STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homewood Health Campus	2494 N Lebanon St Lebanon, IN 46052

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure an informed consent for antipsychotic medication use was obtained for 1 of 5 residents reviewed for unnecessary medication. (Resident 34) Findings include: The clinical record for Resident 34 was reviewed on 5/14/25 at 8:48 a.m. The diagnoses included, but were not limited to, dementia with psychotic disturbance, anxiety, and depression. A physician's order, with a start date of 4/15/25, indicated Resident 34 was to take risperidone (an antipsychotic medication) 0.5 milligrams twice a day. A care plan, dated 4/16/25, indicated Resident 34 was at risk for adverse consequences related to receiving an antipsychotic medication. There was no documentation found in Resident 34's electronic health record to indicate the resident or the resident's representative was informed of the risks and benefits of the antipsychotic medication, treatment alternatives, and the option to choose the preferred treatment. During an interview, on 5/15/25 at 5:20 p.m., Resident 34's daughter indicated Resident 34 was admitted to an area hospital for evaluation in April 2025. Resident 34 had been discharged from the hospital and had returned to the facility. The facility did not inform the family of the changes to Resident 34's medication regimen. During an interview, on 5/16/25 at 8:33 a.m., the Interim Director of Nursing indicated Resident 34's medications were reviewed with Resident 34's Power of Attorney (POA) during a care planning meeting but informed consent was not completed at the time the meeting took place. During an interview, on 5/16/25 at 2:54 p.m., Resident 34's POA indicated she was not aware of any medication changes made during the hospital stay. The facility had not informed her of black box warnings or the risks and benefits for any medications since Resident 34 had returned to the facility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Psychotropic medication use and gradual dose reduction guidelines, dated 3/2025 and received from Clinical Support Nurse 4 on 5/16/25 at 1:43 p.m., indicated .To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefits with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team .A consent shall be obtained upon admission for ordered psychotropic medications to ensure appropriate indications for use and that the Resident/Responsible party is educated on the risks, benefits, alternative treatment options and applicable black box warnings 3.1-3(n)(2)

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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 interview and record review, the facility failed to ensure a resident's preference of having female caregivers was documented and followed for 1 of 1 resident reviewed for accommodation of needs. (Resident 25) Findings include: During an interview, on 5/12/25 at 1:55 p.m., Resident 25 indicated she preferred females to complete catheter care on her and there were males who would complete her catheter care. During an interview, on 5/13/25 at 1:50 p.m., Certified Nursing Assistant (CNA) 8 indicated the staff knew Resident 25 did not like male staff members to complete peri-care or catheter care for her. It was known, females should be completing the catheter and peri-care for Resident 25 and not male staff members. The clinical record for Resident 25 was reviewed on 5/13/25 at 1:44 p.m. The diagnoses included, but were not limited to, Parkinson's disease and heart failure. A physician's order, dated 12/21/21, indicated to complete catheter care every shift, three (3) times per day. A quarterly Minimum Data Set (MDS) assessment, dated 3/12/25, indicated Resident 25 was cognitively intact and had indwelling catheter. There was no documentation in the clinical record to indicate Resident 25 preferred female caregivers and there was no care plan related to Resident 25's preference for female caregivers prior to 5/13/25. A Medication Administration Record (MAR), dated May of 2025, indicated the following: a. catheter care was completed by Registered Nurse (RN) 15 (a male nurse) on the 3rd shift on 5/1/25, 5/14/25, and 5/18/25. b. catheter care was completed by Licensed Practical Nurse (LPN) 14 (a male nurse) on the 3rd shift on 5/3/25, 5/9/25, and 5/12/25. c. catheter care was completed by CNA 13 (a male CNA) on the 3rd shift on 5/5/25, 5/6/25, 5/7/25, 5/8/25, and 5/11/25. During an interview, on 5/16/25 at 3:07 p.m., the Director of Nursing (DON) indicated it was known the resident did not want male staff members caring for her. This was an off and on thing for Resident 25. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Resident Rights Guidelines, dated 12/17/24 and received from Clinical Support Nurse 4 on 5/19/25 at 10:40 a.m., indicated .Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus. The following is a list of rights recognized by staff . Our residents have a right to .Be treated with dignity and respect. b. Be given the information necessary to participate in decisions which affect them both individually and cooperatively .Be consulted and encouraged to have input into their care plan which guides the services delivered to the residents 3.1-3(n)(3) 3.1-3(t) 3.1-3(u)(1) 3.1-3(u)(3) 3.1-3(v)(1)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure there was documentation the bed hold policy was provided to a resident for 1 of 1 resident reviewed for bed hold policy. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 5/12/25 at 10:52 a.m. The diagnoses included, but were not limited to, falls, chronic pain, and low back pain. A nursing progress note, dated 12/3/24, indicated the resident had sustained a fracture to the tail bone and was transported to the hospital. A copy of the bed hold policy was not located in the resident's clinical record. During an interview, on 5/19/25 at 1:45 p.m., the Corporate Minimum Data Set (MDS) nurse indicated a bed hold policy was not provided. A current facility policy, titled Bed Hold Notification, dated as last reviewed 1/8/25 and received from the Corporate MDS nurse on 5/19/25 at 1:59 p.m., indicated .Residents and Responsible Parties have a right to be notified verbally and in writing on reserve bed payment policy per the state plan when someone goes out to the hospital .Before a nursing facility transfers a resident to a hospital .the nursing facility must provide written information to the resident and resident representative that specifies the duration of the state bed hold policy 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)

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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 observation, interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded correctly for 1 of 1 resident reviewed for MDS assessments. (Resident C) Findings include: During an observation, on 5/12/25 at 12:16 p.m., Resident C was receiving oxygen from a portable oxygen tank. During an observation, on 5/13/25 at 9:43 a.m., Resident C was receiving oxygen from a portable oxygen tank. During an observation, on 5/13/24 at 1:54 p.m., Resident C was receiving oxygen. During an observation, on 5/14/25 at 9:19 a.m., Resident C was receiving oxygen from a portable oxygen tank. The clinical record for Resident C was reviewed on 5/14/25 at 10:45 a.m. The diagnoses included, but were not limited to, saddle embolus of the pulmonary artery with cor pulmonale (a clot at the bifurcation of the pulmonary artery which obstructed blood flow), pulmonary fibrosis, and atelectasis (part or full collapse of the lung). Resident C's care plan, dated 11/5/24, indicated to administer oxygen per the physician's order. A physician's order, dated 11/19/24, indicated to administer oxygen at four (4) liters per minute as needed to maintain saturation of 92 percent or greater. A quarterly Minimum Data Set (MDS) assessment, dated 2/20/25, indicated the resident was not receiving oxygen administration. During an interview, on 5/13/25 at 9:53 a.m., the Director of Nursing indicated Resident C received four (4) liters of oxygen. During an interview, on 5/14/25 at 3:29 p.m., MDS Coordinator 11 indicated the resident was on supplemental oxygen and it was not correct on the MDS assessment. A current facility document, titled CMS's RAI Version 3.0, dated 10/2023 and received from the Executive Director on 5/16/25 at 9:33 a.m., indicated .Code continuous or intermittent oxygen administered via mask, cannula, etc 3.1-31(c)(6)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure documentation showed as needed (PRN) medications were administered under the direction of a licensed nurse for 1 of 1 resident reviewed for pain. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 5/14/25 at 1:49 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy, spondylosis of the lumbar region, and pain. A current care plan, dated 10/19/23, indicated Resident 26 was at risk for pain and to administer medications as ordered. 1. A physician's order, dated 7/20/24, indicated to give acetaminophen 650 milligrams (mg) for mild to moderate pain every 6 hours as needed. The Medication Administration Record (MAR) dated 5/1/25-5/16/25, indicated acetaminophen was given as needed for pain by a QMA without record of an assessment or permission from a licensed nurse on 5/2/25 and 5/8/25. 2. A physician's order, dated 7/11/24, indicated to give Norco (a narcotic pain medication) 7.5 mg- 325 mg for moderate to severe pain every 6 hours as needed. The MAR, dated April 2025, indicated Norco was given as needed for pain by a QMA without a record of an assessment or permission from a licensed nurse on 4/4/25, 4/24/25, and 4/30/25. The MAR dated 5/1/25-5/16/25, indicated Norco was given as needed for pain by a QMA without record of an assessment or permission from a licensed nurse on 5/10/25 and 5/16/25. During an interview, on 5/15/25 at 10:43 a.m., LPN 2 indicated the QMA should let her know if a resident needed a PRN medication and she would assess the resident, verify the appropriateness of giving the medication, and then authorize the administration based on the physician's order. The process would all be charted in the medical record on the MAR. During an interview, on 5/15/25 at 10:50 a.m., QMA 10 indicated if a resident needed a PRN medication, a licensed nurse on duty would be asked to assess the resident and give permission to administer the medication. It would then be charted the medication was given under the direction of the nurse on the MAR. During an interview, on 5/16/25 at 2:55 p.m., Clinical Support Nurse 4 indicated a QMA was required to have a nurse assess the resident and give permission for the PRN administration. A current facility policy, titled ADMINISTRATION OF PRN MEDICATIONS, dated 12/13/24 and received from the Executive Director (ED) on 5/16/25 at 1:25 p.m., indicated .If PRN medication is to be administered by a QMA, the Standards of Practice for PRN medication administration by a Qualified Medication Assistant shall be observed under the direction of licensed nurse (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled MEDICATION ADMINISTRATION- GENERAL GUIDELINES, dated 11/18 and received from Clinical Support Nurse 4 on 5/19/25 at 3:58 p.m., indicated .Medications are administered only by .personnel authorized by state laws and regulations to administer medications A current job description, titled Certified Resident Medication Associate, (QMA) received from the Clinical Support Nurse 4 on 5/16/25 at 2:55 p.m., indicated .Follow the policies and procedures of the facility governing the administering of medications to residents This citation relates to Complaints IN00454050 and IN00458258. 3.1-35(g)(1) 3.1-35(g)(2)

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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 interview and record review, the facility failed to ensure staff obtained and documented a resident's vital signs prior to administering a medication with physician's ordered hold parameters for 1 of 1 resident reviewed for quality of care. (Resident 22) Findings include: The clinical record for Resident 22 was reviewed on 5/15/25 at 11:07 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic polyneuropathy and hypoglycemia, hypertension, cognitive communication deficit, edema, and bradycardia. A physician's order, dated 4/18/25, indicated to give metoprolol succinate (a medication which lowers blood pressure and heart rate) 25 milligrams once a day with special instructions to hold the medication for a heart rate of less than 55 or a systolic blood pressure less than 110. A physician's order, dated 4/18/25, indicated to obtain a blood pressure and heart rate reading twice a day for 7 days. A Medication Administration Record (MAR), dated April 2025, indicated Resident 22's vital signs were obtained as ordered 4/18/25 through 4/26/25. Metoprolol was given with a documented heart rate of less than 55 on the following dates: On 4/19/25, with a heart rate of 51. On 4/20/25, with a heart rate of 48. On 4/22/25, with a heart rate of 51. After 4/26/25, the MAR did not include a documented heart rate or blood pressure to verify the safety of giving the metoprolol. A MAR, dated 5/1/25 through 5/15/25, indicated the only vital signs recorded for Resident 22 was on 5/3/25. The heart rate recorded was 53. Metoprolol was administered. The MAR did not include any other documented heart rate or blood pressures to verify the safe administration of metoprolol according to the hold parameters for the remaining administrations. During an interview, on 5/15/25 at 10:43 a.m., LPN 2 indicated vital signs should have been obtained and recorded on the MAR before administering a medication with physician ordered hold parameters. During an interview, on 5/16/25 at 11:09 a.m., the Clinical Support Nurse 4 indicated she could not find any verification of vital signs being obtained prior to the medication administration. A current facility policy, titled MEDICATION ADMINISTRATION-GENERAL GUIDELINES, dated 11/18 and received from Clinical Support Nurse 4 on 5/19/25 at 3:58 p.m., indicated .Medications are administered in accordance with written orders of the prescriber (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-37(a)

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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. 2. The clinical record for Resident 6 was reviewed on 5/15/25 at 12:56 p.m. The diagnoses included, but were not limited to, falls, chronic pain, and low back pain. An interdisciplinary team (IDT) note, dated 5/5/25 at 11:00 a.m., indicated Resident 6 was found lying on the floor in her room. She was more than two (2) feet from her bed. The bed was documented to be in a semi-low position. The resident had indicated to the staff she had rolled out of the bed. She was barefoot and laying on her right side. The root cause of the fall was related to the resident rolling from her bed. The intervention was to provide a perimeter mattress. A care plan, dated 9/13/24, indicated the resident was at risk for falling related to weakness. An intervention, initiated on 5/5/25, indicated .Perimeter mattress During an observation and interview, on 5/16/25 at 1:51 p.m., the Director of Nursing indicated the mattress on the bed of Resident 6 was not a perimeter mattress. The resident should have had a perimeter mattress as it was part of her fall precautions. During an interview, on 5/16/25 at 2:08 p.m., the Director of Nursing indicated the mattress had been moved to a different room during the remodeling of the resident's room. The mattress was not moved back to the resident's room after the remodel. It should have been moved back to her room with her. A current facility policy, titled Fall Management Program Guidelines, dated 12/17/24 and received from Clinical Support Nurse 4 on 5/19/25 at 10:40 a.m., indicated .The purpose of this policy is to .mitigate fall risk factors and implement preventative measures .Care plan interventions should be implemented .Any orders received from the physician should be noted and carried out This citation relates to Complaints IN00458006 and IN00458258. 3.1-45(a)(1) 3.1-45(a)(2) Based on observation, interview and record review, the facility failed to ensure a resident was transferred according to the plan of care to prevent a fall and a post fall parameter mattress intervention was in place for 2 of 8 residents reviewed for accidents. (Resident 2 and 6) Findings include: 1. The clinical record for Resident 2 was reviewed on 5/14/25 at 1:53 p.m. The diagnoses included, but were not limited to, age related osteoporosis, history of falling, and unspecified glaucoma. A physician's order, dated 6/4/24, indicated to use the sit-to-stand lift to transfer Resident 2 in and out of bed only per Resident 2's request and therapy approval. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, dated 10/10/24, indicated staff should use the sit-to-stand lift to transfer Resident 2 in and out of bed. A nursing progress note, dated 4/28/25 at 6:24 p.m., indicated an aide was assisting the resident into bed when the resident started to lose strength and balance. The resident was then assisted to the floor without further incident. No injury was noted. Additional staff were able to assist Resident 2 off the floor and into bed. An interdisciplinary team (IDT) note, dated 4/30/25 at 10:01 a.m., indicated the IDT team reviewed the incident, and it was found the staff did not use the sit-to-stand lift to transfer the resident to the bed. The root cause was the staff did not use the proper lift, and Resident 2 had an increased weakness. During an interview, on 5/15/25 at 10:34 a.m., the Director of Nursing (DON) indicated the staff should have used the sit-to-stand lift to transfer the resident in and out of bed. During an interview, on 5/15/25 at 10:42 a.m., the DON indicated the aide used the wrong transfer method. She was supposed to use the sit-to-stand lift. During an interview, on 5/16/25 at 11:45 a.m., the DON indicated they did not complete audits on the other residents to ensure they were receiving proper transfers.

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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 interview and record review, the facility failed to ensure catheter urine output was accurately recorded as ordered for 1 of 1 resident reviewed for urinary catheters. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 5/14/25 at 1:49 p.m. The diagnoses included, but were not limited to, sepsis, infection and inflammatory reaction due to indwelling urethral catheter, bacteremia, hematuria, obstructive and reflux uropathy, and retention of urine. A physician's order, dated 11/11/24, indicated to place an indwelling urinary catheter for obstructive and reflux uropathy. A physician's order, dated 1/26/24, indicated to monitor the catheter output three times a day. A physician's order, dated 7/31/24, indicated give 20 milligrams of Lasix (a diuretic medication) twice a day for edema (swelling). A facility document, dated 5/1/25 through 5/15/25, indicated the following: On 5/2/25 at 3:19 a.m., large was recorded. On 5/2/25 at 9:13 a.m., large was recorded. On 5/3/25 12:28 p.m., medium was recorded. On 5/3/25 10:22 p.m., large was recorded. On 5/4/25 12:04 p.m., medium was recorded. On 5/4/25 9:06 p.m., medium was recorded. On 5/5/25 12:57 p.m., large was recorded. On 5/5/25 8:00 p.m., large was recorded. On 5/5/25 9:57 p.m., large was recorded. On 5/6/25 at 1:08 a.m., large was recorded. On 5/6/25 at 12:56 p.m., medium was recorded. On 5/6/25 at 8:15 p.m., large was recorded. On 5/6/25 at 11:30 p.m., large was recorded. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 10:59 a.m., medium was recorded. On 5/7/25 at 2:22 p.m., medium was recorded. On 5/7/25 at 8:18 p.m., large was recorded. On 5/7/25 at 9:30 p.m., large was recorded. On 5/8/25 at 12:58 a.m., large was recorded. On 5/8/25 at 9:21 p.m., large was recorded. On 5/9/25 at 3:12 p.m., medium was recorded. On 5/9/25 at 9:31 p.m., large was recorded. On 5/10/25 at 3:17 p.m., large was recorded. On 5/10/25 at 11:36 p.m., large was recorded. On 5/11/25 at 1:35 p.m., medium was recorded. On 5/12/25 at 11:56 a.m., medium was recorded. On 5/13/25 at 10:39 a.m., medium was recorded. On 5/13/25 at 2:03 p.m., medium was recorded. On 5/13/25 at 10:06 p.m., medium was recorded. On 5/14/25 at 1:35 a.m., large was recorded. On 5/14/25 at 12:27 p.m., large was recorded. On 5/14/25 at 11:55 p.m., large was recorded. On 5/15/25 at 1:09 p.m., large was recorded. During an interview, on 5/15/25 at 10:39 a.m., Certified Nursing Assistant (CNA) 9 indicated the staff should use a urinal to measure the urine when emptying residents' catheters and then record the exact milliliter (ml) each shift in the medical record. During an interview, on 5/16/25 at 2:57 p.m., Clinical Support Nurse 4 indicated it was not acceptable to use the terms small, medium, or large for catheter output in the medical record. (continued on next page)

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	155680	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homewood Health Campus	2494 N Lebanon St Lebanon, IN 46052

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Emptying Urinary Bag, dated 12/16/24 and received from Clinical Support Nurse 4 on 5/16/25 at 2:55 p.m., indicated .Assemble the equipment and supplies .Measuring container (calibrated) . Position the measuring container under the drainage bag .Measure and record the urinary output .The following information as applicable may be recorded in the resident's medical record .The amount of urine emptied from the drainage bag A current facility policy, titled Urinary Catheter Care, dated 12/16/24 and received from the Executive Director on 5/15/25 at 1:15 p.m., indicated .Observe the resident's urine level for noticeable increases or decreases .Maintain an accurate record of the resident's daily output 3.1-41(a)(2)

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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. Based on observation, interview and record review, the facility failed to ensure physician's orders were obtained and followed for 2 of 2 residents reviewed for oxygen administration. (Resident C and 109) Findings include: 1. During an observation, on 5/12/25 at 12:16 p.m., Resident C was observed in the dining room with a portable oxygen tank set to administer two (2) liters per minute of oxygen via nasal cannula. During an observation, on 5/13/25 at 9:43 a.m., Resident C was in an activity with a portable oxygen tank set to administer two (2) liters per minute of oxygen via nasal cannula. During an interview, on 5/13/25 at 9:53 a.m., the Director of Nursing (DON) reviewed Resident C's physician's orders. She indicated Resident C was to receive four (4) liters per minute of oxygen and Resident C's tank was set at two (2) liters. During an observation, on 5/13/24 at 1:54 p.m., Resident C's oxygen was set at four (4) liters per nasal cannula. The clinical record for Resident C was reviewed on 5/14/25 at 10:45 a.m. The diagnoses included, but were not limited to, saddle embolus of the pulmonary artery with cor pulmonale (a clot at the bifurcation of the pulmonary artery which obstructed blood flow), pulmonary fibrosis, and atelectasis (part or full collapse of the lung). A care plan, dated 11/5/24, indicated the resident had the potential for cardiovascular distress and to administer oxygen per the order. A care plan, dated 11/5/24, indicated the resident had the potential for complications due to pulmonary fibrosis and to administer oxygen per the orders. A physician's order, dated 11/19/24, indicated to administer oxygen at four (4) liters per nasal cannula as needed to maintain saturation of 92 percent or greater. The order was noted to be discontinued and a new order for oxygen at two (2) liters was initiated on 5/13/25 at 12:17 p.m. 2. During an observation, on 5/12/25 at 2:12 p.m., Resident 109 was observed to receive supplemental oxygen set between 2.5 and 3 liters per minute via nasal cannula. During an observation, on 5/14/25 at 1:36 p.m., Resident 109 was observed with supplemental oxygen at three (3) liters per minute via nasal cannula. The clinical record for Resident 109 was reviewed on 5/14/25 at 9:47 a.m. The diagnoses included, but were not limited to, chronic respiratory failure, chronic lung disease, and emphysema. A care plan, dated 4/17/25, indicated the resident had a potential for functional and cognitive decline related to pulmonary fibrosis. An intervention indicated to administer oxygen per the physician's orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, dated 4/17/25, indicated Resident 109 had the potential for shortness of breath while lying flat. An intervention indicated to administer oxygen per the physician's order and as needed. A physician's order, dated 4/17/25, indicated the resident had chronic lung disease to manage oxygen administration in coordination with the physician to prevent respiratory acidosis. Resident 109 did not have a physician's order which addressed how much oxygen the resident was to receive. A current facility policy, titled Administration of Oxygen, dated 12/13/24 and received from the Corporate Minimum Data Set (MDS) nurse, indicated .Verify physician's order This citation relates to Complaint IN00458258. 3.1-47(a)(6)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 3. During a resident council meeting, on 5/14/25 at 10:01 a.m., Resident 14 indicated the facility had an issue with the call light response, he indicated it was on and off. Resident 1 indicated she had rung the call light a bunch of times with no answer. The resident council meeting notes were reviewed, on 5/14/25, and indicated: a. The meeting note, dated 7/22/24, indicated concerns about call light response times. There were no further notes about call lights. b. The meeting note, dated 8/19/24, indicated all residents at the meeting were upset about the waiting time for the call lights and indicated some staff would come in, turn off the light, and not return. c. The meeting note, dated 10/22/24, indicated residents were concerned about call lights. There were no further notes about the call lights. d. The meeting note, dated 11/18/24, indicated residents had voiced concerns over the waiting time for call lights, and had indicated at times the wait was over an hour. It was noted all staff had been educated on answering call lights and everyone could answer the call light. e. The meeting note, dated 1/21/25, indicated residents had voiced concerns about call lights. There were no other notes found addressing call lights. f. The meeting note, dated 2/17/25, indicated residents voiced concerns over call light wait times. One resident indicated they had waited 25 minutes in the bathroom. It was noted staff were spoken to regarding waiting times and staff were educated to round and answer call lights in a timely manner. g. The meeting note, dated 3/17/25, indicated residents voiced concerns over call light waiting times. Some residents indicated they had waited over an hour. It was noted staff were educated on call light expectations and answering call lights in a timely manner. h. The meeting note, dated 4/21/25, indicated call light response times were worse between 2:00 p.m. and 6:00 p.m. It was noted staff were educated on the importance of answering call lights in an appropriate time frame. 4. During an observation, on 5/14/25 at 1:37 p.m., Resident 109 activated her call light to get assistance to lay down. The call light was responded to by CNA 9 on 5/14/25 at 1:43 p.m. The CNA was observed to enter the room, address the resident, and turn off the call light. The CNA did not assist the resident and instead, left the room. During an interview, on 5/14/25 at 1:44 p.m., CNA 9 indicated she was not supposed to turn off the light without taking care of the residents' needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A current facility policy, titled On-Call (Clinical and Caregivers) Policy, last updated in February 2023 and received from Clinical Support 4 on 5/19/25 at 10:40 a.m., indicated .To deliver excellence in customer service, we must provide sufficient staff to meet the needs of our residents. The purpose of this policy is to provide guidance for efficient and orderly administration of the on-call policy .The on-call person will be required to come into the campus if there is a vacancy that has caused the campus to fall below their minimum staffing requirements .The person on-call must be available by phone and must be able to arrive at the campus within two (2) hours of a call .If a significant event or reportable occurs (e.g., abuse, misappropriation, elopement, significant injury, etc.) the ED and DHS/DPAS must be notified regardless of on-call status A facility document, titled Clinical In-Service, dated 4/2/25 and received from the Executive Director on 5/14/25 at 12:08 p.m., indicated .Call lights are to be answered by everyone, not just the aids A current facility policy, titled Guidelines for Answering Call Lights, dated as last reviewed on 12/14/24 and received from Executive Director on 5/14/25 at 12:08 a.m., indicated .Provide the service the resident requested and turn off the call light This citation relates to Complaints IN00454050, IN00455509, IN00458006, IN00458080 and IN00458258. 3.1-17(a) 3.1-17(b)(2) 3.1-17(c)(2) 3.1-17(d) Based on interview and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide nursing and related services to the residents and a licensed staff member was available on-call to cover the staffing needs of the facility. This deficient practice had the potential to affect 92 of 92 residents who resided in the facility. Findings include: 1. A [NAME] Payroll Based Journal (PBJ) for the first quarter of 2025 indicated the facility had a 1-star staffing rating. 2. A nursing progress note, dated 4/19/25 at 2:30 a.m., indicated Licensed Practical Nurse (LPN) 12 heard an alarm sounding. A resident was at the end of the 200-hallway. LPN 12 ran to the end of the hallway. The resident opened the door and stepped outside. While trying to bring the resident back inside, the resident hit LPN 12 in the head with a glass vase full of water and flowers. The resident was brought back inside the facility. The Director of Nursing (DON), Executive Director (ED), Assistant Director of Nursing (ADON) was notified. LPN 12 was given an order from the ED to send the resident to the emergency room to be evaluated and treated. 911 was notified and the police and paramedics arrived to take the resident to the hospital. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, on 5/12/25 at 2:58 p.m., LPN 12 indicated the resident did hit her in the head with a vase and she sustained a concussion. She contacted the DON, and they could not find any staff to cover her. She was the only licensed staff member in the building and no other licensed staff member came in to replace her all night. During an interview, on 5/16/25 at 10:25 a.m., the ED indicated she was aware of the incident, and she had asked the nurse to seek medical treatment immediately. They called to get the nurse a replacement. No other staff member came in to relieve LPN 12. The facility's back up plan was an on-call staff member would come in if something were to happen. The back-up staff were not able to come in. During an interview, on 5/16/25 at 10:56 a.m., the ED indicated the staff member on call the night of the incident was a Qualified Medical Assistant (QMA) and not a licensed staff member. They attempted to call the ADON. The DON lived out of state. The DON tried to make phone calls. They did not have a licensed staff on-call. The facility did not have a licensed nurse available to replace the licensed nurse who was hit on the head with a glass vase and was told to go seek medical attention.

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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 interview and record review, the facility failed to ensure Abnormal Involuntary Movement Scale (AIMS) assessments were completed for evaluation of adverse reactions related to antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 19) Findings include: The clinical record for Resident 19 was reviewed on 5/14/25 at 11:10 a.m. The diagnoses included, but were not limited to, psychosis not due to a substance or known physiological condition, dementia with psychotic disturbance, psychotic disorder with hallucinations due to a known physiological condition, delirium due to known physiological condition, major depressive disorder, anxiety disorder, auditory hallucinations, and visual hallucinations. A physician's order, dated 8/12/24, indicated to give olanzapine (an antipsychotic medication) 5 milligrams at bedtime. A psychiatry progress note, dated 9/23/24, indicated the resident was taking olanzapine and the last AIMS assessment was completed on 6/21/23. A care plan, dated 11/1/24, indicated Resident 19 was at risk for adverse consequences related to antipsychotic medications and to conduct an AIMS test per guidelines. During an interview, on 5/16/25 at 11:09 a.m., Clinical Support Nurse 4 indicated the facility could not find a documented AIMS assessment and one should have been conducted. A current facility policy, titled Guidelines for: Abnormal Involuntary Movement Scale, dated 12/17/24 and received from the Executive Director on 5/16/25 at 1:25 p.m., indicated .To assess residents that have prescribed antipsychotic medications to identify symptoms that may indicate the presence of Tardive Dyskinesia; a neurologic disorder characterized by abnormal involuntary movements which may occur .The AIMS assessment will be completed .at the earliest possible time; either after admission; after medications . are prescribed; and with dosage changes. 3. The AIMS assessment will be repeated .every six months 3.1-48(a)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications were labeled with pharmacy labels and the date the medications were opened in 2 of 2 medication carts reviewed for medication storage. (100 hall and 200 hall) Findings include: 1. The medication cart, on the 100-hall, was reviewed on 5/15/25 at 10:11 a.m. The following was observed: a. The first drawer contained an open bottle of Carbamide Peroxide 6.5% (ear drops). The medication was not labeled with the date it had been opened. b. The second drawer contained an open bottle of liquid Haloperidol (an antipsychotic medication). The bottle was half empty and was not labeled with the date the medication had been opened. During an interview, on 5/15/25 at 10:20 a.m., LPN 2 indicated the medications should have been labeled with the date they were opened. 2. The medication cart, on the 200-hall, was reviewed on 5/15/25 at 10:55 a.m. The following was observed in the top drawer: a. Spiriva (an inhalation spray), with a sticker, indicating the medication should be discarded 90 days after being opened. The medication was not labeled with the date it had been opened. b. Lispro (an insulin injection pen) without a pharmacy label. c. Lantus (an insulin injection pen) without a pharmacy label. During an interview, on 5/15/25 at 10:55 a.m., QMA 3 indicated the pharmacy labels must have fallen off the insulin injection pens, and all medications should be dated when they are opened. A current facility policy, titled Medication Storage in the Facility, dated 11/18 and received from the Executive Director on 5/16/25 at 9:57 a.m., indicated .Medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier .All medications dispensed by the pharmacy are stored in the container with the pharmacy label .When the original seal of a manufacturer's container or vial is initially broke, the container or vial will be dated .A [date opened] sticker shall be placed on the medication .The expiration date of the vial or container will be [(30)] days unless the manufacturer recommends another date or regulations/guidelines require different dating 3.1-25(j) 3.1-25(k)(1) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure staff wore personal protective equipment (PPE) correctly, performed hand hygiene, and changed gloves for 2 of 2 randomly observed staff members reviewed for infection control. (QMA 10 and RN 7) Findings include: During an observation, on 5/15/25 at 1:17 p.m., RN 7 and QMA 10 tied PPE gowns at the back of their neck, neither staff member tied the gowns closed at their waist and entered Resident C's room. 1. QMA 10 with gloves on, cleaned Resident C's mouth with a toothette (an oral swab) and discard it. QMA 10 then moved the mechanical lift into place. She picked up the resident's catheter drainage system with her left gloved hand and attached the bag to the mechanical lift strap. She ensured the sling was properly connected to the mechanical lift and used the control to lift the resident. The resident was then lowered to the bed. QMA 10 removed the resident's hearing aids and put them onto the charger. She assisted the resident to turn onto her left side. QMA 10 was then observed to handle the resident's oxygen line/nasal cannula and place it on the resident. She was not observed to remove her gloves, perform hand hygiene, or apply new gloves. QMA 10 then assisted in removing the resident's pants. QMA 10 held the catheter bag and tubing to guide it through the resident's pant leg. QMA 10 was observed to handle the cleaning wipe packaging and remove a clean wipe for RN 7. QMA 10 retrieved another clean wipe from the package and handed it to the RN. After handing more wipes to RN 7, QMA 10 was then observed to remove her gloves. She indicated she needed to get washcloths and wash her hands with soap and water. During an interview, on 5/15/25 at 1:28 p.m., QMA 10 indicated she had not changed her gloves between the observed tasks. 2. During an observation, on 5/15/25 at 1:32 p.m., RN 7 used wipes to clean Resident C's bowel movement. She removed and discarded her gloves and put on a pair of clean gloves. She was not observed to have performed hand hygiene after removing her gloves or before applying new gloves. Resident C was then positioned for wound care to the left coccyx area. RN 7 was observed to clean the wound area with normal saline. She then wiped all around the surrounding area and then back to the wound. She repeated the process of cleaning the wound then the surrounding area including the wound area. During an interview, on 5/15/25 at 1:50 p.m., RN 7 indicated she should have cleaned the wound from the inside to the outside, their gowns should have been tied correctly, and gloves should have been changed after handling the catheter bag and in between tasks. During an interview, on 5/16/25 at 8:32 a.m., the Director of Nursing indicated wounds were to be cleaned from the inside to the outside. A current facility document, titled SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE), undated, and received from the Executive Director on 5/16/24 at 9:17 a.m., indicated .GOWN .fasten in back at neck and waist (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Guidelines for Handwashing/Hand Hygiene, dated 12/17/24 and received from the Executive Director on 5/16/25 at 9:17 a.m., indicated .Health Care Workers .shall use hand hygiene at times such as .After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc This citation relates to Complaint IN00458080. 3.1-18(b)(2) 3.1-18(l)