitchen) The facility also failed to ensure a microwave and a refrigerator on 2 of 4 units were clean. (The Memory Care Unit and Independence Hall) Findings include:1. During the Kitchen Sanitation Tour on 3/16/26 at 9:20 a.m., with the Dietary Food Manager (DFM) the following was observed: a. A portable fan was observed on top of the garbage can located next to the handwashing sink. The fan had an accumulation of dirt and dried food spillage. During an interview at that time, the Dietary Food Manager (DFM) indicated the fan needed to be thrown out. b. A white garbage can located next to the handwashing sink had an accumulation of dried food spillage and debris on top of the lid and sides. c. An accumulation of dirt and debris was observed along the baseboards underneath the food prep counter.d. An accumulation of dirt and debris was observed on the floor in front of the oven.e. An accumulation of dried food spillage was observed on the white PVC pipes located underneath the food prep counter. During an interview at that time, the DFM indicated all of the above was in need of cleaning. 2. On 3/20/26 at 1:59 p.m., the microwave located in the Memory Care Unit pantry had an accumulation of dried food spillage.3. On 3/20/26 at 2:03 p.m., the refrigerator located on the Independence Hall had an accumulation of dried juice spillage on the shelves.During an interview on 3/20/26 at 2:30 p.m., the Director of Nursing indicated the microwave and the refrigerator would be cleaned. 410 IAC (Indiana Administrative Code) 16.2-3.1-19(f)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a self-administration of medication assessment was complete and a physician's order to self-administer medication was in place, for 1 of 1 resident reviewed for self-administration of medication. (Resident 127)Finding includes:On 3/16/26 at 11:08 a.m., Resident 127 was observed sitting in the chair in his room. An unopened box of Salonpas patches (medicated pain relief patches) and a Breo Ellipta (respiratory medication) inhaler were on his overbed table.On 3/18/26 at 2:19 p.m., the resident was not in his room, but the Breo Ellipta inhaler remained on his overbed table.On 3/19/26 at 10:21 a.m., the resident was in his room preparing to leave for dialysis. The Breo Ellipta inhaler remained on his overbed table. The resident's record was reviewed on 3/20/26 at 9:23 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The resident was admitted to the facility on [DATE].A Physician's Order, dated 3/14/26, indicated fluticasone-salmeterol 100/25 micrograms (mcg) inhaler, inhale 1 puff two times a day. There was no Physician's Order to indicate the resident could self-administer the inhaler. There was no Physician's Order for the Salonpas patches.A Care Plan, dated 3/16/26, indicated the resident had a Physician's Order for self-administration of his inhalers.A Self-Administration of Medication Assessment, dated 3/16/26, indicated the resident wanted to self-administer some of his medications and those medications would be stored in the resident's room. The medications to be self-administered were not specified.During an interview on 3/19/26 at 1:23 p.m., the Administrator and Nurse Consultant indicated the resident had a care plan for self-administration of the inhaler, but the information had not been included in the physician's order or the medication assessment. The resident had brought in the Salonpas patches and there were no orders for the medication. The ADON had found them and taken them out of the room. A facility policy, titled, Self-Administration of Medication Program, indicated, .7. The admitting nurse or designee will complete the Self-Administration of Medication Evaluation and report the findings to the unit manager or designee. 8. a. Who will be responsible [the resident or the nursing staff] for storage [If medications are stored at the resident's bedside, a lockbox or locked drawer must be used to store the medications] .9. Once the resident has been deemed safe by the IDT an order will be obtained from the resident's physician or NP 410 IAC (Indiana Administrative Code) 16.2-3.1-11(a)

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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. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to a Wanderguard alarm (wearable device that alarms when approaching a restricted area) not documented for a resident with history of wandering for 1 of 23 MDS assessments reviewed. (Resident 30)Finding includes: The record for Resident 30 was reviewed on 3/18/26 at 2:34 p.m. Diagnoses included, but were not limited to, dementia.A Care Plan, revised on 6/13/25, indicated the resident was an elopement risk/wanderer related to diagnosis of dementia. Interventions included, but were not limited to, check Wanderguard placement (right ankle) and function.The Physician's Order, dated 12/4/25, indicated Wanderguard to right ankle. Check placement each shift.The Quarterly Minimum Data Set (MDS) assessment, dated 12/18/25, indicated the resident had moderate cognitive impairment. The Wander/elopement alarm assessment was marked as 0 indicating not used.During an interview on 3/19/26 at 11:42 a.m., the Administrator indicated an MDS modification was going to be submitted. No further information was provided.410 IAC (Indiana Administrative Code) 16.2-3.1-31(i)

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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 observation, record review, and interview, the facility failed to ensure the current care plan was implemented related to documentation of food intake for 1 of 6 residents reviewed for nutrition and documentation of urinary catheter output for 2 of 3 residents reviewed for catheters. (Residents 32, 62 and 80)Findings include: 1. The record for Resident 32 was reviewed on 3/18/26 at 1:15 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, dysphagia (difficulty swallowing) and protein calorie malnutrition. A Care Plan, dated 11/4/25 and reviewed on 1/5/26, indicated the resident had the potential for a nutritional problem related to the diagnoses of dementia, dysphagia, and protein calorie malnutrition. The resident received a mechanically altered diet and had a history of weight loss. Interventions included, but were not limited to, monitor meal consumption and record every meal. The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. She was also dependent on staff for eating, she had a history of weight loss, and received a mechanically altered diet. The Food Consumption documentation located in the Task section of the medical record, indicated there was no dinner intake documented on 2/20/26, 3/7/26, and 3/12/26. There was no breakfast and lunch intake documented on 2/21/26 and 3/8/26. During an interview on 3/19/26 at 4:01 p.m., the Director of Nursing (DON) indicated the resident did not have a true weight loss. She indicated the facility scale had not been calibrated in over two years and the weight loss was questionable. The DON also indicated the resident's food consumption was to be documented after each meal. 2. On 3/16/26 at 1:38 p.m., Resident 62 was observed in her room in bed. A Foley catheter was observed to be in use. The record for Resident 62 was reviewed on 3/19/26 at 9:35 a.m. Diagnoses included, but were not limited to, vascular dementia and neurogenic bladder (a dysfunction of the lower urinary tract). A Physician's Order, dated 4/13/25 and listed as current on the March 2026 Physician's Order Summary (POS), indicated the resident had a 16 French 30 milliliter (ml) Foley catheter for neurogenic bladder. The catheter was to be changed as needed for dislodgement, leakage, or blockage. A Care Plan, dated 11/5/25 and reviewed on 1/19/26, indicated the resident was at risk for complications secondary to requiring the use of an indwelling catheter related to neurogenic bladder. Interventions included, but were not limited to, monitor and document intake and output as per facility policy. The Quarterly Minimum Data Set (MDS) assessment, dated 1/19/26, indicated the resident was severely impaired for daily decision making and she had an indwelling catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's urinary output documented in the Task section of the medical record indicated there was no urinary output documented on the following dates and shifts: Evening shift: 2/20/26, 2/25/26, 3/12/26, and 3/15/26. Day shift: 2/21/26, 2/28/26, 3/2/26, 3/8/26, and 3/11/26. Night shift: 2/22/26, 3/3/26, 3/9/26, 3/10/26, 3/11/26, and 3/14/26. During an interview on 3/19/26 at 3:40 p.m., the Director of Nursing indicated the resident's output should have been documented every shift. 3. Resident 80's record was reviewed on 3/18/26 at 1:38 p.m. Diagnoses included, but were not limited to, obstructive and reflux uropathy and neuromuscular dysfunction of the bladder. A Care Plan, revised on 3/21/24, indicated the resident had a suprapubic catheter (urinary catheter inserted directly into the bladder through the abdomen) related to neurogenic bladder and obstructive uropathy. Interventions included, but were not limited to, change suprapubic catheter monthly and as needed and record output every shift. The Quarterly Minimum Data Set (MDS) assessment, dated 12/17/25, indicated the resident was cognitively intact and had an indwelling urinary catheter. The resident was dependent on staff for toileting hygiene. The last 30 days of the CNA Tasks were reviewed. There was no documented urinary outputs in the record. During an interview on 3/19/26 at 11:15 a.m., the Nurse Consultant indicated the facility staff should not be routinely documenting urinary output and the care plan intervention should have been discontinued. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(g)(2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, the facility failed to ensure ADL (activities of daily living) care was provided to a dependent resident related to lack of documentation of incontinence care for 1 of 1 resident reviewed for ADL care. (Resident 4)Finding includes:During an interview on 3/16/26 at 11:28 a.m., Resident 4 indicated she was not receiving incontinence care routinely and would be left in a wet brief for long periods of time.Resident 4's record was reviewed on 3/19/26 at 9:44 a.m. Diagnoses included, but were not limited to, Charcot-Marie-Tooth disease (slowly progressive genetic disorders that damage peripheral nerves).A Care Plan, revised on 11/8/24, indicated the resident needed assistance with ADLs. Interventions included, but were not limited to, resident required a one staff assist for bathing and preferred bed baths.The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/25, indicated the resident was cognitively intact and was dependent on staff for toileting hygiene.The CNA Task: B&B - Bladder Elimination, indicated there was no documentation of incontinence care provided on the following dates and shifts:-Day shift: 2/28/26, 3/8/26, 3/13/26, 3/15/26-Evening shift: 3/2/26, 3/6/26, 3/7/26-Night shift: 2/19/26, 2/21/26, 2/24/26During an interview on 3/19/26 at 3:44 p.m., the Director of Nursing indicated it was the expectation that the staff members were to document incontinence care at least once a shift (three times a day).410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure compression wraps were used for 1 of 1 resident with edema. The facility also failed to ensure physician's orders were in place for a biliary drain (abdominal drain inserted into the liver to assist with bile duct blockage) and the drain was monitored for 1 of 3 residents reviewed for catheters. (Residents 89 and 6)Findings include: 1. On 3/17/26 at 9:51 a.m., Resident 89 was seated in her wheelchair participating in an activity. No tubi grips (compression wraps) were visible to the resident's legs. At 11:51 a.m., the resident was seated in her wheelchair in the dining room. Again, there were no tubi grips visible to the resident's legs. At 3:05 p.m., the resident was seated in a chair in her room. Her pants were pulled down below her knees and her socks were visible. She was not wearing tubi grips on either leg. On 3/19/26 at 2:25 p.m., the resident was seated in her room watching television. During an interview at that time, the resident indicated she only had socks on and nothing else on her legs. At 3:22 p.m., LPN 1 entered the resident's room. She pulled up the resident's pant legs and pulled down her socks. She had no tubi grips in use to either leg. The record for Resident 89 was reviewed on 3/19/26 at 3:07 p.m. Diagnoses included, but were not limited to, vascular dementia and congestive heart failure. A Physician's Order, dated 2/12/26, indicated tubi grips were to be applied every morning and removed at bedtime for bilateral lower extremity edema (swelling). A Care Plan, dated 2/13/26, indicated the resident had edema to her bilateral lower extremities. Interventions included, but were not limited to, tubi grips as ordered. The Quarterly Minimum Data Set (MDS) assessment, dated 2/18/26, indicated the resident was cognitively impaired and required partial to moderate assistance with dressing. The March 2026 Treatment Administration Record (TAR) indicated the tubi grips were signed out as being applied on 3/17/26 and 3/19/26. During an interview on 3/19/26 at 3:30 p.m., the Director of Nursing ((DON) indicated the resident's tubi grips should have been applied as ordered. 2. On 3/16/26 at 11:15 a.m., Resident 6 was observed laying in her bed. There was biliary drain on the mattress next to her. The resident's record was reviewed on 3/17/26 at 2:45 p.m. Diagnoses included, but were not limited to, cholecystitis (inflammation of the gallbladder) and urinary tract infection. The resident had been readmitted to the facility following a hospital stay on 3/13/26. The Significant Change Minimum Data Set assessment, dated 1/29/26, indicated the resident had severe cognitive impairment and was dependent for toileting, bed mobility and eating. There were no physician's orders for the biliary drain or care of the drain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/16/26 at 2:54 p.m., the DON was made aware there were no orders for the biliary drain or care of the drain. She indicated she would look into the issue. No additional information was provided. 410 IAC (Indiana Administrative Code) 16.2-3.1-37

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on record review and interview, the facility failed to ensure a resident with a colostomy (opening in the colon that lets stools pass from the body) received appropriate treatment and services related to a lack of documentation of completed colostomy bag changes and stoma care for 1 of 1 resident reviewed for ostomies. (Resident 1)Finding includes:The record for Resident 1 was reviewed on 3/18/26 at 10:39 a.m. Diagnoses included, but were not limited to, history of cancer of the rectum, rectosigmoid, and anus, and colostomy status.A Care Plan, revised on 6/18/24, indicated the resident had an alteration in gastrointestinal status related to abdominoperineal resection (APR) (surgery that removes your sigmoid colon, rectum and anus) for rectal cancer. The resident had a colostomy. Interventions included, but were not limited to, monitor and record bowel movements (empty ostomy pouch), monitor and record peri-stoma condition, and provide and maintain appropriate ostomy supplies.The Quarterly Minimum Data Set (MDS) assessment, dated 2/24/26, indicated the resident was severely cognitively impaired. The resident had an indwelling catheter and ostomy.A Physician's Order, dated 2/26/26, indicated check colostomy pouch every shift for patency and if full, empty or change every shift and as needed.The March 2026 Medication and Treatment Administration Record indicated the colostomy pouch was monitored every shift as ordered.The record lacked documentation that the colostomy pouch was fully changed and/or stoma care was provided.During an interview with the DIrector of Nursing on 3/20 at 2:21 p.m., she had no information to provide when asked about the frequency of stoma care and complete bag changes.During an interview on 3/19/26 at 2:45 p.m., the Administrator indicated the resident's colostomy pouch was a one-piece system, meaning there was no separate wafer or pieces to the colostomy bag that needed to be changed out. There was no further information provided.A facility policy titled, Colostomy, Urostomy, or Ileostomy Care, indicated, .I. Protecting the skin around the stoma 1. Use the right size pouch and skin barrier opening. 2. Change the pouching system regularly to avoid leaks and skin irritation. 3. Be careful when pulling the pouching system away from the skin and don't remove it more than once a day unless there's a problem. Remove the skin barrier gently by pushing your skin away from the sticky barrier rather than pulling the barrier away from the skin. 4. Clean the skin around the stoma with water. Dry the skin completely before putting on the skin barrier or pouch. Watch for sensitivities and allergies to the adhesive, skin barrier, paste, tape, or pouch material.III.3. When to change the pouching system May change every day, or weekly as needed, depends on the type of pouch used.410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(3)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review and interview, the facility failed to ensure G-tube (gastrostomy tube, a tube inserted directly into the stomach) flushes were instilled via gravity for 1 of 9 residents observed for medication administration. (Resident 9)Finding includes: On 3/28/26 at 3:03 p.m., LPN 2 was observed preparing Resident 9's medication. She crushed the pill and placed it in a medication cup. She entered the resident's room, washed her hands, donned a gown and gloves, filled the water bottle with tap water, put the tube feeding on hold, and checked for residual. She inserted the G-tube syringe into the water bottle and drew up 30 cc of water. She opened the G-tube and placed the syringe directly into the tube and pushed the 30 cc of water down the tube using the plunger. She diluted the medication in 30 cc of water and administered the medication and remaining flush by gravity.During an interview on 3/18/26 at 3:15 p.m., LPN 2 indicated she had not administered the initial G-tube flush by gravity. She would always administer the medications by gravity but would sometimes push the flushes in. She was unsure what the facility policy was.During an interview on 3/18/26 at 3:35 p.m., the Director of Nursing was made aware the G-tube flush had not been administered by gravity. She indicated the facility policy did not specify to administer flushes by gravity.A current facility policy, titled Placement and Residual Volume Check of Enteral Feeding Tubes indicated, .7. If acceptable placement and gastric residual volume is verified, flush feeding tube with 30 cc of water or as ordered by the physician. 8. Administer feeding and or medications as ordered, followed by flush, as appropriate .An article titled, Flushing Your Feeding Tube, published by Ohio State University Medical Center, dated 1/23/25, indicated .Steps for Flushing Your Feeding Tube.7. Pour the water into the syringe. Raise the syringe above your stomach. Let the water flow into your feeding tube by gravity.410 IAC (Indiana Administrative Code) 16.2-3.1-44(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Health Campus	6685 East 117th Avenue Crown Point, IN 46307

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. Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to clarification orders for diet and assistive devices for 1 of 6 residents reviewed for nutrition. The facility also failed to ensure urinary catheter care was accurately documented for 1 of 3 residents reviewed for catheters. (Residents 41 and 6)Findings include:1. On 3/17/26 at 11:42 a.m., Resident 41 was served a bowl of chicken and rice soup. The soup contained chunks of carrots and chicken. During an interview at that time, CNA 1 indicated the resident had orders for a pureed diet but she thought she could have soup. The CNA indicated the soup had chunks of carrots and chicken and she proceeded to take the soup from the resident. At 11:51 a.m., the resident was served thickened juice in a clear plastic cup. On 3/18/26 at 11:35 a.m., the resident was seated in her wheelchair in the dining room. She was served her lunch and a glass of thickened juice in a clear plastic cup. On 3/19/26 at 11:51 a.m., the resident was seated in her wheelchair in the dining room. She was asking for soup but was told that she couldn't have any due to the chunks of meat. She received her meal and was given thickened juice in a clear plastic cup. The record for Resident 41 was reviewed on 3/19/26 at 2:43 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset and dysphagia (difficulty swallowing). The Annual Minimum Data Set (MDS) assessment, dated 1/8/26, indicated the resident was moderately impaired for daily decision making and she received a mechanically altered diet. A Physician's Order, dated 2/17/26, indicated the resident was to receive a pureed diet with nectar thickened liquids. The resident was to use a scoop plate and Provale cup (a sippy cup) for meals. During an interview on 3/17/26 at 3:30 p.m., the Director of Nursing (DON) provided the resident's speech therapy discharge summary which indicated the resident could have mechanical soft pleasure feeds. The DON indicated the resident's diet order needed to be updated. During an interview on 3/19/26 at 4:01 p.m., the DON indicated the Provale cup was used when the resident was not receiving thickened liquids. The cup couldn't be used for thickened liquids and the order should have been updated. 2.On 3/16/26 at 11:15 a.m., Resident 6 was observed lying in her bed. There was biliary drain on the mattress next to her, and there was no urinary catheter observed hanging on the bed. On 3/16/26 at 2:54 p.m., the resident was observed with the DON. The DON removed her covers and indicated there was no urinary catheter, it must have been removed while in the hospital. The resident's record was reviewed on 3/17/26 at 2:45 p.m. Diagnoses included, but were not limited to, cholecystitis (inflammation of the gallbladder) and urinary tract infection. The resident had been readmitted to the facility following a hospital stay on 3/13/26. The Significant Change Minimum Data Set assessment, dated 1/29/26, indicated the resident had severe cognitive impairment and was dependent for toileting, bed mobility and eating. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. Building B. Wing	03/23/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 3/13/26, indicated the resident had a urinary catheter, size 16 French with a 10-milliliter balloon, catheter care every shift. The March 2026 Treatment Administration Record indicated catheter care had been completed 3/13, 3/14, 3/15 and 3/16. During an interview on 3/18/26 at 3:15 p.m., the Administrator was made aware staff had been documenting catheter care when no catheter was present. No additional information was provided. 410 IAC 16.2-3.1-50(a)(2)