STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a registered nurse was serving as the Director of Nursing (DON) on a full time basis (40 hours per week) for 1 of 1 DON reviewed. The facility had an interim DON that was not working on a full-time basis. (DON)Finding includes:On 12/8/25 at 1:00 P.M., the employee records were reviewed and indicated the DON was interim. On 12/10/25 at 9:54 A.M., the Administrator provided copies of the posted nurse staffing form from 11/1/25 through 12/7/25 which indicated the DON worked the following hours per week:November 1-7=36 hoursNovember 8-14=36 hoursNovember 15-21=34 hoursNovember 22-30=31 hours December 1-7=39 hours The facility assessment, last revised 11/26/25, indicated facility staff would include 1 full-time DON. During an interview on 12/9/25 at 9:30 P.M., the DON indicated she did not clock in or out but was there 1-2 days a week and she works mostly on MDS assessments. She was not aware of any hiring processes or plan for a full-time DON at that time. She indicated she retired a year and a half ago and did not want the responsibilities of the DON but was here to help on an as needed basis. During an interview on 12/10/25 at 12:00 P.M., the Administrator indicated she knew the full-time DON position needs filled but they were having trouble finding someone. On 12/10/25 at 8:31 A.M., a non dated DON job description was provided by the Administrator and indicated, . The Director of Nursing (DON) is responsible for the overall management of the Nursing Department and for ensuring the delivery of high-quality, resident-centered care in accordance with CMS regulations, Indiana Department of Health (IDOH) requirements, and facility policies. The DON oversees nursing operations, supervises staff, ensures regulatory compliance, and leads quality improvement initiatives . 3.1-17(b)(4)

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure staff were certified to fill the role of a Certified Nurse Aide (CNA) for 1 of 5 CNA licenses reviewed. An employee was working as a CNA without being certified. (CNA 24)Finding includes: On 12/8/25 at 1:00 P.M., the employee records were reviewed. There was not a license found on CNA 24. She was hired 8/28/24 and her 120 days would have been up 12/26/24.During an interview on 12/9/25 at 9:50 A.M., the Administrator provided a certificate of completion for the 105 hour nurse aide training from the Indiana State Department of Health and said that was what was provided to them. She wanted to double check with the employee to see if she was under a different name because she was working as a CNA in the facility.During a 12/9/25 at 2:45 P.M., the Administrator indicated she was not aware that CNA 24 was not licensed. The license was not verified upon hire. She usually worked eight hours on night shift and had 35 shifts working alone as a CNA since September of 2025.On 12/10/25 at 8:31 A.M., a current non dated CNA job description was provided by the Administrator and indicated, . Must possess a current CNA license within the state of Indiana . 3.1-14(b)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure appropriate certification of the Kitchen Manager for 1 of 1 employee identified as Kitchen Manager. The current Kitchen Manager was not certified in food safety or food service management. (Kitchen Manager)Finding includes:On 12/1/25 at 9:50 A.M., the Kitchen Manager indicated she did not have a certification in kitchen management. She indicated she started in the facility about 3 months ago and had experience in the kitchen, but did not have any type of certification. On 12/10/25 at 12:10 P.M., the Administrator indicated the Kitchen Manager was hired on 9/16/25. She indicated the plan was to train in the kitchen first, then obtain certification the first of the year. On 12/10/25 at 7:23 A.M., the Administrator provided a non-dated Food and Nutrition Services Staff policy. The policy did not indicate the specific training required of the Kitchen Manager. 3.1-20(e)

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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, interview, and record review, the facility failed to ensure food was stored in accordance with professional standards for food service safety for 2 of 2 observations of the kitchen. Food items were open to air and not labeled, refrigerator temperatures were not recorded, and debris was observed in the refrigerators.Findings include: On 12/1/25 at 9:50 A.M., the kitchen was observed with the following:Three clear containers that contained cereal were under the food preparation counter not dated. Refrigerator #1:A baggie of cheese slices in the door not labeled. A pitcher of applesauce not labeled.A pitcher of clear liquid not labeled.An open package of deli meat in the door not labeled.A tray of bacon strips on the bottom shelf not labeled. Freezer #2:An open package of meat patties not labeled.An open package of breadsticks not labeled. Refrigerator/Freezer #3:One of the two drawers in the bottom of the refrigerator cracked with a large portion missing with exposed jagged edges.Debris in the freezer. An air conditioning unit was observed surrounded by silver duct tape that was coming off in several places. A brown paper towel was observed wadded up and stuffed into the lower left corner. A black substance was observed surrounding the unit. Basement: The large freezer was observed with a thick layer of frost surrounding the inside. A black substance was observed surrounding the suction part of the lid.The same was observed on 12/8/25 at 1:06 A.M. The black refrigerator/freezer was observed with a dried yellow substance and debris in the bottom of the refrigerator.The same was observed on 12/8/25 at 1:06 A.M. The white refrigerator/freezer was observed with October's temperature log attached to the front of it, partially filled out. At that time, the Kitchen Manager indicated the new December temperature log should have been posted, and once that was done the previous month was thrown out. There were no logs kept of previous months. The ice machine was observed with an ice scoop sitting on top of the machine not covered. A brown substance was observed on the top inside of the machine.The same was observed on 12/8/25 at 1:06 A.M. Refrigerator #8 and #9 were observed in the dry storage room with debris littering the inside of both.The same was observed on 12/8/25 at 1:06 A.M. On 12/8/25 at 1:06 P.M., Freezer #7 was observed with an open bag of cookies open to air and not labeled.At the time of the first observation, the Kitchen Manager indicated she was aware that items needed to be labeled, and was in the process of trying to get all staff to label the items. She indicated she was also in the process of cleaning out the refrigerators and freezers, and was aware that they needed to be done.On 12/10/25 at 8:49 A.M., the Administrator provided a current non-dated Food Receiving and Storage policy that indicated Foods shall be received and stored in a manner that complies with safe food handling practices . Food services, or other designated staff, will maintain clean food storage areas at all times . Dry foods that are stored in bins will be removed from original packaging, labeled and dated . All foods stored in the refrigerator or freezer will be covered, labeled and dated3.1-21(i)(1) 3.1-21(i)(3)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure waste was properly contained in dumpsters for 2 of 2 random observations. Staff observed to place garbage bags on top of the dumpster lid, and trash was observed on the ground around the dumpster.Findings include:On 12/1/25 at 1:30 P.M., during a random observation, the dumpster in the back parking lot was observed with several trash bags sitting on top of the front lids. At that time, a staff member was observed to place a bag of trash with the other bags sitting on the lids. Another staff member then went to the back of the dumpster, lifted the back lids, and placed a trash bag inside the dumpster. At that time, trash was observed on the ground surrounding the dumpster.On 12/8/25 at 2:02 P.M., during a random observation, the dumpster was observed overflowing with trash. Bags of trash were observed sitting on top of the lids, and empty boxes were observed on the ground surrounding the dumpster. On 12/10/25 at 12:10 P.M., the Administrator indicated trash pickup days were Tuesday and Friday. She indicated they were currently having issues with staff putting bags of trash on top of the dumpster and not inside of it. She also indicated at that time that although there was no policy, staff were expected to place bags of trash in the dumpster. 3.1-21(i)(5)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate one or more individual(s) as the Infection Preventionist with qualifying training or certification for 7 of 7 days of the survey. The facility did not have a current certified Infection Preventionist.Finding includes:During an interview on 12/1/25 at 9:56 A.M., the Director of Nursing (DON) indicated she was unsure who the Infection Preventionist was.During an interview on 12/9/2025 12:17 P.M., Registered Nurse (RN) 3 indicated she was the Infection Preventionist, but was not yet certified.On 12/10/25 at 8:25 A.M., the Administrator provided an Infection Preventionist job description that indicated, .Minimum Qualifications .Completion of a CMS-approved Infection Prevention and Control Training Course .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide an ongoing resident centered activity program for 2 of 2 halls in the facility. The activity calendar was not followed and resident's interviews indicated there weren't enough activities. (Front Hall, Back Hall)Finding includes:During anonymous interviews, the following comments were made about the activity program:I'm a busy body and there really isn't anything to do around here. We have asked them for more activities but they say they are limited. The director is gone a lot with transportation because all our appointments are out of the building. So if she isn't here, there usually aren't any activities. Sometimes if the activity director isn't available to hold the activity, a couple of residents will do it instead. A copy of the December 2025 activity calendar was observed hanging in the hallway between the Back and Front Hall. The facility assessment, last revised 11/26/25, indicated the facility would offer activities based on resident preference and would have one full time staff member for activity therapy. On 12/4/25 at 9:20 A.M., six residents were gathered out by the TV. Exercise activity scheduled for 9:00 A.M. was not observed. On 12/4/25 at 1:30 P.M., a resident was conducting bingo. No staff was present at that time. On 12/5/25 at 9:06 A.M., the Activity Director and a resident were walking out the front door. Exercise at 9:00 A.M. was not observed. On 12/8/25 at 11:00 A.M., the activity on the schedule was Walmart but was not done. On 12/8/25 at 9:07 A.M., exercise activity scheduled for 9:00 A.M. was not observed. On 12/8/25 at 1:00 P.M., movie and popcorn activity scheduled at 1:00 P.M. was not observed. On 12/8/25 at 1:09 P.M., the Administrator indicated the Activity Director was not there at the time because she was transporting a resident to an appointment.During an interview on 12/9/25 at 9:40 A.M., the Activity Director indicated some days were better than others. She indicated she was currently taking the Activity Director certification class. She indicated she was the only staff member that took residents to their appointments and that did activities in the facility. She had been trying to get them to schedule appointments in the morning if possible but there could be emergency ones. She would have to cancel activities if she can't be there which happened quite a bit. She was not aware of how to put in the resident's activity care plans so that's probably why some of the newer residents did not have one. On 12/10/25 at 12:38 P.M., a current non dated Activities Policy was provided by the Administrator and indicated, . It is the policy of this facility to provide an ongoing program of meaningful, person centered activities designed to meet the physical, cognitive, social, emotional, and spiritual needs of each resident, in accordance with their individual preferences, functional abilities, and comprehensive care plan. The activities program will comply with all federal regulations under 42 CFR 5483 and Indiana state regulations under 410 IAC 16.2 . 3.1-33(a)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review, the facility failed to ensure the Activity Director was certified for 1 of 1 Activity Director reviewed. (Activity Director)Finding includes:On 12/8/25 at 1:00 P.M., the employee records were reviewed. On 12/9/25 at 9:40 A.M., the Activity Director indicated she was not certified at this time. On 12/9/25 at 4:05 P.M., the Administrator indicated she was hired for another position and took over the Activity Director position on 8/22/25. She was currently enrolled in the Activity Director course but had not taken the test to be certified. She was aware that she needed certification. On 12/10/25 at 12:38 A.M., a non dated current Activity Director Policy was provided by the Administrator and indicated, . PERSONNEL SPECIFICATION: High School graduate, aptitude and some training in arts and crafts, and ability to plan and organize recreation al activities . 3.1-33 (e)

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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, interview and record review, the facility failed to maintain safe and secure storage of medications for 1 of 1 medication carts observed. Medication cups with loose pills and a narcotic was observed in a medication cart. (Resident 7, Resident 15, Resident 24, Resident 30)Findings include:During an observation on 12/1/25 at 10:09 A.M., Qualified Medication Aide (QMA) 5 opened the second drawer of the medication cart that was not under a double lock and pulled out a medication cup that was unlabeled and indicated the medications were for Resident 15. At that time, she indicated she was unsure of what the specific medications were and entered Resident 15's room. During the medication pass, QMA 5 indicated 1 of the 11 pills was a pain pill to Resident 15.During an interview on 12/1/25 at 10:15 A.M., QMA 5 indicated the pain pill was a 5 milligram (mg) oxycodone (narcotic).During an observation on 12/4/25 at 10:37 A.M., QMA 5 opened a medication drawer and an unlabeled medication cup had a yellow substance in it with a tablet. At that time, QMA 5 indicated it was for Resident 24 and she liked her medications soaked in applesauce. Another drawer was opened and contained a clear, unlabeled medication cup that QMA 5 indicated was for Resident 7, but she was unsure what medications were in the cup.During an observation on 12/4/25 at 10:41 A.M., QMA 5 removed a clear, unlabeled medication cup that had 10 pills in it. QMA 5 indicated the medications were for Resident 30, she was unsure what the medications were, and put applesauce in the medication cup and gave the medications to Resident 30.During an interview on 12/10/25 at 10:58 A.M., the Director of Nursing (DON) indicated medications should not be set up for multiple residents and unlabeled, and all narcotics should be under a double lock at all times in the medication cart.On 12/10/25 at 8:40 A.M., the Administrator provided a Storage of Medications policy, revised November 2020 that indicated, .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.Schedule ll-V controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications.3.1-25(r)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on interview and record review, the facility failed to ensure diets were provided that met nutritional and special dietary needs for 12 of 35 residents that ate facility provided meals. All residents were served a regular diet despite other therapeutic diet orders. (Resident 4, Resident 9, Resident 11, Resident 13, Resident 20, Resident 3, Resident 29, Resident 8, Resident 30, Resident 22, Anonymous Resident A, Anonymous Resident B)Findings include:During the survey, two anonymous residents indicated the facility did not provide a diabetic menu. One resident indicated their blood sugars had been three times higher than they needed to be since a diabetic meal was not provided. The other resident indicated it was up to the residents to know what they could and couldn't have from their meals and to not eat the items that were contraindicated with their diet. On 12/8/25 at 1:04 P.M., the Kitchen Manager indicated although several residents did have therapeutic diet orders, there were no alternative meals or selections for any diets other than regular that were provided. She indicated she was unaware of any diabetic or renal (low/no salt) diet meal options, and that all residents were served the same meals. She indicated the residents could choose alternative meals if they did not like what was provided that included ramen noodles, soup and crackers, or peanut and butter sandwiches. She indicated she had meal cards that indicated preferences and anything the resident could not eat, but other than that everyone was served the same regular diet. On 12/9/25 at 10:11 A.M., all current resident meal cards and all current resident diet orders were provided. The following residents had a therapeutic diet order different from a regular diet order:Resident 4 No concentrated sweets (NCS) diet, regular texture, thin consistency, finger foods and double protein with meals (meal card did not indicate finger foods).Resident 9 NCS diet, regular texture, thin consistency.Resident 11 NCS diet, regular texture, thin consistency.Resident 13 Regular diet mechanical soft texture, thin consistency, mechanical soft ground meat, low concentrated sweets (LCS), low carb diet with thin liquids (meal card did not indicate LCS or low carb diet).Resident 20 No added salt (NAS) diet, mechanical soft texture, thin consistency, ground meat.Resident 3 Regular diet, regular texture, thin consistency, LCS.Resident 29 Regular diet, regular texture, thin consistency, LCS.Resident 8 Regular diet, regular texture, thin consistency, LCS.Resident 30 Regular diet, regular texture, thin consistency, LCS.Resident 22 Regular NCS, think liquid diet.Anonymous Resident A Regular diet, regular texture, thin consistency.Anonymous Resident B Regular diet, regular texture, thin consistency, LCS.On 12/10/25 at 12:10 P.M., the Administrator indicated the Kitchen Manager had been in that position since 9/16/25 and she had not taken the food management certification course yet.On 12/10/25 at 9:24 A.M., the Administrator provided a current non-dated Therapeutic Diets policy that indicated Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his/her goals and preferences . A therapeutic diet is considered a diet order as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet or to alter the texture of a diet for example: NCS (No concentrated sweets) NAS (no added salt) or an altered consistency such as Mechanical soft or puree3.1-20(a)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had a diet ordered by a prescribing practitioner for 3 of 15 residents reviewed for diet orders. The resident orders did not include an order for a diet. (Resident 7, Resident 23, Resident 10)Findings include:1. On 2/5/25 at 1:17 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, Parkinson's disease, hypertension, and cancer of kidney and prostate. Resident 7 was admitted [DATE]. The most recent admission MDS assessment, dated 9/15/25, indicated the resident's cognition was severely impaired. Current Physician's Orders lacked a diet order. A current Nutritional Care Plan, last revised 9/8/25, included, but was not limited to, an intervention to provide and serve diet as ordered. 2. On 12/4/25 at 1:00 P.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, hypertension, anxiety, and depression. Resident 23 was admitted [DATE]. The most recent admission MDS assessment, dated 9/15/25, indicated the resident's cognition was severely impaired. Current Physician's Orders lacked a diet order.A current Nutritional Care Plan, last revised 9/15/25, included, but was not limited to, an intervention to provide and serve diet as ordered. 3. On 12/3/25 at 2:00 P.M., Resident 10's clinical record was reviewed. Diagnoses included, but were not limited to, constipation, unspecified vitamin D deficiency, insomnia, anxiety disorder, and unspecified protein calorie malnutrition. The most recent annual minimum data set (MDS) assessment, dated 9/12/25, indicated the resident's cognition was severely impaired. Current Physician's Orders lacked a diet order.A current Skin Care Plan, last revised 5/13/25, included, but was not limited to, an intervention to encourage food and fluid intakes within therapeutic diet.During an interview on 12/9/25 at 12:34 P.M., Registered Nurse (RN) 3 indicated there should be a diet order from the MD (Medical Doctor) for every resident. On 12/10/25 at 9:24 A.M., a current non dated Diet Policy was provided by the Administrator and indicated, . A therapeutic diet must be prescribed by his/her attending physician. 3.1-21(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary environment for 2 of 2 observations of the basement and laundry room. The basement floor was full of dirt and debris, vent covers were caked with dust, and the laundry room had debris and dust. (Basement, Laundry Room)Findings include:1. On 12/1/25 at 10:00 A.M., the basement was observed with dirt and debris on the floor in the area where the refrigerators and freezers for the kitchen were stored. Two of two vent covers in the hallway from that room to the ice machine room were observed with a thick layer of dust between the vent slats. On 12/8/25 at 1:06 P.M., the same was observed. 2. On 12/8/25 at 10:05 A.M., the laundry room area had debris scattered throughout the floor where clean clothing was kept. Multiple pieces of debris accumulated where the wall and floor meet. There was multiple wires exposed on the ceiling with a thick layer of dust caked on the wires. The electrical panel box lacked a door to cover it, and had exposed wires caked with dust. A window air condition unit on the wall had a thick layer of dust caked on it. A carbon monoxide detector was observed sitting in the room caked with dust. On 12/9/25 at 9:55 A.M., the same was observed in the laundry room area. During an interview on 12/10/25 at 10:59 A.M., the Director of Nursing (DON) indicated she was unsure who was responsible for cleaning the laundry room. During an interview on 12/10/25 12:04 P.M., the Administrator indicated they do not have a specific policy related to the environment, but their policy would be to check the laundry room, basement floors, and vents monthly. 3.1-19(f)

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	155708	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was informed in advance by the prescribing practitioner of the risks and benefits of proposed treatment and treatment alternatives for 1 of 6 residents reviewed for unnecessary medications. A prescribing practitioner ordered an antipsychotic for a resident they had not seen and the clinical record lacked documentation of education provided to the resident prior to the medication being given. (Resident 23)Finding includes:During an interview on 12/3/25 at 10:23 A.M., Resident 23 indicated that before she came, she was not on any medications, and now she was on several, but she didn't know why. At that time, the resident was observed in the dining room walking with her hand along the wall and shuffling her gait. The resident indicated she thought it was from the different medications. On 12/4/25 at 1:00 P.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors, anxiety, and hypertension. Resident 23 was admitted on [DATE]. The most recent admission Minimum Data Set (MDS) assessment, dated 9/15/25, indicated Resident 23's cognition was severely impaired, supervision for transfers, and on an antipsychotic. Current Physician's Orders included, but were not limited to, the following:Risperadol 0.5 milligrams (mg) twice daily, ordered 9/15/25, related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (Black Box Warning: Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperidone is not approved for the treatment of patients with dementia-related psychosis.)A current Psychotropic Medication Care Plan, last revised 9/15/25, included the following interventions:Administer psychotropic medications as ordered by the physician. Monitor for side effects and effectiveness prn, initiated 9/15/25Discuss with the Medical Doctor (MD) and family regarding the ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy, initiated 9/15/25Monitor/document/report as needed (PRN) any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles,shaking, frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss ofappetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person, initiated 9/15/25 A progress note, dated 9/15/25 at 1:33 P.M., indicated the resident was witnessed as being very anxious and delusional at times. The Director of Nursing (DON) reported to the behavioral Nurse Practitioner (NP), who gave an order for Risperdal. The clinical record lacked documentation of the resident and/or representative being notified, education given on the medication regarding risks and benefits, black box warning, and alternative methods tried and/or contraindicated for the newly prescribed antipsychotic. On 12/10/25 at 12:40 P.M., the DON indicated they were not able to provide documentation that consent and notification were done prior to the resident receiving the medication. She indicated the documentation should be in the clinical record because if it was not documented, it was not done. The NP usually sees residents monthly. On 12/10/25 at 9:35 A.M., a current non-dated Antipsychotic Policy was provided by the Administrator and indicated, . people receiving health care have a right to participate in the planning of their treatment. Informed consent is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a treatment. The patient must be competent to make a voluntary decision about the treatment. Written informed consent is required for the use of psychotropic medications. If written informed consent is not given, the psychotropic medication cannot be administered without a court order, unless in an emergency. 3.1-3(n)(2)3.1-4(c)3.1-48(b)(1)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure accurate representation of advanced directive status for 1 of 2 residents reviewed for advance directives. A resident's actual code status was not reflected accurately in all documentation. (Resident 32)Finding includes:On 12/4/25 at 10:43 A.M., Resident 32's clinical record was reviewed. Diagnosis included, but was not limited to, anxiety.The most recent quarterly Minimum Data Set (MDS) assessment, dated 9/27/25, indicated a moderate cognitive impairment.Current physician orders included, but were not limited to:Full code, dated 5/2/25.A POST (physician order for scope of treatment) form, dated 12/10/24, indicated Resident 32 had a DNR (do not resuscitate) code status. On 12/5/25 at 1:35 P.M., Registered Nurse (RN) 3 indicated all resident's code status were located in a binder at the nurses station. At that time, the binder was observed with Resident 32's face sheet. At the top of the face sheet, DNR was written. RN 3 indicated in the event of a code situation, Resident 32 would not be resuscitated due to the DNR in the binder. She indicated code status was also documented on the CNA (certified nurse aide) sheets. At that time, a current CNA sheet was provided that indicated Resident 32 was full code. On 12/5/25 at 2:00 P.M., the Administrator indicated she spoke with Resident 32 and he indicated he wished to be a full code. She indicated all information with code status needed to be changed to reflect the full code. On 12/10/25 at 9:13 A.M., the Administrator provided a current non-dated Advance Directive policy that indicated All residents of [facility name] are informed of their rights regarding healthcare decision making and advance directives . The facility will document using the Indiana POST form for each resident and maintain a copy in his/her record 3.1-4(l)(4)3.1-4(l)(5)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was discharged with sufficient preparation for 1 of 1 closed records reviewed. A discharged resident was not educated to follow up with a specialist as needed, and a current list of medications was not provided. (Resident 38)Finding includes: On 12/8/25 at 9:45 A.M., Resident 38's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension.Resident 38 was admitted to the facility on [DATE] and discharged to home on 9/25/25.An admission minimum data set (MDS), dated [DATE], indicated a moderate cognitive impairment.Physician orders included, but were not limited to:Losartan Potassium-HCTZ (hydrochlorothiazide) oral tablet 100-12.5mg (milligram), give one tablet a day for hypertension, dated 6/21/25.Progress notes lacked information related to Resident 38's discharge.Resident 38's clinical record lacked any discharge assessments.Resident 38's clinical record lacked a referral or any other information related to a cardiologist appointment.An exam note from the local Health Department, dated 6/19/25, indicated Resident 38 had been homeless and was seen that day for admission to a nursing home. Her blood pressure in the office was 222/89. Notes from the provider indicated to start Losartan/HCTZ, and a concern about some epigastric pain and uncontrolled hypertension. The note indicated the resident would likely need a cardiology consult once insurance was fully established.On 12/8/25 at 1:38 P.M., a written discharge form, dated 9/25/25, was provided. The form indicated the current diet, and to make an appointment with a primary care doctor within 30 days. Resident 38's medication was not listed on the form, and information directing to see a cardiologist was not listed. On 12/8/25 at 10:45 A.M., the Interim Director of Nursing (DON) indicated that when a resident is discharged , a discharge summary sheet should have been completed in the clinical record. A copy of the sheet, along with any follow-up appointments and a medication sheet, should have been provided to the resident.On 12/9/25 at 11:55 A.M., Registered Nurse (RN) 3 indicated that if a resident had a long list of medications, staff would print it and send it with the discharged resident. She indicated that since Resident 38 was only taking one medication, her sheet was probably not printed and provided. On 12/10/25 at 12:16 P.M., the Social Services Director (SSD) indicated when Resident 38 was discharged , she was informed to follow up with the primary care physician, but no other specialties. On 12/10/25 at 1:30 P.M., a discharge policy was requested and not provided. 3.1-12(a)(21)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) Assessment was completed for 3 of 12 residents reviewed for MDS Assessments. Residents taking anticonvulsant medications, antianxiety, and hypoglycemic medications were not marked as administered. (Resident 3, Resident 8, Resident 2)Findings include:1. On 12/4/25 at 12:59 P.M., Resident 2's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/28/25, indicated no cognitive impairment and no use of a hypoglycemic medication. Current physician orders included, but were not limited to: Jardiance (a hypoglycemic) oral tablet, one daily, related to diabetes mellitus, dated 9/23/25. Humalog (insulin), inject 12 units with meals related to diabetes mellitus, dated 6/10/25. Tresiba FlexTouch (insulin) 50 units once daily related to diabetes mellitus, dated 6/4/25. Resident 2's medication administration record (MAR) indicated that during the MDS look-back period, Jardiance, Humalog, and Triseba FlexTouch were administered. 2. On 12/5/2025 at 11:17 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but was not limited to, diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 11/5/25, indicated Resident 3 received insulin for 7 of 7 days on the look-back period, and lacked documentation that Resident 3 received an anticonvulsant. The most recent Quarterly MDS, dated [DATE], indicated Resident 3 received insulin for 7 days of the look-back period. Resident 3's clinical record lacked a current order for insulin. Current Physician's Orders included, but were not limited to, Gabapentin (anticonvulsant) 400 milligrams (mg), one tablet three times a day by mouth. A review of the October and November Medication Administration Record (MAR) indicated Resident 3 received Gabapentin 5 of 7 days on the look-back period. The MDS lacked documentation that Resident 3 received an anticonvulsant. During an interview on 12/10/25 at 10:50 A.M., the Director of Nursing (DON) indicated Resident 3's insulin was coded in error, and Gabapentin should have been coded as an anticonvulsant. 3. On 12/5/25 at 1:54 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but was not limited to, paranoid schizophrenia, diabetes mellitus, and bipolar disorder. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 10/8/25, indicated Resident 8 received an antidepressant. The MDS lacked documentation that Resident 8 received an anticonvulsant and an antianxiety medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 8's clinical record lacked a current order for an antidepressant. Current Physician's Orders included, but were not limited to, Gabapentin (anticonvulsant) 300 milligrams (mg) three times a day by mouth and buspirone (antianxiety) 15 mg three times a day by mouth. A review of the October MAR indicated Resident 8 received Gabapentin and buspirone 7 out of 7 days on the look-back period. The MDS lacked documentation that Resident 8 received an anticonvulsant. During an interview on 12/10/25 at 10:50 A.M., the DON indicated the antidepressant was coded in error and buspirone should have been coded as an antianxiety medication. She further indicated that Gabapentin should have been coded as an anticonvulsant. On 12/10/25 at 10:45 A.M., the Director of Nursing (DON) indicated Resident 2's MDS should have been marked with a hypoglycemic. She further indicated that, in lieu of a policy, the facility used the Resident Assessment Instrument (RAI) was used for MDS accuracy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the appropriate care and services for a suprapubic catheter were given for 1 of 2 residents reviewed for catheter care. Staff was not measuring output and not cleaning the insertion site of a resident with a suprapubic catheter. (Resident 7)Finding includes: During an interview on 12/1/25 at 2:17 P.M., Resident 7's wife indicated the doctor did not want the facility to change his catheter, he wanted to do it in his office. She was not sure what care the staff performed with the catheter. During an observation on 12/4/25 at 10:05 A.M., Resident 7's catheter bag and tubing were dragging on the hallway on floor while he was walking from his room to nurse's station, Qualified Medication Aide (QMA) 55 picked it up and hung it back on his pant's pocket. On 12/4/25 at 10:45 A.M., Resident 7's catheter site was observed in his room with small amount of yellow drainage, slight redness/irritation, no odor, and brownish crust around it. There was no signage for Enhanced Barrier Precautions (EBP) observed. On 12/5/25 at 1:17 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, Parkinson's disease, hypertension, and cancer of kidney and prostate. Resident 7 was admitted [DATE] with a suprapubic catheter. The most recent admission MDS assessment, dated 9/15/25, indicated the resident's cognition was severely impaired, he took a diuretic, had an indwelling catheter, and was a substantial/maximum assist of staff (staff perform over half the effort) for toileting. Current Physician's Orders, included, but were not limited to, the following:Document SP catheter output every shift, ordered 9/10/25Maintain suprapubic (SP) catheter per Medical Doctor (MD) orders/facility policy, ordered 9/18/25The Physician's Orders lacked an order for EBP to be used with catheter care. A current Indwelling Catheter Care Plan, last revised 9/15/25, included the following interventions:maintain catheter per MD ordersmonitor and document intake and output as per facility policyMonitor/record/report to MD for signs/symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The Treatment Administration Record (TAR) and electronic health record was reviewed from 11/1/25-12/5/25 and indicated the catheter was to be emptied daily for day and night shift, but there was not an amount of urine documented. The record also lacked care being done for the catheter.On 12/9/25 at12:35 P.M., Registered Nurse 3 indicated his wife changed his catheter bag from drainage to leg bag when she was there and has been educated on it. He has had UTIs in the past and he is uncircumcised, so the Certified Nurse Aides (CNAs) needed educated on how to pull the foreskin back and clean it. Catheter care should be done every day, nurses do the care and CNA's should drain the catheter bag to get the output measurement. I don't know if it was documented that it was cleaned every day but it was imperative that they do that. The only precaution used was gloves because it was contained. She indicated the in-services for catheter care had been by a handout or done by CNA 4. She was unsure when the last one was.On 12/10/25 at 10:32 A.M., the Director of Nursing (DON) indicated the orders were not put in to the electronic health record correctly because there should be a measurement of how much urine was emptied each shift to watch for renal failure, etc. Also for the care of the catheter, there should be an order to document when it was done every time.On 12/10/25 at 8:33 A.M., a current non dated Catheter Care Policy was provided by the Administrator and indicated, . Do not allow the catheter bag to touch the floor. Catheters should be emptied every shift. Avoid contact with the side of the collection container when emptying urine. Record the amount of urine output on the CNA documentation tool. Report the amount of urine output to the charge nurse. Also report any unusual findings such as blood in the urine. 3.1-41(a)(2)

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on interview and record review, the facility failed to receive registry verification before filling the role of a Certified Nurse Aide (CNA) for 1 of 5 CNA licenses reviewed. An employee was working as a CNA without the facility verifying registration. (CNA 24)Finding includes:On 12/8/25 at 1:00 P.M., the employee records were reviewed. There was not a license found on CNA 24. She was hired 8/28/24 and her 120 days would have been up 12/26/24.During an interview on 12/9/25 at 9:50 A.M., the Administrator provided a certificate of completion for the 105 hour nurse aide training from the Indiana State Department of Health and said that was what was provided to them. She wanted to double check with the employee to see if she was under a different name because she was working as a CNA in the facility.During a 12/9/25 at 2:45 P.M., the Administrator indicated she was not aware that CNA 24 was not licensed. The license was not verified upon hire. She usually worked eight hours on night shift and had 35 shifts working alone as a CNA since September of 2025.On 12/10/25 at 8:31 A.M., a current non dated CNA job description was provided by the Administrator and indicated, . Must possess a current CNA license within the state of Indiana . 3.1-14(e)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure person-centered dementia treatment and services were provided for 1 of 2 residents reviewed for dementia care. (Resident 7)Finding includes:During an observation on 12/3/25 at 9:30 A.M., Resident 7 was sitting by the front door asking to play Connect Four. Staff told the resident his wife would be here soon to play. During an observation on 12/4/25 at 10:09 A.M., Resident 7 came out of room and asked the nurse when his wife would be here. She indicated Anytime. Why don't you wait in your room for her.On 12/5/25 at 1:17 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, Parkinson's disease, hypertension, and cancer of kidney and prostate. Resident 7 was admitted [DATE].The most recent admission MDS assessment, dated 9/15/25, indicated the resident's cognition was severely impaired.The clinical record lacked an activities care plan about likes, dislikes, and preferences.During an interview on 12/4/25 at 10:19 A.M., Resident 7's wife indicated she was here during most days and kept him entertained because there was not much for him to do. She indicated the resident didn't do much with the community because of his dementia. The activities leader would bring him word searches but he wasn't able to do that. During an interview on 12/9/25 at 9:40 A.M., the Activity Director indicated for dementia care, she did one on one visits and more one or two step activities because if not, it might confuse them. Usually a lot of reminding and cueing them on how to do things. He liked walking, loved food, and had an obsession with ice cream. He liked playing Connect Four and checkers. He was family oriented. He wanted to know when his wife was coming in and had to remind him every 30 to 60 seconds. Sometimes he would participate in exercise and devotions but with his dementia, other residents got upset or aggravated because he repeated himself. She indicated that she was the only one that took residents to their appointments so her time was limited.On 12/10/25 at 9:31 A.M., a current non dated Dementia Care Policy was provided by the Administrator and indicated, . The IDT [Interdisciplinary Team] will identify a resident-centered care plan to maximize function and quality of life . will support the resident in initiating and completing activities and tasks of daily living and therapeutic and recreational activities . The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors . 3.1-37(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 2 residents reviewed for urinary tract infections (UTI). A resident was given medications that caused severe sedation when taken together resulting in unresponsiveness and a subsequent hospitalization. (Resident 6)Finding includes:On 12/5/25 at 9:40 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, paraplegia, polyneuropathy, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 9/25/25, indicated a moderate cognitive impairment, no behaviors, and use of an indwelling urinary catheter. Resident 6 was dependent on staff for toileting and bathing. Physician orders included, but were not limited to:Cipro (an antibiotic) oral tablet 500mg (milligrams), give 2 tablets a day, started 11/17/25 and ended 11/21/25. tizanidine 2mg three times a day for muscle spasm, give with 4mg tablet totaling 6mg, dated 5/5/25 and current. tizanidine 4mg three times a day for muscle spasm, give with 2mg tablet totaling 6mg, dated 7/12/25 and current. Current care plans included, but were not limited to:Risk for side effects related to antibiotic therapy, initiated and revised 12/3/25, that indicated to administer antibiotic medications as ordered by the physician, monitor/document side effects and effectiveness, monitor/document report adverse reactions, and report pertinent lab results to the physician. A urinalysis, dated 11/11/25, indicated a UTI. Culture and sensitivity was indicated. A culture and sensitivity report, dated 11/14/25, indicated the following two organisms:morganella morganii ssp morganii (resistant to Cipro). pseudomonas aerugirosa (sensitive to Cipro). Resident 6's November 2025 medication administration record (MAR) indicated Cipro was given as ordered from 11/17/25 through 11/21/25. Tizanidine was given once on 11/17/25, three times a day from 11/18/25 through 11/20/25, and once on 11/21/25. An order note, dated 11/17/25, for Cipro indicated a severe drug to drug interaction with tizanidine. The note indicated Cipro was contraindicated with tizanidine due to the risk of hypotension and dizziness. (The National Institute of Health warned against the use of Cipro with tizanidine as it may cause excessive sedation) Resident 6's clinical record lacked documented communication with the physician related to the new order of Cipro and the interaction risk with tizanidine. Resident 6's clinical record lacked documented communication or a review from the pharmacy that provided the Cipro related to the new order of Cipro and the interaction risk with tizanidine. A nurse's note, dated 11/21/25, indicated Resident 6 was found in his room unresponsive. The resident did not respond to verbal stimuli, and was only awoken by use of three sternal rubs. Hospital emergency room (ER) notes, dated 11/21/25, indicated Resident 6 presented with a change in mental status related to a loss of consciousness. In the ER, the resident indicated he felt as if he could not stay awake and was confused. The final impression was ureteral stone with hydronephrosis (kidney stones) and an acute urinary tract infection. On 12/9/25 at 11:55 A.M., Registered Nurse (RN) 3 indicated she was the nurse on duty on 11/21/25 and was with Resident 6 when he was found unresponsive. She indicated she performed three sternal rubs and on the last one, the resident woke up and was confused and drowsy. She indicated he was very lethargic, but prior to the event he had been awake and had just taken his medications. She indicated he had not started any new medications that she could recall. On 12/10/25 at 10:45 A.M., the Interim Director of Nursing (DON) indicated if there was a contraindication to a new medication order, a box would pop up with the information that should be addressed. The nurse should then take that information back to the physician. Communication with the physician would be documented in the progress notes. The nurse then would sign off that the information was read, generating an order note in the progress notes. She further indicated a concern with the pharmacy as they did not alert the facility to the interaction between Resident 6's tizanidine and Cipro, as well as a concern with the nursing staff and physician reviews of the new order. She indicated Resident 6's sedation could have been a combination of giving an antibiotic that was resistant to one of the organisms found, as well as giving Cipro when the resident was taking (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tizanidine. On 12/10/25 at 8:45 A.M., the Administrator provided a current non-dated Medication Administration policy that indicated Medications are administered as prescribed in accordance with good nursing principles and practices . Personnel authorized to administer medications do so only after they have familiarized themselves with the medication 3.1-48(c)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure accurate documentation for 3 of 6 residents reviewed for unnecessary medications. Resident's Medication Administration Record (MAR) lacked documentation of medications and treatments that were received. (Resident 3, Resident 7, Resident 23)Findings include:1. On 12/5/2025 at 11:17 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but was not limited to, diabetes mellitus, hypertension (high blood pressure), hyperlipidemia (high cholesterol), and stroke. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 11/5/25 indicated Resident 3 had severe cognitive impairment. Current Physician's Orders included, but were not limited to the following: Baclofen tablet 10 milligrams (mg), 1 tablet by mouth 1 time a day for muscle spasms. Baclofen tablet 20 mg, 1 tablet by mouth in the evening for muscle spasms. Oxybutynin Chloride extended-release tablet 5 mg, 1 tablet by mouth in the evening for neuromuscular dysfunction of the bladder. Oxybutynin Chloride 10 mg tablet, 1 tablet by mouth one time a day for neuromuscular dysfunction of the bladder. Ropinirole Hydrochloride tablet 0.25 mg , 1 tablet by mouth in the evening related to restless leg syndrome. Xarelto Oral tablet 10 mg, 1 tablet by mouth 1 time a day related to cerebral infarction (stroke). metformin tablet 850 mg, 1 tablet by mouth 2 times a day related to diabetes mellitus. Protein Oral Liquid, 30 milliliters (ml) by mouth 2 times a day for wound healing. Gabapentin tablet 400 mg, 1 tablet by mouth 3 times a day for polyneuropathies. Atorvastatin Calcium tablet 20 mg, 1 tablet by mouth at bedtime related for hyperlipidemia (high cholesterol). Lisinopril tablet 10 mg, 1 tablet by mouth 1 time a day for hypertension (high blood pressure). Vraylar capsule 6 mg, give 6 mg by mouth 1 time a day for bipolar type schizoaffective disorder. Benztropine Mesylate tablet 0.5 mg, 1 tablet by mouth 2 times a day for muscle spasms. Carvedilol tablet 6.25 mg, give 1 tablet by mouth 2 times a day for hypertension (high blood pressure). Clonazepam Oral tablet 0.5 mg, give 0.25 mg by mouth 2 times a day for mood disorder. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Duloxetine capsule delayed release particles 60 mg, give 60 mg by mouth 2 times a day related to bipolar type schizoaffective disorder. Hydroxyzine tablet 50 mg, give 1 tablet by mouth 2 times a day related for mood disorder. Refresh Optive Ophthalmic Solution 0.50-9 % , place 1 drop in both eyes 2 times a day for bilateral dry eye syndrome. Oxycodone-Acetaminophen tablet 7.5-325 mg, give 1 tablet by mouth 3 times a day for polyneuropathies. A review of Resident 3's Medication Administration Record (MAR) for October and November indicated she missed these medication on the following dates and time: Baclofen tablet 20 mg: October 21—6:00 P.M. October 28—6:00 P.M. November 1—6:00 P.M. November 2—6:00 P.M. November 7—6:00 P.M. November 15—6:00 P.M. November 16—6:00 P.M. November 24—6:00 P.M. Oxybutynin Chloride extended-release 5 mg tablet: October 21—6:00 P.M. Ropinirole Hydrochloride 0.25 mg tablet: October 21—6:00 P.M. October 28—6:00 P.M. November 1—6:00 P.M. November 2—6:00 P.M. November 7—6:00 P.M. November 15—6:00 P.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November 16—6:00 P.M. November 24—6:00 P.M. Xarelto Oral 10 mg tablet: October 21—5:30 P.M. October 28—5:30 P.M. November 1—5:30 P.M. November 2—5:30 P.M. November 15—5:30 P.M. November 16—5:30 P.M. November 24—5:30 P.M. Metformin 850 mg tablet: October 21—4:00 P.M. October 28—4:00 P.M. November 1—8:00 A.M. November 1—4:00 P.M. November 2—8:00 A.M. November 2—4:00 P.M. November 7—4:00 P.M. November 15—8:00 A.M. November 15—4:00 P.M. November 16—8:00 A.M. November 16—4:00 P.M. November 24—4:00 P.M. Protein Oral Liquid (Protein) 30 mls: October 21—4:00 P.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October 28—4:00 P.M. November 1—8:00 A.M. November 1—4:00 P.M. November 2—8:00 A.M. November 2—4:00 P.M. November 7—4:00 P.M. November 15—8:00 A.M. November 15—4:00 P.M. November 16—8:00 A.M. November 16—4:00 P.M. November 24—4:00 P.M. Gabapentin tablet 400 mg: October 21—4:00 P.M. October 28—4:00 P.M. November 1—9:00 A.M. November 1—4:00 P.M. November 1—7:00 P.M. November 2—9:00 A.M. November 2—4:00 P.M. November 2—7:00 P.M. November 15—9:00 A.M. November 15—4:00 P.M. November 16—9:00 A.M. November 16—4:00 P.M. November 24—4:00 P.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Atorvastatin Calcium 20 mg tablet: November 1—7:00 P.M. November 2—7:00 P.M. Baclofen tablet 10 mg tablet: November 1—8:00 A.M. November 2—8:00 A.M. November 15—8:00 A.M. Novmeber 16—8:00 A.M. Lisinopril 10 mg tablet: November 1—8:00 A.M. November 2—8:00 A.M. November 15—8:00 A.M. November 16—8:00 A.M. Oxybutynin Chloride 10 mg tablet: November 1—8:00 A.M. November 2—8:00 A.M. November 15—8:00 A.M. November 16—8:00 A.M. Vraylar 6 mg capsule: November 1—8:00 A.M. November 2—8:00 A.M. November 15—8:00 A.M. November 16—8:00 A.M. Benztropine Mesylate 0.5 mg tablet: November 1—8:00 A.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November 1—7:00 P.M. November 2—8:00 A.M. November 2—7:00 P.M. November 15—8:00 A.M. November 16—8:00 A.M. Carvedilol 6.25 mg tablet: November 1—8:00 A.M. November 1—7:00 P.M. November 2—8:00 A.M. November 2—7:00 P.M. November 15—8:00 A.M. November 16—8:00 A.M. Clonazepam Oral 0.5 mg tablet, give 0.25mg: November 1—8:00 A.M. November 1—7:00 P.M. November 2—8:00 A.M. November 2—7:00 P.M. November 15—8:00 A.M. November 16—8:00 A.M. Duloxetine 60 mg capsule: November 1—8:00 A.M. November 1—7:00 P.M. November 2—8:00 A.M. November 2—7:00 P.M. November 15—8:00 A.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November 16—8:00 A.M. Hydroxyzine 50 mg tablet: November 1—8:00 A.M. November 1—7:00 P.M. November 2—8:00 A.M. November 2—7:00 P.M. November 15—8:00 A.M. November 16—8:00 A.M. Refresh Optive Ophthalmic Solution 0.50-9%: November 1—8:00 A.M. November 1—7:00 P.M. November 2—8:00 A.M. November 2—7:00 P.M. November 15—8:00 A.M. November 16—8:00 A.M. Oxycodone-Acetaminophen 7.5-325 mg tablet: November 1—8:00 A.M. November 1—2:00 P.M. November 1—7:00 P.M. November 2—8:00 A.M. November 2—2:00 P.M. November 2—7:00 P.M. November 15—8:00 A.M. November 15—2:00 P.M. November 16—8:00 A.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November 16—2:00 P.M. November 21—2:00 P.M. 2. On 12/5/25 at 1:17 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, Parkinson's disease, hypertension, and cancer of kidney and prostate. Resident 7 was admitted [DATE] with a suprapubic catheter. The most recent admission MDS assessment, dated 9/15/25, indicated the resident's cognition was severely impaired and had an indwelling catheter. Physician's Orders included, but were not limited to, the following: Document SP catheter output every shift Amlodipine besylate 5 mg tablet, give 5 mg by mouth one time a day for hypertension (high blood pressure) Donepezil hydrochloride 5 mg tablet, give 5 mg by mouth one time a day related to paranoid personality disorder Escitalopram Oxalate 10 mg tablet, give 10 mg by mouth one time a day related to paranoid personality disorder Folic Acid 1 mg tablet, give 1 mg by mouth one time a day related to weakness Furosemide 40 mg tablet, give 40 mg by mouth one time a day related to hypertension Lactobacillus Capsule, give 1 capsule by mouth in the morning for probiotic Thiamine HCl 100 mg, give 100 mg by mouth one time a day for vitamin Augmentin 875-125 mg, give 1 tablet by mouth two times a day for toe infection Medroxyprogesterone Acetate 5 mg tablet, give 2 tablets by mouth three times a day related to other sexual disorders Oxcarbazepine 150 mg tablet, give 150 mg by mouth three times a day for seizures related to unspecified dementia disorder with behaviors Benztropine Mesylate 0.5 mg tablet, give 0.5 mg by mouth two times a day for Parkinson's Cephalexin 250 mg tablet, give 250 mg by mouth three times a day for infection of right great toe Estradiol Transdermal 0.1 MG/24 HR (hour) patch, apply 1 patch transdermally weekly every Monday for hormone replacement Potassium Chloride Extended Release (ER) 20 Milliequivalent (mEq) tablet, give 20 mEq by mouth in the morning related to hypokalemia (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bactrim DS 800-160 mg tablet, give 1 tablet by mouth two times a day for urinary tract infection Buspirone HCl 7.5 mg tablet, give 1 tablet by mouth two times a day related to anxiety disorder Memantine HCl 5 mg tablet, give 5 mg by mouth two times a day related to unspecified dementia disorder with behaviors Metoprolol Tartrate 50 mg tablet, give 50 mg by mouth two times a day related to hypertension The September 2025 MAR/TAR included the following missing medications and treatments: 9/8/25 2:00 P.M., dose of Medroxyprogesterone Acetate 9/9/25 at 5:00 P.M., dose of Oxcarbazepine 9/18/25 day shift suprapubic (SP) catheter output 9/18/25 at 5:00 P.M., dose of Oxcarbazepine 9/28/25 day shift SP catheter output 9/28/25 9:00 A.M., doses of Amlodipine, Donazapril, escitalopram, folic acid, Furosemide, Lactobacillus, thiamine, Augmentin, Medroxyprogesterone Acetate, Oxcarbazepine 9/28/25 at 1:00 P.M., dose of Oxcarbazepine 9/28/25 2:00 P.M., dose of Medroxyprogesterone Acetate 9/28/25 at 5:00 P.M., dose of Oxcarbazepine The October 2025 MAR/TAR included the following missing medications and treatments: 10/14/25 day shift SP catheter output 10/21/25 day shift SP catheter output 10/21/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 10/24/25 day shift SP catheter output 10/27/25 day shift SP catheter output 10/28/25 day shift SP catheter output 10/28/25 at 5:00 P.M., dose of Benztropine Mesylate, Cephalexin, Oxcarbazepine The November 2025 MAR/TAR included the following missing medications and treatments: 11/1/25 day shift SP catheter output (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/1/25 at 9:00 A.M., dose of Amlodipine, Donepezil Hydrochloride, Escitalopram Oxalate, Folic Acid, Furosemide, lactobacillus, Potassium Chloride, Thiamine, Benztropine Mesylate, Buspirone HCl, Memantine HCl, Metoprolol Tartrate, Medroxyprogesterone Acetate 11/1/25 at 1:00 P.M., dose of Oxcarbazepine 11/1/25 at 2:00 P.M., dose of Medroxyprogesterone Acetate 11/1/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 11/2/25 day shift SP catheter output 11/2/25 at 9:00 A.M., dose of Amlodipine, Donepezil Hydrochloride, Escitalopram Oxalate, Folic Acid, Furosemide, lactobacillus, Potassium Chloride, Thiamine, Benztropine Mesylate, Buspirone HCl, Memantine HCl, Metoprolol Tartrate, Medroxyprogesterone Acetate 11/2/25 at 1:00 P.M., dose of Oxcarbazepine 11/2/25 at 2:00 P.M., dose of Medroxyprogesterone Acetate 11/2/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 11/7/25 day shift SP catheter output 11/7/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 11/15/25 day shift SP catheter output 11/15/25 at 1:00 P.M., dose of Oxcarbazepine 11/15/25 at 2:00 P.M., dose of Medroxyprogesterone Acetate 11/15/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 11/16/25 day shift SP catheter output 11/16/25 at 9:00 A.M., dose of Amlodipine, Escitalopram Oxalate, Folic Acid, Furosemide, lactobacillus, Potassium Chloride, Medroxyprogesterone Acetate, Thiamine, Bactrim DS, Benztropine Mesylate, Buspirone HCl, Memantine HCl, Metoprolol Tartrate, Medroxyprogesterone Acetate 11/16/25 at 1:00 P.M., dose of Oxcarbazepine 11/16/25 at 2:00 P.M., dose of Medroxyprogesterone Acetate 11/16/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 11/17/25 day shift SP catheter output 11/17/25 at 9:00 A.M., dose of Amlodipine, Escitalopram Oxalate, Folic Acid, Estradiol Transdermal (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patch Weekly, Furosemide, lactobacillus, Potassium Chloride, Medroxyprogesterone Acetate, Thiamine, Bactrim DS, Benztropine Mesylate, Buspirone HCl, Memantine HCl, Metoprolol Tartrate, Medroxyprogesterone Acetate 11/17/25 at 1:00 P.M., dose of Oxcarbazepine 11/17/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 11/21/25 at 1:00 P.M., dose of Oxcarbazepine 11/21/25 at 2:00 P.M., dose of Medroxyprogesterone Acetate 11/21/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 11/24/25 at 9:00 A.M., dose of Estradiol Transdermal Patch Weekly 11/27/25 day shift SP catheter output The December 1-4, 2025 MAR/TAR included the following missing medications and treatments: 12/3/25 at 5:00 P.M., dose of Benztropine Mesylate, Oxcarbazepine 12/3/25 day shift SP catheter output 12/4/25 day shift SP catheter output 3. On 12/4/25 at 1:00 P.M., Resident 23's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors, anxiety, and hypertension. Resident 23 was admitted on [DATE]. The most recent admission Minimum Data Set (MDS) assessment, dated 9/15/25, indicated Resident 23's cognition was severely impaired, supervision for transfers, and on an antipsychotic. Current Physician's Orders included, but were not limited to, the following: Depakote Delayed Release 125 mg tablet, give 125 mg by mouth two times a day related to unspecified dementia, without behaviors and anxiety Risperidone 0.5 mg tablet, give 0.5 mg by mouth two times a day related to unspecified dementia, without behaviors and anxiety Vitamin D3 125 micrograms (mcg) tablet, give 1 capsule by mouth in the morning for vitamin Donepezil HCl 10 mg tablet, give 10 mg by mouth in the morning for dementia Lisinopril 10 mg tablet, give 1 tablet by mouth one time a day for hypertension Multivitamin Women tablet, give 1 tablet by mouth in the morning for vit deficiency (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The October 2025 MAR included the following missing medications: 10/21/25 at 5:00 P.M., dose of Depakote, Risperidone 10/28/25 at 5:00 P.M., dose of Depakote, Risperidone The November 2025 MAR included the following missing medications: 11/1/25 at 8:00 A.M., dose of vitamin D3, Donepezil HCl, Multivitamin Women, Depakote, risperidone 11/1/25 at 5:00 P.M., dose of Depakote, risperidone 11/2/25 at 8:00 A.M., dose of vitamin D3, Donepezil HCl, Multivitamin Women, Depakote, risperidone 11/2/25 at 5:00 P.M., dose of Depakote, risperidone 11/7/25 at 5:00 P.M., dose of Depakote, risperidone 11/15/25 at 8:00 A.M., dose of vitamin D3, Donepezil HCl, Lisinopril, Multivitamin Women, Depakote, risperidone 11/15/25 at 5:00 P.M., dose of Depakote, risperidone 11/16/25 at 8:00 A.M., dose of vitamin D3, Donepezil HCl, Lisinopril, Multivitamin Women, Depakote, risperidone 11/16/25 at 5:00 P.M., dose of Depakote, risperidone 11/17/25 at 8:00 A.M., dose of vitamin D3, Donepezil HCl, Lisinopril, Multivitamin Women, Depakote, risperidone 11/17/25 at 5:00 P.M., dose of Depakote, risperidone 11/24/25 at 5:00 P.M., dose of Depakote, risperidone 11/29/25 at 5:00 P.M., dose of Depakote, risperidone On 12/9/25 at12:35 P.M., Registered Nurse 3 indicated the medications and treatments were probably completed but staff probably forgot to document that in the MAR/TAR. They should be documented each time they were given. On 12/10/25 at 10:32 A.M., the Director of Nursing (DON) indicated the staff were absolutely supposed to keep accurate documentation of medications and treatments given. They should all be documented in the MAR/TAR when completed. On 12/10/25 at 8:41 A.M., a current non dated Documentation Policy was provided by the Administrator and indicated, All services provided to the resident . shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . Documentation in the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record will be objective (not opinionated or speculative), complete, and accurate. 3.1-50(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Residents were not placed on Enhanced Barrier Precautions (EBP) when indicated for 1 of 1 resident reviewed for catheter care. (Resident 6)Findings include: On 12/4/25 at 10:45 A.M., Resident 7's catheter site was observed in his room with small amount of yellow drainage, slight redness/irritation, no odor, and brownish crust around it. There was no signage for Enhanced Barrier Precautions (EBP) observed.On 12/5/25 at 1:17 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, Parkinson's disease, hypertension, and cancer of kidney and prostate. Resident 7 was admitted [DATE] with a suprapubic catheter.The most recent admission MDS assessment, dated 9/15/25, indicated the resident's cognition was severely impaired, he took a diuretic, had an indwelling catheter, and was a substantial/maximum assist of staff (staff perform over half the effort) for toileting.Current Physician's Orders, included, but were not limited to, the following:Document SP catheter output every shift, ordered 9/10/25Maintain suprapubic (SP) catheter per Medical Doctor (MD) orders/facility policy, ordered 9/18/25The Physician's Orders lacked an order for EBP to be used with catheter care.A current Indwelling Catheter Care Plan, last revised 9/15/25, included the following interventions:maintain catheter per MD ordersmonitor and document intake and output as per facility policyMonitor/record/report to MD for signs/symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.On 12/9/25 at12:35 P.M., Registered Nurse 3 indicated his wife changed his catheter bag from drainage to leg bag when she was there and has been educated on it. He has had UTIs in the past and he is uncircumcised, so the Certified Nurse Aides (CNAs) needed educated on how to pull the foreskin back and clean it. Catheter care should be done every day, nurses do the care and CNA's should drain the catheter bag to get the output measurement. I don't know if it was documented that it was cleaned every day but it was imperative that they do that. The only precaution used was gloves because it was contained. She indicated the in-services for catheter care had been by a handout or done by CNA 4. She was unsure when the last one was.On 12/10/25 at 10:32 A.M., the Director of Nursing (DON) indicated the orders were not put in to the electronic health record correctly because there should be a measurement of how much urine was emptied each shift to watch for renal failure, etc. Also for the care of the catheter, there should be an order to document when it was done every time.On 12/10/25 at 11:33 A.M., a current non dated EBP Policy was provided by the Administrator and indicated, . This policy seeks to prevent the spread of MDROs [mulit-drug resistant organisms] among residents and staff members by expanding the use of personal protective equipment (PPE) during high contact resident care. Residents in skilled nursing facilities are particularly vulnerable to colonization and infection with MDROs, which can lead to limited treatment options and adverse health outcomes. EBP are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP expands upon standard precautions by requiring the use of gowns and gloves during specific high contact resident care activities for residents known to be colonized or infected with an MDRO as well as those at increased risk of MDRO acquisition (residents with wounds or indwelling medical devices). High contact resident care activities are activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated.3.1-18(b)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an antibiotic stewardship program was used to monitor appropriate use of antibiotics for 2 of 2 residents reviewed for antibiotic use. Resident antibiotic orders were not followed. (Resident 6, Resident 7)Findings include: 1. On 12/5/25 at 9:40 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, paraplegia, polyneuropathy, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 9/25/25, indicated a moderate cognitive impairment, no behaviors, and use of an indwelling urinary catheter. Resident 6 was dependent on staff for toileting and bathing. Physician orders included, but were not limited to: Cipro (an antibiotic) oral tablet 500mg (milligrams), give 2 tablets a day, started 11/17/25 and ended 11/21/25 (resident was admitted to the hospital on [DATE]). Macrobid (an antibiotic) oral capsule (nitrofurantoin monohyd macro), give 100mg twice a day, started 11/17/25 and ended 11/23/25. Macrobid (an antibiotic) oral capsule (nitrofurantoin monohyd macro), give 100mg twice a day for 7 days, started 11/24/25 and current. nitrofurantoin macrocrystal oral capsule, give 100mg twice a day, started 11/24/25 and current. Current care plans included, but were not limited to: Risk for side effects related to antibiotic therapy, initiated and revised 12/3/25, that indicated to administer antibiotic medications as ordered by the physician, monitor/document side effects and effectiveness, monitor/document report adverse reactions, and report pertinent lab results to the physician. A urinalysis, dated 11/11/25, indicated a UTI. Culture and sensitivity was indicated. A culture and sensitivity report, dated 11/14/25, indicated the following two organisms: morganella morganii ssp morganii (resistant to Cipro and Macrobid). pseudomonas aerugirosa (sensitive to Cipro and Macrobid was not listed). Resident 6's medication administration record (MAR) indicated the Macrobid that was ordered for 7 days was currently on day 12 of being given. On 12/10/25 at 10:45 A.M., the Director of Nursing (DON) indicated all new antibiotic orders should be checked by the nurse taking the order as well as the pharmacy when filled. Antibiotic usage was then monitored by the Infection Preventionist (IP). She indicated she was unsure why the Cipro had been ordered as it was resistant to one of the two organisms from Resident 6's culture report. She (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated it should have been questioned. She further indicated since the order for Macrobid and the order for nitrofurantoin were entered on the same day, the nurse that entered the nitrofurantoin probably did not realize it was the generic form of Macrobid and put in a duplicate order. 2. On 12/5/25 at 1:17 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, cancer of kidney and prostate, and hypertension. The most recent admission MDS assessment, dated 9/15/25, indicated Resident 7's cognition was severely impaired, was supervision of staff for transfers and eating, and substantial to maximum assist of staff (staff performs over half the effort) for toileting and showering, and had an indwelling catheter. Physician's Orders included, but were not limited to, the following: cephalexin 250 mg, give 1 tablet by mouth three times daily for 7 days for cellulitis of right great toe, ordered 10/20/25 Cipro 500 mg, give 1 tablet by mouth twice daily for 5 days for UTI, ordered 11/13/25 The October and November 2025 MAR were reviewed for the cephalexin antibiotic and indicated the resident did not receive his first dose until 10/22/25 (two days later) at 9:00 A.M. He received his first 20 doses, missed a dose on 10/28/25 at 5:00 P.M., got 9 more doses, then skipped 2 days of 3 doses on 11/1/25 and 11/2/25, then got 5 more doses. He should have received a total of 21 doses ordered and got 34 total doses. The November 2025 MAR indicated the resident received 9 doses of Cipro 500 mg instead of 10 doses ordered. During an interview on 12/10/25 at 12:32 A.M., the DON indicated the cephalexin should have been started on 10/20/25 as ordered. The nurse should have gotten it from the emergency medication pyxis. She was not sure why he got too many doses of that and not enough of the Cipro other then the order was entered into the electronic health record incorrectly and no one paid attention. They should have been given them as ordered. On 12/4/25 at 11:56 A.M., a current Antibiotic Stewardship Policy, revised 8/1/25 was provided by the Administrator and indicated, . Registered Nurse (RN) 3 was appointed to oversee the monitoring and tracking of infections and antibiotic [sic] that occurs within the facility . [facility name] is committed to combating antibiotic-resistant bacteria through antibiotic stewardship. We understand the importance and expectations for this program and how it will help to enhance patient safety and promote better care in our facility . We commit to ensure that antibiotics are being prescribed appropriately with the right dose and duration . 3.1-18(b)

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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 was posted on a daily basis at the beginning of each shift for 3 of 6 days reviewed for the survey. The Posted Nurse Staffing form was not updated on a daily basis. (12/4/25, 12/5/25, 12/8/25)Findings include:On 12/4/25 at 10:01 A.M., the Posted Nurse Staffing form was observed dated 12/3/25. On 12/5/25 at 9:09 A.M., the Posted Nurse Staffing form was observed dated 12/4/25. On 12/8/25 at 9:06 A.M., the Posted Nurse Staffing form was observed dated 12/5/25.During an interview on 12/10/25 at 12:00 A.M., the Administrator indicated she was in charge of posting the form with the correct date each day first thing in the morning. It should be up to date.On 12/9/25 at 4:02 P.M., a current non dated Posted Nurse Staffing Policy was provided by the Administrator and indicated, It is the policy of [facility name] to keep the daily staffing schedule posted at the back hall. This schedule will be visible at all times for all staff to view. This schedule will be updated by the DON [Director of Nursing], ADON [Assistant Director of Nursing], or designee.