STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnshire Health & Rehabilitation Center	8380 Virginia St Merrillville, IN 46410

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food was stored and served under sanitary conditions related to touching food with bare hands, glove use, beard restraints, dirty food equipment, ice on the freezer floor, food spillage in the walk in cooler, and food brought in by visitors or resident's food that was not labeled for 1 of 1 kitchen and 1 of 2 wings. (The main kitchen and the A Wing)Findings incude:1. During the Brief Kitchen Sanitation Tour on 11/17/2025 at 9:56 a.m. with the Dietary Food Manager (DFM) the following was observed:a. Dietary [NAME] 1 was observed with a disposable glove on her left hand and her right hand was bare. She was observed using her bare right hand reaching into the pan of the cheese and cracker crumbs and was putting it on top of the turkey noodle casserole she had in front of her.During an interview on 11/17/25 at 10:12 a.m., Dietary [NAME] 1 indicated right.b. Dietary Aide 1 was observed standing right by Dietary [NAME] 1 while she was preparing the food with his beard guard lowered down around his neck. The aide had facial hair on his face and chin. c. The convection oven was dirty on the inside with black dried food spillage noted on bottom. The inside of both doors had an accumulation of dried food spillage noted.d. There was moderate amount of dried milk spillage under the milk crates inside the walk in cooler. e. There was a large amount of ice build up on the floor in the freezer. During an interview at that time, the DFM indicated there were work orders out for the ice and the Maintenance Director was aware, as they were waiting for bids. During an interview on 11/20/25 at 12:00 p.m., the Maintenance Director indicated the freezer had been repaired a couple of months ago for the ice build up. He was not aware there was more ice on the floor since the repair. f. Underneath the steam table hood there was a moderate amount of grease, grime, and dirt noted. g. Another steam table that was not in use had a large amount of food crumbs and debris noted in all four of the pans. h. A non-functioning plate warmer was dirty with clean plates stacked on top of it. During an interview on 11/20/25 at 10:40 a.m., the DFM indicated all of the above was in need of cleaning and/or repair. 2. During an observation during the noon meal on 11/17/25 at 12:17 p.m., Dietary [NAME] 1 was observed serving food to the residents. She was wearing gloves to both hands and handling plates, utensils, lids, and other items. At 12:21 p.m., the cook was observed to scoop food onto a plate and used her gloved hand to move the food back on the plate after touching other items with those gloves. A CNA had asked for a hot dog for a resident. Dietary [NAME] 1 was observed wearing one glove to a hand and the other hand was bare. She proceeded to pick up utensils, handle plates, and then used her gloved hand to reach into the plastic bag and removed a hot dog bun with that same gloved hand and put it on the resident's plate. She put a hot dog inside the bun and gave the plate to the CNA, who then passed it to the resident. During an interview on 11/20/25 at 11:45 a.m., the DFM indicated the cook should have changed her gloves after touching other items and she should have not touched any food with her bare hands. The current 9/1/2020, Safe Food Handling policy, provided by the Administrator on 11/20/25 at 1:35 p.m., indicated all staff will use serving utensils appropriately to prevent to prevent cross contamination. 3. During an observation on 11/20/25 at 2:45 p.m., the A wing nourishment refrigerator was observed with the following:There was one open bottle of ice tea with no name or date opened. There was 1 Styrofoam box of vanilla strawberry cake with no name or date. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was a container of cake with no name or date on it. There was a container of fresh strawberries no name or date on it.There was a brown and green banana with no name or date on it.During an interview on 11/20/25 at 2:53 p.m., the Administrator had no additional information to provide. The current 9/1/202020, Food Items Brought from Outside-Safe Storage policy, provided by the Administrator on 11/20/25 at 3:00 p.m., indicated all resident foods and beverages shall be labeled with the resident's name and dated. 3.1-21(i)(3)

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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. Based on observation and interview, the facility failed to keep the kitchen and residents' environment clean and in good repair related to dirty walls, ceilings, floor tile, ceiling vents and adhered dirty against the baseboard for 1 of 1 kitchen (The main kitchen); marred and water-damaged walls, grab bar not secured to the wall, and uncontained basins (Resident Rooms A02, B01, B08) Findings include:1. During the Brief Kitchen Sanitation Tour on 11/17/2025 at 9:56 a.m. with the Dietary Food Manager (DFM) the following was observed: a. The dish room walls were observed with dried food spillage. b. The floor drains under the dish machine were dirty with a large accumulation of dirt and debris under the dish machine. c. The floor tile grout was discolored near the steam tables. d. There was a moderate amount of adhered dirt and debris against the base board by the steam tables. e. There was a large amount of food spillage noted on random walls in the kitchen as well as areas on the ceiling. f. The ceiling vent was dusty, dirty and rusted over. During an interview on 11/20/25 at 10:40 a.m., indicated all of the above was in need of cleaning and/or repair 2. During the Environmental Tour on 11/24/25 at 11:15 a.m. with the Administrator, Maintenance Supervisor, and Housekeeping Supervisor, supervisors the following was observed: a. Room A02: There was a basin on the floor of the bathroom in the corner where a pipe was located. There was a hole in the wall, and visible water damage to the adjacent wall area. The grab bar next to the toilet was not securely connected to the wall. One resident in the room used the bathroom. b. Room B01: The wall was marred next to the resident's bed. c. Room B08: There were 3 uncontained basins on the floor of the bathroom. The wall next to the toilet had visible water damage. One resident used the bathroom. 3.1-19(f)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a treatment to a surgical incision was completed as ordered, areas of bruising and scabbing were assessed and monitored, and interventions were in place for areas of dry scaly skin for 5 of 6 residents reviewed for skin conditions non-pressure related. (Residents D, H, J, F, and G)Findings include:1. The closed record for Resident D was reviewed on 11/19/25 at 3:22 p.m. Diagnoses included, but were not limited to, aortocoronary bypass graft, atherosclerotic heart disease, and type 2 diabetes mellitus. The Medicare 5-day Minimum Data Set (MDS) assessment, dated 8/9/25, indicated the resident had moderate cognitive impairment and required partial/moderate assistance with bathing and dressing. The resident was also identified as having a surgical wound. A Care Plan, dated 8/6/25, indicated the resident had actual impairment to the skin integrity of her chest related to a surgical incision. Interventions included, but were not limited to, follow facility protocols for treatment of injury and monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, and signs and symptoms of infections to physician. Physician's Orders, dated 8/3/25, indicated the incision could be left open to air and if drainage was observed, apply gauze 4 x 4's and change daily or as needed (PRN). The incision was to be cleansed with antiseptic soap and water as follows: start at the top of the chest incision, using a clean wash cloth wipe down the chest incision once with soap and water. Use another clean washcloth and rinse the incision starting at the top and going down the incision one time a day for treatment. The surgical incision was assessed by the Wound Nurse on 8/5/25 and measured 8.6 centimeters (cm) in length by 0.3 cm in width by undetermined in depth. There was no odor, no signs of infection, and no exudate (drainage). The August 2025 Medication and Treatment Administration records indicated the treatment was not listed on either form and the treatment had not been signed out as being completed. A Nurse's Note, dated 8/9/25 at 6:15 a.m., indicated while the resident's morning medications were being administered, the resident informed the writer that she felt some drainage and discomfort to her mid chest surgical area. The surgical wound appeared open with some light greenish colored skin noted. The resident requested to go to the emergency room. The Physician was notified and orders were obtained to transfer the resident to the hospital for evaluation. During an interview on 11/24/25 at 11:02 a.m., the Director of Nursing (DON) indicated the Wound Nurse stated she did complete the treatment to the resident's incision but she didn't document it on the medication or treatment records. The DON indicated the treatment to the surgical incision should have been signed out as ordered. 2. On 11/17/25 at 3:36 p.m. fading bruises that were purplish/brown in color were observed on top of Resident H's right hand. On 11/20/25 at 9:45 a.m., the fading bruises remained to the top of the resident's right hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record for Resident H was reviewed on 11/19/25 at 10:26 a.m. Diagnoses included, but were not limited to, Parkinson's disease and anemia. The admission Minimum Data Set (MDS) assessment, dated 8/19/25, indicated the resident was moderately impaired for daily decision making. The resident required partial to moderate assistance rolling from left to right and with chair to bed transfers. There was no current care plan related to the bruising. The November 2025 Physician's Order Summary (POS) indicated the resident's skin was to be assessed weekly. The November 2025 Medication Administration Record (MAR) indicated a skin assessment was to be completed on 11/18/25. The box was coded with a 6 which indicated the resident was hospitalized . The resident was not in the hospital on [DATE]. During an interview on 11/20/25 at 3:10 p.m., the B Wing Unit Manager indicated the bruising to the resident's right hand was most likely from a lab draw and the area should have been monitored. She also indicated the resident was not in the hospital on [DATE] and the weekly skin assessment should have been completed. 3. On 11/18/25 at 11:18 a.m., Resident J was observed with a fading reddish/purple discoloration to the top of her left hand. On 11/20/25 at 11:40 a.m., the resident was observed in her room in bed. The fading reddish/brown bruise remained to the top of her left hand and a scabbed area was observed to her right knee. The resident was unable to state how she obtained the areas. The record for Resident J was reviewed on 11/20/25 at 11:20 a.m. Diagnoses included, but were not limited to, lack of coordination and history of falling. A Significant Change Minimum Data Set (MDS) assessment, dated 10/31/25, indicated the resident was moderately impaired for daily decision making. The resident required partial to moderate assistance with rolling left to right and chair to bed transfers. A Care Plan, dated 10/16/25, indicated the resident was at risk for complications such as bleeding or bruising secondary to anticoagulant (a blood thinner) therapy. Interventions included, but were not limited to, daily skin inspections and report abnormalities to the nurse and observe/document/report as needed (PRN) adverse reactions of anticoagulant therapy such bruising. A Physician's Order, dated 11/1/25, indicated the resident was to receive Xarelto (a blood thinner) 10 milligrams (mg) daily. The medication was discontinued on 11/15/25 and orders were received to start Aspirin 81 mg daily. A Weekly Skin Assessment, dated 11/18/25, indicated the resident had no new skin issues. During an interview on 11/20/25 at 3:10 p.m., the B Wing Unit Manager indicated the bruising to the resident's right hand and the scabbed area to her knee were most likely from a recent fall and the areas should have been assessed and monitored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During random observations on 11/17/25 at 10:35 a.m. and 3:30 p.m., 11/19/25 at 9:09 a.m., and 11/20/25 at 9:32 a.m., Resident D was observed lying in bed. The skin on his legs appeared dry and scaly. There were many dark skin flakes on bed sheet. The record for Resident was reviewed on 11/19/25 at 10:03 a.m. Diagnoses included, but were not limited to, heart failure, pain, and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/11/25, indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs), and had 2 arterial ulcers to his lower extremities (wounds caused by poor blood flow). A Care Plan, initiated 6/5/25, indicated the resident had a pressure ulcer. Interventions included keeping skin clean and moisturized. The record lacked interventions or treatments for the dry, scaly skin. During an interview on 11/17/25 at 10:46 a.m., CNA 1 indicated she was not aware of any treatment for the resident's dry, flaking skin. During an interview on 11/21/25 at 1:07 p.m., the DON indicated the resident should have treatment for dry, scaly skin, and she would look into it. 5. During a random observation on 11/18/25 at 9:30 a.m., Resident G had dry, patchy, discolored skin to her elbows. At that time, the resident indicated she had psoriasis for years and had used a topical medication for it before she was admitted to the facility. She indicated the skin patches were itchy, and she was not receiving any treatment for them. The resident's record was reviewed on 11/20/25 at 2:57 p.m. Diagnoses included, but were not limited to, psoriasis. The record lacked assessments of or treatment for the resident's psoriasis. During an interview on 11/20/25 1:24 p.m., LPN 3 indicated she did not know the resident had psoriasis. During an interview on 11/24/25 8:55 a.m., the DON indicated she observed the resident's psoriasis and she did not find any documentation of it being assessed or treated in the record. A policy, titled Skin Care, received as current from the Nurse Consultant on 11/21/25 at 1:59 p.m., indicated, . Weekly skin checks will be conducted by the licensed nurse. This will be documented in the resident's Electronic Medical Record (EMR). Daily, during routine care, the Certified Nursing Assistant (CNA) will observe the resident's skin. When abnormalities are noted this will be communicated to the licensed nurse . This citation relates to Intake 2585462. 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interview, the facility failed to ensure proper medication storage related to insulin pens not labeled when opened, and loose pills observed in the medication carts for 1 of 2 units (A Wing) and medications at the bedside for residents who did not self-administer medications. (Residents G, 71)Findings include: 1. During an observation on 11/18/2025 at 1:12 p.m., the C hall medication cart on the A Wing was observed with LPN 4. There were many loose pills in all of the medication drawers. During an interview at that time, LPN 4 was unaware there were loose pills in the cart. 2. During an observation on 11/18/2025 1:16 p.m., the B hall medication cart on the A Wing was observed with LPN 4. There were many loose pills in all the drawers. There was one opened multiuse vial of Humulin Regular insulin with no date. There was one opened Lantus insulin pen with date opened. There was one opened multiuse vial of Lantus insulin with an open date of 10/8/25. During an interview at that time, LPN 4 indicated she was aware the insulin vials and pens should be dated after they were opened. During an interview on 11/19/25 at 2:00 p.m., the Director of Nursing indicated the insulin vials and pens should have been dated after opening. The current Medication Storage policy, dated 9/1/2020 and provided by Nurse Consultant 1 on 11/19/25 at 2:30 p.m., indicated once any medication was opened, facility should follow manufacture guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. facility should ensure medications were stored in an orderly manner in cabinets, drawers, and carts to prevent overcrowding. 3. During a random observation on 11/18/25 at 9:30 a.m., 11/19/25 at 9:16 a.m., 11/20/25 at 9:41 a.m., and 11/21/25 at 1:53 p.m., there was a bottle of Debrox (an earwax remover) eardrops and a bottle of nystatin (anti-fungal) powder on Resident G's nightstand. The resident's record was reviewed 11/20/25 at 2:57 p.m. Diagnoses included, but were not limited to, subarachnoid hemorrhage (bleeding between the brain and skull) and psoriasis. A Physician's Order, dated 11/7/25, indicated nystatin external powder, apply to groin / abdominal folds every day and evening shift. The record lacked a current order for Debrox. There were no orders or assessments for self-administration. During an interview on 11/20/25 at 1:24 p.m., LPN 3 indicated the resident did not self-administer any medications, and the resident received Debrox about a month ago, and someone must have left the medications in the room. During an interview on 11/21/25 at 1:11 p.m., the DON indicated medications should not be at kept at (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's bedside. 4. During random observations on 11/17/25 at 12:50 p.m., 11/19/25 at 9:13 a.m. and 9:50 a.m., 11/20/25 at 9:50 a.m. and 1:51 p.m., and 11/21/25 at 9:42 a.m., Resident 71 was sitting in his wheelchair next to his bed. There was a bottle of nystatin powder on top of his refrigerator. The resident's record was reviewed on 11/20/25 at 11:20 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), diabetes, and left below the knee amputation. The Quarterly Minimum Data Set (MDS) assessment, dated 10/21/25, indicated the resident was cognitively intact for daily decision making, required moderate assist with activities of daily living (ADLs), and had an indwelling urinary catheter. A Physician's Order, dated 7/1/25, indicated nystatin external powder, apply to abdominal folds every 8 hours as needed for preventative. There were no orders or assessments for self-administration. During an interview on 11/20/25 at 1:24 p.m., LPN 3 indicated the resident did not self-administer any medications. During an interview on 11/21/25 at 1:11 p.m., the DON indicated medications should not be at kept at the resident's bedside. 3.1-25(k)(6)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review and interview, the facility failed to follow the recipe for pureed spinach. This had the potential to affect the 5 residents who received a pureed diet. Finding includes:During a meal preparation observaton on 11/20/25 at 10:30 a.m., Dietary [NAME] 2 was observed preparing pureed spinach. He placed six scoops (1/2 cup) of cooked spinach into the blender and started the machine. He stopped the blender, stirred the spinach, and added an unmeasured amount of chicken broth into the blender. He started the machine again to mix it together. The cook stopped the machine, stirred the spinach and added more chicken stock, again it was not measured. He blended the spinach and stopped the machine again, removed the lid and stirred the mixture. He then added an unmeasured amount of the product Thick and Easy (a food thickening agent) to the spinach, turned the machine back on and blended it together. He continued to blend and stir the mixture three more times with adding an unmeasured amount of the food thickening agent. He poured the pureed spinach into a pan and placed plastic wrap over it. The spinach was smooth and thick. During an interview on 11/20/25 at 10:35 a.m., Dietary [NAME] 2 indicated he did read the recipe before he started to prepare the pureed spinach. The pureed spinach recipe for 5 servings indicated add one pound and 13 ounces of spinach. 3/4 ounce of margarine, and 1/8 teaspoon of salt. Add the spinach and margarine to the blender and mix until smooth. The recipe did not indicate to add chicken broth or food thickener. During an interview on 11/20/25 at 11:40 a.m., the Dietary Food Manager indicated the cook should have followed the recipe. 3.1-21(a)(3)

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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, record review, and interview, the facility failed to ensure residents were assessed for self-administration of medications and had a physician's order to self-administer medications, for 1 of 1 resident reviewed for self-administration of medication. (Resident 59) Finding includes:On 11/17/25 at 2:58 p.m., a bottle of nasal spray was observed on the resident's over bed table. Clotrimazole ointment was observed on the resident's nightstand. On 11/18/25 at 8:54 a.m., refresh eye drops and a bottle of nasal spray were observed on the resident's over bed table. Clotrimazole ointment and Neosporin ointment were observed on the resident's nightstand. On 11/20/25 at 10:10 a.m., refresh eye drops and a bottle of nasal spray were observed on the over bed table. Clotrimazole ointment was observed on the resident's nightstand. The resident's record was reviewed on 11/19/25 at 2:31 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, congestive heart failure, and hypertension. The Annual Minimum Data Set (MDS) assessment, dated 9/15/25, indicated the resident was cognitively intact. A Care Plan, updated 10/7/24, indicated The resident has a Physician's Order for unsupervised self-administration of the following medications. No medications were listed. The interventions included to assess the resident's ability to safely self-administer medications specified on admission/re-admission, quarterly, with change in medication orders, and with significant changes in condition. A Self Administration of Medication Assessment, dated 7/16/24, indicated the resident would not be self-administering any medications. There were no other self-administration assessments. A Physician's Order, dated 7/16/24, indicated the resident could self-administer medications with assistance of the facility to set them up. There were no Physician's Orders for the clotrimazole ointment or Neosporin ointment. During an interview on 11/21/25 at 1:00 p.m., the Director of Nursing (DON) was made aware of the medications at the resident's bedside. She indicated the resident's daughter would sometimes bring medications in for the resident and not make the facility aware. A facility policy, titled, Self Administration of Medication Program, indicated, .9. Once the resident had been deemed safe by IDT an order will be obtained from the physician or physician extender listing the medication(s) that may be self-administered, where the medications will be stored, who will be responsible for documentation and the location of administration .14. The resident will be re-evaluated on their ability to continue to self-administer medication in conjunction with the resident assessment instrument . 3.1-11(a)

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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, record review and interview, the facility failed to ensure the call light was in reach for 1 of 14 active residents reviewed who were able to use the call light. (Resident 71)Finding includes:During random observations on 11/17/25 at 12:50 p.m., 11/19/25 at 9:13 a.m. and 9:50 a.m., 11/20/25 at 9:50 a.m. and 1:51 p.m., and 11/21/25 at 9:42 a.m., Resident 71 was sitting in his wheelchair next to his bed. His call light pad was clipped onto its cord on the wall, on the opposite side of the bed. The resident's record was reviewed on 11/20/25 at 11:20 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), diabetes, and left below the knee amputation. The Quarterly Minimum Data Set (MDS) assessment, dated 10/21/25, indicated the resident was cognitively intact for daily decision making, and required moderate assist with activities of daily living (ADLs). During an interview on 11/21/25 at 1:09 p.m., the Director of Nursing (DON) indicated the resident was able to use the call light, and it should have been kept in his reach. 3.1-3(v)(1)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnshire Health & Rehabilitation Center	8380 Virginia St Merrillville, IN 46410

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to visual impairment for 1 of 1 resident reviewed for sensory / communication. (Resident F)Finding includes:During a random observation on 11/17/25 at 10:40 a.m., Resident F was observed in bed with a blanket pulled over his head and his television on. He indicated he kept his head under the blanket because it was comfortable, and he could not see the television anyway because he was blind. The record for Resident was reviewed on 11/19/25 at 10:03 a.m. Diagnoses included, but were not limited to, heart failure, pain, and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/11/25, indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs) and had adequate vision.An Interdisciplinary Team Note, dated 6/9/25, indicated a contributing factor to the resident's recent fall was their vision impairment. A Physician's History and Physical, dated 4/21/25, indicated the resident was blind.During an interview on 11/21/25 at 9:38 a.m., LPN 3 indicated the resident was legally blind. During an interview on 11/21/25 at 1:07 p.m., the Director of Nursing (DON) indicated the resident was legally blind and there should be a care plan for vision loss. During an interview on 11/21/25 at 1:50 p.m., the MDS Coordinator was informed of the finding and offered no further information.3.1-31(i)

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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 observation, record review, and interview, the facility failed to ensure a dependent resident received assistance with activities of daily living (ADL's) related to nail care for 1 of 5 residents reviewed for ADL's. (Resident C)Finding includes:On 11/17/25 at 10:20 a.m., Resident C was observed lying in bed. Her fingernails were jagged and uneven with dark debris underneath. On 11/18/25 at 10:00 a.m., Resident C was observed lying in bed. Her fingernails were jagged and uneven with dark debris underneath. Resident C's record was reviewed on 11/19/25 at 9:51 a.m. Diagnoses included, but were not limited to, dementia, diabetes, and hypertension. The Significant Change Minimum Data Set (MDS) assessment, dated 11/5/25, indicated the resident was mildly cognitively impaired and was dependent on staff for assistance with bathing and personal hygiene. A Care Plan, updated 6/26/25, indicated the resident required assistance with ADLs. The interventions included to assist with personal hygiene including dressing and grooming as needed. A Care Plan, updated 10/7/25, indicated the resident had scattered scabs to her skin. The interventions included to keep fingernails short. During an interview on 11/21/25 at 1:00 p.m., the Director of Nursing (DON) was made aware of the resident's jagged fingernails with debris underneath. No further information was provided. 3.1-38(a)(3)(E)

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents received foot care and had routine visits with a podiatrist related to long and thick toenails for 3 of 5 residents reviewed for ADL's (activities of daily living). (Residents C, 33, and G)Findings include:1. On 11/17/25 at 11:00 a.m., Resident C was observed lying in bed. Her toenails were long and thick. There was a dried dark red substance under her left great toenail. Her feet were scaly and dry. On 11/18/25 at 10:00 a.m., Resident C was observed lying in bed. Her toenails were long and thick. There was a dried dark red substance under her left great toenail. Her feet were scaly and dry. Resident C's record was reviewed on 11/19/25 at 9:51 a.m. Diagnoses included, but were not limited to, dementia, diabetes, and hypertension. The resident was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS) assessment, dated 11/5/25, indicated the resident was mildly cognitively impaired and was dependent on staff for assistance with bathing and personal hygiene. The Physician's Order Summary, dated 11/2025, indicated the resident may receive services of the eye care physician, audiologist, dentist and podiatrist. There were no podiatry consultation notes. During an interview on 11/21/25 at 1:00 p.m., the Director of Nursing (DON) was made aware of the resident's long toenails. She was unsure if the resident had seen the podiatrist. During an interview on 11/21/25 at 1:53 p.m., the Social Service Director indicated she had just had a care plan meeting with the resident's family yesterday and offered podiatry services. The family wanted the podiatrist consent sent to them to sign. She was unsure if the resident had been offered podiatry services prior to that as she was new to the position in September. 2. On 11/17/25 at 10:40 a.m., Resident 33 indicated his toenails were very long and thick. He had requested multiple times to see the podiatrist and had signed a consent to see the podiatrist in September. Resident 33's record was reviewed on 11/20/25 at 2:02 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and hypothyroidism. The resident was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) assessment, dated 10/13/25, indicated the resident was cognitively intact. The Physician's Order Summary, dated 11/2025, indicated the resident may receive services of eye care physician, audiologist, dentist and podiatrist. A Podiatry Services Consent was signed by the resident on 9/15/25. There were no podiatry consultation notes. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/25 at 1:53 p.m., the Social Service Director indicated she was new to the position in September and was unaware the resident wanted to see the podiatrist. 3. During a random observation on 11/18/25 at 9:30 a.m., Resident G was observed sitting in her wheelchair, dressed and wearing shoes without socks. At that time, the resident indicated her feet hurt when her shoes were on because her toenails were too long. She removed her shoes, and her toenails were observed to be very long. During observations on 11/19/25 at 9:16 a.m., 11/20/25 at 9:41 a.m., and 11/21/25 at 1:53 p.m. the resident's toenails remained long. The resident's record was reviewed 11/20/25 at 2:57 p.m. Diagnoses included, but were not limited to, subarachnoid hemorrhage and psoriasis. The Physician's Order Summary, dated 11/2025, indicated the resident may receive services of the eye care physician, audiologist, dentist and podiatrist. The record lacked documentation of foot care provided or refused. During an interview on 11/21/25 at 1:53 p.m., the Social Service Director indicated the resident had not received podiatry services because they were private pay, but they could get it if they wanted to pay for it. 3.1-47(a)(7)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide treatment for limited range of motion related to splints not in place and lack of instructions for use of a splint for 3 of 4 residents reviewed for range of motion. (Residents 1, E, and F)Findings include: 1.On 11/17/25 at 3:00 p.m., Resident 1 was observed lying in bed. His left hand was in a fist and there was no splint in place. The resident indicated staff didn't usually put anything on or in his hand. On 11/18/25 at 8:55 a.m. Resident 1 was observed lying in bed. His left hand was in a fist and there was no splint in place. On 11/20/25 at 10:31 a.m. Resident 1 was observed lying in bed. His left hand was in a fist and there was no splint in place. Resident 1's record was reviewed on 11/21/25 at 12:54 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease (COPD), atrial fibrillation, and left side hemiplegia. The Quarterly Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was cognitively impaired, dependent on staff for all activities of daily living (ADLs), and had impairment to range of motion on one side upper and lower extremities. A Care Plan, updated 11/19/25, indicated the resident requires assistance with activities of daily living. The interventions included left upper extremity (LUE) resting hand splint to be worn in a.m./p.m. as tolerated. A Physician's Order, dated 8/29/25, indicated LUE resting hand splint to be worn in a.m/p.m. as tolerated. The Treatment Administration Record, dated 11/2025, indicated the LUE splint had been signed out as on at 9:00 a.m. and off at 5:00 p.m. daily. There were no refusals documented. During an interview on 11/21/25 at 1:00 p.m., the Director of Nursing (DON) was made aware the resident's splint had not been in place as ordered. During an interview on 11/21/25 at 3:15 p.m., the DON and Nurse Consultant indicated they had spoken with therapy and found the resident's splint. The resident was physically able to remove the splint himself and would do so at times. 2. During random observations on 11/17/25 at 11:51 a.m., 11/18/25 at 9:46 a.m. and 10:51 a.m., 11/20/25 at 9:38 a.m. and 11:10 a.m., and 11/21/25 at 9:40 a.m., Resident E was observed lying in bed. Her hands were contracted, fingernails long, and there were no palm protectors in place. The resident's record was reviewed on 11/18/25 at 3:09 PM. Diagnoses included, but were not limited to, Parkinson's, stroke, and epilepsy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/24/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs) and transfers. A Physician's Order, dated 7/28/25, indicated palm protectors to both hands, may remove for care. Hospice to provide. A Care Plan, dated 7/30/25, indicated palm protectors to bilateral hands. The record lacked documentation of palm protectors used or refused. During an interview on 11/20/25 at 1:16 p.m., LPN 2 indicated she did not know anything about the resident's palm protectors. During an interview on 11/21/25 at 1:05 p.m., the DON indicated she did not know about the palm protectors, but would look into it. By the end of the survey, no additional information was received. 3. During random observations on 11/17/25 at 10:35 a.m. and 3:30 p.m., 11/19/25 at 9:09 a.m. and 1:43 p.m., and 11/20/25 at 9:32 a.m., Resident D was observed lying in bed. His right arm was contracted and there was a splint in his right hand. The record for Resident D was reviewed on 11/19/25 at 10:03 a.m. Diagnoses included, but were not limited to, heart failure, pain, and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/11/25, indicated the resident had severe cognitive impairment and was dependent in activities of daily living (ADLs). A Physician's Order, dated 5/4/25, indicated to apply resting hand splint to the right hand for 2 hours daily or as tolerated in the morning, one time a day. The resident's record lacked documentation of the splint being removed and assessments of the skin underneath. During an interview on 11/21/25 at 9:38 a.m., LPN 3 indicated she did not do anything with the resident's hand splint, restorative care did that. During an interview on 11/21/25 at 1:07 p.m., the DON indicated splint application/removal was usually documented by the nurse on the treatment administration record (TAR). During an interview on 11/21/25 at 1:50 p.m., the restorative care coordinator indicated the resident was not receiving restorative care. A policy, titled Mobility, Range of Motion, received as current from the Nurse Consultant on 11/21/25 at 1:59 p.m., indicated, . The facility will ensure that . a resident with limited range of motion receives appropriate treatment and services to increase range of motion and / or to prevent further decrease in range of motion . 3.1-42(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 4 residents reviewed for accidents. (Resident 60)Finding includes:On 11/17/25 at 2:54 p.m., Resident 60 was observed getting out of bed unassisted. She had on non-skid socks and pushed her wheelchair to the bathroom. There were no non-skid strips on the floor by her bed.On 11/18/25 at 11:51 a.m., Resident 60 was lying in bed. There were no non-skid strips on the floor by her bed, and the bed was not in the lowest position.On 11/20/25 at 10:29 a.m., Resident 60 was lying in bed. There were no non-skid strips on the floor by her bed, no Dycem (anti-slip material) to her wheelchair seat, and no anti-tippers to her wheelchair.Record review for Resident 60 was completed on 11/19/25 at 3:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and nontraumatic subarachnoid hemorrhage.The Quarterly Minimum Data Set (MDS) assessment, dated 10/30/25, indicated the resident was cognitively intact. The resident required supervision with bed mobility and transfers. She required partial/moderate staff assistance with walking and used a wheelchair. She had two or more falls since the prior assessment.A Care Plan, updated 8/22/25, indicated the resident was a high risk for falls. The interventions included non-skid strips next to bed, anti-tippers to the back side of the wheelchair, Dycem to the wheelchair cushion, and place bed in the lowest position.The Special Instructions tab in the resident's chart indicated the resident was a fall risk due to transferring self without assistance. Fall interventions included anti-tippers to the back of the wheelchair, Dycem to the wheelchair, and non-skid strips next to the bed.A Fall IDT Note, dated 9/24/25 at 10:59 a.m., indicated the resident had an unwitnessed fall while attempting to self-transfer from her wheelchair to her bed. The intervention was to add additional non-skid strips to the floor next to the bed.During an interview on 11/21/25 at 1:00 p.m., the Director of Nursing was made aware of the fall interventions not in place. No further information was provided.A facility policy, titled Fall Prevention and Management, indicated, .c. Safety interventions will be implemented for each resident identified and documented in medical record .Post fall documentation guidelines: .g. Post fall intervention should be documented in the medical record .k. The IDT team will meet within the next business day to discuss causative factors and implement fall interventions.3.1-45(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure an urinary indwelling catheter collection bag was maintained below the level of the bladder for 1 of 3 residents reviewed for urinary catheters. (Resident 71)Finding includes: During random observations on 11/17/25 at 12:50 p.m., 11/19/25 at 9:13 a.m. and 9:50 a.m., 11/20/25 at 9:50 a.m. and 1:51 p.m., and 11/21/25 at 9:42 a.m., Resident 71 was sitting in his wheelchair next to his bed. The urine collection bag was hooked on the side of his wheelchair, near waist level. On 11/20/25 2:40 p.m., the resident was observed propelling himself in his wheelchair in the halls. The urine collection bag was hooked on the side of his wheelchair, near waist level. On 11/21/25 at 11:05 a.m., the resident was observed in the hallway, in his wheelchair. Multiple staff members walked by. The urine collection bag remained hooked on the side of his wheelchair, near waist level. The resident's record was reviewed on 11/20/25 at 11:20 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), diabetes, and left below the knee amputation. The Quarterly Minimum Data Set (MDS) assessment, dated 10/21/25, indicated the resident was cognitively intact for daily decision making, required moderate assist with activities of daily living (ADLs), and had an indwelling urinary catheter.A Care Plan, dated 5/4/24, indicated the resident had an indwelling catheter. Interventions included positioning the catheter bag and tubing below the level of the bladder.During an interview on 11/21/25 at 1:09 p.m., the Director of Nursing (DON), indicated the urine collection bag should be maintained lower than the level of the bladder.A policy, titled Urinary Catheter Care, received as current from the Nurse Consultant on 11/21/25 at 1:59 p.m., indicated, .Catheters shall be positioned to maintain a downhill flow of urine to prevent a back flow of urine into the bladder or tubing . 3.1-41(a)(2)

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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 a resident was positioned with their head elevated while a tube feeding was infusing for 1 of 1 resident reviewed for tube feedings. (Resident E)Finding includes:During a random observation on 11/18/25 at 9:46 a.m., Resident E was observed lying nearly flat in bed. A tube feeding was infusing via a pump. Unit Manager 1 was immediately brought to the room. She stopped the tube feeding, repositioned the resident, elevated the head of the bed, and restarted the feeding. At that time, she indicated resident's head should be elevated at least 30 degrees while the tube feeding was infusing. The resident's record was reviewed on 11/18/25 at 3:09 PM. Diagnoses included, but were not limited to, Parkinson's, stroke, vascular dementia, and epilepsy.The 8/24/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs) and transfers.A Physician's Order, dated 4/11/23, indicated to elevate the head of the bed 30 to 45 degrees during tube feeding and 1 hour after completion, unless contraindicated.A Care Plan, revised 11/14/25, indicated the resident was at risk for complications secondary to requiring a tube feeding due to dysphagia (difficulty swallowing). Interventions included keeping the head of the bed elevated 45 degrees during and thirty minutes after the tube feeding. During an interview on 11/18/25 at 11:18 p.m., the Director of Nursing (DON) was informed of the finding. No additional information was received.A policy, titled Enteral Feeding, received as current from the Nurse Consultant on 11/21/25 at 1:59 p.m., indicated, . Proper elevation of the Resident's head will be maintained according to Resident's condition .3.1-44(a)(2)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an intravenous (IV) access site was assessed upon admission and removed in a timely manner for 1 of 1 resident reviewed for parenteral/IV fluids. (Resident D)Finding includes:The closed record for Resident D was reviewed on 11/19/25 at 3:22 p.m. Diagnoses included, but were not limited to, aortocoronary bypass graft, atherosclerotic heart disease, and type 2 diabetes mellitus. The Medicare 5-day Minimum Data Set (MDS) assessment, dated 8/9/25, indicated the resident had moderate cognitive impairment. The admission Nursing Assessment, dated 8/3/25, indicated the resident did not have an IV (intravenous) present. The After Visit Summary from the hospital, dated 8/3/25, had no documentation related to an IV access site. A Nurse's Note, dated 8/3/25 at 12:40 p.m., indicated the resident had multiple areas of small bruising related to IV insertion. The note did not indicate if the IV access was still present. A Nurse's Note, dated 8/4/25 at 9:49 p.m., indicated the resident had multiple small bruising related to IV insertion. Again, the note did not indicate if the IV access was still present. A Physician's Progress note, dated 8/5/25 at 2:36 a.m., indicated the resident had a peripheral IV line from the hospital that the hospital did not remove. A Physician's Order, dated 8/6/25, indicated it was okay to remove the peripheral IV site. A Nurse's Note, dated 8/6/25 at 3:22 p.m., indicated the resident had a peripheral IV line from the hospital that the hospital did not remove. The hospital stated it was to come out there. The IV was removed per the physician's order and family was notified. A Physician's Discharge summary, dated [DATE] at 7:45 a.m., indicated the resident had draining and discomfort to her surgical area and she was discharged to the hospital for evaluation based on the resident's request. The resident was admitted to the facility on [DATE] with a peripheral IV line in from the hospital that the hospital did not remove. The IV was removed on 8/6/25 while in the facility. During an interview on 11/24/25 at 11:02 a.m., the Director of Nursing (DON) indicated the IV was an oversight on the admission assessment and it should have documented as being present. The facility policy titled, PICC (peripherally inserted central catheter) Line Maintenance, was provided by the Nurse Consultant on 11/24/25 at 4:02 p.m. and identified as current. The policy indicated the IV site should be checked for at least each shift for signs of infection, infiltration, or other complications. This citation relates to Intake 2585462.3.1-47(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and treatment related to oxygen administration for 2 of 3 residents reviewed for respiratory care. (Residents 1 and 9)Findings include:1. On 11/17/25 at 3:00 p.m., Resident 1 was observed lying in bed. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 3.5 liters.On 11/18/25 at 8:55 a.m., Resident 1 was observed lying in bed. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 3.5 liters.Resident 1's record was reviewed on 11/21/25 at 12:54 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic obstructive pulmonary disease (COPD), and atrial fibrillation.The Quarterly Minimum Data Set (MDS) assessment, dated 9/3/25, indicated the resident was cognitively impaired, dependent on staff for all activities of daily living (ADLs), and received oxygen therapy.A Care Plan, updated 12/4/25, indicated the resident had COPD. The interventions included to administer oxygen as ordered.A Care Plan, updated 12/4/25, indicated the resident required oxygen therapy. The interventions included oxygen via nasal cannula at 3 L continuous and 5 L when lying down.A Care Plan, updated 7/29/25, indicated the resident has COPD and may unplug his oxygen tank, remove his nasal cannula, and may refuse to wear the liter flow ordered. Interventions included to educate the resident on importance of wearing oxygen and encourage resident to wear the oxygen.A Physician's Order, dated 8/29/25, indicated oxygen 3 L (liters) via nasal cannula continuously, 5 L when lying down.The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 11/2025, indicated the oxygen had been signed out as administered every shift. There was no documentation of any refusals and there was no indication if the flow rate was 3 L or 5 L.During an interview on 11/21/25 at 1:00 p.m., the Director of Nursing (DON) was made aware of the oxygen at the incorrect flow rate. No further information was provided. 2. On 11/17/25 at 3:10 p.m., Resident 9 was observed lying in bed. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 3.5 liters.On 11/18/25 at 8:56 a.m., Resident 9 was observed lying in bed. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 3.5 liters.Resident 9's record was reviewed on 11/20/25 at 3:15 p.m. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus, and vascular dementia.The Annual Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was cognitively impaired, dependent on staff for all activities of daily living (ADLs), and received oxygen therapy.A Care Plan, updated 5/31/25, indicated the resident required oxygen therapy. The interventions included oxygen at 3 L continuously.A Physician's Order, dated 1/7/25, indicated oxygen 3 L (liters) via nasal cannula continuously.The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 11/2025, indicated the oxygen had been signed out as administered every shift. During an interview on 11/21/25 at 1:00 p.m., the Director of Nursing (DON) was made aware of the oxygen at the incorrect flow rate. No further information was provided.A facility policy, titled Oxygen Administration, indicated, .An order is required when administering supplemental oxygen. The order should include the oxygen liter flow, delivery device as well as the diagnosis/indication for use .Document the initiation of oxygen therapy, including the prescribed flow rate and delivery device used on the treatment administration record .3.1-47(a)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155650	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnshire Health & Rehabilitation Center	8380 Virginia St Merrillville, IN 46410

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure blood pressure monitoring was completed for residents receiving blood pressure medications with parameters for 2 of 7 residents reviewed for unnecessary medications. (Residents H and D)Findings include:1.The record for Resident D was reviewed on 11/19/25 at 10:26 a.m. Diagnoses included, but were not limited to, Parkinson's disease and hypertension. The admission Minimum Data Set (MDS) assessment, dated 8/19/25, indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 8/17/25, indicated the resident was at risk for complications secondary to the diagnosis of hypertension. Interventions included, but were not limited to, give anti hypertensive medications as ordered and obtain blood pressure readings as ordered or indicated. A Physician's Order, dated 8/12/25 and listed as current on the November 2025 Physician's Order Summary (POS), indicated the resident was to receive Losartan Potassium (a blood pressure medication) 100 milligrams (mg) daily for hypertension, hold if systolic blood pressure (top number) was less than 110 and notify the physician. The August 2025 Medication Administration Record (MAR) indicated the resident received the medication 8/13/25 through 8/31/25, however, the resident's blood pressure was not obtained prior to administering the medication.The September 2025, October 2025, and November 2025 MARs indicated the resident received the Losartan Potassium as ordered, however, the resident's blood pressure was not obtained prior to administering the medication for all three months.During an interview on 11/20/25 at 3:10 p.m., the B Wing Unit Manager indicated the resident's blood pressure should have been checked before being given the medication and she would update the MAR. 2. The closed record for Resident D was reviewed on 11/19/25 at 3:22 p.m. Diagnoses included, but were not limited to, aortocoronary bypass graft, atherosclerotic heart disease, hypertension, and syncope and collapse (fainting). The Medicare 5-day Minimum Data Set (MDS) assessment, dated 8/9/25, indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 8/4/25, indicated the resident was at risk for complications secondary to the diagnosis of hypotension (low blood pressure). Interventions included, but were not limited to, give medications as ordered and monitor for side effects and effectiveness. A Physician's Order, dated 8/5/25, indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) 5 milligrams (mg) three times a day for hypotension. Hold the medication if the resident's systolic blood pressure (top number) was above 130. The August 2025 Medication Administration Record (MAR) indicated the resident's blood pressure was not obtained prior to giving the midday dose of Midodrine HCl on 8/5/25, 8/6/25, 8/7/25, and 8/8/25.During an interview on 11/24/25 at 3:30 p.m., the Director of Nursing indicated the resident's blood pressure should have been checked prior to giving the mid day dose of Midodrine. 3.1-48(a)(3)