STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155238	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yorktown Manor	2000 S Andrews Rd Yorktown, IN 47396

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure a resident receiving psychotropic medications was evaluated for either a gradual dose reduction (GDR) by the indicated prescriber or was determined to have an individualized clinical contraindication for GDR for 1 of 3 residents reviewed for psychotropic medications. (Resident 6)Finding includes: Resident 6's clinical record was reviewed on 9/5/25 at 10:54 a.m. Diagnoses included dementia, bipolar disorder, and major depressive disorder. Current physician orders included quetiapine fumarate (antipsychotic medication) 300 milligram (mg) give one tab one time a day, sertraline (antidepressant) 100 mg give two tabs one time a day, buspirone (anti-anxiety medication) 15mg give 1 tab 2 times a day, divalproex sodium (anti-seizure medication) 500mg give 2 tablets one time a day, and No GDR of Psych Medications per Psychiatrist.Discontinued orders were reviewed concurrently and indicated doses of the above medications were not changed since 2023.A 5/29/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and received an antipsychotic, anxiety, and antidepressant medications during the assessment look back period. No delusions or hallucinations were observed. A current care plan, revised on 11/9/20, indicated the resident was under the care of a psychiatrist since 2009 and staff were to keep the psychiatrist and family informed of any concerns as indicated.A facility pharmacy recommendation, dated 11/15/24, indicated the need for evaluation of quetiapine, sertraline, divalproex, and buspirone doses. The response to the recommendation by the physician indicated Resident 6 was followed by a psychiatrist who preferred to be the only practitioner to make recommendations for medication changes. Resident 6 was last seen by the psychiatrist in May 2024. The facility should continue to defer to the psychiatrist for medication changes. No changes were indicated at the time the document was signed. The clinical record and pharmacy recommendation document lacked indication of the psychiatrist being consulted regarding a GDR. A facility pharmacy recommendation, dated 3/7/25, recommended evaluations of quetiapine, sertraline, divalproex, and buspirone doses and indicated no GDRs were performed in many years. The physician response indicated to continue to defer to the psychiatrist. The clinical record and pharmacy recommendation document lacked indication of the psychiatrist being consulted regarding a GDR.During a phone interview with Resident 6's Psychiatrist, on 9/8/25 at 1:03 p.m., he indicated he was unaware of current pharmacy recommendations for the resident. The facility previously presented him with recommendations, but he could not recall the last instance. He did not write specific notes in the electronic health record (EHR).During an interview with the DON, on 9/8/25 at 1:54 p.m., she indicated no log was kept of communication with Resident 6's Psychiatrist. Normally, documents were faxed to his office, but no log was kept of what was faxed. On 9/8/25 at 1:54 p.m., the DON indicated she would look for facility policies for physician notification and unnecessary medications.No further information was provided prior to survey exit regarding facility policies for physician notification and unnecessary medications.3.1-3(w)

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to provide a prescribed therapeutic diet for 1 of 2 residents reviewed for nutrition. (Resident 7)Finding includes:The facility's weekly menus, provided after entrance conference, indicated mechanical soft diet offerings for lunch on 9/2/25 included ground ham steak, pureed cream corn, chopped Italian vegetables, soft dinner roll, assorted ice cream, milk, and coffee or hot tea.During an interview with [NAME] 9 while serving the lunch meal on 9/2/25 at 10:56 a.m., he indicated residents who received a mechanical soft diet could not have regular kernel corn and would be served creamed corn instead. During the interview, creamed corn was observed in a pan on the steam table.During a dining observation on 9/2/25 at 12:14 p.m., Resident 7's meal tray included an uncut piece of ham (the size of a digital camera), whole kernel corn, cooked carrots, and vegetable soup with crackers. During the meal, Resident 7 indicated she was on an altered diet that required her food to be pre-cut or ground-up and she was unable to eat the ham on her tray. She was unable to choose what was served to her.Resident 7's clinical record was reviewed on 9/4/25 at 8:54 a.m. Diagnoses included dysphagia (difficulty swallowing), type two diabetes, and congestive heart failure. Current physician orders included regular diet, mechanical soft texture (5/29/25), resident to have all meds crushed and in applesauce or pudding (5/29/25), and ondansetron (anti-nausea) 4mg give 1 tab by mouth one time a day (7/5/25).A nursing note dated 5/5/25 at 4:00 p.m. indicated the resident failed a swallow study and changed to a mechanical soft diet.A 7/17/25, quarterly, Minimum Data Set (MDS) indicated the resident was cognitively intact and required set-up assistance for eating and oral hygiene.A current care plan, initiated on 5/6/25, indicated the resident was diagnosed with dysphagia. Interventions included providing appropriate diet consistency as ordered.During an interview on 9/5/25 at 2:17 p.m., RN 5 indicated Resident 7 was on a regular diet and typically ordered extra items from the kitchen.During an interview on 9/8/25 at 11:00 a.m. the Dietary Manager indicated the resident was on a mechanical soft diet and any meat she was served should have been cut up or ground. The resident should not have received a whole piece of ham steak.During an interview on 9/8/25 at 11:57 a.m., CNA 7 was unsure what type of diet Resident 7 required. Her diet had been changed from regular to mechanical soft and back again several times.An undated facility document titled, Mechanical Soft Diet observed on the conference room table prior to survey exit on 9/8/25 at 4:00 p.m. indicated the following, .This diet consists of ground meats (not dry) with soft fruits, vegetables, and breads allowed.Food Groups: Vegetables.Foods Allowed: soft, well cooked, mashable vegetables (beans, mashed peas, creamed corn) except those listed to avoid. Foods Not Allowed: All raw vegetables; corn kernels; stir fry vegetable.Meats, fish, poultry, meat alternatives.Foods Allowed: moistened ground meats with gravy or sauce; moist ground meatballs, meatloaf with sauce or gravy; flaked fish with sauce.Foods Not Allowed: dry tough meats.3.1-46(a)(2)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered according to physician's orders and delayed release medications were not opened for crushed administration for 2 of 3 residents observed for medication administration, resulting in a 10 % medication error rate. (Resident 47 and Resident 13) Findings include:1.During a medication administration observation on 9/4/25 at 9:17 a.m., LPN 8 administered one oral puff of fluticasone furoate-vilanterol inhalation aerosol powder (inhaler for respiratory conditions) to Resident 47. LPN 8 did not prompt the resident to rinse her mouth. nor did the resident rinse her mouth following administration. During an interview on 9/4/25 at 9:22 a.m., LPN 8 indicated she did not prompt the resident to rinse her mouth after administering the inhalation powder during the medication observation. She should have instructed the resident to rinse her mouth immediately after the medication was administered, for prevention of thrush (a fungal infection of the mouth), according to the physician's order.Resident 47's clinical record was reviewed on 9/4/25 at 10:13 a.m. Diagnosis included unspecified asthma. Physician's orders included fluticasone furoate-vilanterol inhalation aerosol power breath activated 100-25 mcg 1 puff orally once daily. Ensure the resident's mouth is rinsed after each administration to reduce the chance of thrush development (7/17/25). 2. During an observation on 9/4/25 at 9:32 a.m., LPN 8 prepared Resident 13's medications for administration. LPN 8 indicated the resident required her medications crushed. She opened the duloxetine (depression) delayed release 20 mg capsule and duloxetine delayed release 60 mg capsule and poured the contents of the capsules into a medication cup along with applesauce for administration. She stirred the capsule contents into the applesauce, entered the resident's room, and administered the medications in the applesauce.During an interview on 9/4/25 at 9:52 a.m., LPN 8 indicated she had administered Resident 13's delayed release duloxetine capsules opened and poured into applesauce during the medication observation. She did not have a reference list of medications that should not be opened or crushed to follow when she administered medications crushed. The facility may have a list somewhere, but she was not aware where it was located. Resident 13 had an order to receive her medications crushed and the nurse assumed the provider would not have ordered medications that should not be crushed. She was aware that enteric coated medications, extended-release medications, and delayed-release medications should not be crushed or opened. She probably should have contacted the physician prior to administration of the medication to see if there was a different formula available instead of assuming.Resident 13's clinical record was reviewed on 9/4/25 at 10:54 a.m. Diagnosis included recurrent depressive disorders. Physician's orders included duloxetine hydrochloride delayed release 20 mg capsule once daily given with 60 mg capsule to equal 80 mg (3/15/25), duloxetine hydrochloride delayed release 60 mg capsule once daily given with 20 mg capsule to equal 80 mg (3/15/25), and crush medication unless otherwise contraindicated (5/31/24). During an interview on 9/4/25 at 1:43 p.m., LPN 8 indicated she checked a list of medications that should not be crushed and found the duloxetine delayed release capsules should have been administered whole rather than opened and placed in applesauce. The provider was notified after the duloxetine was administered.Review of a facility document titled Meds That Should Not Be Crushed, provided on 9/4/25 at 1:53 p.m., included duloxetine modified-release capsules.During an interview on 9/5/25 at 4:05 p.m., the DON indicated staff should follow provider orders regarding rinsing the resident's mouth after administration of inhaled medications. Nursing staff should follow the Meds That Should Not Be Crushed list and notified the physician, prior to administering delayed release medications opened or crushed, to determine if it was appropriate for the medication to be opened or crushed. The facility contacted the pharmacy who notified them there was a different order of duloxetine available for residents who (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	need to take their medications crushed.The manufacturer instructions for Breo Ellipta (respiratory inhaler), revised in May 2023, retrieved on 9/4/25 at 1:06 p.m. from https://gskpro.com. included Warnings and Precautions. Candida albicans infection of the mouth and pharynx may occur. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk.The manufacturer instructions for Cymbalta (depression), dated 8/2023, retrieved on 9/4/25 at 10:33 a.m. from https:/pi.lilly.com. included DOSAGE and ADMINISTRATION. Important Administration Instructions.Administer CYMBALTA orally (with or without meals) and swallow whole. Do not chew or crush, and do not open the delayed-release capsule and sprinkle its contents on food or mix with liquids because these actions might affect the enteric coating.A current facility policy, dated 2021 and titled Crushing Medications, provided by the DON on 9/5/25 at 4:37 p.m., indicated the following: Policy Statement. Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders. Policy Interpretation and Implementation. 2.The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long acting or enteric coated medications.). 3.1-48(c)(1)