STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newburgh Health and Rehab	10466 Pollack Ave Newburgh, IN 47630

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interview and record review, the facility failed to ensure care plan conferences were completed quarterly for 2 of 2 residents reviewed for Activities of Daily Living (ADL) assistance. (Resident 6 and Resident 13) Findings include: 1. On 2/11/25 at 9:22 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and type 4 fracture of sacrum. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 11/15/24, indicated Resident 6 had mild cognitive impairment and required substantial to maximal assistance of staff (staff does more than half) for eating, toileting, and bathing. The most current care plan conference was completed on 7/10/24 at 1:00 P.M. On 2/12/25 at 10:49 A.M., the Social Services Director (SSD) provided a document entitled Care Plan Meetings that indicated a letter had been sent on 9/10/24 to invite Resident 6's family to a care plan conference. The clinical record lacked documentation to indicate a care plan conference had been completed at that time or at any time since 7/10/24. 2. On 2/10/25 at 11:25 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome and major depressive disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 11/5/24, indicated Resident 13 was cognitively intact and was dependent on staff (staff does everything) for toileting and bathing. The most current care plan conference was completed on 10/30/24 at 1:30 P.M. During an interview on 2/12/25 at 10:35 A.M., the Social Service Director (SSD) indicated care plan conferences were completed quarterly. During an interview on 2/12/25 at 10:49 A.M., the SSD indicated that a care plan conference had not been scheduled for Resident 6 and Resident 13 in the last three months, but they would be scheduled to have meetings to review their care plans later in February. On 2/13/25 at 9:13 A.M., the MDS Coordinator provided a current Care Plan Development, Review, and Revision policy, last updated 5/8/24, that indicated .care plan conference will be held quarterly . (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation of this meeting and care plan review will be completed in the medical record. 3.1-35(d)(2)(B)

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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. 2. On 2/10/25 at 8:34 A.M., Resident 46's clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer Disease. The most current Quarterly Minimum Data Set Assessment (MDS) Assessment, dated 11/22/24, indicated Resident 46 was severely cognitively impaired and was dependent on staff (staff does everything) for transferring and bathing, Current physician orders included, but were not limited to: cefuroxime axetil oral tablet 250 mg (milligrams) (an antibiotic) - Give 250 mg by mouth two times a day for Urinary Tract Infection (UTI) for 5 days, dated 2/3/25. The most current care plan conference, dated 11/19/24, indicated the Interdisciplinary Team (IDT) reviewed the care plan and would continue with the current plan of care. Resident 46's care plans lacked a care plan for UTI or antibiotic use that dated between 2/3/25 and 2/8/25. During an interview on 2/11/25 at 10:59 A.M., the MDS Coordinator indicated there should be a new care plan with each new infection and antibiotic order. On 2/13/25 at 9:13 A.M., the MDS Coordinator provided a current Care Plan Development, Review, and Revision policy, updated 5/8/24, that indicated care plans will be revised every business date and PRN (as needed) as changes in the resident's condition dictate. Changes include but are not limited to changes in physician orders, diet changes, therapy changes, behavior changes, ADL changes, skin changes, etc. 3.1-35(a) 3.1-35(g)(2) Based on record review, observation, and interview, the facility failed to ensure care plans were being developed and implemented after new diagnoses and physician orders for 1 of 2 residents reviewed for nutrition and 1 of 1 resident reviewed for urinary tract infections. (Resident 43 and Resident 46) Findings include: 1. On 2/11/25 at 9:56 A.M., Resident 43's clinical record was reviewed. The resident had diagnoses that included, but were not limited to, pneumonia and congestive heart failure. An admission Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 43's cognition was significantly impaired, required partial to moderate assistance of staff (staff does less than half) with eating, and substantial to maximum assistance of staff (staff does more than half) with bathing, toileting and bed mobility, and no weight loss during the last month. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current physician orders included, but were not limited to: mirtazapine tablet 7.5 mg (milligrams) - one tablet by mouth at bedtime for appetite, ordered 1/27/25. Nursing Measure: Fax Daily Weights every day shift every Monday and Thursday for physician notification, ordered 1/13/25. Weekly weight every day shift every Wednesday for weight loss, weigh before breakfast with the same scale for consistency, ordered 1/29/25. Discontinued physician orders included, but were not limited to: Daily weight, every day-shift for weight loss related to congestive heart failure, weigh before breakfast with the same scale for consistency, ordered 1/10/25 and discontinued 1/27/25. An Interdisciplinary Team care conference meeting was held on 1/14/25 for Resident 43. The progress note indicated to continue the current plan of care. Current care plans for Resident 43 included, but were not limited to: Resident is at nutritional risk related to use of therapeutic diet. Interventions included but were not limited to: follow Registered Dietician recommendations and monitor weights routinely, dated 1/16/25. Resident 43's recorded weights from 1/10/25 to 1/27/25 were reviewed. Weights were not recorded on the following dates: 1/17/25 1/19/25 1/24/25 A Nutrition/Dietary note on 1/16/25 at 10:50 A.M. made by the Registered Dietician recommended Resident 43 trial an appetite stimulant due to inadequate intakes at meals with weight loss. The clinical record indicated the appetite stimulant was not ordered until 1/27/25. On 2/12/25 at 11:40 A.M., the Director of Nursing (DON) indicated when the Registered Dietician made recommendations, they informed the physician of the recommendations to obtain the orders.

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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 the care plan to reflect changes to a resident's gastrostomy device for 1 of 1 reviewed. (Resident 41) Finding includes: On 2/11/25 at 12:27 P.M., Resident 41's clinical record was reviewed. The resident had diagnoses that included, but were not limited to, cerebral palsy. A Quarterly Minimum Data Set (MDS) Assessment, dated 12/10/24, indicated the resident was not cognitively intact, was dependent on staff (staff does everything) for bed mobility, and had an enteral feeding tube. Current physician orders included, but were not limited to: Percutaneous endoscopic gastrostomy (PEG) tube 18F (French), 7-10 cc (cubic centimeters) in place, dated 4/30/23. The clinical record lacked an order for a Mic-Key gastro tube button. On 12/10/24, an Interdisciplinary Team care plan conference meeting was held for Resident 41 and the assessment indicated to continue current plan of care. Care plans for Resident 41 included, but were not limited to: The resident requires tube feeding related to: dysphagia, dated 6/11/21. PEG tube 18Fr, 7-10 cc: Mic-Key (type of enteral feeding device) gastro tube button is 14fr/2.5 cm, initiated on 12/20/21 and revised on 10/3/23. On 2/12/25 at 9:24 A.M., Resident 41 was observed to have an intact PEG tube. A Mic-Key gastro tube button was not observed. On 2/12/25 at 9:43 A.M., the MDS Coordinator indicated they expected Resident 41 to have the appropriate tube feeding device listed in the care plan. On 2/13/25 at 9:13 A.M., the MDS Coordinator provided a current Care Plan Development, Review, and Revision policy, updated 5/8/24, that indicated care plans will be revised every business date and PRN (as needed) as changes in the resident's condition dictate. Changes include but are not limited to changes in physician orders, diet changes, therapy changes, behavior changes, ADL changes, skin changes, etc. 3.1-35(d)(2)(B)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. On 2/10/25 at 11:54 A.M., Resident 36's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with anxiety and major depression. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 36 was moderately cognitively impaired, required substantial to maximal assistance of staff (staff does more than half) with showering, dressing, and transferring, and had one fall since the prior assessment. Current physician orders included, but were not limited to: Encourage resident to wear proper footwear when out of bed every shift for fall prevention, dated 4/17/23. The most current fall risk assessment, dated 2/12/25, indicated that the resident was at high risk for falls. An Interdisciplinary Team (IDT) Care Plan Health Meeting note, dated 1/14/25 at 2:00 P.M., indicated that the care plan was reviewed and the facility would continue the current plan of care. The most current Fall Risk care plan, dated 4/18/23, included the following interventions: Bed in lowest position, dated 4/18/23 Care system and bedside table in reach. Explain use of it upon admission and reinforce as needed, dated 4/18/23 Educate the resident/family/caregivers about safety reminders and what to do if that fall occurs, dated 4/18/23 Education to staff about fall prevention efforts and strategies, dated 4/18/23 Encourage and assist with wearing non-skid footwear, footwear properly fitted, dated 4/18/23 Ensure bed wheels are locked, dated 4/18/23 Ensure environment is free of clutter, dated 4/18/23 Evaluate effectiveness and side affects of psychotropic drugs with physician for possible decrease in dosage/elimination of medication, dated 4/18/23 Gait belt for all transfers, dated 4/18/23 Increase observation for the duration of the shift, dated 12/11/24 The clinical record indicated Resident 36 had seven falls between 1/5/24 and 1/19/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall 1 On 1/5/24 at 1:30 P.M., the fall log indicated the resident had an unwitnessed fall while toileting without assistance. The resident sustained four skin tears. The IDT Fall Meeting note indicated new interventions were to increase observation in each shift, encourage proper footwear, and encourage call light use. Those interventions were not added to the care plan. Fall 2 On 1/27/24 at 6:45 A.M., the fall log indicated the resident had an unwitnessed fall when transferring from the recliner to a wheelchair. There were no injuries. The IDT Fall Record Review indicated the new intervention was to encourage use of the call light for assistance with transfer. That intervention was not added to the care plan. Fall 3 On 5/28/24 at 5:35 P.M., the fall record review indicated that the resident had an unwitnessed fall while reaching for a call bell on the floor and slid from the bed. There were no injuries. The IDT Fall Meeting note indicated the new interventions were to encourage call bell, personal belongings are within reach, and educate to call for assistance. Those interventions were not added to the care plan. Fall 4 On 8/20/24 at 12:15 A.M., the resident had an unwitnessed fall after rolling out of bed. Injuries sustained were knee skin tears. The IDT Fall Review meeting note, dated 8/22/24, indicated the new intervention was the resident should have the call light within reach. That intervention was not added to the care plan. Fall 5 On 9/23/24 at 6:10 A.M., the resident had an unwitnessed fall after taking himself to the bathroom. There were no injuries. The IDT Fall Review Meeting note, dated 9/24/24, indicated the new interventions were to keep the areas clutter free and increase observations for 24 hours. Those interventions were not added to the care plan. Fall 6 On 12/11/24 at 12:20 P.M., the resident had a witnessed fall after sliding out of bed. There were no injuries. The IDT fall record review, dated 12/12/24, indicated the new interventions were to keep the path free of clutter, encourage the resident not to lie so close to the edge of the bed, and increase observation for 24 hours. Those interventions were not added to the care plan. Fall 7 On 1/19/25 at 11:30 A.M., the resident had a witnessed fall while trying to get up from bed, fell to his knees, and sustained skin tears to both knees. The IDT Fall Review Meeting note, dated 1/21/25, indicated the new intervention was to increase observation for 24 hours. That intervention was not added to the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure residents had interventions in place to prevent accidents for 4 of 4 residents reviewed for falls. A resident's fall interventions were observed out of place, care plans were not updated with new interventions, and fall reviews were not completed. (Resident 6, Resident 34, Resident 36, and Resident 27) Findings include: 1. On 2/11/25 at 9:22 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and type 4 fracture of sacrum. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 11/15/24, indicated Resident 6 had mild cognitive impairment, required substantial to maximal assistance of staff (staff does more than half) for eating, toileting, and bathing, and had no falls since the prior assessment on 9/12/24. The most current fall risk assessment, dated 12/7/24, indicated Resident 6 was at high risk for falls. All previous fall risk assessments were also high risk. The most current care plan conference was completed on 7/10/24 at 1:00 P.M. where the care plan was reviewed and it was determined to continue the current plan of care. A Fall Risk care plan, initiated 6/1/23, included the following interventions: Bed in lowest position, dated 6/1/23 Call system and bedside table in reach. Explain use of it upon admission and reinforce as needed, dated 6/1/23 Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, dated 6/1/23 Education to staff about fall prevention efforts and strategies, dated 6/1/23 Encourage and assist with wearing non-skid foot-wear; footwear properly fitted, dated 6/1/23 Ensure bed wheels are locked, dated 6/1/23 Ensure environment is free of clutter, dated 6/1/23 Evaluate effectiveness and side effects of psychotropic drugs with physician for possible decrease in dosage/ elimination of medication, dated 6/1/23 The clinical record indicated Resident 6 sustained seven falls between 5/26/24 and 12/20/24. Fall 1 On 5/26/24 at 11:45 A.M., Resident 6 had an unwitnessed fall with no injury. The resident was unable to indicate why she fell but was found sitting on the floor in her room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked documentation to indicate the Interdisciplinary Team (IDT) reviewed the fall. The care plan was not updated with a new intervention. Fall 2 On 10/9/24 at 7:45 P.M., Resident 6 had an unwitnessed fall with no injury. The resident was unable to indicate why she fell. She was found in her room with her leather recliner tilted on the floor with the resident sitting on the left arm of the recliner. An IDT note, dated 10/14/24 at 1:21 P.M., indicated for the resident to continue therapy services due to weakness. Orders for physical therapy indicated the resident was discharged from physical therapy on 10/1/24 and was restarted on physical therapy from 10/31/24 to 11/13/24. The care plan was not updated with a new intervention. Fall 3 On 10/24/24 at 8:30 A.M., Resident 6 had an unwitnessed fall with no injury while attempting to go to the sitting area. The clinical record lacked documentation to indicate a neurological assessment had been completed for the fall. Staff to encourage proper use of assistive device was added to the care plan on 10/25/24. Fall 4 On 10/26/24 at 1:05 P.M., Resident 6 had an unwitnessed fall while in her room. An abrasion on the top of her scalp measuring 1 centimeter (cm) x 0.2 cm was noted. The resident was sent to the emergency room (ER) for treatment and evaluation. UA (urinalysis) C&S (culture and sensitivity) was added to the care plan on 10/26/24. A nursing progress note, dated 11/4/24 at 1:28 P.M., indicated results were received from the UA and no new orders were received. The clinical record lacked documentation to indicate the fall interventions were reviewed and updated following the result of the UA. Fall 5 On 11/6/24 at 12:30 A.M., Resident 6 had an unwitnessed fall while in her room. The resident complained of pain in her left arm and right side of neck, and she was sent to the ER for treatment and evaluation. The resident returned to the facility on [DATE] with an appointment to followup with (name of orthopaedic surgeon). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility Nurse Practitioner progress note, dated 11/14/24 at 1:42 P.M., indicated Patient presents today for a follow-up after a recent fall with right-sided neck pain and left arm pain and weakness. Patient was recently made hospice and experienced a fall, resulting in right-sided neck pain, pain with moving the left arm, and weakness. Patient sustained a sacral fracture and a fracture around the prosthetic right hip joint. Patient was admitted to the hospital and treated for pneumonia and altered mental status . Orthopedic surgery was consulted for the non-displaced femoral fracture, but a follow-up appointment was canceled. Patient is currently on Norco for pain management. Pain management regimen was added to the care plan on 11/6/24. Increase observation from hospital, observe for increased confusion that may warrant order for lab work, and resident usually up ad lib at time was added to the care plan on 11/8/24. Fall 6 On 12/7/24 at 2:15 A.M., Resident 6 had a witnessed fall with no injury while attempting to climb out of bed. Contact hospice. Use regular mattress with bolster and keep bed in lowest position was added to the care plan on 12/10/24. Fall 7 On 12/20/24 at 2:00 P.M., Resident 6 had an unwitnessed fall with no injury while in her room. An IDT note, dated 12/24/24 at 7:47 A.M., indicated the immediate intervention was to increase observation for 24 hours. The care plan was not updated with a new intervention. 2. On 2/10/25 at 2:11 P.M., Resident 34's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and general weakness. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/23/24, indicated Resident 34 had severe cognitive impairment, was independent with transfers, was partial to moderately dependent on staff (staff does less than half) with toileting, and had 2 or more fall without injury and 2 or more fall with injury since the prior assessment on 9/27/24. The most current fall risk assessment, dated 1/2/25, indicated Resident 34 was at high risk for falls. The most current care plan conference was completed on 1/17/25 at 11:30 A.M. where the care plan was reviewed and it was determined to continue the current plan of care. A Fall Risk care plan, initiated 10/2/23, included the following interventions: Bed in lowest position, dated 10/2/23 Call system and bedside table in reach. Explain use of it upon admission and reinforce as needed, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan was not updated with a new intervention. Fall 4 On 4/12/24 at 6:40 P.M., Resident 34 had an unwitnessed fall while attempting to go to the bathroom. The following injuries were noted: Facial skin tear measuring 2.1 centimeters (cm) x 0.1 cm Left knee abrasion measuring 0.1 cm x 0.1 cm Bruising to the right and left elbows The clinical record lacked documentation to indicate the IDT reviewed the fall. The care plan was not updated with a new intervention. Fall 5 On 8/12/24 at 3:40 P.M., Resident 34 had an unwitnessed fall with no injury while attempting to ambulate using her walker. The walker had a left front wheel that was broken. An IDT note, dated 8/15/24 at 12:04 P.M., indicated the walker would be repaired to avoid future falls. Fall 6 On 10/5/24 at 6:39 P.M., Resident 34 had a witnessed fall with no injury while ambulating with her walker. An IDT note, dated 10/7/24 at 11:47 A.M., indicated staff were to encourage the resident to utilize storage on her walker. The care plan was not updated with a new intervention. Fall 7 On 10/10/24 at 3:45 P.M., Resident 34 had an unwitnessed fall with no injury while attempting to self transfer. An IDT note, dated 10/10/24 at 3:45 P.M., indicated staff should offer to toilet the resident every two hours while awake. The care plan was not updated with a new intervention. Fall 8 On 11/1/24 at 11:55 A.M., Resident 34 had a witnessed fall while attempting to pick a sock up off the floor in the bathroom. The resident hit her head on the sink and had a knot measuring 3.5 cm x (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.5 cm on the back of her head. An IDT note, dated 11/4/24 at 7:41 A.M., indicated staff should offer for the resident to wear nonskid socks at bedtime. Offer resident to wear nonskid socks at bedtime was added to the care plan on 11/4/24. Fall 9 On 11/14/24 at 12:00 P.M., Resident 34 had an unwitnessed fall while looking for something on the closet floor. The clinical record lacked documentation that a post fall assessment was completed. The clinical record lacked documentation to indicate the IDT reviewed the fall. The clinical record lacked documentation that the physician and family were notified of the fall. The care plan was not updated with a new intervention. Fall 10 On 12/22/24 at 11:40 P.M., Resident 34 had an unwitnessed fall with no injury while attempting to go to the bathroom. An IDT note, dated 12/23/24 at 10:01 A.M., indicated that the immediate intervention was to increase observation for the duration of the shift and encourage proper footwear while in and out of bed. The care plan was not updated with a new intervention. The clinical record lacked documentation that a neurological assessment had been completed for the fall. Fall 11 On 1/2/25 at 8:00 P.M., Resident 34 had an unwitnessed fall while attempting to go to the bathroom. The following injuries were noted: Abrasion on the upper back measuring 3.2 cm x 0.4 cm Hematoma on the back of head measuring 2.5 cm x 2.5 cm The care plan was updated with the immediate intervention to increase observation for 24 hours, dated 1/2/25. An IDT note, dated 1/5/25 at 9:59 A.M., indicated staff were to anticipate bedtime by 8:00 P.M. for assistance. The care plan was not updated with a new intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/24/24 1/27/25 The facility failed to update Resident 27's care plan after each of the falls. On 2/12/25 at 11:34 A.M., Resident 27 was observed attempting to crawl out of bed. The bed was not in the lowest position. At that time, the Staff Development Nurse indicated that the bed was not in lowest position. The Staff Development Nurse requested another staff to help get Resident 27 to the bathroom. A sit to stand lift was used to transfer the resident to go to the bathroom. On 2/12/25 at 9:43 A.M., the MDS Coordinator indicated it was expected that care plans be updated with new interventions after each fall. On 2/12/25 at 12:48 P.M., the Director of Nursing (DON) indicated that after a fall, nursing staff completed a fall report which included details surrounding the fall, notifications, assessments, vital signs, and neurological assessment initiation. The IDT met the next day during morning meeting to review the falls and determine a new and relevant intervention. Immediate interventions in the fall report such as increase observation for 24 hours were for the nurse to do until IDT could come up with a new and relevant intervention. Interventions that involved observation or testing such as obtain urinalysis required follow up after the results were obtained to determine if that was the cause of the fall. If it wasn't, a new intervention would be determined and placed in the care plan. On 2/12/25 at 3:05 P.M., the MDS Coordinator indicated IDT notes were documented in the clinical record under assessments and labeled as IDT Notes. At that time, she indicated that if neurological assessments were not documented in the assessments, they were not done because the facility did not chart neuro assessments on paper. On 2/13/25 at 9:13 A.M., the MDS Coordinator provided a current Care Plan Development, Review, and Revision policy, updated 5/8/24, that indicated Care plans will be revised every business day and PRN (as needed) as changes in the resident's condition dictate. On 2/13/25 at 10:56 A.M., the MDS Coordinator provided a current Assessing Falls and Their Causes policy, revised 10/2010, that indicated Nursing staff will notify the resident's Attending Physician and family in an appropriate time frame . An incident report must be completed for resident falls . Within 24 hours of a fall, the nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence . If the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why . When a resident falls, the following should be recorded in the resident's medical record: 1. the condition in which the resident was found . 2. assessment data, including vital signs and any obvious injuries 3. interventions . 4. notification of the physician and family . 5. completion of a falls risk assessment . 6. appropriate interventions taken to prevent future falls . 3.1-45(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was properly labeled and respiratory services were provided according to professional standards for 3 of 4 residents reviewed for respiratory care. (Resident 25, Resident 16, Resident 13) Findings include: 1. On 2/9/25 at 9:30 A.M., Resident 25 was observed lying in bed with Oxygen (O2) at 3 Liters Per Minute) L/m per nasal cannula and the oxygen tubing was not dated. On 2/10/25 at 8:48 A.M., Resident 25 was observed lying in bed with O2 at 3L/m per nasal cannula and the oxygen tubing was not dated. On 2/11/25 at 8:34 A.M., Resident 25 was observed lying in bed with O2 at 3L/m per nasal cannula and the oxygen tubing was not dated. On 2/12/25 at 10:20 A.M., Resident 25 was observed lying in bed with O2 at 3L/m nasal cannula and the oxygen tubing was not dated. On 02/10/25 at 11:27 A.M., Resident 25's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Diseased (COPD). The most current Annual Minimum Data Set (MDS) Assessment, dated 12/4/24, indicated Resident 25 was slightly cognitively impaired, was independent with dressing, transferring, eating, needed substantial to maximal assistance of staff (staff does more than half) with showering, and received oxygen therapy. Current Physician Orders included, but were not limited to: Change oxygen tubing weekly every night shift Monday, dated 8/5/21 Continuous O2 per nasal cannula at three liters per minute, every shift for oxygen therapy to maintain O2 saturation related to COPD, dated 8/13/20. On 12/23/24 at 11:00 A.M., the most current Interdisciplinary Team (IDT) Health Care Plan review indicated to continue the current plan of care. A current COPD care plan, dated 10/24/23, included interventions to change oxygen tubing per facility protocol and continuous O2 at 3L/m per nasal cannula. 3. On 2/9/25 at 2:12 P.M., Resident 13 was observed sitting in a bariatric chair receiving four liters (L) of oxygen via face mask from an oxygen concentrator. The concentrator was behind the resident's chair. The humidification bottle was dated 2/1/25 and the tubing was not dated. On 2/10/25 at 11:25 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD). The most current Quarterly Minimum Data Set (MDS) Assessment, dated 11/5/24, indicated Resident 13 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was cognitively intact, was dependent on staff (staff does everything) for toileting and bathing, required substantial to maximal assistance of staff (staff does more than half) for bed mobility, and received oxygen therapy. Physician orders included, but were not limited to: Oxygen per nasal cannula at 2L as needed (PRN) for shortness of breath, dated 7/28/21 (Name of Company) average volume-assured pressure support (AVAPS) (a non-invasive ventilation technique that adjusts air pressure to deliver a set amount of air into the lungs) machine at 4L every shift for shortness of breath, 7/30/21 Change oxymask every Tuesday and as needed, dated 9/13/23 A current COPD care plan, initiated 7/29/21, included interventions to change the oxygen tubing per facility protocol and administer oxygen as ordered. An altered cardiovascular status care plan, initiated 7/29/21, included interventions to administer oxygen as ordered. Initiate oxygen monitoring when oxygen applied: Check flow rate, tubing, and placement as ordered and PRN. An altered respiratory status care plan, initiated 7/29/21, indicated to change the oximask every Tuesday and PRN as ordered. The care plan was last reviewed by the resident and Social Services Director (SSD) on 10/30/24 at 1:30 P.M. and indicated to continue with the current plan of care. During an interview on 2/11/25 at 11:15 A.M., Resident 13 indicated she used the AVAPS machine at night and the oxygen concentrator during the day. At that time, Resident 13 was observed sitting in a bariatric chair receiving 4L of oxygen via face mask from an oxygen concentrator. The concentrator was behind the resident's chair. The humidification bottle was dated 2/9/25 and the tubing was not dated. During an interview on 2/12/25 at 8:40 A.M., Licensed Practical Nurse (LPN) 6 indicated Resident 13 was supposed to be on 2L of oxygen while using the concentrator, but the resident got the aides to adjust it to 4L for her. During an interview on 2/12/25 at 11:50 A.M., Resident 13 indicated that the aides turn on and off her oxygen for her. During an interview on 2/13/25 at 11:04 A.M., Licensed Practical Nurse (LPN) 12 indicated that the tubing and water bottles should be dated and changed weekly as per order. During an interview on 2/13/25 at 11:15 A.M., the Director of Nursing (DON) indicated aides were not supposed to be turning oxygen on or off or adjusting it for residents and that oxygen tubing was to be dated every time it was changed. On 2/13/25 at 12:30 P.M., the MDS Coordinator provided a current non-dated Departmental (Respiratory)-Prevention of Infection policy that indicated .obtain equipment (example oxygen tubing, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reservoir, and distilled water) .mark with date and initials .change the oxygen cannula and tubing every seven (7) days, or as needed. 3.1-47(a)(6) 2. On 2/10/25 at 10:24 A.M., Resident 16 had oxygen in place via nasal cannula. Tubing was not labeled with a date. On 2/11/25 at 2:33 P.M., Resident 16's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 1/14/25, indicated the resident was cognitively intact, was independent with eating, required substantial to maximum assistance of staff (staff does more than half) for bathing and bed mobility, was dependent on staff for transfers, had congestive heart failure, and was not receiving oxygen therapy. Current physician orders included, but were not limited to: Continuous oxygen per nasal cannula at four liters per minute, every shift for oxygen therapy to maintain oxygen saturation. Check oxygen saturation, flow rate, tubing, placement and amount of oxygen left in tank every four hours, dated 2/2/25. Oxygen per nasal cannula at four liters as needed for shortness of breath, dated 2/1/25. The clinical record lacked a current care plan for oxygen use. On 2/12/25 at 10:09 A.M., Resident 16's oxygen concentrator was observed to be set to 3.5 liters per minute. On 2/12/25 at 10:18 A.M., Licensed Practical Nurse (LPN) 4 indicated Resident 16's oxygen concentrator was set to 3.5 liters per minute and was unsure of what it was supposed to be set on. At that time, she indicated nurses were responsible for setting the oxygen concentrators and tanks. On 2/12/25 9:43 A.M., the MDS Coordinator indicated they expected a resident to have a care plan for oxygen if they were regularly using it.

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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, record review, and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 2 of 4 residents (Residents 54 and Resident 36) observed during medication pass. Two medication errors were observed during #25 opportunities for error in medication administration. This resulted in a medication error rate of eight (8) percent. Findings include: 1. During a medication administration observation on 2/11/25 at 11:59 A.M., Registered Nurse (RN) 5 prepared an insulin injection for Resident 36. RN 5 attempted to prime the insulin pen without the needle attached. RN 5 then administered 14 units of insulin lispro (an antidiabetic injection medication) into Resident 36's upper right arm. On 2/11/25 at 12:30 P.M., Resident 36's clinical record was reviewed. Physician orders included, but were not limited to: Admelog (insulin lispro) - Inject 14 units subcutaneously in the afternoon, dated 11/26/24 2. During a medication administration observation on 2/12/25 at 1:02 P.M., Licensed Practical Nurse (LPN) 6 prepared an insulin injection for Resident 54. LPN 6 did not prime the insulin pen needle. LPN 6 administered 18 units of insulin lispro into Resident 54's lower left quadrant of his stomach. On 2/12/25 at 1:15 P.M., Resident 36's clinical record was reviewed. Physician orders included, but were not limited to: Admelog (insulin lispro) - Inject 18 units subcutaneously with meals for diabetes mellitus; if meal time blood glucose less than 100, give Admelog after eating, dated 2/10/25 During an interview on 2/11/25 at 11:59 A.M., RN 5 indicated an insulin pen needle should be primed before administering insulin. On 2/13/25 at 9:54 A.M., the Administrator provided a policy titled Insulin Administration, revised 10/2010, that indicated The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery systems prior to their use. On 2/13/25 at 11:09 A.M.,manufacturer drug insert was reviewed, the instructions for use (insulin lispro subcutaneous) were reviewed and indicated Keep needle straight and screw onto the pen until fixed . Always do a safety test before each injection to: Check your pen and the needle are working properly. Make sure that you get the correct insulin dose. Select two units by turning the dose selector until the dose pointer is at the 2 mark. Press the injection button all the way in. If no insulin appears, you may need to do this step up to 3 times before seeing insulin. 3.1-48(c)(1)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and interview, the facility failed to ensure the Dietary Manager met required qualifications for 1 of 1 dietary manager qualifications reviewed. (Dietary Manager) Finding includes: During an interview on 2/10/25 at 11:39 A.M., the Dietary Manager indicated he did not have a dietary manager certification and was not currently enrolled in a program. On 2/11/25 at 10:15 A.M., the Dietary Manager's employee file was reviewed. The Dietary Manager started employment as a dietary cook on 8/5/23, and signed a job description on the start of the role as Dietary Manager on 10/3/24. During an interview on 2/12/25 at 9:27 A.M., the Administrator indicated the dietician worked through a contract and was only in the facility approximately once a week. On 2/13/25 at 9:54 A.M., the Administrator provided a policy titled Dietary Manager Job Description, dated 1/17, that indicated Completion of approved dietary manager training course is preferred. Employee is required to enroll and successfully complete the course after hire if certification has not been completed at the time of hire. 3.1-20(e)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to comprehensively complete and implement a facility assessment to accurately determine the care and resources needed for resident care. This had the potential to affect 59 residents in the facility. Finding includes: On 2/9/25 at 10:03 A.M. during the Entrance Conference with the Administrator, the facility assessment was requested. Census at that time was 59 residents. On 2/11/25 at 3:00 P.M., the Administrator provided a facility assessment and indicated it had been completed by the Administrator and Director of Nursing (DON) that day (2/11/25). She indicated a facility assessment had not been completed or updated for the facility since 2022. At that time, she indicated it should be updated annually. On 2/13/25 at 10:44 A.M., the Minimum Data Set (MDS) Coordinator provided a Facility Assessment Tool policy, dated 8/18/17, that indicated To ensure the required thoroughness, individuals involved in the facility assessment should, at a minimum, include the administrator, a representative of the governing body, the medical director, and the director of nursing. The environmental operations manager and other department heads (e.g., the dietary manager, director of rehabilitation services, or other individuals including direct care staff) should be involved as needed. Facilities are encouraged to seek input from residents, their representative(s), or families, and consider that information when formulating their assessment . The facility must review and update this assessment annually or whenever there is/the facility plans for any change that would require a modification to any part of this assessment .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) meetings were held quarterly and the required staff were present. This had the potential to affect 59 residents in the facility. Finding includes: During an interview on 2/9/25 at 10:03 A.M., the Administrator indicated census in the facility was 59 residents. On 2/13/25 at 8:30 A.M., the QAA and QAPI Minutes sign in sheet for a meeting held on 1/15/25 was reviewed. The sign in sheet lacked documentation that the Medical Director (MD) or a designee was present for the meeting. During an interview on 2/13/25 at 9:13 A.M., the Administrator indicated that the QAPI meeting on 1/15/25 was the first QAPI meeting held since she began employment at the facility on 4/17/24. She indicated QAPI was supposed to meet quarterly. During an interview on 2/13/25 at 10:09 A.M., the Director of Nursing (DON) indicated the QAPI committee had not been meeting as consistently as it should. On 2/10/25 at 10:30 A.M., the Administrator provided a current undated Quality Assurance and Performance Improvement policy that indicated Executive members of this committee include at a minimum the Director of Nursing, the Administrator and at least 2 other facility staff members, and a designated physician (usually the Medical Director) . The full QAPI committee will meet monthly to review reports of monitoring activities and action plans for problem areas identified . 3.1-52(a)(2) 3.1-52(b)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 2. On 2/11/25 at 8:34 A.M., Certified Nurse Aide (CNA) 8 was observed performing a shower on Resident 10. CNA 8 did not wash her hands before donning gloves. She removed a used brief from the resident. She removed her gloves and did not wash her hands before donning new gloves to start the resident's shower. She cleaned the perineal area and did not remove gloves. She dried the resident with a clean towel, placed lotion on the resident's back, pulled a call bell for assistance, and placed clean clothes on the resident without removing her gloves. 3. During an interview on 2/9/25 at 10:03 A.M., the Administrator indicated census in the facility was 59 residents. During an interview on 2/12/25 at 10:17 A.M., the Assistant Director of Nursing (ADON) indicated she was in charge of the infection prevention (IP) program in the facility. The ADON indicated she was unaware if the facility performed legionella testing. During an interview on 2/12/25 at 10:30 A.M., the Maintenance Director indicated the facility did not have any mapping or perform any testing for legionella or other opportunistic waterborne pathogens. During an interview on 2/12/25 at 12:48 P.M. the Director of Nursing (DON) indicated no residents in the facility had been diagnosed with legionellosis. During an interview on 2/13/25 at 10:35 A.M., the MDS Coordinator provided a document containing six residents with a diagnosis of pneumonia, unspecified organism, in the last 12 months. She indicated none of the residents diagnosed with pneumonia had been tested for legionellosis. On 2/12/25 at 12:33 P.M., the Staff Development Nurse provided a policy titled Legionella Surveillance and Detection, dated 7/2017, that indicated As part of the Infection Prevention and Control Program, all cases of pneumonia that are diagnosed in residents at or greater than 48 hours after admission will be investigated for possible Legionnaire's disease. The infection preventionist will meet with the water management team to investigate the possible source of contamination. On 2/13/25 at 9:43 A.M., the Minimum Data Set (MDS) Coordinator provided a current Enhanced Barrier Precaution-(EBP) AN extension of Personal Protective Equipment-(PPE) policy, revised 12/2022 that indicated .EBP (Enhanced Barrier Precautions) are defined as the use of PPE (gowns and gloves) in high-contact activities .high contact activities included. Feeding tubes . On 2/13/25 at 10:37 A.M., the MDS Coordinator provided a current, non-dated Policy and Procedure for Handwashing that indicated . handwashing should always be performed: before and after contact with a resident, after removing gloves, and after contact with contaminated items . On 2/13/25 at 10:37 A.M., the MDS Coordinator provided a current, non-dated Gloves policy that indicated .gloves will be worn during resident care .after each possible area of contamination gloves are to be changed . gloves should be changed before going back .and then once again before perineal care . 3.1-18(b)(1) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newburgh Health and Rehab	10466 Pollack Ave Newburgh, IN 47630

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.1-18(b)(2) 3.1-18(l) 3.1-18(j) Based on observation, interview, and record review, the facility failed to ensure hand hygiene and Enhanced Barrier Precautions (EBP) were implemented for 2 of 2 residents observed for care (Resident 41 and Resident 10) and opportunities for waterborne illness were tested for 59 of 59 residents who consume water in the facility. Findings include: 1. During an observation on 2/11/25 at 9:51 A.M., Qualified Medication Aide (QMA) 7 entered Resident 41's room. QMA 7 put on gloves and began administering medications through Resident 41's percutaneous endoscopic gastrostomy (PEG) tube (a tube inserted through the abdominal wall into the stomach). Resident 41's PEG tube began leaking the medication and stomach contents back out of the tube. QMA 7 exited the room and came back into the room with two nurses who assisted QMA 7 in changing the adapter valve on the PEG tube. QMA 7 began administering medications again. Hand hygiene was not performed during care of Resident 41, and a gown was not worn by QMA 7 or either of the nurses providing direct patient care to Resident 41. On 2/11/25 at 12:27 P.M., Resident 41's clinical record was reviewed. The resident had diagnoses that included, but were not limited to, cerebral palsy. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/10/24, indicated the resident was not cognitively intact, was dependent on staff (staff does everything) for bed mobility, and had an enteral feeding tube. Current physician orders for Resident 41 included: PEG (percutaneous endoscopic gastrostomy) tube 18F (French), 7-10 cc (cubic centimeters) in place, dated 4/30/23. Enhanced Barrier Precautions due to Feeding Tube every shift, dated 3/22/23. Care plans for Resident 41 included, but were not limited to: Enhanced Barrier Precautions as ordered due to feeding tube, dated 3/22/23. On 2/12/25 at 8:35 A.M., an Enhanced Barrier Precaution (EBP) sign was observed on Resident 41's door. On 2/12/25 at 9:24 A.M., Licensed Practical Nurse (LPN) 6 was observed administering tube feeding to Resident 41. LPN 6 was not wearing a gown.

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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 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 IP had not received specialized training in infection prevention and control when starting the IP role and did not dedicate at least part time hours to the role of IP for 1 of 1 staff members reviewed for IP. Finding includes: During an interview on 2/12/25 at 10:17 A.M., the Assistant Director of Nursing (ADON) indicated that she was responsible for the Infection Prevention and Control Program in the facility but did not have a current Infection Preventionist certification. She indicated she was able to dedicate approximately 12 hours per week to the infection control program. On 2/12/25 at 1:12 P.M., the ADON's employee file was reviewed. The employee file lacked any job description or roles in the facility related to infection preventionist. On 2/9/25 at 12:30 P.M., the Administrator provided a policy titled Infection Prevention and Control Program, revised 10/2018, that indicated The infection prevention and control program is coordinated and overseen by an infection preventionist specialist (infection preventionist). On 2/13/25 at 9:54 A.M., the Administrator provided an Infection Preventionist job description that indicated Minimum Qualifications: Have primary professional training in nursing be qualified by education, training, experience, or certification in infection control.