STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155720	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cathedral Health Care Center	520 W 9th St Jasper, IN 47546

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 3 of 5 residents reviewed for unnecessary medications. The clinical record lacked a plan of care for resident's taking anticonvulsant and diuretic medications. (Resident 2, Resident 7, Resident 59)Findings include: 1. On 7/22/25 at 10:56 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, paranoid schizophrenia, bipolar disorder, and Parkinson's disease. The most recent quarterly Minimum Data Set (MDS) assessment, dated 6/24/25, indicated Resident 2's cognition was severely impaired and received an antipsychotic medication. Current physician's orders included, but were not limited to, the following:Gabapentin (anticonvulsant) 400 milligram (mg), give one capsule by mouth three times a day for pain, ordered 6/2/25 Lasix 40 mg, give one tablet orally two times a day for edema, ordered 6/12/25 The clinical record lacked a care plan for diuretic and anticonvulsant use. The July 2025 Medication Administration Record (MAR) indicated resident was currently taking both medications routinely. 2. On 7/22/25 at 1:40 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors, stroke, diabetes mellitus type II, and heart failure. The most recent quarterly MDS assessment, dated 6/2/25 indicated resident 7's cognition was severely impaired and received an anticoagulant medication. Current Physician's Orders included, but were not limited to, the following:Xarelto (anticoagulant) 10 mg, give 1 orally once daily for personal history of stroke, ordered 5/24/25The clinical record lacked a care plan for anticoagulant use.The July 2025 MAR indicated Resident 7 was currently taking the medication routinely. 3. On 7/23/25 at 8:34 A.M., Resident 59's clinical record was reviewed. Diagnoses included, but were not limited to, bipolar disorder, dementia with psychotic disturbances, and chronic cystitis. The most recent quarterly MDS assessment, dated 7/2/25, indicated Resident 59's cognition was severely impaired and received a diuretic medication. Current Physician's Orders included, but were not limited to, the following:Lasix (diuretic) 20 mg, give one tablet orally daily for chronic cystitis, ordered 10/16/24. The clinical record lacked a care plan for diuretic use. During an interview on 7/23/25 at 1:55 P.M., the Administrator indicated the resident's were currently on those medications but she was unable to provide a care plan for them. She would expect a care plan to have been added by the nursing staff, Director of Nursing (DON), or herself. She was unsure why these were missed. On 7/23/25 at 3:23 P.M., a current Care Plan Policy, last revised December 2016, was provided by the Administrator and indicated, A comprehensive, person-centered care plan . is developed and implemented for each resident . The comprehensive, person-centered care plan is to be completed within 21 days from admission to the facility . 3.1-35(a)

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