STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155719	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
George Ade Memorial Health Care Center	3623 East State Rd 16 Brook, IN 47922

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident received care in accordance with professional standards of practice related to a lack of assessments with changes in condition after a fall including pain, weight bearing, and ambulation status which delayed treatment for a fractured right hip for 1 of 3 residents reviewed for quality of care. (Resident D)Finding includes:Resident D's record was reviewed on 11/12/25 at 1:18 p.m. The diagnoses included, but were not limited to, right hip fracture, Alzheimer's disease, dementia, and moderate intellectual disabilities.A Quarterly Minimum Data Set assessment, dated 10/21/25, indicated a severely impaired cognitive status, physical behaviors and rejection of care were present for one to three days and verbal behaviors were present for four to six days. There was no impairment of the upper and lower extremities. Supervision was required for dressing and hygiene. Bathing had been refused. He was independent for bed mobility, sitting to standing, transfer and ambulation.A Nurse's Progress Note, dated 10/23/25 at 6 a.m. and recorded as a late entry on 10/23/25 at 6:51 a.m., indicated the resident had fallen in the shower while he attempted to get out of the shower chair. A laceration above the right eye, four centimeters (cm) by 1 cm was received when he hit his head on the shower chair. A one cm abrasion was noted to the right knee. The resident was transferred to the hospital Emergency Room. A Nurse's Progress Note, dated 10/23/25 at 9:59 a.m., indicated the resident returned from the Emergency Room, four sutures were present on the laceration of the right eyebrow. A CT scan of the head and neck had been completed and were negative for injuries.A Rehabilitation Screen form, dated 10/23/25, indicated the resident had been moderately independent and had a fall in the shower. He now complained of right knee and leg pain and was in a wheelchair for safety. A recommendation was made for the physician to look at the leg to rule out injury and then therapy would be provided.A Nurse's Note, dated 10/23/25 at 5:24 p.m., indicated the physician gave the approval for therapy to evaluate and treat the resident.The Nurses' Progress Notes indicated the following:On 10/24/25 at 3:48 a.m., the resident was able to move all his extremities as usual.On 10/24/25 at 4:48 a.m., he complained of right leg pain and acetaminophen was administered as ordered. There was no nursing assessment of the right leg documented on 10/24/25.On 10/25/25 at 7:57 a.m., the resident was yelling, nurse. He indicated his legs would not work while standing. He refused to walk. A wheelchair was provided.There was no nursing assessment of the right leg documented on 10/25/25.On 10/26/25 at 10:35 a.m., A CNA reported to the nurse that the resident had complained of pain to the right lower extremity during a transfer. He has been using a wheelchair since he had been out of bed. The resident pointed to his right thigh and the right side of his face when asked about the pain. Acetaminophen was given as ordered by the physician.There was no nursing assessment of the right leg documented on 10/26/25 after the pain was reported.On 10/26/25 at 12:16 p.m., the resident was hesitant to use his right leg during transfers. He was agitated and tried to stand and stated his leg hurt. There was no nursing assessment of the right leg documented on 10/26/25 when the pain continued.On 10/26/25 at 9:47 p.m., indicated at 9:40 p.m. the resident had severe pain in the right knee and neck. There was decreased strength and range of motion of the right leg and edema of the right knee and right foot. Acetaminophen was administered as ordered by the physician and the resident was assisted to bed and positioned with his right leg elevated. The physician was notified.On 10/27/25 at 11:54 A.M., the resident was assisted to the bathroom and would not stand. He required two staff to transfer on and off the toilet. He indicated his legs were hurting. The physician was made aware of the pain.There was no nursing assessment of the legs documented.On 10/27/25 at 6:35 p.m. an order was received from the physician for a right knee x-ray.A Physician's Progress Note, dated 10/29/25 at 7:39 p.m., indicated it was very difficult to evaluate the resident related to dementia. He complained of back, right leg, and right knee pain and still had trouble walking. The right leg had full passive range of motion. The right knee x-ray was negative for injuries. A Medicare Meeting Report, dated 10/30/25, indicated the resident ambulated with moderate to maximum assistance of one - two staff members with a front-wheeled walker. The gait training indicated he used a front-wheeled walker with moderate to maximum assistance of two staff.A Nurse's Progress Note, dated 11/1/25 at 6:40 a.m., indicated the CNA reported the right leg appeared shorter than the left. There was a discoloration of the right hip of light yellow in color with a purple color in the center and measured six cm by five cm. The resident complained of pain to the right leg when touched. The right leg was shorter than the left and rotated laterally. An order for a right hip x-ray was obtained from the Physician and the resident

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident received adequate supervision and assistance to prevent accidents, related to one staff member (CNA 1) assisting a resident with a shower who was care planned for two staff assistance for activities of daily living (ADL's) resulting in the resident falling in the shower and receiving an abrasion to the right knee and a laceration to the right eyebrow that required four sutures. The resident also had a decline in normal functioning related to ambulation after the fall and was diagnosed eight days later with a fractured right hip for 1 of 3 residents reviewed for accidents and supervision. (Resident D)Finding includes: Resident D's record was reviewed on 11/12/25 at 1:18 p.m. The diagnoses included, but were not limited to, right hip fracture, Alzheimer's disease, dementia, and moderate intellectual disabilities.A Care Plan, dated 7/16/25, indicated a self-care deficit was present related to the impaired cognitive status. The interventions included assistance would be provided with bathing and transfers.A Care Plan, dated 7/16/25, indicated a risk for falls. The interventions included verbal reminders not to ambulate or transfer without assistance would be provided.A Care Plan, dated 10/13/25, indicated a behavior of threatening harm to the staff. On 10/16/25, an intervention of care in pairs was added to the care plan.A Fall Assessment, dated 10/21/25 at 3:59 p.m., indicated a high risk for falls.A Quarterly Minimum Data Set assessment, dated 10/21/25, indicated a severely impaired cognitive status, physical behaviors and rejection of care were present for one to three days and verbal behaviors were present for four to six days. There was no impairment of the upper and lower extremities. Supervision was required for dressing and hygiene. Bathing had been refused. He was independent for bed mobility, sitting to standing, transfer and ambulation.A Nurse's Progress Note, dated 10/23/25 at 6 a.m. and recorded as a late entry on 10/23/25 at 6:51 a.m., indicated the resident had fallen in the shower when he attempted to get out of the shower chair. A laceration above the right eye, four centimeters (cm) by 1 cm was received when he hit his head on the shower chair. A one cm abrasion was noted to the right knee. The resident was transferred to the hospital Emergency Room.A Nurse's Progress Note, dated 10/23/25 at 9:59 a.m., indicated the resident returned from the Emergency Room, four sutures were present on the laceration of the right eyebrow. A CT scan of the head and neck had been completed and were negative for injuries.An Indiana Department of Health (IDOH) reported incident, dated 10/23/25, indicated the incident occurred on 10/23/25 at 6:01 a.m. The resident was in the shower and attempted to stand from the shower chair and fell. The injuries included a one cm abrasion to the right knee and a four cm by one cm laceration to the right eyebrow that required four sutures. First aid was administered at the time of the fall, and the resident was transferred to the hospital Emergency Room. The facility investigation of the fall, dated 10/23/25, indicated the resident was in the shower chair and he attempted to stand. CNA 1 was in front of the resident and attempted to assist him back on the shower chair. The shower chair moved, and he fell on his right knee and buttocks. He also hit his head on the shower chair. CNA 1 was re-educated that the resident was care planned to be care in pairs. The CNA Care Card (care plan interventions), attached to the investigation of the fall, indicated the resident required cares in pairs.A typed statement from CNA 1, dated 10/23/25 and unsigned by CNA 1, indicated the shower had been given so he could go to BINGO. She was drying him off and when she was going to dry his feet, he stood up from the shower chair. She stood in front of him to assist him back in the chair and the shower chair tolled back and he fell on his buttocks and right knee. She thought he hit his head on the shower chair. His head was bleeding, pressure was applied and the nurse was notified.A Rehabilitation Screen form, dated 10/23/25, indicated the resident had been moderately independent and had a fall in the shower. He now complained of right knee and leg pain and was in a wheelchair for safety. A recommendation was given for the physician to look at the leg to rule out injury and then therapy would be provided.A Nurse's Note, dated 10/23/25 at 5:24 p.m., indicated the Physician gave the approval for therapy to evaluate and treat the resident.The Nurses' Progress Notes indicated the following:On 10/24/25 at 3:48 a.m., the resident was able to move all his extremities as usual.On 10/24/25 at 4:48 a.m., he complained of right leg pain and acetaminophen was administered as ordered.On 10/25/25 at 7:57 a.m., the resident was yelling, nurse. He indicated his legs would not work while standing. He refused to walk. A wheelchair was provided.On 10/25/25 at 9:53 a.m., there were no complaints of pain or discomfort from the fall.On 10/26/25 at 10:35 a.m., A CNA reported to the nurse that the resident had complained of pain to the right lower extremity during a transfer. He had been using a wheelchair since he had been out of bed. The resident