STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155688	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freelandville Community Home	310 W Carlisle Street Freelandville, IN 47535

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner for 1 of 3 dining observations. Butter packets were placed on top of food for the residents that were served and an ice scoop was observed in the container with ice used for resident drinks. (Kitchen)Findings include: On 2/19/26 at 11:59 A.M., plating of resident trays was observed. [NAME] 7 grabbed an individual plastic butter container with a gloved hand and placed it directly on top of the food on the plate to be served to the residents. At that time, there was ice in a metal container on a cart with the ice scoop laying in the container on the ice. During an interview on 2/20/26 at 9:47 A.M., the Dietary Manager indicated the ice with the scoop laying in it was used for resident drinks and should not have been laid on the ice. On 2/23/26 at 9:10 A.M., a current Ice machine Policy, dated 12/1/25, was provided by the Business Office Manager (BOM) and indicated, . infection control . is important to decrease the risk of illness to residents, staff, and visitors . 3.1-21(i)(3)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's were treated with dignity and respect for 2 of 2 random observations and 1 of 1 resident reviewed for dignity. A resident totally dependent on staff was observed to wait 44 minutes and 19 minutes to use the bathroom. A resident in a Hoyer lift complained of pain when she was lifted but was not attended to at that time. (Resident 3, Resident 26)Findings include: 1. During the resident council meeting on 2/18/26 at 1:30 P.M., three of 14 residents complained that they had to wait longer than 15 minutes for staff to help them go to the bathroom. 2. On 2/18/26 at 12:26 P.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease and intellectually disabled. The most recent quarterly Minimum Data Set (MDS) assessment, dated 1/30/26, indicated Resident 3's cognition was moderately impaired and was totally dependent on staff for toileting. On 2/19/26 from 10:00 A.M., Resident 3 indicated he needed to go to the bathroom. His call light was observed on and he was sitting in the doorway of his room waiting for staff. On 2/19/26 at 10:23 A.M., Staff 4 asked if he had been to the bathroom yet and resident indicated he had not. Staff 4 asked other staff members where the aide was and walked away. On 2/19/26 at 10:25 A.M., Staff 5 asked other staff members who had Resident 3 on their patient roster that day because he was still waiting to go to the bathroom. Staff members were not sure and walked away. Staff 6 came to the resident and said other staff was going to see if they could find help. On 2/19/26 at 10:27 A.M., Certified Nurse Aide (CNA) 6 was observed to walk down the hallway past Resident 3 with his call light still on. On 2/19/26 at 10:33 A.M., CNA 6 asked CNA 14 if she was busy because she needed help laying Resident 3 down. CNA 14 indicated she was helping another resident at that time. On 2/19/26 at 10:35 A.M.,CNA 6 grabbed the Hoyer lift and told Resident 3 she was going to see if she could find Registered Nurse (RN) 22. On 2/19/26 at 10:37 A.M., Resident 3 indicated he needed to have a bowel movement and was tired of waiting. At that time, he indicated he took a laxative that morning and he usually had to wait on staff to go to the bathroom. On 2/19/26 at 10:38 A.M., CNA 6 brought the resident and Hoyer lift into his room and hooked the resident up to the lift. On 2/19/26 at 10:40 A.M., RN 22 and CNA 14 walked into Resident 3's room to assist with lifting the resident from the wheelchair and laying him into bed. On 2/19/26 at 10:42 A.M., CNA 6 took the Hoyer lift out of the room, washed her hands and put gloves (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on. CNA 14 left the room. On 2/19/26 at 10:44 A.M., CNA 6 grabbed a bedpan from the closet, pulled Resident 3's pants down, took his incontinence pad off, and RN 22 indicated at that time, she wanted to look at the skin on his buttocks. She proceeded to assess his skin and then CNA 6 placed the bedpan underneath Resident 3. On 2/20/26 at 1:20 P.M., Resident 3 was observed wheeling himself down the hallway. The call light on his room was activated. The Social Services Director (SSD) stopped and asked what he needed. He indicated he needed to go to the bathroom. The SSD went to nurse's station and came back and told resident they will be with him when they get done with another resident. On 2/20/26 at 1:32 P.M., RN 22 asked the resident where he was going and the resident indicated he had to go to the bathroom. She responded Oh, you're waiting for the girls. She proceeded to answer another call light. When she came out of that room, she indicated to the resident, Here (name of resident), you're in the way. Come up here. She pushed the resident up the hallway farther from his room and walked away. On 2/20/26 at 1:35 P.M., housekeeping staff asked the resident where he was going. The resident indicated he had to go to the bathroom. She indicated she couldn't help him with that and pushed him back to his room. She told the resident she would find someone for him. On 2/20/26 at 1:38 P.M., RN 22 returned and indicated Resident 3's call light was on and she would go find the girls. On 2/20/26 at 1:38 P.M., CNA 10 walked down the hall and indicated told the resident she would be back in a minute. On 2/20/26 at 1:39 P.M., CNA 14 and CNA 10 both went into Resident 3's room to assist him. During an interview on 2/20/26 at 10:15 A.M., the Director of Nursing (DON) indicated she expected call lights to be answered and residents taken into the bathroom within 15 min if possible. 44 minutes was much longer than she would expect a resident to wait on staff to go to the bathroom. During an interview on 2/20/26 at 10:17 A.M., RN 22 indicated nurses were able to help take resident's to the bathroom and any CNA or nursing staff could do it even if it was not on their assigned halls. 3. During an interview on 2/17/2026 at 2:01 P.M., Resident 26 indicated about a month ago, after her shower on night shift, she was placed on the Hoyer lift to get her back to bed. At that time, she told the Certified Nurse Aide (CNA) that her skin was being pinched. She indicated that the CNA ignored her and continued to push her toward the bed. She indicated when they got her to bed her right leg was bleeding from a skin tear in a fold of her leg. On 2/18/2026 at 2:08 P.M., Resident 26's medical records were reviewed. Diagnosis included, but were not limited to metabolic encephalopathy, Type II diabetes mellitus, morbid obesity, muscle weakness, and chronic venous hypertension with inflammation of bilateral lower extremities. The most recent Annual Minimum Data Set (MDS), dated [DATE], indicated Resident 26 was cognitively intact, and was dependent on staff for showers, and transfers (Helper does ALL of the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effort). Current Physician Orders included, but were not limited to: Resident to use Hoyer lift for all transfers, every day and night shift for safety, dated 12/5/25 Review of Nursing Progress Notes, included but were not limited to the following: On 1/12/26 at 3:27 P.M., Health Status Note: Resident obtained a skin tear/laceration to left inner leg, where she has a skin fold. Injury occurred after transfer from shower chair to the bed. Area cleaned, measured and cream applied. Resident is aware. Risk Management completed. On 1/12/26 at 11:37 A.M., Health Status Note: Reported to MD [Medical Doctor] that res [resident] had rec's [received] a shearing injury to left thigh skin fold during Hoyer transfer after shower. New order rec'd [received], res [resident] aware and agreeable. Clean area to left thigh skin fold with wound cleanser, pat dry with gauze and apply medihoney 2x's [times] daily, re-eval [re-evaluate] tx [treatment] in 2 weeks.Nursing Administration (DON) During an interview on 2/19/2026 at 9:39 A.M., the Director of Nursing (DON) indicated when staff were taking Resident 26 from shower room to her room in the Hoyer lift the pad folded up in a skin fold and caused some shearing of the skin. On 2/23/26 at 11:15 A.M., a Dignity policy, dated 12/1/25, was provided by the Business Office Manager (BOM) which indicated, 5. When interacting with a resident, pay attention to the resident as an individual. 6. Respond to requests for assistance in a timely manner. On 2/23/26 at 9:10 A.M., a Lifting Machine, Using a Mechanical policy, dated 2001, was provided by the Business Office Manager (BOM) which indicated, Steps in the Procedure, 14. Check the resident's comfort level by asking or observing for signs of pinching or pulling of the skin. 3.1-3(a)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician notification of change for 2 of 2 residents reviewed for dialysis, and 1 of 4 residents reviewed for nutrition. The physician was not notified of a significant weight loss, signs/symptoms of atrial fibrillation (afib), and a resident that wanted to discontinue dialysis. (Resident 1, Resident 28, Resident 2) Findings include:1. On 2/18/26 at 12:36 P.M., Resident 1's clinical record was reviewed. Diagnosis included, but was not limited to, afib (a common heart condition causing a rapid, irregular, and often chaotic heart rhythm). The most recent annual Minimum Data Set (MDS) assessment, dated 2/13/26, indicated no cognitive impairment. A cardiac defibrillator related to atrial fibrillation care plan, last revised 7/14/25, included but was not limited to the following interventions: Monitor vital signs as ordered/per facility protocol and record. Notify MD of significant abnormalities, dated 7/11/25. Monitor, document, and report to MD as needed any signs/symptoms of altered cardiac output, dated 7/11/25. A progress note, dated 1/27/26 at 12:29 P.M., indicated Resident 1's heart rate was 120 an in an irregular rhythm. At that time, the practitioner indicated if the heart rate remained elevated or the resident became symptomatic (of afib) further treatment would be needed. A progress note, dated 1/28/26 at 10:10 A.M., indicated Resident 1 had been using his prn (as needed) Albuterol inhaler routinely every morning and night, and a new order was added for routine use of the inhaler twice a day. Resident 1's vitals from January 2026 through February 2026 included but was not limited to the following heart rates: 1/30/26 112 x2 2/4/26 117 x2 The clinical record lacked notification to the physician of the increased heart rates. Dialysis communication forms from January 2026 through February 2026 included but was not limited to the following: 1/28/26 pre-dialysis heart rate 103, post-dialysis heart rate 96 1/30/26 pre-dialysis heart rate 95, post-dialysis heart rate 92 2/2/26 pre-dialysis heart rate 120, post-dialysis heart rate 120 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/6/26 pre-dialysis heart rate 102 The clinical record lacked notification to the physician of the increased heart rates at dialysis. On 2/19/26 at 9:47 A.M., Registered Nurse (RN) 7 indicated heart rate was monitored via the pulse oximetry machine, and anything over 90 would be considered abnormal. She indicated signs of symptoms of afib would include shortness of breath, increased respirations, and an irregular fast heart rate. She further indicated if a resident was supposed to be monitored for signs and symptoms of afib, the physician should be notified immediately of any one of those symptoms. She indicated when a resident returned from dialysis, the communication form information would be reviewed and added to the resident's clinical record by the nurse on duty. On 2/19/26 at 9:50 A.M., the Director of Nursing (DON) indicated Resident 1's physician should have been notified of any heart rate over 100, or with any symptoms of shortness of breath. 2. On 2/18/26 at 12:34 P.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, weakness and anemia. The most recent admission Minimal Data Set (MDS) assessment, dated 2/6/26, indicated a severely impaired cognitive status with no behaviors. Resident 28 required setup and cleanup assistance with meals. A current nutritional care plan related to not wanting to eat, last revised on 2/10/26, included but was not limited to and intervention to monitor, record, and report to the physician signs and symptoms of malnutrition, significant weight loss: 3 pounds in 1 week, >5% in one month, >7.5% in three months, or >10% in 6 months, dated 2/3/26. Resident 28's weights from January 2026 through February 2026 included the following: 1/30/26 102.0 pounds 2/2/26 102.0 pounds 2/9/26 98.0 pounds 2/16/26 90.8 pounds (7.34% loss in 1 week, and 10.98% loss in 2 weeks) Resident 28's clinical record lacked notification to the physician of weight loss. On 2/20/26 at 10:00 A.M., Certified Nurse Aide (CNA) 10 was observed to weigh Resident 28. At that time, Resident 28 weighed 88.2 pounds. On 2/23/26 at 10:34 A.M., the Director of Nursing (DON) indicated the nurse should identify weight loss when entering the resident's new weight and comparing it to the old weight. If there was a 3 pound difference in weights, the resident should be re-weighed. At that point, the physician should be notified of any true weight losses. 3. During an interview on 2/17/26 at 11:26 A.M., Resident 2 indicated he had dialysis on Monday, Wednesday, and Fridays. At that time, he indicated he didn't like going because he felt like it made (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him weak. On 2/19/26 at 10:03 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, dependence on renal dialysis. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, indicated Resident 2's cognition was cognitively impaired and on dialysis. Current Physician's Orders included, but were not limited to, the following: Dialysis: Monday, Wednesday, and Friday. Chair time: 11:00 A.M. Dialysis pick up time: 4:00 P.M. at (name and address of dialysis center), ordered 11/26/25 Progress notes from 1/1/26-present were reviewed and included, but were not limited to, the following: On 1/8/26 at 5:50 P.M., Secure Conversation Message: Subject: Dialysis Res [Resident] goes to dialysis 3x's [times] weekly, res often refuses to go and has strong opinions about not liking dialysis. I was looking into his dialysis options and spoke with them yesterday, the dialysis nurse reported to me they only take 200 ml [milliliters] fluid off of [resident name] when he is there each time, is this enough to warrant him going to dialysis 3x's a week, can we check his kidney functions in house, is he ok to only go 2x's weekly if his kidney functions are good, or not at all? Nurse Practitioner (NP) response: We can get a CMP [comprehensive metabolic profile] next lab day- is he still seeing neprhology [sic]/when does he see them next? Nurse note: Will draw lab on the 13th. There is no follow up appointments with Dr. [NAME] except scheduled for venogram access eval on 1/1/2026. Additional notes: resident and daughter aware of lab draw order. On 1/13/26 at 1:50 P.M., a Health Status Note indicated resident had a doppler scheduled for placement of a port for dialysis from the nephrologist. Resident refused to have the procedure done. Explained the reason to resident and resident indicated he was not getting it done and he did not need it. Called Power of Attorney (POA) and left message. The clinical record lacked any further communication and notification to the physician, nephrologist, and resident/resident representative about the resident's request to discontinue dialysis and not have the port replacement appointment. During an interview on 2/20/26 at 9:57 A.M., the (Director of Nursing) DON indicated the resident was currently on dialysis. She would expect notifications and communication with the providers, resident, and family about the requests and refusals from the resident and documentation in the clinical record for all. She was unable to provide the documentation. On 9/23/26 at 9:10 A.M., a current Notifications of Changes Policy, dated 12/1/25, was provided by the Business Office Manager (BOM) and indicated, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification . Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition . 3. Circumstances that require a need to alter treatment. This may include: a. new treatment b. discontinuation of current treatment due to: i. adverse consequences ii. acute condition iii. exacerbation of a chronic condition . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-5(a)(2) 3.1-5(a)(3)

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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 prevent and appropriately treat a urinary tract infection (UTI) for 1 of 1 resident reviewed for UTI. A resident was observed soiled from previous incontinence care, and an antibiotic was given prior to culture results that was resistant to the bacteria. (Resident 9) Finding includes:On 2/18/26 at 11:12 A.M., Resident 9's clinical record was reviewed. Diagnosis included, but was not limited to, Alzheimer's disease and dementia. The most recent quarterly Minimum Data Set (MDS) assessment, dated 1/20/26, indicated a severe cognitive impairment. Resident 9 was dependent on staff for toileting and always incontinent of bladder and bowel.Cephalexin (an antibiotic) 500mg (milligrams), give 1 tablet by mouth every 12 hours related to urinary tract infection, dated 2/14/26 and discontinued 2/16/26.Cefdinir (an antibiotic) 300mg (Cefdinir), give 1 capsule by mouth two times a day for UTI for 7 days, dated 2/16/26.A current need for assistance with toileting care plan, last revised 1/5/25, indicated but was not limited to and intervention to provide pericare after each incontinence episode, dated 8/14/23.A urinalysis dated 2/14/26 indicated Resident 9 had a UTI. A urine culture was then completed and resulted on 2/16/26 which indicated resistance to Cephalexin.Resident 9's Medication Administration Record (MAR) indicated 4 doses of Cephalexin had been administered prior to the start of Cefdinir.On 2/19/26 at 11:24 A.M., Certified Nurse Aide (CNA) 10 was observed to provide incontinence care for Resident 9. A liquid soaked brief was taken off of the resident, and at that time the resident was not observed to have a bowel movement. While wiping the resident, a brown streak approximately 6 inches long, was observed behind her right thigh. At that time, CNA 10 attempted to wipe it off of her leg and indicated it was stuck to the resident's leg as it had been there a while. CNA 10 indicated Resident 9 had not had a bowel movement that day, so it must have been left from the night shift. On 2/23/26 at 10:48 A.M., the Infection Preventionist (IP) indicated Resident 9's physician had started Cephalexin prior to the urine culture report, as they often do. The bacteria in the culture report was found to be resistant to Cephalexin, and a different antibiotic was then started. On 2/23/26 at 9:18 A.M., the Administrator provided a current Urinary Tract Infection policy, dated 12/1/25, that indicated To prevent UTIs, appropriate perineal hygiene shall be regularly provided to residents who are incontinent of bladder and bowel . Antibiotic therapy shall not be initiated based on symptoms alone; the nurse shall request a physician's orders to obtain a urine specimen, which may include culture, for testing and proper diagnosis and treatment accordingly [sic] to the facilities [sic] defined method for determining infections3.1-41(a)(2)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure ongoing communication between the dialysis center and the facility for 2 of 2 residents reviewed for dialysis. Clinical records lacked complete communication forms and documentation of dialysis access site being assessed after dialysis. (Resident 2, Resident 1)Findings include:1. On 2/18/26 at 12:36 P.M., Resident 1's clinical record was reviewed. Diagnosis included, but was not limited to, end stage renal disease (ESRD). The most recent annual Minimum Data Set (MDS) assessment, dated 2/13/26, indicated no cognitive impairment, and dialysis. Physician orders included, but were not limited to: Dialysis every Monday, Wednesday, and Friday, dated 12/17/25. Dialysis communication forms from January 2026 through February 2026 included, but were not limited to, the following: 1/9/26 no information from the dialysis center 1/14/26 lacked post-dialysis vital signs 2/4/26 no information from the dialysis center 2/6/26 lacked post-dialysis vital signs 2/9/26 form brought back from dialysis center incomplete 2. On 2/19/26 at 10:03 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, dependence on renal dialysis. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, indicated Resident 2's cognition was cognitively impaired and on dialysis. Current Physician's Orders included, but were not limited to, the following: Dialysis: Monday, Wednesday, and Friday. Chair time: 11:00 A.M. Dialysis pick up time: 4:00 P.M. at (name and address of dialysis center), ordered 11/26/25 Resident to have right tunneled central venous catheter for dialysis, to be maintained by dialysis center. No directions specified for order, ordered 11/19/25 Observe dialysis access site for signs and symptoms of infection twice daily. If observed, report to Dialysis center and MD, ordered 11/25/25 Complete the Hemodialysis Communication Form (top section) one time a day every Mon, Wed, Fri, ordered 12/8/25 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current Hemodialysis Care Plan, last revised 11/25/25, included, but was not limited to, the following interventions: Check and change dressing per orders at access site. Document.Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis M-W-F. Monitor/document/report to MD PRN for signs/symptoms of the following: Bleeding, Hemorrhage, Bacteremia, septic shock.Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and BP immediately. Hemodialysis Communication Forms from 1/1/26-present were reviewed and were missing information for the following dates: 1/7/26-noted pre and post forms were not completed from dialysis 1/30/26-noted no paperwork returned with resident from dialysis 2/2/26-noted Dialysis did not complete pre and post treatment assessment sheet 2/9/26-noted n/a The clinical record lacked any documentation on staff assessing the dialysis access site after dialysis. During an interview on 2/20/26 at 9:52 A.M., Registered Nurse (RN) 22 indicated the nurse should fill out the pre dialysis information on the communication form and send a paper copy with the resident. When the resident returns from dialysis, they should bring the form back and the post dialysis information should be completed by the dialysis center. Sometimes the dialysis center won't fill them out or they come back without a communication form at all. When resident comes back, they usually take him to the bathroom to see how steady and oriented he is and should look at dialysis site for bleeding. That assessment information was not documented but probably should be. The communication form information should be put into the clinical record as assessment and then into medical records to be scanned into the record. During an interview on 2/20/26 at 9:57 A.M., the (Director of Nursing) DON indicated there should be a communication form from returned from dialysis every time the resident went. She would expect documentation on the resident's condition, especially vitals and access site, when they return in the clinical record. If the resident comes back without a form from dialysis, the nurse should call and get it faxed to them completed. On 2/15/26 at 1:58 P.M., a current Dialysis Contract, signed by the facility Administrator and dialysis company on 7/15/24, was provided by the Business Office Manager (BOM) and indicated, . b) . Center shall provide to Facility information on aspects of the management of a Designated Resident's care related to the provision of dialysis services . 5. Medical Records. Center shall maintain reports of all services rendered by Center in accordance with its usual medical records procedures. The ownership and right of control of all such reports, records, and supporting documents prepared in connection with the services shall vest exclusively in Center. Facility shall have the right to photocopy any such reports, records or documents for inclusion in its records . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155688	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freelandville Community Home	310 W Carlisle Street Freelandville, IN 47535

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/26 at 9:10 A.M., a current Hemodialysis Policy, dated 12/1/25, was provided by the BOM and indicated, . the facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices: Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services . 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure the Posted Nurse Staffing form contained the actual hours worked by the registered nurses, licensed practical nurses and certified nurse aides for 4 of 5 days reviewed for the survey. The Posted Nurse Staffing form did not contain the actual hours worked by the staff. (2/17/26, 2/18/26, 2/19/26, 2/20/26).Findings include: On 2/17/26 at 1:10 P.M., the Posted Nurse Staffing form was observed and lacked the actual hours the registered nurses, licensed practical nurses, and certified nurse aides worked.On 2/18/26 at 12:31 P.M., the Posted Nurse Staffing form was observed and lacked the actual hours the registered nurses, licensed practical nurses, and certified nurse aides worked.On 2/19/26 at 9:44 A.M., the Posted Nurse Staffing form was observed and lacked the actual hours the registered nurses, licensed practical nurses, and certified nurse aides worked.On 2/20/26 at 11:18 A.M., the Posted Nurse Staffing form was observed and lacked the actual hours the registered nurses, licensed practical nurses, and certified nurse aides worked.During an interview on 2/20/26 at 2:05 P.M., the Scheduler indicated the night shift nurses filled out the Posted Nurse Staffing form. During an interview on 2/23/26 at 9:44 A.M., the Scheduler indicated she had not read the policy on how to fill out the Posted Nurse Staffing form.On 2/23/26 at 9:10 A.M., a Posted Daily Nurse Staffing Form Information policy, dated 12/1/25, was provided by the Business Office Manager (BOM) which indicated, 1. The facility will provide the required information that needs to be posted daily which includes: . d. Total number of staff and actual hours worked per shift for: Registered NursesLicensed NursesCertified Nurse Aides