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	03/06/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to an uncovered urinary catheter bag and a resident's choice was honored for bathing for 2 of 2 residents reviewed for dignity. (Residents G and 57)Findings include: 1.On 3/3/26 at 9:53 a.m. Resident G was observed lying in bed. A urinary catheter bag was hanging from the side of the bed with visible urine in the bag. There was no cover over the bag, and the bag was visible from the hallway. On 3/3/26 at 2:47 p.m. Resident G was observed lying in bed. A urinary catheter bag was hanging from the side of the bed with visible urine in the bag. There was no cover over the bag, and the bag was visible from the hallway. On 3/4/26 at 11:23 a.m. Resident G was observed lying in bed. A urinary catheter bag was hanging from the side of the bed with visible urine in the bag. There was no cover over the bag, and the bag was visible from the hallway. Record review for Resident G was completed on 3/4/26 at 2:23 p.m. Diagnoses included, but were not limited to, obstructive and reflux uropathy, urine retention, and neuromuscular dysfunction of the bladder. A Care Plan, updated 2/9/26, indicated the resident had impaired urinary elimination and had an indwelling catheter. During an interview on 3/4/26 at 3:29 p.m., the Director of Nursing was made aware the urinary catheter bag was visible from the hallway and the facility's catheter care policy was requested. A facility policy, received as current from the Director of Nursing, titled Catheter Care, indicated .Catheter covers/dignity bags are used to preserve the resident's dignity and privacy when out of the room or per residents request. Nursing staff are responsible for the application and securing of catheter bag covers/dignity bags . 2. During an interview on 3/2/26 at 3:31 p.m., Resident 57 indicated that she was supposed to receive three showers a week. The aides had gotten the resident ready for a shower and took her down to the shower room. She had noticed her usual shower chair was not there and so she started to back herself out of the shower room. LPN 2 pushed her wheelchair back into the shower room and said that she was always complaining about her showers and so she was going to take one now. The resident felt that she was forced to take a shower. Resident 57's record was reviewed on 3/3/36 at 2:03 p.m. The Quarterly Minimum Data Set (MDS) assessment, dated 12/9/25, indicated the resident was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact and required substantial/maximal assistance for showering/bathing. A Care Plan, revised on 2/9/26, indicated the resident had a self-care deficit. Interventions included, but were not limited to, the resident needed assistance with bathing on Tuesday, Friday, and Sunday evening shifts. A Facility Reported Incident, dated 3/4/26, indicated Resident 57 reported that LPN 2 had pushed her back into the shower room forcefully. LPN 2 told her that she had been refusing showers and was not going to refuse and she had to take one. Resident 57 felt that this was verbal abuse telling her she had to take a shower. The staff member was immediately suspended pending investigation. Social Services interviewed other alert residents to see if there were any other issues. The Investigation Form, dated 3/4/26, indicated the incident occurred in the previous week when LPN 2 forced Resident 57 to take a shower. The incident met the definition of abuse, as Resident 57 indicated it was verbal abuse. Actions taken during the investigation included LPN 2 was immediately suspended, residents were interviewed on the unit with no findings, LPN 2 was suspended for 3 days and assigned more in-servicing related to abuse and resident rights, all staff in-serviced on abuse. The Summary indicated the resident did feel safe and does not have a problem with the nurse as long as she does not force her to take a shower. The incident was substantiated because residents' rights were violated. A statement by the Social Service Designee, dated 3/4/26, indicated during an interview with Resident 57, she stated that LPN 2 had taken her right away and was verbally abusive stating that she could not refuse her shower. A statement written by CNA 2, on 3/4/26, indicated CNA 1 had talked to the resident and the resident agreed to allow the NA to shower them before dinner. The NA got the resident into the shower room, and the resident did not like the chair that was in there. The NA went to find the chair she wanted but was unable to locate the chair. The NA went back to the nurses' station and said that the resident did not want their shower unless we could find the right chair. LPN 2 got up and said that the resident was going to take a shower and that she would handle it. CNA 1 and CNA 2 heard some commotion from the shower room and went to see what was going on and LPN 2 was telling the resident that she was going to take a shower and that we were going to help. LPN 2 had her arms under the resident's arms and was assisting her to stand up and grab onto the bar. CNA 1 helped LPN 2 stand up the resident and got her situated in the shower chair. The NA indicated she could handle it from there and finish the shower. A written statement by CNA 3, dated 3/4/26, indicated CNA 3 had asked the resident if she wanted to take a shower and responded that she didn't want it until after dinner. CNA 3 told LPN 2 that the resident did not want the shower until after dinner so the person relieving CNA 3 would have to do it because the shift ended at 6:00 p.m. LPN 2 said No she's taking it now, and then went into the residents room, moved her bedside table that was in front of her, and told the resident she was taking her shower now. CNA 3 assisted the resident with her shower and the resident indicated she was upset with LPN 2 because she did not want to take her shower before dinner. A statement written by NA 1, on 3/5/26, indicated she was getting Resident 57 into the shower, and the resident indicated it was the wrong chair. The NA searched for the chair but was unable to find it. Other staff members indicated the chair was no longer at the facility, so Resident 57 then indicated she was not going to take her shower and she wanted to refuse. The resident started back towards her room because she did not want to use the chair that hurt her. NA 1 said ok. LPN 2 then said no that the resident needed the shower, so she was getting it and started to take the resident back to the shower. Then two aids, CNA 1 and CNA 2, helped the resident get into the shower and then NA 1 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	helped her with the shower. The resident was upset and saying no. The resident was still upset during the shower and after the shower, but she was not giving NA 1 trouble or anything while giving care to her. NA 1 indicated she did not feel like she was forced to give the shower to the resident, but she felt that the resident was forced to take the shower and the other staff had NA 1 do it. During an interview on 3/6/26 at 8:56 a.m., the Director of Nursing indicated the investigation resulted in the nurse being suspended and she was going to have to do more in-service training on resident rights. The nurse was trying to encourage the resident to take her shower, however the line was crossed. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-3(t)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to a Wanderguard alarm (wearable device that alarms when approaching a restricted area) not documented for a resident with history of wandering for 1 of 21 MDS assessments reviewed. (Resident 37) Finding includes:The record for Resident 37 was reviewed on 3/3/26 at 8:59 a.m. Diagnoses included, but were not limited to, dementia and Parkinson's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 1/26/26, indicated the resident had moderate cognitive impairment, required partial to moderate assistance with shower, personal hygiene, and taking footwear on and off. The alarm assessment was marked as 0 indicating not used. The Physician's Order, dated 12/15/25, indicated Wanderguard to right wrist. Monitor for proper placement every shift and functioning daily. During an interview on 3/5/26 at 1:44 p.m., the MDS Coordinator indicated she thought the Wanderguard was discontinued. When asked for policy regarding MDS, she indicated she used the Resident Assessment Instrument (RAI). The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025, indicated P0200: Alarms. Coding Instructions. Identify all alarms that were used at any time (day or night) during the 7-day look back period. After determining whether or not an item listed in P0200 was used during the 7-day look back period, code the frequency of use:. Code 0, not used: if the device was not used during the 7-day look back period. Code 1, used less than daily: if the device was used less than daily. Code 2, used daily: if the device was used on a daily basis during the look back period .Coding Tips.Wander/elopement alarm includes such bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activates an alarm and /or the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the residents assistive device (e.g., walker, wheelchair, cane) or other belongings. 410 IAC (Indiana Administrative Code) 16.2-3.1-31(i)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review and interview, the facility failed to update care plans to reflect the resident's transfer status for 1 of 19 resident care plans reviewed. (Resident 16)Finding includes:On 3/2/26 at 3:18 p.m., Resident 16 was observed lying in bed. The resident indicated she required a Hoyer lift (mechanical device to transfer an individual) for staff to transfer her out of bed. Sometimes the facility was short staffed and they would not always have 2 staff members to transfer her out of bed.Record review for Resident 16 was completed on 3/3/26 at 2:14 p.m. Diagnoses included, but were not limited to stroke and anxiety.The Annual Minimum Data Set (MDS) assessment, dated 12/2/25, indicated the resident was cognitively intact. The resident was dependent on staff for transfers.A Care Plan, dated 12/5/24 and revised 3/2/26, indicated the resident had a self care deficit related to impaired mobility. An intervention included for staff to assist with transfers.A Care Plan, dated 12/6/24 and revised 3/2/26, indicated the resident was at risk for falls due to impaired mobility and weakness. An intervention included for staff to assist with transfers and ambulation.The Care Plans lacked any documentation the resident required a Hoyer lift for transfers. During an interview on 3/4/26 at 10:47 a.m., LPN 1 indicated the resident required a Hoyer lift for transfers.During an interview on 3/4/26 at 10:49 a.m., the Director of Nursing indicated the Care Plans should have been updated to indicate the resident was a 2 person assist with a Hoyer lift for transfers. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(1)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, record review, and interview, the facility failed to provide activities to support the psychosocial well-being of cognitively impaired, dependent residents for 1 of 1 resident reviewed for activities. (Resident H)Finding includes:On 3/2/26 at 10:18 a.m., Resident H was observed lying flat in bed with her eyes open staring at the ceiling. The bed had half side rails with padding on them and the curtain was pulled. The resident was unable to see out into the hall as her bed was furthest from the door. There was no television or music on at the time of observation. The resident was picking at her hair repeatedly. There was an activity occurring in the dining room at the time. On 3/2/26 at 2:59 p.m. and 3:10 p.m., Resident H was observed lying flat in bed with her eyes open staring at the ceiling. The bed had half side rails with padding on them and the curtain was pulled. The resident was unable to see out into the hall as her bed was furthest from the door. There was no television or music on at the time of observation. The resident was picking at her hair repeatedly.On 3/4/26 at 10:03 a.m., Resident H was observed lying flat in bed smacking her teeth together and pulling at the top of her hair. There were no activities occurring in her room. On 3/4/26 at 1:44 p.m., Resident H was observed lying flat in bed smacking her teeth together and pulling at her hair. There was an activity occurring in the Main Dining Room at the time of observation. On 3/5/26 at 10:30 a.m., Resident H was observed lying flat in bed. There were no activities occurring in her room at the time. On 3/5/26 at 11:11 a.m., Resident H was observed up in a Broda chair. A staff member took her to the dining room located in the Oak Blvd Unit. There was musician visiting for the activity occurring in the main dining room at the time. On 3/5/26 at 2:23 p.m., Resident H was observed in her room lying in the bed. There were no activities occurring in the room at the time. There was an activity in the main dining room. Resident H's record was reviewed on 3/4/26 at 2:21 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, and psychotic disorder with delusions. The Annual Minimum Data Set (MDS) assessment, dated 1/5/26, indicated the resident was severely impaired for daily decision making. The staff assessment of daily and activity preferences indicated the resident preferred receiving a shower, family or significant other involvement in care discussions, reading books/newspapers/magazines, listening to music, being around animals such as pets, and participating in religious activities or practices. A Care Plan, revised on 2/8/26, indicated activities: the resident shows little awareness of programs, and can complete few or no simple tasks, and was on palliative care. Interventions included, but were not limited to, assist to programs which may be most comfortable and potentially stimulating, target, sing a long, church services, special events and music programs, modify length of programs based on attention span, position chair in a location which enables frequent one-on-one staff contact during activities, and simplify tasks, segment steps or tasks. The January and February 2026 Activity Logs indicated the resident received daily room visits. During an interview on 3/6/26 at 10:00 a.m., the Activity Director indicated the staff go to the resident's room daily for a room visit which includes talking, reading, and/or massage. They have tried to get her to go to activities and she doesn't respond or says, lay down. The staff are supposed to go into the resident's room and turn on music for her.410 IAC (Indiana Administrative Code) 16.2-3.1-33(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to not notifying the physician when a resident was having frequent diarrhea for 1 of 1 resident reviewed for constipation/diarrhea. (Resident 16) The facility also failed to ensure physician's orders were followed related to a resident's catheter securement device for 1 of 1 resident reviewed for catheters. (Resident 52) Findings include:1. On 3/2/26 at 3:18 p.m., Resident 16 was observed lying in bed. The resident indicated she had been having episodes of diarrhea for a while. Record review for Resident 16 was completed on 3/3/26 at 2:14 p.m. Diagnoses included, but were not limited to stroke and anxiety. The Annual Minimum Data Set (MDS) assessment, dated 12/2/25, indicated the resident was cognitively intact. The resident was dependent on staff for transfers and toileting hygiene. The resident was always incontinent of bowel and bladder. The March 2026 Physician's Order Summary (POS) indicated an order for loperamide (antidiarrheal medication) 2 mg. Take 2 capsules by mouth after 1 unformed stool then take 1 capsule by mouth after each stool thereafter as needed. The February 2026 Medication Administration Record (MAR) indicated the loperamide was administered on 2/6/26 at 4:34 p.m., and again on 2/21/26 at 6:48 p.m. A Progress Note, dated 2/28/26 at 9:19 a.m., indicated the resident had two episodes of diarrhea and her stomach was upset. The March 2026 MAR indicated the loperamide was administered on 3/3/26 at 6:52 p.m., due to the resident had three episodes of diarrhea. The follow up indicated the medication was not effective and the resident had another episode of diarrhea. There was no documentation indicating the physician was notified after the resident had multiple episodes of diarrhea. During an interview on 3/4/26 at 11:20 a.m., the Director of Nursing (DON) indicated she was unable to provide any documentation the physician was notified after the resident had multiple episodes of diarrhea. 2. On 3/2/26 at 11:30 a.m., Resident 52 was observed sitting up in her bed. She had a catheter draining clear, yellow urine to gravity. The catheter tubing was secured to her right leg using an adhesive catheter securement device. On 3/4/26 at 10:07 a.m., Resident 52 indicated the adhesive for the catheter securement device rips her skin open. She was not sure what type of securement was being used at the time. The resident was covered with a blanket at the time. Resident 52's record was reviewed on 3/4/26 at 11:31 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and retention of urine. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 12/2/25, indicated the resident was cognitively intact and had an indwelling catheter. A Physician's Order, dated 3/1/26, indicated to place clean abdominal pads to the bilateral inner upper thighs to keep catheter tubing off the skin and do not use catheter securement device, the resident's skin will blister. A Care Plan, revised on 3/2/26, indicated the resident was at risk for infection related to an invasive indwelling urinary catheter secondary to neurogenic bladder dysfunction and retention of urine. Interventions included, but were not limited to, catheter care every shift. During an interview on 3/5/26 at 8:50 a.m., the Director of Nursing indicated the resident had been out to the hospital and came back over the weekend. The hospital had put the adhesive on the resident and the staff should have noticed it and removed it. The adhesive had caused problems to her skin previously. The Director of Nursing had assessed the skin and there were no new issues at the time from the adhesive. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interview, the facility failed to provide treatment for limited range of motion related to splints not in place for 2 of 3 residents reviewed for range of motion (ROM). (Residents G and H)Findings include:1.On 3/2/26 at 11:10 a.m., Resident G was observed sitting in his wheelchair in his room. There was no splint in place to his left hand. The splint was observed on his bed. On 3/3/26 at 2:47 p.m., Resident G was observed lying in bed. There was no splint in place to his left hand. The splint was observed on the seat of his wheelchair. On 3/3/26 at 11:24 a.m., Resident G was observed lying in bed. There was no splint in place to his left hand. The splint was observed on the seat of his wheelchair. He indicated he had a splint that he would wear to on his left hand sometimes. He was unable to put it on himself and unsure when he was supposed to wear it. The resident's record was reviewed on 3/4/26 at 2:23 p.m. Diagnoses included, but were not limited to, hemiplegia left non dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 1/12/26, indicated the resident was cognitively intact and had impaired ROM to the upper and lower extremities on one side. A Care Plan, updated 2/9/26, indicated the resident required the use of a splint due to contracture of the left hand. The interventions included to apply the splint per schedule. A Physician's Order, dated 3/1/26, indicated left hand splint 2-4 hours daily or as tolerates to help prevent future contractures. There were no times to indicate when the splint should be on or off. The Medication Administration Record and the Treatment Administration Record, dated 3/2026, indicated the left-hand splint had been in place as ordered. There were no documented refusals or times to indicate when the splint was on or off. During an interview on 3/5/26 at 8:43 a.m., the Director of Nursing indicated there had been no clear schedule of when the splint was to be worn, the orders were updated, and it would now be put on at night. 2. On 3/2/26 at 10:34 a.m., at 2:59 p.m., and 3:10 p.m., Resident H was observed lying flat in bed with her eyes open staring at the ceiling. The resident had no palm protector in place to the left hand. On 3/4/26 at 10:03 a.m., Resident H was observed lying flat in bed smacking her teeth together and pulling at the top of her hair. The resident had no palm protector in place to the left hand. On 3/4/26 at 1:44 p.m., Resident H was observed lying flat in bed smacking her teeth together and pulling at her hair. The resident had no palm protector in place to the left hand. Resident H's record was reviewed on 3/4/26 at 2:21 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and adult failure to thrive. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual Minimum Data Set (MDS) assessment, dated 1/5/26, indicated the resident was severely impaired for daily decision making and had a limitation in range of motion to one side on the upper extremity. A Physician's Order, dated 3/1/26, indicated palm protector to the left hand on in the morning and off at night. The March 2026 Medication and Treatment Administration Record indicated the palm protector was applied as ordered daily from 3/1/26 thru 3/4/26. During an interview on 3/5/26 at 8:50 a.m., the Director of Nursing indicated she had no further information to provide. This citation relates to Intake 2724581. 410 IAC (Indiana Administrative Code) 16.2-3.1-42(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to ensure residents were provided with adequate equipment to prevent falls for 1 of 5 residents reviewed for accidents. (Resident D)Finding includes:Resident D's record was reviewed on 3/3/26 at 3:10 p.m.The Quarterly Minimum Data Set (MDS) assessment, dated 12/16/25, indicated the resident was moderately cognitively impaired and was dependent on staff for showering/bathing.An Event: Safety Events - Fall, dated 3/3/26 at 10:27 a.m., indicated the resident had a fall in the shower room while receiving a shower. There were no injuries. A Progress Note, dated 3/3/26, indicated the shower chair tipped in the shower and the resident was lowered to the floor by the CNA. The resident did not hit her head. There were no injuries. The physician and Director of Nursing were notified.During an interview on 3/3/26 at 3:40 p.m., CNA 4 indicated she did not typically work on the unit that Resident D resides on, so for care questions she had to rely on the other aids that were there most often. She was told that the resident usually had a larger lay down chair that was for bariatric residents. It was a rented chair that the facility no longer rented. The other option was a regular shower chair that did not recline/lay down, which was used for Resident D's shower on 3/3/26. The shower was provided for Resident D and everything was going fine. She indicated she started to dry her off and was going to bring the shower chair forward in the shower towards the heat. The chair that was used had arm rests on it, so she had unlocked the wheels and pulled the arm rests forwards. As soon as she started to pull, the chair tipped forward towards the aid. CNA 4 was able to hold the resident up and then safely lower her to the ground with no injuries. The aide then called for help, and they were able to get the resident into her wheelchair. The chair that was used had the appropriate weight capacity of 400 pounds; however, the resident's shape was not proportionate, and the aide had to reposition her multiple times at first to get her bottom half into the chair correctly. The aide indicated she had checked with the staff again about using the chair because once the resident was sitting in it, she still did not feel the chair was safe to use due to the resident's size and weight distribution in the chair.During an interview on 3/4/26 at 9:59 a.m., Resident D indicated she was dumped from the shower chair yesterday. The shower chair had tipped over on her when the aide went to move her in the shower room. Multiple staff had to come in and get her back into her wheelchair. She had been using a long bed for showering and the facility got rid of it recently. The resident indicated she was refusing to take a shower with that type of chair anymore because she was afraid that she would fall again.During an interview on 3/4/26 at 2:28 p.m., the Social Service Designee indicated the facility had been renting a bariatric lay down shower chair for two to three months and then they decided to purchase a chair. The residents did not like the one that was purchased because it did not have the reclining feature. She indicated she was recently told to rent the old chair again.During an interview on 3/4/26 at 3:28 p.m., the Director of Nursing indicated the facility was looking into buying a bigger shower chair and they were renting one to try out the sizes. They had purchased a new chair and sent the rented chair back. The new chair worked for some of the residents, but not all due to the size of the chair. The facility was going to resume the rental with the bariatric lay down chair.This citation relates to Intake 2724581.410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2)

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	03/06/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to ensure physician's orders were followed related to a fluid restriction for 1 of 1 resident reviewed for hydration. (Resident 52)Finding includes: Resident 52's record was reviewed on 3/4/26 at 11:31 a.m. Diagnoses included, but were not limited to, heart failure.The Quarterly Minimum Data Set (MDS) assessment, dated 12/2/25, indicated the resident was cognitively intact. A Care Plan, revised on 3/3/26, indicated the resident was on a fluid restriction. Interventions included, but were not limited to, fluid restrictions as ordered and monitor and record intake.A Physician's Order, dated 3/1/26, indicated document fluid intake with medication every shift. A Physician's Order, dated 3/2/26, indicated diet: regular and 1,200 milliliters (ml) per day fluid restriction. The Intake: Fluids documentation section indicated the resident had 1,030 ml on 3/1/26, 1,080 ml on 3/2/26, and 900 ml on 3/3/26. The March 2026 Medication Administration Record indicated the resident received 510 ml of fluid on 3/1/26, 540 ml of fluid on 3/2/26, and 360 ml of fluid on 3/3/26 with medication pass. During an interview on 3/5/26 at 8:50 a.m., the Director of Nursing indicated the order needed to be clear on how much fluid each department was to give the resident as that was not specific to reflect 600 ml for nursing and 600 ml for dietary. She had no further information to provide. 410 IAC (Indiana Administrative Code) 16.2-3.1-46(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to oxygen administration, implementing physician's orders, and testing for a resident with respiratory symptoms for 2 of 3 residents reviewed for respiratory care. (Residents 32 and 12)Findings include:1.On 3/3/26 at 9:39 a.m. Resident 32 was observed seated at a table in the Main Dining Room. Oxygen was in place via nasal cannula and the portable tank was set at 2 liters. On 3/3/26 at 2:52 p.m. Resident 32 was observed in the Main Dining Room doing a coloring activity. Oxygen was in place via nasal cannula and the portable tank was set at 2 liters. On 3/4/26 at 11:29 a.m. Resident 32 was observed seated at a table in the Main Dining Room. Oxygen was in place via nasal cannula and the portable tank was set at 2 liters. Resident 32's record was reviewed on 3/4/26 at 11:58 a.m. Diagnoses included, but were not limited to, emphysema and asthma. A Physician's Order, dated 3/1/26, indicated oxygen 2-4 liters as needed (PRN) to keep sats above 90%. The Medication and Treatment Administration Records, dated 3/2026, lacked any documentation that the PRN oxygen had been administered or titrated. During an interview on 3/4/26 at 3:29 p.m., the Director of Nursing (DON) was made aware the PRN oxygen had not been signed off as administered. The facility's oxygen administration policy was requested. A facility policy, received as current from the Director of Nursing, titled Oxygen Therapy, indicated .12. Turn on liter flow to the ordered rate. Make residents comfortable. Visit frequently to observe response to oxygen therapy .18. Record oxygen therapy on the treatment or special record and nursing notes if PRN. Include type of catheter, liter flow, and response to treatment .21. Document time, type of oxygen device used, assessment findings, precipitating factors, liter flow, residents' response to procedure, teaching, and level of understanding. 2. On 3/2/26 at 12:20 p.m., Resident 12 was observed laying in her room with eyes closed. She had an intermittent cough. Resident 12's record was reviewed on 3/5/26 at 2:24 p.m. The Quarterly Minimum Data Set assessment, dated 2/2/26, indicated the resident was severely cognitively impaired. A Progress Note, dated 2/17/26 at 1:45 p.m., indicated the resident's appetite was poor, temperature was 99.4 degrees Fahrenheit, skin pale, and cough was noted. She was given Tylenol for comfort. A Physician's Note, dated 2/18/26 at 7:42 p.m., indicated the resident had cough, congestion, no fever, and no respiratory distress. Labs/Data indicated COVID/Flu negative. The assessment indicated viral upper respiratory infection. The plan indicated Robitussin. A Progress Note, dated 2/28/26 at 6:06 a.m., indicated the resident had a moist congested cough. Her (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lungs had expiratory crackles to the upper left lobe and diminished and the right upper lobe was clear. A Progress Note, dated 3/2/26 at 10:35 p.m., indicated the resident had a cough that was dry and non-productive with diminished lung sounds. The February 2026 Physician Order Summary indicated there were no orders for Robitussin. The record lacked documentation of any COVID/Flu testing completed on 2/18/26 when the cough started. There was a COVID test recorded on 2/25/25 which was negative. During an interview on 3/6/26 at 10:07 a.m., the Director of Nursing indicated she was unable to find documentation of a COVID/Flu test for 2/18/26. There were no orders implemented for Robitussin. The physician was supposed to put that order in himself. 410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(6)