STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155803	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Pointe Health and Rehab	3800 Eli Place Newburgh, IN 47630

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 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 dishwasher temperatures were within range and food was prepared under sanitary conditions for 2 of 2 kitchen observations. The temperature on the final rinse of the dishwasher did not reach required levels, floors were sticky, and bulk food was outdated. (Kitchen)Findings include:1. On 7/29/25 at 9:17 A.M., an initial tour of the kitchen was completed with the Kitchen Manager. During the initial tour, the following was observed:A dishwasher cycle was observed. The final rinse temperature was 175 degrees Fahrenheit (F). At that time, the Kitchen Manager indicated the dishwasher was a high temperature dishwasher and she expected the temperature of the wash cycle to reach 160 degrees F and the final rinse cycle to reach at least 180 degrees F. Staff checked the temperatures three times a day. At that time, the Dishwasher Chart for July 2025 was reviewed. The chart indicated the dishwasher was a low temperature dishwasher. The log indicated that staff were to check the temperature of the wash and the rinse cycle three times a day (morning, noon, and evening). The following days were below the expected wash and rinse cycle temperatures or did not have a temperature listed:7/1/25 morning - final rinse 165 F7/1/25 evening - no temperatures listed7/2/25 morning, noon, and evening - no temperatures listed7/3/24 morning, noon, and evening - no temperatures listed7/4/25 morning, noon, and evening - no temperatures listed7/5/25 morning, noon, and evening - no temperatures listed7/6/25 morning, noon, and evening - no temperatures listed7/7/25 morning - final rinse 170 F7/7/25 evening - no temperatures listed7/8/25 morning - final rinse 171 F7/8/25 evening - no temperatures listed7/9/25 noon and evening - no temperatures listed7/10/25 morning, noon, and evening - no temperatures listed7/11/25 morning - final rinse 170 F7/11/25 evening - no temperatures listed7/12/25 morning - final rinse 169 F7/12/25 noon - final rinse 179 F7/12/25 evening - no temperatures listed7/13/25 morning and noon - no temperatures listed7/13/25 evening - final rinse 130 F7/14/25 morning - wash 140 F, final rinse 165 F7/14/25 noon - final rinse 179 F7/14/25 evening - final rinse 178 F7/15/25 evening - final rinse 170 F7/16/25 morning, noon, and evening - no temperatures listed7/17/25 morning, noon, and evening - no temperatures listed7/18/25 morning - final rinse 165 F7/18/25 noon and evening - no temperatures listed7/19/25 morning - final rinse 163 F7/19/25 noon and evening - no temperatures listed7/20/25 morning - wash 158 F, 166 F7/20/25 noon and evening - no temperatures listed7/21/25 morning, noon, and evening - no temperatures listed7/22/25 morning - final rinse 170 F7/22/25 evening - no temperatures listed7/23/25 morning, noon, and evening - no temperatures listed7/24/25 morning, noon, and evening - no temperatures listed7/25/25 morning, noon, and evening - no temperatures listed7/26/25 morning - final rinse 170 F7/26/25 evening - no temperatures listed7/27/25 morning, noon, and evening - no temperatures listed7/28/25 morning, noon, and evening - no temperatures listed The floor was sticky in the dry storage area.Cheerios in a bulk container had a label that indicated must use by 7/24/25.2. On 8/1/25 at 10:23 A.M., a follow-up visit to the kitchen was completed with the Kitchen Manager.A dishwasher cycle was observed. The final rinse temperature was 175 degrees Fahrenheit (F). At that time, the Kitchen Manager indicated the dishwash was a high temperature dishwasher and they did not test it with sanitization strips.The floor was sticky in the (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dry storage area.Cheerios in a bulk container had a label that indicated must use by 7/24/25.On 8/5/25 at 12:48 P.M., the Administrator provided a current Food Safety Requirements policy, dated 4/9/24, that indicated Food will .be stored, prepared, distributed and served in accordance with professional standards for food service safety . Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms.On 8/5/25 at 12:48 P.M., the Administrator provided a current Dishwasher Temperature policy, dated 11/1/23, that indicated All items cleaned in the dishwasher will be washed in water that is sufficient to sanitize any and all items . For high temperature dishwashers (heat sanitization): The wash temperature shall be . For a single tank, conveyor, dual temperature machine: 160 F . The final rinse temperature shall be 180 F or above but not to exceed 194 F . Corrective actions shall be taken for final temperatures below the required final rinse temperatures . Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes.On 8/6/25 at 9:46 A.M., the Administrator provided a current Cleaning Schedules policy, revised 6/2020, that indicated The Dining and Nutrition Services staff will maintain the cleanliness and sanitation of the dining and food service areas.3.1-21(i)(2)3.1-21(i)(3)

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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 ensure designation of a certified Infection Preventionist (IP). The full time director of nursing was unable to provide documentation of infection prevention certification, and did not currently dedicate at least part time to the role of IP for 1 of 1 staff members reviewed for IP. Finding includes:During an interview on 8/5/25 at 10:07 A.M., the full-time Director of Nursing (DON) indicated she was managing the Infection Preventionist (IP) role, and dedicated about two hours each working day to the infection prevention program tasks. On 7/29/25 at 9:11 A.M., the Administrator indicated the facility had a full time DON.On 8/5/25 at 2:36 P.M., a copy of the Infection Prevention certification was requested; the DON indicated she was unable to provide a infection prevention certification. On 8/5/25 at 12:48 P.M., the Administrator provided a job description titled Infection Preventionist that indicated Minimum qualifications: have completed specialized training in infection prevention and control and must work at least part time

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure the kitchen was free of pests during 2 of 2 kitchen observations. Gnats were observed in the dry storage room and flies were observed in the food holding area. (Kitchen)Findings include:On 7/29/25 at 9:17 A.M., an initial tour of the kitchen was completed with the Kitchen Manager. Gnats were observed in the dry storage room. On 8/1/25 at 10:51 A.M., a follow-up visit of the kitchen was completed with the Kitchen Manager. Mexican corn and Spanish rice were observed on the steam table and were not covered. A fly was observed flying around the uncovered food. On 8/5/25 at 9:04 A.M., the Kitchen Manager indicated there was an open drain in the dry storage room which was where the pests were coming from. On 8/5/25 at 2:54 P.M., the Administrator provided a current Maintenance Policy, revised 7/2024, that indicated The Director of Plant Operations will monitor the contract services for pest control on a regular and as-needed basis and assure the building is kept free of any possible infestations of rodents or insects. This shall be accomplished by maintaining window screens in good repair and eliminating sites of breeding and entry. 3.1-19(f)(4)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the development and implementation of care plans for 1 of 3 residents reviewed for notification of change, 1 of 2 residents reviewed for urinary tract infections (UTI) or catheter, and 1 of 3 residents reviewed for falls. A resident on comfort measures did not have a care plan related to palliative care, monitoring was not completed following a seizure, and a fall intervention was not in place. (Resident S, Resident M, Resident L)Findings include:1. On 7/30/25 at 1:29 P.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to, displaced intertrochanteric fracture of the right femur, history of falling, and dementia. The most current Annual Minimum Data Set (MDS) Assessment, dated 4/7/25, indicated Resident L had severe cognitive impairment, was independent in rolling left to right and for sit to stand transfers, required supervision of staff for toilet transfers, toileting, and bathing, used a walker, and had two or more falls without injury and one fall with injury since the prior assessment. A Quarterly Fall Risk Assessment, dated 4/27/25, indicated Resident L was at high risk for falls. A current risk for falls care plan, revised 7/28/25, included, but were not limited to, the following interventions:Bedside table with locked wheels, dated 7/2/25 A nursing falls progress note, dated 6/21/25 at 4:10 P.M., indicated Resident L had an unwitnessed fall. The resident was observed on the floor next to his roommate's bed. The bedside table was sideways on the floor, and the dishes were on the floor. The resident complained of severe pain in the right hip. There was external rotation of the right foot noted, and the right leg appeared shortened. The resident was transported to the hospital by ambulance. Hospital discharge paper, dated 6/25/25, indicated Resident L was admitted to the hospital on [DATE] with a right intertrochanteric femur fracture. On 6/22/25, the resident underwent a cephalomedullary fixation (a surgical procedure used to stabilize and fix fractures of the proximal femur, specifically involving the femoral neck and intertrochanteric region) for the right intertrochanteric femur fracture. The resident was discharged back to the facility on 6/25/25. A Quarterly Fall Risk Assessment, dated 6/26/25, indicated Resident L was at moderate risk for falls. A Significant Change MDS Assessment was completed on 7/2/25. Resident L had severe cognitive impairment, was dependent on staff (staff does all of the work) for eating, toileting, and to roll left to right, required substantial to maximal assistance of staff (staff does more than half of the work) for bathing, and sit-to-stand and toilet transfers were not attempted. The resident used a wheelchair and had a fall with a fracture in the last month. On 7/31/25 at 2:34 P.M., Resident L was observed in bed in his room. He indicated that staff had just helped him back to bed after he attended an activity. A large bedside table with wheels was observed next to his bed. The bedside table's wheels were not locked. There was a smaller stationary table without wheels next to his recliner. The smaller stationary table was not in reach of the resident's bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/1/25 at 9:11 A.M., Resident L was observed sitting in his wheelchair next to his bed. A large bedside table with wheels was observed at the foot of his bed. The large bedside table had breakfast dishes on it. The bedside table's wheels were not locked. There was a smaller stationary table without wheels next to his recliner. The smaller stationary table was not in reach of the resident. On 8/1/25 at 2:22 P.M., Resident L was observed in bed working with Speech-Language Pathologist (SLP) 5. A large bedside table with wheels was observed next to the resident's bed. A smaller stationary table without wheels was next to his recliner and not in reach of Resident L. At that time, SLP 5 indicated that the large bedside table was not locked. On 8/6/25 at 9:45 A.M., the Director of Nursing (DON) indicated that Resident L fell on 6/21/25 while using his roommate's bedside table to balance himself while attempting to sit on his roommate's bed. The facility attempted to replace the large bedside table with wheels with the smaller stationary table, but neither the resident nor the resident's family member liked it, so the larger bedside table with wheels was left in the room. 2. On 7/31/25 at 10:53 A.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD). The resident was admitted to the facility on [DATE]. The current Quarterly Minimum Data Set (MDS) Assessment, dated 6/17/25, indicated Resident S was cognitively intact and required partial to moderate assistance of staff (staff does less than half of the work) for Activities of Daily Living (ADLs). Nursing orders included, but were not limited to:Resident under the care of (name of Palliative Care) admitted with terminal diagnoses, COPD (with oxygen dependency. The condition/chronic disease may result in a life expectancy of less than six months. Please contact the Palliative service with all changes in conditions, to receive orders, dated 7/24/2025 A Care Plan Conference was completed on 7/24/25 with the resident and the resident's family members in attendance. Advanced Care Planning and current Advance Directives were reviewed. The clinical record lacked a care plan related to palliative care services. On 8/1/25 at 10:17 A.M., MDS Coordinator 11 indicated Resident S did not have a care plan for palliative care.3. On 8/01/25 at 1:40 P.M., Resident M's clinical record was reviewed. Resident M was admitted on [DATE]. Diagnosis included, but was not limited to, epilepsy. The most recent Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident M was moderately cognitively impaired and was dependent on staff (staff do all of the work) for toileting and transfers. Physician orders included, but were not limited to: Onfi oral tablet 20 MG (milligrams), give 20 mg by mouth at bedtime for seizures; Start date 4/1/25Levetiracetam Oral Tablet 750 MG, give 750 mg by mouth two times a day for seizures; Start date 4/1/25Lamictal Tablet 200 MG, give one tablet by mouth two times a day for seizures; Start date 4/1/25 Current care plan included, but was not limited to: I am currently prescribed an anticonvulsant for seizure disorder; Date Initiated: 11/26/24 I have a seizure disorder and convulsions; Date Initiated: 8/10/20 During a witnessed seizure, you will observe for type of activity (jerks, convulsive movements, tremors), duration of seizure, level of consciousness during and after seizure, and incontinence. Date Initiated: 7/6/23 Report and observe for speech changes, headache, change in mental status or level of consciousness, weakness, changes in the pupil; Date Initiated: 8/10/20 A nursing progress note dated 7/3/2025 7:08 P.M., (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident began having seizure activity in the hallway. Tremors of all extremities, particularly arms. Hands grasping and eyes blinking. Lasted no more than 3 minutes. She was then taken to her room. She had seizure activity twice more. Complain of headache. The clinical record, including progress notes, assessments, and documentation, lacked observation of changes for Resident M post-seizure activity. During an interview on 8/5/25 at 10:20 A.M., the Director of Nursing indicated that after a resident experienced a seizure, staff should monitor the resident and notify the family and physician. On 8/5/25 at 12:36 P.M., the Administrator provided a current Comprehensive Care Plans policy, revised 2/5/25, that indicated It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . The comprehensive care plan will describe, at a minimum, the following: . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. On 8/5/25 at 12:48 P.M., the Administrator provided a current Fall Investigation and Risk Evaluation policy, revised 8/2024, that indicated It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents. This tag relates to complaint 2567193. 3.1-35(a)3.1-35(b)(1)3.1-35(g)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 proper infection control protocols) for 1 of 2 residents for catheter and 3 random observations of cleaning equipment and using Personal Protective Equipment (PPE). (Licensed Practical Nurse (LPN) 2 Registered Nurse (RN) 3, Certified Nursing Assistant (CNA) 6, CNA 10, Resident S, Resident 10)Findings include: 1. On 7/29/25 at 9:10 A.M., a wrist blood pressure cuff/monitor was observed sitting on top of the 500 Hall medication cart with several layers of tape attached to the top of it. On 8/5/25 at 9:27 A.M., the 800 Hall vitals machine was observed. The oxygen saturation tubing was observed with tape wrapped around the area where the two sections of tubing were connected. The ends of the tape were discolored. On 8/5/25 at 11:07 A.M., the Director of Nursing (DON) indicated she was unaware of any tape on the blood pressure cuff or oxygen saturation machines, but would look into them. On 8/6/25 at 8:31 A.M., the DON indicated a piece had broken off the blood pressure cuff/monitor, and the tape had been placed to keep the batteries in, and the oxygen saturation monitor had two cords with a latch between them that had broken, and someone had put tape around the connection to keep it together. She indicated that staff education was needed. 2. On 7/29/25 at 10:07 A.M., Resident S was observed lying in bed. His catheter bag was uncovered and lying on the floor beside his bed. On 7/31/25 at 10:53 A.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, neurogenic bladder and obstructive uropathy. The current Quarterly Minimum Data Set (MDS) Assessment, dated 6/17/25, indicated Resident S was cognitively intact, required partial to moderate assistance of staff (staff does less than half of the work) for toileting, and had an indwelling catheter. A care plan conference was completed on 7/24/25 with the resident and the resident's family members in attendance. Care plans were reviewed. Current care plans included, but were not limited to:I require enhanced barrier precautions related to a medical device (supra pubic catheter), dated 7/22/24 I have a suprapubic catheter related to Benign Prostatic Hypertrophy, Neurogenic bladder, dated 7/15/24 Physician orders included, but were not limited to:Suprapubic Catheter: 16 French 10 milliliter balloon for neuromuscular dysfunction of bladder, dated 7/24/25 Enhanced Barrier Precautions (EBP) implemented due to an Indwelling Medical Device (Foley Catheter) will require EBP until the device is removed - Gown and Gloves required for Direct Care, dated 7/24/25 On 7/31/25 at 2:36 P.M., Resident S was observed sitting in his motorized wheelchair. His catheter bag was hanging on the arm of the wheelchair above the level of his bladder. On 8/1/25 at 9:11 A.M., Certified Nurse Aide (CNA) 6 and CNA 10 were observed performing perineal care and a bed bath for Resident S. CNA 6 and CNA 10 were not wearing a gown. On 8/1/25 at 9:25 A.M., Resident S was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed sitting in his motorized wheelchair. His catheter bag was hanging on the arm of the wheelchair above the level of his bladder. On 8/5/25 at 10:07 A.M., the Director of Nursing (DON) indicated she also served as the Infection Preventionist (IP). She indicated that catheter bags should not touch the floor and should be placed below the waistline. Staff should wear a gown and gloves while providing care to any resident with an indwelling line, such as a catheter. 3. On 8/4/25 at 1:30 P.M., Licensed Practical Nurse (LPN) 2 was observed performing catheter care on Resident 10 without putting on Personal Protective Equipment (PPE) when the resident is on Enhanced Barrier Precautions. 4. On 8/4/25 at 12:15 P.M., during a random observation, Registered Nurse (RN) 3 was observed going into room [ROOM NUMBER] and performed an Accu-Chek and did not clean the glucometer. Took blood sugar in room [ROOM NUMBER]. Put the glucometer back in the med cart without cleaning it. Locked the cart and walked away. During an interview on 8/4/25 at 1:45 P.M., LPN 2 indicated she forgot to put on the required PPE before entering the room. During an interview on 8/5/25 at 2:34 P.M., the Director of Nursing (DON) indicated the staff should clean the glucometer between each resident. On 8/5/25 at 12:36 P.M., the Administrator provided a current Catheter Care policy, revised 6/7/24, that indicated Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. Ensure tubing and catheter bag does not touch the floor. On 8/5/25 at 12:36 P.M., the Administrator provided a current Enhanced Barrier Precautions policy, revised 2/5/25, that indicated An order for enhanced barrier precautions will be obtained for residents with any of the following: . indwelling medical devices (e.g., .urinary catheters .) even if the resident is not known to be infected or colonized with a MDRO . PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact resident care activities include: Dressing, Bathing, Transferring, Providing hygiene .Changing briefs or assisting with toileting . On 8/6/25 at 11:21 A.M., the Administrator provided a current policy, Glucometer Disinfection dated 2/12/24. The policy indicated . glucometers will be cleaned and disinfected after each use and according to the manufacturer's instructionsregardless of whether they are intended for single resident or multiple resident use ." 3.1-18(b)(1)3.1-18(b)(2)

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure an assessment was completed for a resident who self administered medications for 1 of 1 random observation. A bottle of eye drops was observed in a resident's room. (Resident 13)Finding includes: On 8/1/25 at 6:55 A.M., Resident 13 was observed lying in his bed with a bedside table next to him during a medication pass with Licensed Practical Nurse (LPN) 9. A bottle of eye drops with no label was observed on the bedside table. After the resident's medications were administered, LPN 9 did not address or obtain the bottle of eye drops. After being asked about the bottle, LPN 9 obtained the eye drop bottle and carried it to the medication cart in the hall. At that time, LPN 9 indicated Resident 9 did have an order for eye drops, but did not have an order to self administer them, and did not have a self administration assessment for the eye drops on file. A separate bottle of eye drops with a label that indicated they were for Resident 13 was then observed in the medication cart. LPN 9 indicated the resident's family would sometimes bring in items such as the eye drops, and that the bottle would be returned to them. On 8/1/25 at 10:44 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but was not limited to, dry eyes. The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/31/25, indicated no cognitive impairment and no behaviors. Resident 13 required supervision or touching assistance for bed mobility and transfers. Current physician orders included, but were not limited to:Refresh tears 0.5% solution, 1 drop in each eye every hour as needed for dry eyes, dated 5/13/25. Resident 13's clinical record lacked a care plan related to self administration of eye drops. Resident 13's clinical record lacked a self administration assessment for eye drops. On 8/5/25 at 2:00 P.M., the Administer provided a current Self Administration of Medications policy, dated 6/26/24, that indicated A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. 3.1-11(a)

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	155803	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Pointe Health and Rehab	3800 Eli Place Newburgh, IN 47630

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the residents' families for 2 of 3 residents reviewed for notification of changes. A resident's family was not notified of a change in the resident's physical condition and a resident's fall. (Resident F, Resident M)Findings include: 1. On 7/30/25 at 2:37 P.M., Resident F's clinical record was reviewed. Diagnoses included but were not limited to hypertension and acute respiratory failure. The Current admission Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was cognitively intact. Resident F needs supervision for transferring, setting up for eating, partial assistance with hygiene, and substantial/maximum assistance of 2 for toileting and dressing. Current physician orders included, but were not limited to, Tylenol Extra Strength Oral Tablet (pain relief) 500 Milligrams (MG). Give 1 tablet by mouth three times a day for Shoulder pain dated 7/24/25. The Current Fall Risk Care Plan dated 7/1/25 indicated the resident was at risk for falls due to a history of falls and impaired balance. Current interventions included but were not limited to, call bell within reach, call don't fall sign to bathroom door, and wear proper footwear or non-slip footwear when up. A nursing progress dated 7/20/25 at 10:00 A.M., composed by RN 7, indicated the daughter came to visit and was informed at that time that the resident had a fall. The daughter noticed that the resident had a mental status change and wanted the resident sent to the hospital. During a phone interview on 7/30/25 at 8:38 A.M., the Power of Attorney indicated she was not notified about the fall until the family came to visit and found Resident F confused. She also indicated that the nurse who was assigned to the resident did not start the paperwork until after the family was made aware. During an interview on 7/31/25 at 10:15 A.M., RN 7 indicated she probably should have called the family at the time the resident had fallen instead of doing her medications and several other things at this time. 2. On 8/01/25 at 1:40 P.M., Resident M's clinical record was reviewed. Resident M was admitted on [DATE]. Diagnosis included, but was not limited to, epilepsy. The most recent Quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident M was moderately cognitively impaired and was dependent on staff (staff do all the work) for toileting and transfers. Physician orders included, but were not limited to: Onfi oral tablet 20 MG (milligrams), give 20 mg by mouth at bedtime for seizures; Start date 4/1/25Levetiracetam Oral Tablet 750 MG, give 750 mg by mouth two times a day for seizures; Start date 4/1/25Lamictal Tablet 200 MG, give one tablet by mouth two times a day for seizures; Start date 4/1/25 Resident M's special instructions for plan of care indicated: Please contact Palliative service with all changes in conditions, to receive orders. Current care plan included, but was not limited to: I am currently prescribed an anticonvulsant for seizure disorder; Date Initiated: 11/26/24 I have a seizure disorder and convulsions; Date Initiated: 8/10/20 A nursing progress note dated 7/3/2025 7:08 P.M., indicated Resident began having seizure activity in the hallway. Tremors of all extremities, particularly arms. Hands grasping and eyes blinking. Lasted no more than 3 minutes. She was then taken to her room. She had seizure activity twice more. Complain of headache. The clinical record, including progress notes, assessments, and documentation, lacked notification to family, physician, or palliative care post-seizure activity. During an interview on 8/5/25 at 10:20 A.M., the Director of Nursing indicated that after a resident (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	experienced a seizure, staff should monitor the resident and notify the family and physician. On 7/31/25 at 10:31 A.M., the Administrator provided a current policy Notification of Change dated August 2024. The policy indicated .The facility must inform the resident, consult with the resident’s physician and /or notify the resident’s family member or legal representative when there is a change requiring such notification . This citation relates to complaint 2567193 3.1-59(a)(1)3.1-5(a)(2)

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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, interview, and record review, the facility failed to revise a resident's plan of care to reflect current interventions for 1 of 3 residents reviewed for accidents. A resident's falls care plan was not updated to reflect implementation of a call don't fall sign. (Resident 2)Finding includes:On 7/31/25 at 9:15 A.M., Resident 2's clinical record was reviewed. Diagnosis included, but was not limited to, fracture to right humerus. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/7/25, indicated mild cognitive impairment, and no falls since the prior assessment. A current risk for falls care plan, last revised on 7/30/25, lacked an intervention for a call don't fall sign in the resident's room. A progress note on 6/13/25 at 10:02 A.M. indicated Resident 2 fell, but did not remember how it happened. An immediate intervention was a call don't fall sign in place. An IDT note on 6/16/25 at 8:49 A.M. indicated the resident had fallen on 6/13/25, and would evaluate upon return from hospital for any new interventions. On 7/31/25 at 2:00 P.M., Resident 2's room was observed with a call don't fall sign on the bathroom door. On 8/1/25 at 10:06 A.M., the MDS Coordinator indicated all falls were discussed the following day at a morning clinical meeting. Any new interventions would be added immediately to the resident's care plan following the meeting by either the MDS Coordinator, the Director of Nursing (DON), or the nurses on the floor. She indicated since Resident 2 had went to the hospital after the fall on 6/13/25, the plan was to re-evaluate when he got back for a new intervention and that was not done. The immediate intervention was to put up the sign, but it was not updated to the resident's care plan. On 8/5/25 at 2:00 P.M., the Administrator provided a current Comprehensive Care Plans policy, last revised 2/5/25, that indicated The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. 3.1-35(c)3.1-35(d)

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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. Based on observation, interview, and record review, the facility failed to ensure a resident with an indwelling urinary catheter received appropriate services and treatment related to catheter placement for 1 of 3 residents reviewed for catheter use. A resident with an indwelling urinary catheter received the wrong size catheter. (Resident B)Finding includes:On 7/31/25 at 8:50 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, ulcerative colitis, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/17/25, indicated no cognitive impairment, and use of an indwelling urinary catheter. Resident 10 was dependent on staff for bed mobility and toileting.Current physician orders included, but were not limited to:Foley catheter: 16 French (size of catheter)/30cc (milliliter) balloon, dated 3/14/25.Foley catheter: change catheter as needed 16 French/30cc balloon every 8 hours as needed for maintaining catheter, dated 3/14/25.An indwelling catheter care plan, created 3/17/25, indicated, but was not limited to, an intervention to change catheter system when clinically indicated or ordered, dated 3/17/25.A progress note on 4/22/25 at 6:40 A.M. indicated Resident B's indwelling catheter was changed using an 18 French catheter anchored with 20cc normal saline.A progress note on 7/13/25 at 12:07 P.M. indicated resident's catheter had been unable to flush, and was replaced with a 20 French catheter. On 8/4/25 at 11:02 A.M., Licensed Practical Nurse (LPN) 21 was observed to change Resident B's wound dressing on the buttocks. At that time, Resident B's urine was observed to be bloody with bleeding from the vaginal area. On 8/5/25 at 9:27 A.M., Registered Nurse (RN) 3 indicated the size of an indwelling catheter would be on the physician's order and staff should not deviate from the size ordered. On 8/5/25 at 2:00 P.M., the Administrator provided a current Appropriate Use of Indwelling Catheters policy, dated 11/27/23, that indicated The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter, and frequency of change (if applicable).3.1-41(a)

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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 and record review, the facility failed to ensure accurate documentation for 1 of 2 residents reviewed for change of condition, and 1 of 2 residents reviewed for urinary tract infections (UTI) or catheter. (Resident B, Resident 21)Findings include:1. On 7/31/25 at 8:50 A.M., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, ulcerative colitis, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/17/25, indicated no cognitive impairment and use of an indwelling urinary catheter. Resident B was dependent on staff for bed mobility and toileting.Current physician orders included, but were not limited to:Foley catheter: 16 French (size of catheter)/30cc (milliliter) balloon, dated 3/14/25.An indwelling catheter care plan, created 3/17/25, indicated, but was not limited to, an intervention to change the catheter system when clinically indicated or ordered, dated 3/17/25.A progress note on 7/3/25 at 5:15 P.M. indicated . Catheter was changed with a 15g/30cc . On 8/5/25 at 9:27 A.M., Registered Nurse (RN) 3 indicated urinary catheters came in sizes 14, 16, 18, or 20. She indicated that to her knowledge, there was no size 15g urinary catheter. RN 3 observed the note on 7/2/25 and indicated it could have been a slip of the fingers when entering it into Resident B's medical record. 2. On 7/31/25 at 8:43 A.M., Resident 21's clinical record was reviewed. Diagnoses included, but were not limited to, renal failure, dementia, anxiety, depression, and psychotic disorder. The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/11/25, indicated a mild cognitive impairment, and was not on hospice. Current physician orders included, but were not limited to:Comfort measures: No further hospitalizations or diagnostics. Call (name) for comfort orders when needed, dated 6/1/25. Resident 21 lacked an order for hospice services. A current care plan, dated 6/2/25, indicated comfort measures were elected, and to notify the hospice provider if medications were ineffective, dated 7/26/25. Progress notes included, but were not limited to, the following:5/29/25 at 9:06 A.M. Nurse Practitioner was notified related to daughter's expression for palliative/hospice option for care. 6/2/25 at 11:32 A.M. Daughter stated family wished to proceed with hospice/palliative care. Psychiatry Progress/Encounter notes included, but were not limited to, the following:6/11/25 at 12:00 A.M. She was recently placed on hospice . Hospice discontinued her olanzapine . Namenda 10 mg [milligrams] twice a day - discontinued by hospice . 6/25/25 at 12:00 A.M. She remains on hospice . Hospice discontinued her olanzapine . Namenda - discontinued by hospice . 7/30/25 at 12:00 A.M. Hospice discontinued her olanzapine . Namenda - discontinued by hospice . On 8/5/25 at 9:43 A.M., the Director of Nursing (DON) indicated Resident 21 was in the hospital from [DATE] through 5/11/25 and during that time had a feeding tube placed that she came back to the facility with. The resident did not like it, and the daughter and Nurse Practitioner were called about it. During those discussions, it was decided that the resident would be on comfort care through the facility Nurse Practitioner, as the resident would not have liked hospice staff taking care of her. She indicated the psychiatric provider assumed Resident 21 was on hospice because of the order for comfort care and included hospice in their notes. She also indicated there was no specific care plan for comfort care, so it was possible that the verbiage just had not been changed to exclude hospice from the care plan intervention. On 8/5/25 at 2:00 P.M., the Administrator provided a current Documentation in Medical Record policy, dated 1/30/24, that indicated Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation . Principles of documentation include, but are not limited to . Documentation shall be factual, objective, and resident centered . False information shall not be documented . Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. 3.1-50(a)(2)