STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155104	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Center	1201 W Buena Vista Rd Evansville, IN 47710

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 interview and record review, the facility failed to ensure a resident's dignity was respected for 1 of 1 resident reviewed for dignity. A resident was told to urinate in her brief instead of being assisted to the toilet for staff convenience. (Resident 14) Finding includes: On 4/21/25 at 10:02 A.M., Resident 14 appeared to be teary. She indicated that she was upset about staff treatment of her the night of 4/20/25. She indicated that she was in bed and needed to use the toilet. An agency aide told her that she did not want to help her to the toilet and to urinate in her brief instead because she preferred to change the resident in bed. The resident indicated that she finally did urinate in her brief and the aide changed her. On 4/23/25 at 8:59 A.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/24/25, indicated that Resident 14 was cognitively intact, required partial to moderate assistance of staff (staff does less than half of the effort) for toileting, and had no behaviors. A Bladder Continence Assessment, dated 7/2/24, indicated that the resident was on a toileting program. Staff were to assist the resident at night when awake and as needed to help establish a routine for urinary elimination and improve incontinence. A current Activities of Daily Living (ADL) Self Care Performance Deficit care plan, last revised on 11/20/24, indicated that Resident 14 required physical assistance of two staff with transfers, assistance of one staff onto the bedpan, and assistance of two staff for the bedside commode. A current risk for perineal irritation related to incontinent episodes, last revised on 6/6/24, included an intervention for staff to routinely check for incontinence through the night and offer to assist with toileting when awake. On 4/24/25 at 9:19 A.M., Certified Nurse Aide (CNA) 11 indicated that Resident 14 used the toilet on her own schedule. Whenever she had to go, she was assisted to the toilet. On 4/24/25 at 10:04 A.M., CNA 11 was observed assisting Resident 14 to the toilet. At that time, Resident 14 indicated CNA 11 was much gentler with her than the aide from the night before because the night aide jerked on her gait belt multiple times to get her to stand up. (continued on next page)

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	On 4/25/25 at 9:27 A.M., CNA 11 indicated that if a resident complained of the previous shift being rough, she would report it to the nurse. She indicated she did report Resident 14's complaint about the night shift staff being rough to a nurse. On 4/25/25 at 9:50 A.M., Licensed Practical Nurse (LPN) 7 indicated that if an aide reported that a resident had an issue with another staff member, she would tell the Administrator immediately. In an email from a confidential source on 4/25/25 at 10:54 A.M., it was indicated that Resident 14 was concerned with an aide that did not honor the resident's wishes and was very rude. On 4/25/25 at 1:18 P.M., the Administrator provided a current Quality of Life - Dignity policy, dated 9/15/17, that indicated Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth . Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: . Responding to the resident's request for toileting assistance . 3.1-3(a)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the admission Minimum Data Set (MDS) Assessment was completed within 14 days of admission for 1 of 1 residents reviewed for new admissions. (Resident 335) Finding includes: On 4/22/25 at 1:30 P.M., Resident 335's clinical record was reviewed. Diagnosis included, but was not limited to, end stage renal disease. Resident 335 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) Assessment, dated 4/21/25, indicated it was still in process and not completed. The MDS dashboard included a warning that the admission MDS was overdue. On 4/24/25 at 2:30 P.M., the MDS Coordinator indicated that the facility's policy was to follow the Resident Assessment Instrument (RAI) Manual. The most current RAI Manual, dated October 2024, indicated that an admission MDS Assessment completion date was no later than the 14th calendar day of the resident's admission (admission date + 13 calendar days). 3.1-31(d)(1)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed no less than once every 3 months for 1 of 13 resident quarterly MDS assessments reviewed. (Resident 75) Finding includes: On 4/22/25 at 11:06 A.M., Resident 75's clinical record was reviewed. Diagnosis included, but was not limited to, stage 3 chronic kidney disease. The most recent completed MDS assessment was a significant change MDS assessment, dated 12/24/24. A quarterly MDS assessment, due 3/26/25, was still in progress (13 days late). 3.1-31(d)(3)

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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 interview and record review, the facility failed to ensure a resident's Minimum Data Set (MDS) Assessment was completed accurately for 1 of 5 residents reviewed for unnecessary medications. (Resident 4) Finding includes: On 4/22/25 at 12:27 P.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, prediabetes and chronic pain syndrome. The most recent Annual Minimum Data Set (MDS) Assessment, dated 2/19/25, indicated Resident 4 was cognitively intact, received hypoglycemic medication during the 7-day look back period, and did not receive an anticonvulsant during the 7-day lookback period. Current physician orders included, but were not limited to: gabapentin (an anticonvulsant medication) oral capsule 100 milligrams (mg) - Give one capsule by mouth two times a day for pain, dated 1/31/25 The clinical record lacked an order for a hypoglycemic medication. On 4/24/25 at 2:14 P.M., the MDS Coordinator indicated that she marked hypoglycemic in error and meant to mark anticonvulsant. On 4/24/25 at 2:30 P.M., the MDS Coordinator indicated that the facility's policy was to follow the Resident Assessment Instrument (RAI) Manual.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the development of a resident's comprehensive care plan for 1 of 2 residents reviewed for Hospice and 1 of 1 residents reviewed for UTI. (Resident 45, Resident 22) Findings include 1. On 4/22/25 at 11:09 A.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, transient cerebral ischemic attack, occlusion and stenosis of left middle cerebral artery, and need assistance with personal care. The current Annual Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident was severely cognitively impaired. Resident 45 was dependent on assistance for dressing, transferring and toileting. The current physician order included but was not limited to: Consult (name)Hospice for decline in health dated 3/6/25. There is no care plan for (name) Hospice for Resident 45. During an interview on 4/24/25 at 1:40 P.M., the Director of Nursing indicated there should be an initial care plan if a resident enters Hospice. 2. On 4/22/25 at 12:58 P.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on [DATE]. Diagnosis included, but were not limited to, urinary tract infection. The most recent MDS Assessment, dated 3/19/25, indicated Resident 22 was cognitively intact, required supervision from staff for toileting, required partial assistance from staff (staff do some of the work) for transfers, and was frequently incontinent of urine. Physician orders included, but were not limited to: Nitrofurantoin macrocrystal capsule 50 MG (milligrams) Give one capsule by mouth at bedtime for prophylaxis colonized klebsiella; Start date 1/7/25. Resident 22's clinical record lacked a care plan related to monitoring for frequent urinary tract infections or continuous antibiotic use. The following dates, during the last 12 months, Resident 22 had a positive urine culture indicating a urinary tract infection: 2/25/25 12/14/24 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/20/24 9/28/24 8/3/24 6/30/24 5/11/24 During an interview on 4/25/25 at 1:30 P.M., the Administrator indicated that the development of care plans was based on the Resident Assistant Instrument (RAI) Manual. 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 9. On 4/22/25 at 12:58 P.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on [DATE]. Diagnoses included, but were not limited to, urinary tract infection. The most recent Quarterly MDS Assessment, dated 3/19/25, indicated Resident 22 was cognitively intact, required supervision from staff for toileting, required partial assistance from staff (staff do some of the work) for transfers, and was frequently incontinent of urine. The most recent care plan conference held for Resident 22 was 12/30/24. Additional quarterly care plan conferences held in the last 12 months were requested. During an interview on 4/25/25 at 1:18 P.M., the Administrator indicated there were no additional care plan conferences to be provided. Based on interview and record review, the facility failed to ensure care plan conferences were completed quarterly for 13 of 25 residents admitted reviewed for care plans. (Resident 1, Resident 16, Resident 14, Resident 22, Resident 17, Resident 26, Resident 42, Resident 45, Resident 49, Resident 75, Resident 99, Resident 105, Resident 115) Findings include: 1. On 4/22/25 at 9:03 A.M., Resident 26 indicated that the facility did not involve her in reviewing her care plan and that she did not attend care plan conference meetings quarterly. On 4/23/25 at 9:27 A.M., Resident 26's clinical record was reviewed. Diagnosis included, but was not limited to, generalized anxiety disorder. The most current Quarterly MDS Assessment, dated 2/20/25, indicated Resident 26 was cognitively intact, was dependent on staff (staff does all the effort) for transfers, and received an antianxiety medication and opioid during the 7-day lookback period. The most recent care plan conference was dated 10/29/24. On 4/24/25 at 2:30 P.M., the MDS Coordinator indicated that the IDT met quarterly to discuss residents' plans of care, but they were not documented in the clinical record unless the resident or resident's family attended. On 4/25/25 at 10:54 A.M., the Director of Nursing (DON) indicated that IDT notes for care plan conferences were not able to be provided 2. On 4/22/25 at 10:06 A.M., Resident 75's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety, depression, and respiratory failure. The most recent Significant Change MDS Assessment, dated 12/24/24, indicated no cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 75's clinical record lacked documentation that the IDT had held a care conference in the previous 12 months 3. On 4/22/25 at 12:40 P.M., Resident 42's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and Parkinson's disease. The most recent Quarterly MDS Assessment, dated 2/16/25, indicated a severe cognitive impairment. Resident 42's clinical record lacked documentation that the Interdisciplinary Team (IDT) had held a care conference in the previous 12 months. 4. On 4/22/25 at 12:48 P.M., Resident 99's clinical record was reviewed. Diagnoses included, but were limited to, dementia and adjustment disorder. The most recent Quarterly MDS Assessment, dated 1/15/25, indicated a severe cognitive impairment. Resident 99's clinical record lacked documentation that the IDT had held a care conference in the previous 12 months. 5. On 4/22/25 at 12:49 P.M., Resident 115's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia and need for assistance with personal care. The current Quarterly MDS Assessment date 1/14/25 indicated Resident 115 was severely cognitively impaired. Resident 115 was dependent on transferring and needed partial to moderate less than 1/2 the time showering, dressing, and eating. The most recent care plan conference was dated 10/31/24. 6. On 4/22/25 at 1:14 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, diffuse traumatic brain injury with loss of consciousness and traumatic hemorrhage of cerebrum. The current Quarterly MDS assessment dated [DATE] indicated Resident 1 is severely cognitively impaired. The resident is totally dependent for hygiene, eating, transferring, and dressing. The most recent care plan conference was dated 7/30/24. 7. On 4/22/25 at 1:47 P.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, muscle weakness (generalized), age-related osteoporosis without current pathological fracture, and history of falling. The current Annual MDS assessment dated [DATE] indicated that the resident was severely cognitively impaired. Resident 45 was dependent on assistance for dressing, transferring and toileting The most recent care plan conference was dated 4/18/24 8. On 4/22/25 at 1:50 P.M., Resident 105's clinical record was reviewed. Diagnoses included, but were not limited to, acquired absence of left leg above the knee and muscle weakness generalized. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current Quarterly MDS assessment dated [DATE] indicated Resident 105 was cognitively intact. Resident 105 was dependent on toileting, needed supervision with transferring, and needed partial assistance less than 1/2 time for hygiene. The most recent care plan conference was dated 4/18/24. 13. On 4/23/25 at 9:35 A.M., Resident 49's clinical record was reviewed. Resident 49 was admitted on [DATE]. Diagnoses included, but were not limited to, cerebral infarction. The most recent Quarterly MDS Assessment, dated 2/28/25, indicated Resident 49 was moderately cognitively intact and was dependent on staff (staff do all of the work) for toileting, bathing, and transfers. The clinical record lacked quarterly care plan conferences held for Resident 49 in the last 12 months. During an interview on 4/25/25 at 1:18 P.M., the Administrator indicated there were no care plan conferences to be provided. On 4/25/25 at 1:18 P.M., the Administrator provided a current Care Conference Policy and Procedure, revised 11/2024, that indicated Each resident will have an Interdisciplinary Care Plan developed and maintained by the Interdisciplinary Team . Care Conference will be conducted as requested by Resident/Family or staff. All disciplines will be represented by a health care professional or his/her designee. 3.1-35(d)(2)(B) 3.1-35(e 10. On 4/22/25 at 2:11 P.M., Resident 16's clinical record was reviewed. Diagnosis included, but was not limited to, acute posthemorrhagic anemia. The most current Quarterly MDS Assessment, dated 2/19/25, indicated that Resident 16 was not assessed for cognitive ability because she was rarely or never understood and was dependent on staff (staff does all the effort) for Activities of Daily Living (ADLs). The most recent care plan conference was dated 7/29/24. 11. On 4/23/25 at 8:59 A.M., Resident 14's clinical record was reviewed. Diagnosis included, but was not limited to, Parkinson's disease. The most current Quarterly MDS Assessment, dated 2/24/25, indicated Resident 14 was cognitively intact and required partial to moderate assistance of staff (staff does less than half of the effort) for Activities of Daily Living (ADLs). The clinical record lacked a care plan conference completed in the last 12 months. 12. On 4/23/25 at 1:16 P.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation and history of falling. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most current Quarterly MDS Assessment, dated 2/5/25, indicated Resident 17 had moderate cognitive impairment, required substantial to maximal assistance of staff (staff does more than half of the effort) for toileting and bathing, and had one fall with injury since the prior assessment. The clinical record lacked a care plan conference completed in the last 12 months.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure neurological assessments were completed following unwitnessed falls for 2 of 2 residents reviewed for falls. Facility policy for completion of neurological assessments was not followed when staff failed to complete the required neurological assessments initially following a fall as well as follow-up assessments. (Resident 45, Resident 105) Findings include: 1. On 4/22/25 at 1:47 P.M., Resident 45's clinical record was reviewed. Diagnoses included, but were not limited to, muscle weakness (generalized), age-related osteoporosis without current pathological fracture, and history of falling. The current Annual MDS assessment dated [DATE] indicated that the resident was severely cognitively impaired. Resident 45 was dependent on assistance for dressing, transferring and toileting. The current physician orders included, but were not limited to: Dycem (anti-sliding device) in wheelchair to prevent sliding down in chair dated 3/16/25. Use no-skid mat next to the window side of bed dated 8/12/24. The current fall risk care plan revised on 12/23/24 related to getting up on their own, impaired safety awareness, and muscle weakness included interventions that included, but were not limited to: Reminder sign to call for assistance dated 4/5/25. Offer non-skid socks and or non-skid shoes dated 3/18/24. Upon getting up place resident in day room recliner dated 3/7/25. A progress note dated 4/4/25 at 4:07 P.M. indicated that Resident 45 had an unwitnessed fall in the room doorway into her room lying on her right side. Neurochecks and vital signs were started at 4:00 P.M. and were to be completed every two hours. The initial assessment lacked pupil reactions for the first two assessment time. The neurochecks and vital signs with signatures were lacking at 8:00 P.M. and 10:00 P.M. The neurochecks and vital signs that were to be done every 2 hours from 4/5/25 at 6:00 A.M. until 4:00 P.M. lacked documentation of pupillary response and a nurse's signature. A progress note dated 3/18/25 at 10:51 P.M., indicated that Resident 45 has an unwitnessed fall in the day room where she was found sitting next to her recliner. Neurochecks and vital signs were started on 3/18/25 at 8:51 P.M. and were completed every two hours. The neurochecks and vital signs were not signed off every two hours by a nurse from 6:45 A.M. on 3/19/25 until 4:45 P.M. on 3/19/25. During an interview on 4/24/25 at 1:17 P.M., the Assistant Director of Nursing (ADON) indicated the Registered Nurse (RN) will do a neuro assessment immediately for all falls. If the fall is witness and not hit head vital signs are done every shift for 24 hours. The ADON indicated if the fall was unwitnessed the neurochecks are to be done every 2 hours after the initial hour. The sheets should be filled out completely. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/22/25 at 1:47 P.M., Resident 105's clinical record was reviewed. Diagnoses included, but were not limited to, acquired absence of left leg above the knee and muscle weakness generalized. The current Quarterly Minimum Data Service (MDS) assessment dated [DATE] indicated Resident 105 was cognitively intact. Resident 105 was dependent on toileting, needed supervision with transferring, and needed partial assistance less than 1/2 time for hygiene. The current physician orders included, but were not limited to: Falls prevention measures in place per care plan every shift dated 4/5/24. Activity Order: Up with assistance of (x) 2 with a sliding board for staff every shift dated 5/1/24 The current fall care plan indicated the resident is a fall risk due to injury, weakness, amputation of the leg, and altered mobility revised on 5/21/24. Interventions included but were not limited to: Instruct on use of the call light dated 5/21/24. Ensure anti-tippers are in proper position on each shift dated 2/12/25, and bed in the lowest position dated 5/21/24. A nursing progress note dated 2/12/25 at 6:15 P.M. indicated Resident 105 had a fall from a wheelchair that tipped when anti-tipper rolls were not engaged after resident returned from an appointment. Vital signs and neurochecks were started at this time but lacked documentation of a fall risk assessment. During an interview on 4/24/25 at 1:17 P.M., ADON indicated that the Registered Nurse (RN) will do an assessment to be completed on resident with each fall. On 4/25/25 at 1:18 P.M., the Administrator provided a current policy Fall Risk Assessment reviewed on 4/24. The policy indicated the purpose of the fall risk is .is to identify residents at risk of falling and ensuring that each resident has preventive measures in place to reduce the risk of falls .the procedure was to complete all items on the forms 3.1-37

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident unable to carry out activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for 1 of 4 residents reviewed for skin concerns. A resident with long toe nails had not been seen by podiatry or had toe nails trimmed. (Resident 124) Finding includes: On 4/22/25 at 12:30 P.M., Resident 124's clinical record was reviewed. admission date was 12/4/24. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, and depression. The most recent quarterly Minimum Data Set (MDS) assessment, dated 3/12/25, indicated a severe cognitive impairment. Resident 124 required substantial to maximum assistance (helper does more than half the effort) with showering. Current physician orders included, but were not limited to: May see podiatrist of choice, dated 12/4/24. A current ADL care plan, last revised 12/30/24, included, but was not limited to, an intervention to check nail length and trim and clean on bath day and as necessary, initiated 12/6/24. A consent form for podiatry was signed by Resident 124's Power of Attorney (POA) on 12/6/24 as part of the admission packet. Resident 124's clinical record lacked documentation that her toe nails had been cleaned or trimmed. On 4/23/25 at 9:38 A.M., Resident 124's feet were observed. Toe nails on both feet were very long, thick, and with a layer of dirt underneath. At that time, Unit Manager (UM) 15 indicated podiatry came to the facility once a month, would be there the following week, and Resident 124's daughter had recently requested for the resident to be seen by them. She indicated a resident's podiatry consent might be signed at admission, but the resident would not be seen unless there was a significant change or the family requested it. She further indicated she had spoken to Resident 124's daughter on 3/12/25 and she had voiced a need for podiatry. On 4/23/25 at 9:52 A.M., Registered Nurse (RN) 9 indicated Resident 124 had not seen podiatry, and the nurses on the unit were responsible for trimming her toe nails, and the aides were responsible for nail care (cleaning). She indicated a progress note would be completed when toe nails were trimmed. On 4/25/25 at 1:18 P.M., the Administrator provided a procedure form for nail care. At that time, he indicated there was not an actual policy, but the form was followed by staff. The form indicated step by step instruction for cleaning and trimming nails, but did not include timing on which nail care should have been done. 3.1-38(a)(3)(E)

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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, interview, and record review, the facility failed to ensure daily weights were completed to assess for complications of Congestive Heart Failure and a resident received thorough assessments for care of edema to lower extremities for 1 of 1 residents reviewed for edema. (Resident 22) Finding includes: During an observation on 4/22/25 at 8:46 A.M., Resident 22's bilateral lower legs were observed to have edema. Resident 22 indicated she was not weighed daily and sometimes has to ask for her second edema pill because staff will only bring her one. On 4/22/25 at 12:58 P.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure (CHF), and urinary tract infection. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/19/25, indicated Resident 22 was cognitively intact, required supervision from staff for toileting, required partial assistance from staff (staff do some of the work) for transfers, and was frequently incontinent of urine. Physician orders included, but were not limited to: Weights daily one time a day for CHF (congestive heart failure) Update MD (physician) if three pounds gained in 24 hours or five pounds in seven days; Start date 12/27/24 Current care plans included, but were not limited to: I have diastolic CHF and cardiomegaly, monitor feet and hands for edema; Start date 3/3/25 A care summary, dated 4/21/25, indicated the Nurse Practitioner observed Resident 22 and indicated Resident had some increased edema to bilateral lower extremities. During an interview on 4/25/25 at 9:25 A.M., Nurse 12 indicated Resident 22 had increased bilateral lower extremity swelling recently and was swelling was assessed during daily weight check. The following dates in the clinical record indicated Resident 22 was not weighed or assessed, or refused to be weighed or assessed, for increased edema in April 2025: 4/5 4/7 4/8 4/12 4/15 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/16 4/18 4/22 During an interview on 4/24/25 at 1:43 P.M., the Director of Nursing (DON) indicated weights should be recorded as ordered and was how a resident was monitored with CHF, and weight gain should be reported to physician. On 4/25/25 at 2:32 P.M., the Administrator provided a policy titled Weights, dated 8/06, that indicated More frequent weights may be indicated if: resident exhibits edema. Report fluctuations Record weight. 3.1-37(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure treatment and services were provided to prevent urinary tract infections (UTI) for 1 of 5 residents reviewed for UTIs. The physician was not notified of a suspected UTI, a resident with increased symptoms was not tested for a UTI, an antibiotic was given without a culture, and the resident received double the amount of an antibiotic as ordered. (Resident 102) Findings include: On 4/22/25 at 11:11 A.M., Resident 102's clinical record was reviewed. Resident was admitted [DATE]. Diagnosis included, but were not limited to, Alzheimer's disease. The most recent admission Minimum Data Set (MDS) assessment, dated 3/18/25, indicated a severe cognitive impairment. Resident 102 required partial to moderate assistance (helper does less than half the effort) with toileting and showering. The resident was frequently incontinent of bladder and bowel. Physician orders included, but were not limited to: Ceftriaxone (Rocephin) (an antibiotic) 1 gm (gram) IM (intramuscularly) one time only for suspected UTI, dated 4/4/25. Cephalexin (Keflex) (an antibiotic) 250 mg (milligrams) three times a day for suspected UTI for 6 days, dated 4/5/25. Alert charting - Progress note document urine smell, color, and appearance every shift for suspected UTI for 3 days, dated 4/1/25. A current toileting care plan, last revised 3/17/25, indicated resident required nursing intervention to improve self-performance in toileting. Interventions included, but were not limited to, cleansing self after elimination required assistance with cleaning self, dated 3/17/25. Resident 102's clinical record lacked a current or resolved UTI care plan. Progress notes included, but were not limited to: 4/1/25 at 4:23 P.M. Resident with increased combativeness and resistance to care. Often incontinent of bowel and had to be checked frequently. Urine dark and cloudy with foul odor. Resident was placed on UTI protocol. The facility physician was not notified of increased behaviors or condition of urine. 4/2/25 at 2:13 P.M. Resident was combative with staff during care and agitated. The behavior had increased since admission. Urine continued to be dark and cloudy with a foul odor. Resident was unable to report any other signs or symptoms of UTI due to cognition. Hospice aware. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility physician was not notified of increased behaviors or condition of urine. 4/3/25 at 2:23 P.M. Urine continued to be dark and cloudy with foul odor. Continued with increased behaviors and agitation. New incontinence and hematuria (blood in urine). Reported to triage, and indicated would send off to Nurse Practitioner (NP) to review. The clinical record lacked a response from the NP. 4/3/25 at 2:30 P.M. Resident combative, hitting, resistive to care, yelling and curing at staff. Antianxiety medication administered to resident prior to care did not help with behavior. 4/3/25 at 6:35 P.M. Resident fell to her knees in the dining room. Resident indicated she was getting up and just fell on her knees. 4/4/25 at 9:41 A.M. Triage notified again of signs and symptoms of UTI including increased behaviors, combativeness, hematuria, new incontinence, and cloudy dark urine. Resident not a candidate for in and out cath as resident is combative with any hand-on care from staff. Difficult to toilet and would not be able to accurately get sample New order for an antibiotic obtained from the NP for suspected UTI. The note did not indicate an attempt for a urinalysis. A urinalysis was not ordered. A physician's order note, dated 4/4/25 at 12:37 P.M. indicated to administer a one time dose of Rocephin (an antibiotic) 1 gm (gram) IM (intramuscularly). Also administer Keflex (an antibiotic) 250 mg (milligrams) three times a day for 7 days. 4/7/25 at 11:00 A.M. Resident had 2 doses of IM Rocephin on 4/4/25. 4/7/25 at 2:35 P.M. Urine was straw colored but remained cloudy with foul odor. Resident incontinent of bowel and bladder during shift. Resident also continued with behaviors of being combative, hitting, cursing, and yelling during care. The facility physician was not notified of continued signs and symptoms or behaviors. Resident 102's Medication Administration Record (MAR) for April 2025 included, but was not limited to, the following: Progress note document urine smell, color, and appearance every shift for 3 days checked off as completed, but did not document the progress note for 1 of 3 shifts on 4/2/25, 2 of 3 shifts on 4/2/25, or 1 of 1 shift on 4/4/25. Ceftriaxone (Rocephen) 1 gm IM one time dose was given 4/4/25 at 8:38 P.M. On 4/23/25 at 11:27 A.M., Registered Nurse (RN) 9 indicated when a resident was showing signs of a UTI, the staff would place them on a 3 day UTI protocol to monitor them for sign and symptoms. After 3 days, staff would send the information to the physician. If the resident had hematuria, however, would ask for a urinalysis or if the resident was on hospice would speak with hospice to get a urinalysis ordered. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/25 at 10:12 A.M., the Infection Preventionist (IP) indicated a urinalysis with culture and sensitivity should always be ordered with UTI symptoms prior to ordering an antibiotic to ensure the correct antibiotic was given. On 4/24/25 at 10:43 A.M., Hospice Aide 19 and Certified Nurse Aide (CNA) 21 were observed to assist Resident 102 in the shower. Resident 102 refused to allow staff to wash her peri area, and staff offered to allow her to wash herself. A washcloth with soap was handed to the resident, and the resident washed her front peri area. The resident then washed her back area, then with the same washcloth, wiped the front peri area again. The aides did not address the action with the resident or make an attempt to wash the front peri area with a different washcloth. On 4/25/25 at 12:50 P.M., the DON indicated on 4/4/25 the day shift nurse had given Resident 102 the one time dose of Ceftriaxone 1 gm but had not documented it in the MAR. The same day, evening shift had not seen that it had been given, and gave the dose again. She indicated at that time that Resident 102 could be combative and staff did not feel they could get a urine sample from her. She indicated because of the lack of a urine sample, the NP ordered both the IM injection of Ceftriaxone as well as the course of oral antibiotics for the suspected UTI. At that time, she indicated a care plan for UTI was not always initiated with a positive UTI, and was only entered if care plans happen to be reviewed during the window that the resident had a current infection. On 4/25/25 at 1:18 P.M., the DON provided a current non-dated Suspected UTI Check List form that indicated the procedure for the UTI protocol. The form lacked instructions on when to initiate the protocol, and for how long to keep the protocol in place. On 4/25/25 at 1:18 P.M., the DON provided a current non-dated perineal care procedure form that indicated to wipe from front to back when cleaning to prevent the spread of infection. Policies for the UTI protocol and management of UTI were requested and not provided. A policy for care plan initiation was requested and not provided. 3.1-41(a)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dietitian recommendations were implemented to prevent unnecessary weight loss for 1 of 3 residents reviewed for nutrition. (Resident 49) Finding includes: On 4/23/25 at 9:35 A.M., Resident 49's clinical record was reviewed. Resident 49 was admitted on [DATE]. Diagnosis included, but were not limited to, cerebral infarction. The most recent Quarterly MDS Assessment, dated 2/28/25, indicated Resident 49 was moderately cognitively intact and was dependent on staff (staff do all of the work) for toileting, bathing, and transfers, required set-up assistance from staff for eating, and had experienced unexpected weight loss. The clinical record indicated Resident 49 had lost 21.44% body weight from 10/4/24 (147.4 pounds) to 4/1/25 (115.8 pounds). On 12/20/24 1:01 P.M., the Registered Dietitian (RD) entered a progress note that indicated RD reviewed weight loss and intake, requesting to start 90 Milliliters (ml) Med Pass (nutritional supplement) BID. The clinical record lacked an order for MedPass started or a rationale for Med Pass not being started per RD recommendation from 12/20/24 through 1/26/25. On 1/10/25 at 9:40 A.M., the RD entered a progress note that indicated review of weight changes, requesting for physician/nurse practitioner to consider appetite stimulant and start 90 ml MedPass twice a day, and weekly weights. The electronic medication administration record indicated MedPass 90 ml supplement two times a day was not started until 1/27/25. On 2/28/25 at 10:41 A.M., the RD entered a progress note that indicated follow up and review of weight changes. Current weight 124 pounds on 2/21/25. Requesting Mighty Shake (supplement) with lunch meal. Weekly weights for four weeks. The clinical record lacked an order for Mighty Shakes started or a rationale for Mighty Shakes not being started per RD recommendations. A progress note, dated 4/7/25 at 4:50 P.M., indicated the nurse notified the physician of of 10% weight loss. On 4/9/25 10:30 A.M., the RD entered a progress note indicating RD reviewed continued weight loss, down 31.6 pounds over the last 6 months, requesting weekly weights. The clinical record lacked an order for weekly weights or a rationale for weekly weights not being completed per RD recommendations after the 4/9/25 RD review. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/25 at 1:43 P.M., the Director of Nursing indicated Resident 49's weight loss and RD recommendations just got overlooked. On 4/25/25 at 2:32 P.M., the Administrator provided a policy titled Weights, dated 8/06, that indicated Weekly weights will be initiated if Resident experiences a five pound weight loss or gain in a one month period, Resident suddenly begins eating less than 50% of meals; Weekly weights are to be continued until weight is stable. 3.1-46(a)(1)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. On 4/22/25 at 11:11 A.M., Resident 102's clinical record was reviewed. Resident was admitted [DATE]. Diagnosis included, but was not limited to, Alzheimer's disease. The most recent admission MDS assessment, dated 3/18/25, indicated a severe cognitive impairment. Physician orders included, but were not limited to: Lorazepam (an antianxiety medication) 2 mg (milligrams)/ml (milliliter), give 0.5 ml every 6 hours as needed, dated 3/12/25 and discontinued 4/15/25. The same order for Lorazepam was placed from 4/15/25 through 4/16/25 and again from 4/16/25 to current. The clinical record lacked a rationale from the physician to continue Lorazepam as needed after the initial 14 days. On 4/24/25 at 1:47 P.M., the Assistant Director of Nursing (ADON) indicated use of an as needed antianxiety medication should be reviewed 14 days after starting the medication and if the medication was to be continued, a rationale for continuance should be documented. On 4/25/25 at 1:18 P.M., the DON provided a current Anti-Anxiety Medication Review policy, dated 2/2025, that indicated PRN [as needed] Anti-psychotic/Anti-anxiety medications will initially be given a 14 day with re-assessment order. After an initial 14-day order, the order must be reassessed. Physicians can choose to extend their preference . 3.1-48(a) 2. On 4/22/25 at 1:59 P.M. Resident 23's clinical record was reviewed. Resident 23 was admitted on [DATE]. Diagnoses included, but were not limited to, hypertensive heart disease with heart failure. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 2/7/25, indicated Resident 23 was moderately cognitively intact, required supervision from staff for transfers, and was receiving hospice services. Current physician orders included, but were not limited to: Lorazepam (antianxiety medication) oral concentrate 2 MG/ML (milligrams/milliliter) Give 0.25 ml by mouth every hours as needed for anxiety or restlessness; Start date 1/29/25 (No end date) Ativan Benadryl Haldol Gel (ABH Gel) 0.5 mg/25 mg/1 mg (milligrams) Apply to wrist topically every four hours as needed for anxiety, wear gloves when administering, rub into wrist, and apply to wrist topically three times a day for anxiety; Start date 3/26/25 (No end date) The clinical record lacked prescribing practitioner rationale for as needed anti-anxiety (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications ordered beyond 14 days, or medication end dates.Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 3 of 4 residents reviewed for as needed (PRN) antianxiety medications. Residents' PRN antianxiety medications were ordered for greater than 14 days. (Resident 16, Resident 23, and Resident 102) Findings include: 1. On 4/22/25 at 2:11 P.M., Resident 16's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 2/19/25, indicated Resident 16 was not assessed for cognitive impairment because she was rarely or never understood, was dependent on staff (staff does all the effort) for Activities of Daily Living (ADLs), and did not receive an antianxiety medication during the 7-day look back period. Current physician orders included, but were not limited to: Ativan (an antianxiety medication) solution 2 milligrams per milliliter (mg/ml) - Give 0.25 ml sublingually every two hours as needed for anxiety for 90 Days, dated 4/7/25 with a stop date of 7/6/25 Discontinued physician orders included, but were not limited to: Ativan solution 2 mg/ml - Give 0.25 ml sublingually every two hours as needed for restlessness/anxiety, dated 8/7/24 and discontinued on 2/3/25 Ativan solution 2 mg/ml - Give 0.25 ml sublingually every two hours as needed for restlessness/anxiety for 60 Days, dated 2/3/25 and completed on 4/4/25 The clinical record lacked a physician evaluation or rationale for the continuance of the PRN antianxiety medication every 14 days. On 4/25/25 at 10:54 A.M., the Director of Nursing (DON) provided a rationale that was signed by the physician and not dated. At that time, the DON indicated she was unsure of when the physician signed the rationale.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure safe and secure storage of all medications for 2 of 5 medication carts and 3 of 3 medication rooms observed. Medication refrigerator temperature logs were not filled out, loose pills were observed in medication carts, and medication carts were observed unlocked. (Horizons Unit, Harbor Unit, Wellsprings Unit) Findings include: 1. On 4/21/25 at 8:56 A.M., the Horizons Unit medication storage room was observed. A temperature log dated February 2025 and included a small fridge, small locked fridge, and large fridge, had temperatures listed for 2/1/25, and 2/16/25 through 2/18/25. All other dates were blank. The same form, dated April 2025, had temperatures listed for 4/16/25 through 4/18/25. All other dates were blank. A separate form dated February 2025 included the medication room temperature and a different refrigerator temperature. The form listed temperatures for 2/1/25. All other dates were blank. The same form, dated April 2025, had temperatures listed from 4/16/25 through 4/18/25. All other dates were blank. At that time, the Unit Manager (UM) 23 indicated she was unaware where the March 2025 temperature logs were, and did not know why the current temperature logs were not filled out. On 4/21/25 at 9:12 A.M., the Harbor Unit medication storage room was observed. A temperature log for the room temperature and refrigerator, dated March 2025, did not have any temperatures documented. The same form, dated April 2025, lacked temperatures for 4/18/25 and 4/20/25. At that time, UM 25 indicated she did not know why the temperatures had not been documented, and could not locate the temperature log for February 2025. On 4/21/25 at 9:18 A.M., the Wellsprings Unit medication storage room was observed. A temperature log for the room temperature and refrigerator, dated March 2025, lacked temperatures for 3/23/25 and 3/29/25. The temperature logs for February 2025 and April 2025 were all filled in and current. On 4/24/25 at 1:36 P.M., the Director of Nursing (DON) provided temperature logs for the Horizons Unit from January 2025 through April 2025. The temperature logs were completely filled out and differed from the temperatures that were documented on the temperature logs in the medication room. The DON indicated the completed temperature logs were located at the nurses station and the Unit Manager was unaware they were kept there. 2. On 4/21/25 at 9:08 A.M., the Harbor Unit medication cart was observed with the following loose pills: a white oval tablet with marking L484 a white capsule with no marking a white round tablet with marking AC358 a pink round tablet with marking L141 At that time, Licensed Practical Nurse (LPN) 27 indicated the medication carts should have been (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaned out every shift. On 4/21/25 at 9:18 A.M., the Wellsprings Unit medication cart was observed with the following loose pills: a white oval tablet with marking APO a yellow oval tablet with marking 152 3. On 4/21/25 at 9:15 A.M., during a random observation, a medication cart on the Harbor Unit was observed unlocked with no staff around the cart or in the hall. At that time, Qualified Medication Aide (QMA) 31 was observed to come out of a resident's room at the other end of the hall, and then to the unlocked medication cart. At that time, she indicated the medication carts should be kept locked. On 4/21/25 at 10:06 A.M., during a random observation, a medication cart on the Wellsprings Unit was observed unlocked with no staff around the cart or in the hall. One resident was observed sitting in a wheelchair by the nurses station where the cart was located. At 10:10 A.M., Registered Nurse (RN) 9 locked the medication cart. On 4/23/25 at 9:56 A.M., during an random observation, a medication cart on the Horizons Unit was observed unlocked with 4 residents sitting in wheelchairs in the common area by the cart. A staff member locked the medication cart at 9:58 A.M. On 4/25/25 at 1:18 P.M., the DON provided a current Storage of Medications policy, last revised April 2007, that indicated The facility shall store all drugs and biologicals in a safe, secure, and orderly manner . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biological's shall be locked when not in use . The policy did not include documentation of temperature logs. 3.1-25(m)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Center	1201 W Buena Vista Rd Evansville, IN 47710

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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. Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections for all residents. Hand washing was not adequately performed during medication administration, cups were handled by the rims during a meal observation, clean linen was not handled appropriately, and activity items were not washed after use. (Wellsprings Unit, Registered Nurse (RN) 42, Resident 89) Findings include: 1. During a medication pass on 4/24/25 at 7:52 A.M., RN 42 was observed to enter Resident 236's room with a medication cup of pills. RN 42 placed the medication cup on the bedside table, assisted the resident to put on her pants and shoes, then washed her hands for 11 seconds. RN 42 then obtained the resident's blood pressure, administered the medications in the cup, and assisted to insert the resident's hearing aides. 2. During a lunch observation on 4/21/25 from 11:47 A.M. through 12:15 P.M. on the Wellsprings Unit, the following was observed: Resident 89 was utilizing a cloth activity board at a table, placing the corner of it in her mouth to bite one of the knots in the board. Prior to lunch being served, the Activities Staff picked up the activity boards from the table, including the one Resident 89 had put in her mouth, and placed them all together on a cart in the corner of the room with other activity items. Certified Nurse Aide (CNA) 45 was observed filling cups with ice and drinks at the counter. She lifted each cup by the rim to fill them. When using the ice scoop, the back of CNA 45's hand was making contact with the ice in the tray. All of the filled drink cups were then served to the residents in the dining room. 3. On 4/21/25 at 10:11 A.M., during a random observation, a staff member was observed to carry folded clean linen against her uniform top, then placed them into the clean linen closet. During an anonymous interview on 4/22/25 at 8:38 A.M., a resident indicated staff would carry linen without a cart, set it on the floor, pick it back up, then use the linen. On 4/25/25 at 10:12 A.M., the Infection Preventionist (IP) indicated staff should carry clean linen away from their body or in a bag and hands should be washed for 20-30 seconds. At that time, the Director of Nursing (DON) indicated staff could put the activity boards away and reuse them without washing per policy, and that staff on that unit typically stayed the same and knew which board had been used by which resident. On 4/25/25 at 1:18 P.M., the Administrator provided a current non-dated Activity/Busy Blanket Suggested Guidance policy that indicated Blankets will be washed when finished using, when soiled, or daily On 4/25/25 at 1:18 P.M., the Administrator provided a current non-dated Linen Handling policy that indicated Always carry soiled or clean linen away from body On 4/25/25 at 1:18 P.M., the Administrator provided a current Water Pass policy, last updated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	November 2024, that indicated Do not touch rim or inside of cup On 4/24/25 at 1:45 P.M., the Assistant Director of Nursing (ADON) provided a current Hand Hygiene policy, last updated November 2016, that indicated hands should be rubbed for 20 seconds during hand washing. 3.1-18(b) 3.1-18(l)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On 4/22/25 at 10:06 A.M., Resident 75's clinical record was reviewed. Diagnoses included, but were not limited to, stage 3 chronic kidney disease, anxiety, and depression. The most recent significant change Minimum Data Set (MDS) assessment, dated 12/24/24, indicated no cognitive impairment and no behaviors. Resident had an indwelling urinary catheter. Physician orders included, but were not limited to: UA (urinalysis) with C&S (culture and sensitivity) if indicated one time only for high wbc (white blood cell) count, dated 4/2/25. Cipro (an antibiotic) 250 mg (milligrams) twice a day for 10 administrations, dated 4/4/25 and discontinued 4/6/25. Cefdinir (an antibiotic) 250 mg twice a day for 5 days, dated 4/6/25 and discontinued 4/7/25. Cefdinir 300 mg twice a day for 10 administrations, dated 4/7/25. A recurrent UTI care plan was resolved on 3/5/25. The clinical record lacked a UTI care plan after that date. The clinical record lacked an order for Ceftin (an antibiotic). Resident 75's April 2025 Medication Administration Record (MAR) indicated the following: a urinalysis was completed on 4/2/25. Cipro 250 mg was given once on 4/4/25, twice on 4/5/25, and once on 4/6/25 for a total of 4 doses. Cefdinir 250 mg was given on 4/6/25 at 8:30 P.M. and on 4/7/25 at 8:30 A.M. Progress notes included, but were not limited to, the following: 4/4/25 at 4:21 P.M. New order from Nurse Practitioner (NP) for Cipro 250 mg twice a day for 5 days. 4/6/25 at 10:03 A.M. Discontinue Cipro and start Ceftin 250 mg twice a day for 5 days. 4/7/25 at 8:30 A.M. Nurse received a call from pharmacy related to the order for Cefdinir 250 mg. Medication did not come in that strength, only 300 mg. A urine culture report, resulted 4/6/25, indicated the bacteria found in the urine was resistant to Cipro. The bacteria was susceptible to cefdinir as well as Ceftin. On 4/25/25 at 11:24 A.M., the Director of Nursing (DON) provided an emergency drug kit (EDK) transaction form that indicated Cefuroxime axetil (Ceftin) 250 mg was obtained for Resident 75 on 4/6/25 at 3:47 P.M. Cefdinir 300 mg was obtained for Resident 75 on 4/7/25 at 9:01 A.M. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/25 at 11:26 A.M., the DON indicated the nurse that entered the antibiotic orders into Resident 75's clinical record picked the wrong medication when she entered cef. She had picked Cefdinir instead of the Ceftin that had been ordered. That was why the pharmacy called the following day to inform that Cefdinir did not come in 250 mg doses. 3. On 4/22/25 at 12:40 P.M., Resident 42's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, anxiety, and Parkinson's disease. The most recent quarterly MDS assessment, dated 2/16/25, indicated a severe cognitive impairment. Resident 42 was frequently incontinent of bladder. Physician orders included, but were not limited to: Ciprofloxacin (Cipro) (an antibiotic) 250 mg twice a day for 9 days and give 1 tablet one time a day only for 1 day, dated 4/19/25 and discontinued the same day. Bactrim DS (an antibiotic) 800-160 mg twice a day for 6 administrations, dated 4/20/25. A urinalysis on 4/18/25 indicated a urinary tract infection (UTI). The culture result indicated the organism found was resistant to Cipro. Resident 42's MAR for April 2025 indicated Cipro had been administered once on 4/19/25. On 4/25/25 at 10:12 A.M., the Infection Preventionist (IP) indicated a urinalysis with culture and sensitivity should always be ordered with UTI symptoms prior to ordering an antibiotic to ensure the correct antibiotic was given. On 4/24/25 at 1:45 P.M., the Assistant Director of Nursing (ADON) provided a current Antibiotic Stewardship and Suspected UTI SBAR policy, last updated September 2017, that indicated The use of this procedure can help reduce unnecessary prescribing and lead to fewer antibiotic failures . The procedure indicated to observe the resident's signs and symptoms for 72 hours, then send findings to the physician if a UTI was suspected. The policy did not indicate guidelines for prescribing antibiotics related to culture results. 3.1-18(b) Based on interview and record review, the facility failed to establish a complete stewardship program for antibiotic use to ensure antibiotics ordered by a physician were given as ordered and that appropriate antibiotics were given based on culture results for 3 of 4 residents reviewed for urinary tract infections. (Resident 22, Resident 75, and Resident 42) Findings include: 1. During an interview on 4/22/25 at 8:39 A.M., Resident 22 indicated she had an ongoing burning pain in her bladder. On 4/22/25 at 12:58 P.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on [DATE]. Diagnosis included, but was not limited to, urinary tract infection (UTI). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 3/19/25, indicated Resident 22 was cognitively intact, required supervision from staff for toileting, required partial assistance from staff (staff do some of the work) for transfers, and was frequently incontinent of urine. Resident 22's clinical record lacked a care plan related to monitoring for frequent urinary tract infections or continuous antibiotic use. UTI #1 On 5/11/24 Resident 22's urine culture resulted with growth of organisms Pseudomonas aeruginosa and Enterococcus faecalis. A physician order was entered for Cefepime HCl (antibiotic) intravenous solution reconstituted two GM (grams) use two gram intravenously two times a day for UTI for 14 administrations; Start date 5/13/24. The Electronic Medication Administration Record (EMAR) indicated doses on 5/13/24 and 5/17/24 at 8:30 P.M. were not given to Resident 22. UTI #2 On 9/28/24 Resident 22's urine culture resulted in growth of organism Citrobacter freundii complex. A physician order was entered for Cephalexin capsule 500 MG (antibiotic) give one capsule by mouth three times a day for UTI for 20 administrations; Start date 10/01/24. The EMAR indicated doses on 10/5/24 at 2:30 P.M. and 10/6/24 at 8:30 P.M. were not given to Resident 22. UTI #3 On 10/20/24 Resident 22's urine culture resulted with growth of organism Klebsiella pneumoniae. A physician order was entered for Ciprofloxacin Oral Tablet 500 MG (Milligrams) (antibiotic) Give one tablet by mouth three times a day for UTI until 10/28/24; Start Date 10/21/24. The EMAR indicated doses on 10/23/24 and 10/24/24 at 8:30 P.M. were unavailable and not given to Resident 22. A progress note dated 11/5/24 at 11:57 A.M., indicated the physician's office called with new order of Macrobid (nitrofurantoin) 50 MG every evening for prophylactic/UTI prevention. A progress note dated 11/5/24 at 3:47 P.M., indicated the physician called and stated resident was worried that order for Macrobid (nitrofurantoin) may cause further cardiac issues, order for Macrobid was placed on hold. A progress note dated 11/6/24 at 9:19 A.M., indicated physician gave an order to discontinue Macrobid (nitrofurantoin) and no prophylactic antibiotic would be started due to multiple allergies. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	UTI #4 C(resistant to Macrobid/nitrofurantoin). A physician order was entered for Nitrofurantoin (Macrobid) macrocrystal (antibiotic) 50 MG Give one capsule by mouth at bedtime for prophylactic antibiotic; Start Date 12/31/24. The EMAR indicated doses on 1/3/25, 1/4/25, 1/5/25, and 1/6/25 were unavailable and not given. UTI #5 On 2/25/25 Resident 22's urine culture resulted with Proteus mirabilis, with no susceptibility available. A physician order was entered for Fosfomycin tromethamine oral packet 3 GM give one packet by mouth every 48 hours for pain until 3/8/25, total of 3 doses; Start date 3/2/25. The EMAR indicated zero doses of Fosfomycin were administered to Resident 22 between 3/2/25 and 3/8/25. On 4/25/25 at 10:12 A.M., the Infection Prevention Nurse (IP) indicated antibiotics should be administered as prescribed, if an antibiotic is unavailable staff should retrieve the antibiotic from the emergency drug kit or order the medication immediately from pharmacy, and that pharmacy delivers medications every night. On 4/25/25 at 1:18 P.M., the Administrator provided a policy titled Antibiotic Stewardship, dated 9/17, that indicated Review antibiotics on a monthly basis along with infections and classify if criteria met or not. Notify physicians of prescribing habits via quarterly review.