STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Christian Home Inc	643 W Utica St Sellersburg, IN 47172

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure a resident's laboratory work was completed per physician's order for 1 of 12 residents reviewed for physician notification. (Resident 34)Findings include: The record for Resident 34 was reviewed on 2/10/26 at 10:45 a.m. The resident's diagnoses included, but were not limited to, dementia (a decline in cognitive functioning), pain, and severe protein-calorie malnutrition (deficiency of protein and calories).On 6/12/25, the physician gave orders for the resident to have the following lab work drawn every June and December: CBC (complete blood count), TSH (thyroid stimulating hormone) a BMP (basic metabolic panel), and a Urine Micro-Albumin (protein produced through the liver).A care plan, dated 1/13/26 with a revision date of 2/6/26, indicated the resident had open areas or potential for pressure ulcers due to immobility. The intervention, dated 1/13/26, included, but were not limited to, obtain labs/diagnostic tests as ordered and report results to the physician or NP.A care plan, dated 6/9/25 with a revision date of 1/30/26, indicated the resident had potential and actual impairment to skin integrity - multiple bruised areas. The intervention dated 6/9/25, included, but were not limited to, obtain blood work such as CBC with Differential, Blood Cultures and culture and sensitivity of any open wounds as ordered by the physician.The review of Resident 34's laboratory results section indicated the facility failed to Indicate the lab work had been drawn in December as ordered.In an interview with the Director of Nursing (DON) on 2/11/26 at 10:15 a.m., she indicated that after she checked the resident's orders, she noticed the physician orders for lab work to be drawn in December. The lab orders were never drawn like they were supposed to be. The physician should have been notified that the resident's lab work were not drawn as ordered and checked to see if the physician wanted to re-order them.The facility's current policy on Laboratory Services, included, but was not limited to, .The facility will: .Ensure that the ordering physician is promptly notified of the findings .The facility's current policy on Provider Orders and Management, included, but was not limited to, .3. The process for communicating test results to providers is as follows: .The LPN or RN is to communicate results to the provider via fax or telephone, dependent on criticality of the result .3.1-5(a)(3)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to update the residents' care plans when changes occurred in psychosocial well-being, pain, falls, implementation of intravenous (IV) therapy, and discontinuation of an antibiotic for 3 of 12 residents' care plans reviewed for revisions. (Residents 2, 24, and 5)Findings include:1.The record for Resident 2 was reviewed on 2/6/26 at 12:32 p.m. The resident's diagnoses included, but were not limited to, dementia with mood disturbance (decline in cognitive functioning), anxiety (occasional worry or fear), major depressive disorder (mental condition causing sadness), and post-traumatic stress disorder (mental health condition re-experiencing trauma). The Quarterly Minimum Data Set (MDS) assessment, dated 1/20/26, indicated the resident had significant cognitive impairment and had no mood or behavior issues. A care plan, dated 5/9/24, indicated the resident was at increased risk for grieving and sadness due to recent passing of spouse. The record lacked documentation of the care plan having been updated to reflect improved mood since death of spouse. The review of the Social Work and Psychiatric progress notes between 9/1/25 and 2/10/25, indicated there was no documentation of the resident still grieving her loss. During an interview with the Social Worker, on 2/10/26 at 10:00 a.m., she indicated that initially after the spouse's death in 2024, the resident was grieving for some time but had not voiced missing him in a while. 2. The record for Resident 24 was reviewed on 2/5/26 at 2:00 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease (a form of dementia), difficulty in walking, depression, (feelings of sadness) and age-related osteoporosis (bone deterioration). The Annual MDS assessment, dated 12/10/25, indicated the resident had moderate cognitive issues, had no mood or behavior issues, no impairment in functional range of motion (ROM) bilaterally upper or lower extremities, used a walker or wheelchair, and was independent for mobility with partial assistance and supervision. A new Significant Change in Condition was in the process of being completed. A care plan, dated 9/10/24, indicated the resident was at risk for fall, had a history of falls related to Alzheimer's, psychotropic medications, and osteoporosis. A care plan, dated 8/28/24, indicated the resident was at risk for pain related to history of a fracture. A physician's order, dated 2/20/24, indicated the resident was prescribed two Acetaminophen Oral tablets 325 milligrams (MG) every four hours as needed for pain. The record lacked documentation the resident's pain and falls care plans had been updated to reflect her current status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse note, dated 2/4/26 at 4:53 p.m., indicated the resident was found on the floor in her room on her backside with her legs out in front of her. When she was asked how she fell, or what she was trying to do, the resident indicated she did not remember. The physician and responsible party were notified, and an X-ray of her hip was ordered. A nurse note, dated 2/4/26 at 10:23 p.m., indicated the physician and the Director of Nursing (DON) were notified the right hip X-ray results were that the resident had fractured her pelvis. The review of the nurse's notes, dated between 2/4/26 and 2/6/26, indicated the resident made several requests for pain medication due to her fracture. On 2/6/26 at 11:33 a.m., a new order was received for one Hydrocodone-Acetaminophen 5-325 mg tablet every four hours as needed for pain. The resident's pain level between 2/4/26 and 2/6/26 usually ranged between a pain level of 5 to 8 out of a 0 to 10 scale. (o = no pain to 10 = sever pain) In an interview with the DON on 2/10/26 at 1:50 p.m., she indicated the care plans should have been updated to reflect her recent fall with fracture and the increased pain levels. 3. The record for Resident 5 was reviewed on 2/6/26 at 10:25 a.m. The resident's diagnoses included, but were not limited to, history of urinary tract infections (UTIs) (infection in any part of the urinary system: kidneys, ureters, bladder, and urethra), and the need for assistance with personal care. The care plan, dated 5/18/21, indicated the resident received a prophylactic antibiotic for the history of UTIs. The interventions, dated 5/18/21 and revised 9/4/22, included, but were not limited to: administer medications as ordered by the physician; obtain vital signs; observe for and report as needed signs of adverse effects to the antibiotic: rash, itching, nausea, vomiting, diarrhea; observe for and report as needed signs of infection; obtain lab work as ordered and report results to the physician; encourage fluids with meds, meals and as needed (PRN). The care plans lacked documentation of revisions made in the resident's prophylactic care plan for UTIs and lacked the addition of the midline intravenous catheter to the resident's care plan The Quarterly Minimum Data Set (MDS), dated [DATE], indicated that Resident 5 was cognitively intact. The resident had no indwelling catheter, external catheter, ostomy or intermittent catheterization and no urinary program was in place. The resident required supervision with toileting hygiene. A physician's order, dated 1/19/26, indicated the resident was to have Meropenem Intravenous Solution Reconstituted 1 gram (GM) intravenous every 8 hours for 7 days for the diagnosis of Escherichia coli (gram negative bacteria found in the intestines) and extended-spectrum beta-lactamases (ESBL) (bacterial infection producing enzymes resistant to most common antibiotics. A nurse's note, dated 1/19/26 at 9:59 p.m., indicated a peripheral IV, 20 gauge was placed in the resident's left forearm. A physician's order, dated 1/20/26, indicated that the prophylactic oral antibiotic was discontinued, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and cranberry capsules 500 milligrams (mg) taken by mouth twice daily were ordered. A physician's order, dated 1/21/26, indicated that the resident was to have a midline peripheral catheter placed to receive the IV antibiotic ordered. During an interview, on 2/10/26 at 1:00 p.m., the DON indicated that the UTI care plan for Resident 5 had been updated to a resolved status since the intravenous treatment was completed and the resident no longer had a UTI. The facility's current policy titled Comprehensive Person-Centered Care Planning, included, but was not limited to, Purpose: To provide guidance to staff on the measures taken to ensure each resident will have a person-centered comprehensive care plan developed and implemented to meet their goals and preferences, and address the resident's medical, physical, mental and psychosocial needs. Care planning drives the type of care and services that a resident receives. If care planning is not complete or is inadequate, the consequences may negatively impact the resident's quality of life, as well as the quality of care and services received .The comprehensive care plan will: .reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments . 3.1-35(d)(2)(B)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure discontinued medications were promptly disposed of during for 1 of 3 residents observed for medication storage. (Resident 54)Findings include:During an observation on [DATE] at 10:31 a.m., of the 200 Hall Medication Room, 2 syringes of heparin (blood thinner used to prevent blood clots) were in the pharmacy return bin in the medication room. The pharmacy label with a physician's order was on the bag of heparin with two syringes inside of the bag for Resident 54. During an interview on [DATE] at 10:35 a.m., Licensed Practical Nurse (LPN) 3 indicated the heparin belonged to Resident 54 and she thought that the resident died after Christmas. The nurse's note, dated [DATE] at 1:31 p.m., indicated Resident 54 passed away. The record for Resident 54 was reviewed on [DATE] at 11:28 a.m. The diagnoses included, but were not limited to, metastatic anal cancer (rectal cancer that had spread to other parts of the body) with a Computed Tomography (CT) implanted port (access to the vein in the upper chest that was power injectable). The physician's order, dated [DATE], indicated to administer 5 milliliters (mL) of heparin intravenously on the 6th of every month for flushing protocol for the CT implanted port to the resident's right chest. The order was discontinued on [DATE]. During an interview on [DATE] at 8:44 a.m., Director of Nursing (DON) indicated the medications were sent back to pharmacy on the computer. There may be some in the medication rooms right now. Once it was in the computer, they would be bagged up and sent to the pharmacy. She could not explain where the heparin for Resident 54 came from. When a resident died, all medications would be taken out and sent back to the pharmacy by mail. The Pharmacy Services policy, reviewed [DATE], included, but was not limited to, . Discontinued, outdated, or deteriorated medication will not be maintained or used in the facility. Medications will be disposed of in compliance with federal, state and local laws. Unopened and unexposed medication may be returned to the issuing pharmacy for credit to the appropriate party. 3.1-25(o)3.1-25(q)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to ensure physician orders for laboratory work were drawn as ordered for 1 of 12 residents reviewed for laboratory services. (Resident 34)Findings include:The record for Resident 34 was reviewed on 2/10/26 at 10:45 a.m. The diagnoses included, but were not limited to, dementia (a decline in cognitive functioning), pain, and severe protein-calorie malnutrition (deficiency of protein and calories).The physician's order, dated 6/12/25, indicated Resident 34 was to have the following labs drawn every June and December: CBC (complete blood count), TSH (thyroid stimulating hormone) a BMP (basic metabolic panel), and a Urine Micro-Albumin. The review of the resident's laboratory results indicated the facility failed to draw the December laboratory test as ordered. The resident's clinical laboratory record indicated the resident's last lab values were drawn on the following dates: TSH-3 on 7/30/25; T 4 on 6/18/25; BMP on 6/13/25; and A Urine Micro-Albumin test on 7/9/25. During an interview with the Director of Nursing (DON) on 2/11/26 at 10:15 a.m., she indicated the resident's laboratory orders for the TSH, BMP and Urine Micro-Albumin were not completed as ordered in December. The facility's current policy on Laboratory Services, included, but was not limited to, Policy: The facility will provide laboratory services to meet the needs of the resident. The facility will be responsible for the quality and timeliness of the services .The facility will: Provide or obtain laboratory services only when ordered by the attending physician. Ensure that the ordering physician is promptly notified of the findings .3.1-49(a)3.1-49(f)(1)