STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155378		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/17/2025	
	ROVIDER OR SUPPLIER			1001 N	ADDRESS, CITY, STATE, ZIP COD GRANT ST ON, IN 46052		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG F 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
F 0000 Bldg. 00	Licensure Survey. T Investigation of Con IN00452427. Complaint IN00449 the allegations are con Complaint IN00452 the allegations are con Survey dates: Februa 2025. Facility number: 00 Provider number: 1: AIM number: 10029 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 1 Medicaid: 77 Other: 6 Total: 84 These deficiencies raccordance with 410	2427 - No deficiencies related to ited. Part 10, 11, 12, 13, 14, and 17, 0468 55378 90270 Perflect State Findings cited in 0 IAC 16.2-3.1. completed on February 19,	F 00	000	Preparation and/or execution of this plan of correction in gener does not constitute an admiss of an agreement by this facility the facts alleged or conclusion set forth in this statement of deficiencies. The plan of corre and specific corrective actions prepared and/or executed in compliance with State and Fet Laws. Facility's date of alleged compliance is 3/03/2025. We requesting a desk review.	ral, ion / of is ection are deral	
SS=E Bldg. 00	Care Plan Timing						

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

Jennifer Lazar Administrator 02/28/2025

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155378	B. Wl	NG		02/17	/2025
		<u> </u>	-	STREET	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIE	R			GRANT ST		
SIGNATI	URE HEALTHCAR	E AT PARKWOOD		LEBAN	ION, IN 46052		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		and record review, the facility	F 06	557	1 What corrective action v	vill	03/03/2025
	failed to ensure res				be accomplished for those		
	_	re invited to participate in care			residents found to have been		
		of 4 residents reviewed for			affected by the deficient pract		
	-	ces. (Residents 36, 64, 75 and			a Resident 36, 58, 64, and		
	58)				were affected. Residents were		
	F: 1: : 1 1				assessed with no concerns a		
	Findings include:				care plan conferences comple		
	1 The climical wass	1. The clinical record for Resident 36 was reviewed on 2/14/25 at 2:55 p.m. The diagnoses included,			2 How other residents have	•	
					the potential to be affected by		
		d to, major depressive disorder,			same alleged deficient practic will be identified and what	es	
					corrective action will be taken		
	type 2 diabetes, and muscle weakness.				a All residents have the		
	A review of Resident 36's medical record indicated				potential to be affected by the		
	the facility had not held a care plan meeting for				alleged deficient practice.	•	
	the resident since 1				b Facility wide audit was		
	the resident since i	. 1/3/23.			completed to ensure all reside	≥nts	
	During an interview	w, on 2/13/25 at 2:43 p.m., the			had a care plan meeting per	JIIIO	
	_	ector indicated care plan			guidelines.		
		e held quarterly. Care plan			3 What measures will be	nut	
	_	een held for Resident 36 in			into place and what systemic	put	
	2024.				changes will be made to ensu	ıre	
					that the alleged deficient prac		
	2. The clinical reco	ord for Resident 64 was reviewed			does not recur:		
	on 2/13/25 at 2:28	p.m. The diagnoses included,			a As a measure of ongoin	g	
		d to, dementia, anxiety disorder,			compliance SSD was re-educ	•	
	and schizoaffective	e disorder.			on facility's care plan policy.		
					b CEO and/or designee w	/ill	
	A review of Reside	ent 64's medical record indicated			audit 5 residents weekly times	s 4	
	the facility had not	held a care plan meeting for			weeks, twice monthly times 2		
	the resident since 1	0/30/23.			months, then monthly times 3	}	
					months to ensure the care pla	an	
	_	w, on 2/13/25 at 2:43 p.m., the			meeting have been completed		
		ector indicated care plan			4 How the corrective action	n	
	_	e held quarterly. Care plan			will be monitored to ensure th		
	meetings had not b	een held for Resident 64 in			alleged deficient practice will		
	2024.				recur, what quality assurance		
					program will be put into place		
	3. The clinical reco	ord for Resident 75 was reviewed			a As a measure of ongoin	g	

TAG REGULATORY OR LSC IDENTIFYING INFORMATION on 2/14/25 at 10:19 a.m. The diagnoses included, but were not limited to, anxiety, schizoaffective disorder, and myocardial infarction (heart attack). A review of Resident 75's medical record indicated the facility had not held a care plan meeting for the resident since 4/8/24. During an interview, on 2/13/25 at 2:43 p.m., the Social Service Director indicated care plan meetings should be held quarterly. Resident 75 was invited and attended a care plan meeting on 4/8/24. Another care plan meeting was scheduled for July 2024 but did not happen.4. The clinical record for Resident 58 was reviewed on 2/12/25 at 11:42 a.m. The diagnoses included, but were not	CENTERS FO	NTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
In the resident since 4/8/24. NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) On 2/14/25 at 10:19 a.m. The diagnoses included, but were not limited to, anxiety, schizoaffective disorder, and myocardial infarction (heart attack). A review of Resident 75's medical record indicated the facility had not held a care plan meeting for the resident since 4/8/24. During an interview, on 2/13/25 at 2:43 p.m., the Social Service Director indicated care plan meetings should be held quarterly. Resident 75 was invited and attended a care plan meeting on 4/8/24. Another care plan meeting was scheduled for July 2024 but did not happen.4. The clinical record for Resident 58 was reviewed on 2/12/25 at 11:42 a.m. The diagnoses included, but were not			IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	LETED	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION on 2/14/25 at 10:19 a.m. The diagnoses included, but were not limited to, anxiety, schizoaffective disorder, and myocardial infarction (heart attack). A review of Resident 75's medical record indicated the facility had not held a care plan meeting for the resident since 4/8/24. During an interview, on 2/13/25 at 2:43 p.m., the Social Service Director indicated care plan meeting should be held quarterly. Resident 75 was invited and attended a care plan meeting on 4/8/24. Another care plan meeting was scheduled for July 2024 but did not happen.4. The clinical record for Resident 58 was reviewed on 2/12/25 at 11:42 a.m. The diagnoses included, but were not PREFIX TAG Compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement (QAPI) Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to the outcomes of audits.					1001 N	GRANT ST			
limited to, chronic obstructive pulmonary disease (COPD), heart failure, and pain. A review of Resident 58's medical record indicated the facility had not held a care plan meeting for the resident since 7/29/24. During an interview, on 2/12/25 at 11: 46 a.m., the Social Services Director indicated she was not able to find documentation for a care plan meeting held after 7/29/24 and the care plan meetings were to be held quarterly. A current facility policy, titled "Comprehensive Care Plans," dated as last reviewed on 1/31/25 and received from the Corporate Support Nurse on 2/17/25 at 11:28 a.m., indicated "The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and time frames to	(X4) ID PREFIX	SUMMARY (EACH DEFICIEN REGULATORY OF on 2/14/25 at 10:19 but were not limited disorder, and myoc A review of Reside the facility had not the resident since 4. During an interview Social Service Dire meetings should be was invited and atte 4/8/24. Another car for July 2024 but direcord for Resident 11:42 a.m. The diag limited to, chronic (COPD), heart failuted the facility had not the resident since 7. During an interview Social Services Dire able to find docume held after 7/29/24 at to be held quarterly A current facility per Care Plans," dated a received from the Ce 2/17/25 at 11:28 a.i. develop and impler person-centered can	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 2 a.m. The diagnoses included, d to, anxiety, schizoaffective ardial infarction (heart attack). ant 75's medical record indicated held a care plan meeting for /8/24. and 2/13/25 at 2:43 p.m., the actor indicated care plan held quarterly. Resident 75 anded a care plan meeting on the plan meeting was scheduled id not happen.4. The clinical and service as a reviewed on 2/12/25 at agnoses included, but were not abstructive pulmonary disease are, and pain. and 58's medical record indicated held a care plan meeting for /29/24. and pain. and the care plan meeting and the care plan meetings and the care plan meeting and the care plan meetings and the care plan meeting and the care plan meetings and the care plan meeting and the care plan meeting and the care plan meetings and the care plan meeting and the care plan me		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assuran Performance Improvement (Q Committee until substantial compliance is achieved. The Committee has the right to mo or extend monitoring times according to the outcomes of	be r nce (API) QAPI odify	COMPLETION	

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A current facility policy, titled "Resident Rights,"

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155378	(X2) MULTIPI A. BUILDIN B. WING	7ING 02/17/202	
	PROVIDER OR SUPPLIEI		100	EET ADDRESS, CITY, STATE, ZIP COE D1 N GRANT ST BANON, IN 46052	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE APPL	ILD BE COMPLETION
F 0679 SS=D Bldg. 00	dated as last revised the Corporate Supplea.m., indicated "F certain basic rights These rights include toParticipate in decomposition of the series of	d on 1/31/25 and received from Fort Nurse on 2/17/25 at 11:28 Federal and state laws guarantee to all residents of this facility. The teresident's right recisions and care planning" The terest/Needs Each Resident on, interview and record failed to ensure a resident who red memory care unit was by stimulating activities an of care for 1 of 4 residents	F 0679	1 What corrective act be accomplished for thos residents found to have be affected by the alleged depractices. a Resident 20 was af Resident was assessed was concerns, and Activity Assessment updated. 2 How other residents the potential to be affected same deficient practices identified and what correct action will be taken: a All residents on the dementia unit have the potential unit have accurate and updated to ensure all residents. 3 What measures will into place and what system that the alleged deficient does not recur:	see been eficient ffected. with no s having ed by the will be ctive otential to eficient was esidents ed I be put emic ensure
		20's room and then went to the		a As a measure of on	ngoing

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155378	B. W	ING		02/17/	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> — </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			GRANT ST		
SIGNATI	URE HEALTHCARI	E AT PARKWOOD			ON, IN 46052		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		offering to take the resident to			compliance, the Activity Direc		
	bingo.				was re-educated was re-educ	ated	
					on the facility's Activity		
	_	ion, on 2/11/25 at 9:53 a.m.,			Documentation Policy.		
	-	ber 3 came back down the			b CEO and/or designee w		
		g other residents if they wanted			audit 5 residents weekly times	; 4	
		peaked inside Resident 20's			weeks, twice monthly times 2		
		ask the resident if she wanted			months, then monthly times 3		
	to play bingo.				months to ensure the Activity		
	During an observation, on 2/12/25 at 8:49 a.m.,				Assessment/Care Plan reflect		
	_				residents interests.		
		urring in the lounge. Resident			4 How the corrective actio		
	20 was resting in her bed with the lights off.				will be monitored to ensue the		
	5				alleged deficient practice will i		
	During an observation, on 2/12/25 at 10:25 a.m., Resident 20 was in her room with the TV off and				recur, what quality assurance		
					program will be put into place		
	was not doing any	activities.			a As a measure of ongoin	-	
					compliance, audit results will l	эе	
	_	nion, on 2/13/25 at 10:36 a.m.,			submitted to the campus		
		vake in her room with the lights			administrator, or designee, for		
		f, and she was not doing any			review by the Quality Assuran		
		ere activities occurring in the			Performance Improvement (Q	API)	
	lounge.				Committee until substantial	0 A DI	
	During on abase	ion, on 2/14/25 at 9:15 a.m.,			compliance is achieved. The		
	_				committee has the right to mo	ally	
	were occurring in t	leep in her room while activities			or extend monitoring times		
	were occurring in t	ne diffing 100m.			according to the outcomes of		
	The clinical record	for Resident 20 was reviewed			audits.		
		a.m. The diagnoses included,					
		d to Alzheimer's disease,					
		or depressive disorder.					
	dementia, and majo	aspressive disorder.					
	A current care plan	, with an edit date of 1/7/25,					
	indicated Resident	20 was involved in group					
	activities such as m	nusic entertainment, socials,					
		r room. She would often refuse					
	to participate but en	njoyed watching other people					
		ties. Her prior occupation was					
		rker and to offer her activities					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155378		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/17/2025	
	PROVIDER OR SUPPLIEF		1001 N	ADDRESS, CITY, STATE, ZIP COD I GRANT ST ION, IN 46052	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE COMPLETION
TAG	towards cleaning. In were not limited to, escort resident to ac with the resident's in the resident's indicated Resident 20 preferrommon areas. A quarterly life enrowmon areas. During an interview Activity staff membrot really a morning in her room in the mand color. She could in the resident's room sure where it was. Substitutes were available to the staff of the st	or, on 2/14/25 at 11:21 a.m., per 5 indicated the resident was g person. She liked to watch TV mornings and to read magazines d not find the remote to the TV m this morning and was not she was not sure what lable in the resident's room. If and observation, on 2/14/25 fied Medication Aide (QMA) 4 nt 20's TV remote. She could note and indicated the resident of in her room. There were no ng books in the resident's Dilicy, titled "Activity Program," and on 1/31/25 and received apport Nurse on 2/17/25 at 11:28 froup Activities will be extivity calendar and will be evenient and reflect the	TAG	DEFICIENCY	DATE

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l ′		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155378	A. BU B. WII	ILDING	00	COMPLETED 02/17/2025	
		155576	B. WII			02/11/2025	
	PROVIDER OR SUPPLIER JRE HEALTHCARE			1001 N	ADDRESS, CITY, STATE, ZIP COD GRANT ST ION, IN 46052		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		e in a large or small group equire a one-to-one delivery					
F 0684 SS=D Bldg. 00	483.25 Quality of Care						
	review, the facility in non-pressure wound manner and to ensurchanged/cleaned aft wound and failed to notified of blood glaphysician's ordered reviewed for quality. Findings include: 1. During a random 11:29 a.m., Resident therapy room. She bright lower leg from The dressing was not drainage soaked thre 2/9/25. The resident changed daily. During an observation Resident 139 was of wearing a pressure on her right lower leg 2/11/25 and had a lawhich had soaked the resident's bedshoon the sheet which wounderstands and the resident's bedshoon the sheet which would be supposed to the sheet which wou	on, interview and record failed to ensure a dressing for a dressing for a dress maintained in a sanitary rebed sheets were set being soiled from the ensure the physician was access readings outside of the parameters for 2 of 2 residents of care. (Resident 139 and 50) observation, on 2/10/25 at at 139 was observed in the mad a wound dressing on her in the ankle to below the knee. Oted to have brown and red ough. The dressing was dated at indicated her dressing was dated at indicated her dressing was dated arge brownish color drainage arough the dressing and onto eets leaving three soiled areas were brown in color.	F 06	84	1 What corrective action was accomplished for those residents found to have been affected by the alleged deficie practices. a Resident 139 and 50 we affected. Residents were assessed with no adverse effected. Practices with a potential to be affected by same deficient practices will be identified and what corrective action will be taken: a All residents have the potential to be affected by alled deficient practice. b Facility wide audit was completed to ensure all resided with diagnosis of diabetes to ensure that are call parameter were correct. A facility wide a was completed to ensure that resident with soiled or disloded dressings were changed per Forder. 3 What measures will be printo place and what systemic changes will be made to ensure that the alleged deficient practices not recur: a As a measure of ongoing	ects. ring the e ged ents rs udit any ed PRN out re tice	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155378	B. W	'ING		02/17/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				GRANT ST		
SIGNATU	JRE HEALTHCARE	AT PARKWOOD			ON, IN 46052		
			ı		· [ar.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		description to change the dressing.		TAG		II bo	DATE
		ed pain medication to the			compliance all nursing staff wi		
		aiting for the effectiveness of			educated on following physicia	an	
		N 1 indicated the CNA was to			order and facility skin policy. b DON and/or designee w	:11	
	change the sheets.	VI indicated the CIVA was to			audit 5 residents weekly times		
	change the sheets.				weeks, twice monthly times 2	4	
	During an observati	ion, on 2/13/25 at 11:22 a.m.,			months, then monthly times 3		
	_	rved in enhanced barrier			months to ensure call parame	ters	
	precautions assisting the resident to her				are in placed and residents wi		
	wheelchair. The resident's dressing on the lower				soiled or dislodged dressings		
	right leg had drainage consistent with the color of				changed per PRN order.	-	
	blood which had soaked through the dressing.				4 How the corrective action	n	
	The resident indicated her dressing had not been				will be monitored to ensure the		
	changed yet. Two towels were also noted to be on				alleged deficient practice will r		
	the bed at about the same area where the				recur, what quality assurance		
	resident's leg would	have laid while in bed. Upon			program will be put into place:		
	lifting the towels, th	ne sheet was found to have a			a As a measure of ongoing		
	blood stain.				compliance, audit results will b	-	
					submitted to the campus		
	During an interview	y, on 2/13/25 at 11:28 a.m., LPN			administrator, or designee, for		
		waiting to change the			review by the Quality Assuran	ce	
	-	sident could have pain			Performance Improvement (Q	API)	
	medication again w	hich would be at 1:40 p.m.			Committee until substantial		
					compliance is achieved. The 0		
	_	y, on 2/13/25 at 11:41 a.m., the			committee has the right to mo	dify	
		Nurse indicated the dressing			or extend monitoring times		
	_	ed now. The Director of			according to the outcomes of		
		ne resident did have an as			audits.		
		ange ordered for soilage of the					
	-	tor of Nursing indicated					
		ot been educated on the					
	_	fection or other risks which					
		t keeping the wound dressing					
	clean and dry.						
	During on interview	y, on 2/13/25 at 11:53 a.m., the					
	-	indicated the resident had					
	-						
	after she finished he	ne dressing would be changed					
	arter she minshed no	nical.					
			1				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		155378	B. W	ING		02/17	/2025
	PROVIDER OR SUPPLIEF			1001 N	ADDRESS, CITY, STATE, ZIP COD GRANT ST ON, IN 46052		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE).TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE
	On 2/14/25 at 10:19	a.m., the wound dressing					
	change to the lower	right leg was observed. The					
		span around the lower					
	· ·	the ankle and up the shin area.					
		ed with serosanguineous					
		d serum fluid) with yellow					
		ordered dressing used. The					
	dressing change was completed, and the						
	appropriate date was placed on the dressing.						
	The clinical record for Resident 139 was reviewed						
	on 2/17/25 at 9:45 a.m. The diagnoses included,						
	but were not limited to, cellulitis of the right lower						
	limb, type 2 diabetes without complication and						
		s (a rare but life-threatening					
	_	which rapidly destroys the soft					
		connective tissue) beneath the					
	skin).	,					
	,						
	A physician's order	, initiated on 1/18/25, indicated					
	for staff to clean the	e right lower venous stasis					
	wound with normal	saline, pat dry, apply					
	Xeroform, cover wi	ith abdominal dressings, wrap					
		ure with an ACE wrap daily and					
	_	age or displacement. Special					
		order indicated for staff to					
		dressing once a day between					
	_	m. The order was discontinued					
	on 2/13/25.						
		1 1/10/05					
		, initiated on 1/18/25, indicated					
		e right lower venous stasis					
		saline, pat dry, apply					
		ith abdominal dressings, wrap ure with an ACE wrap daily and					
		are with an ACE wrap daily and age or displacement. Special					
		order indicated for staff to					
	change the wound						
	change the wound (messing as necucu.					
	A physician's order	, initiated on 1/22/25, indicated					

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155378		onstruction 00	(X3) DATE SURVEY COMPLETED 02/17/2025
	PROVIDER OR SUPPLIER URE HEALTHCARE AT PARKWOOD	1001 N	ADDRESS, CITY, STATE, ZIP COD GRANT ST ON, IN 46052	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	to give hydrocodone-acetaminophen (a narcotic pain reliever) every six (6) hours as needed for pain.			
	The Medication/Treatment Administration Record (MAR/TAR) indicated the resident received the narcotic pain-relieving medication on 2/10/25 at 8:29 a.m., on 2/12/25 at 10:26 a.m., on 2/13/25 at 7:38 a.m., and on 2/14/25 at 9:11 a.m.2. The clinical record for Resident 50 was reviewed on 2/14/25 at 11:51 a.m. The diagnoses included, but were not limited to, type 2 diabetes, type 2 diabetes with ketoacidosis (a complication of diabetes), and acute kidney failure. A care plan, dated 8/7/24, indicated Resident 50 had diabetes. Interventions included, but were not limited to, to administer medications according to the physician's order. A physician's order indicated to notify the physician if Resident 50's blood glucose reading was less than 150. The Medication Administration Record (MAR) indicated Resident 50's blood glucose reading was below 150, 14 times in January 2025 and 14 times in February 2025. There was no documentation in Resident 50's medical record to indicate the physician was notified of the blood glucose readings below 150 according to the physician's order. During an interview, on 2/14/25 at 1:32 p.m., LPN 2 indicated when a blood sugar was below the parameter set by the physician, the blood sugar and notification to the physician would be documented in the progress notes.			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155378	B. WING		02/17/2025	
			CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD		
SIGNATI	JRE HEALTHCARE	AT PARKWOOD		ION, IN 46052		
SIGNATI		ATTAKWOOD	LLDAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	v, on 2/14/25 at 1:38 p.m., the				
	_	g (DON) indicated the facility				
		ystem to communicate with				
		l orders the facility used were				
		if the blood sugar was under				
		was placed into Resident 50's If the order instructed staff to				
	notify the physician when a blood sugar reading was below 150, then staff should have been					
	notifying the physician.					
	notifying the physician.					
	During an interview, on 2/14/25 at 1:48 p.m., the					
	Administrator indicated when an order was placed					
	into the chart, the parameter would need to be set					
	to match the physician's order. When Resident					
		ed, the parameter was not set				
	correctly.	-				
	A current facility po	olicy, titled "Review of				
		dated as last revised 1/31/25				
		he Corporate Support Nurse				
		a.m., indicated "Licensed				
	_	physician's orders as				
	applicable"					
		olicy, titled "Resident Rights,"				
		d on 1/31/25 and received from				
		ort Nurse on 2/17/25 at 11:28				
		all residents will be treated in a				
		nvironment that promotes ancement of quality of life"				
	maintenance or enn	ancement of quanty of me				
	A current facility po	olicy, titled "Skin Integrity,"				
		1 1/31/25 and received from the				
		Nurse on 2/17/25 at 11:28 a.m.,				
		cility will ensureA resident				
		integrity receives necessary				
	treatment and service					
		rds of practice, to promote				
	-	ection and prevent avoidable				

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Event ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155378	B. W	ING		02/17	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			GRANT ST		
SIGNATI	URE HEALTHCARE	AT PARKWOOD			ION, IN 46052		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	skin integrity issues	s from developing"					
	3.1-37(a)						
F 0883	3 483 80(4)(1)(2)						
SS=D	483.80(d)(1)(2)	eumococcal Immunizations					
Bldg. 00	I IIIIueiiza aliu File	edifiococcai illillidilizations					
Diag. 00	Based on interview	and record review, the facility	F 08	283	1 What corrective action w	/ill	03/03/2025
		onsent for an Influenza	1 00	303	be accomplished for those		03/03/2023
		tained prior to administration			residents found to have been		
		enza and Pneumococcal			affected by the alleged deficie	nt	
	vaccines were offer	red for 3 of 5 residents			practices.		
	reviewed for immus	nizations. (Resident 53, 139 and			a Residents 53, 139, and	11	
	11)				were affected. Residents were	е	
					assessed with no concerns an	ıd	
	Findings include:				immunizations consents completed.		
	The immunization i	records for Residents 53, 139,			2 How other residents hav	ing	
	and 11 were review	red, on 2/14/25 at 9:02 a.m., and			the potential to be affected by	-	
	indicated the follow	ving:			same deficient practices will b		
					identified and what corrective		
	a. There was no doo	cumentation to indicate			action will be taken:		
		fered the Influenza or			a All residents have the		
	Pneumococcal vacc	eination in 2024 or 2025.			potential to be affected by alle	ged	
					deficient practice.		
		cumentation to indicate			b Facility wide audit was		
		ffered the Influenza or			completed to ensure all reside		
	Pneumococcal vacc	eination in 2024 or 2025.			had immunizations consents in	n	
	D 11 411	1 ' ' 4 14 1 0			place per facility guidelines.		
		administered the Influenza 9/24, without a documented			3 What measures will be p	out	
	· ·	there was no documentation			into place and what systemic	ro	
		nococcal vaccination was			changes will be made to ensure that the alleged deficient pract		
	offered.	decocal vaccination was			does not recur:	.10 0	1
	onered.				a As measure of ongoing		
	During an interview	v, on 2/14/25 at 10:52 a.m., the			compliance Market Liaison, N	urse	
		eated vaccine status and			Managers, and Nursing Staff v		
		was part of the admission			re-educated on the facility's		
	_	ility. There was a fault in the			vaccine policy.		
	_	h ensuring each resident			b DON and/or designee w	vill	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
		155378		ING	_	02/17/2025		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 1001 N GRANT ST LEBANON, IN 46052					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	signed or declined the vaccination consent forms				audit 5 residents weekly times	4		
	_	ion of the vaccinations.		weeks, twice monthly times 2				
					months, then monthly times 3			
	During an interview, on 2/17/25 at 1:14 p.m., the				months to ensure residents ha	ıve		
		ated the facility had no further			immunization consents and			
	information to prov	-			vaccines given as appropriate			
	A current facility policy, titled "Vaccination of				4 How the corrective action			
					will be monitored to ensure the			
	Resident," dated as	last revised on 1/31/25 and			alleged deficient practice will r	not		
	received by the Clir	nical Support Nurse on 2/12/25			recur, what quality assurance			
	at 10:20 a.m., indicated "All residents will be				program will be put into place:			
	offered vaccines that aid in preventing infections				a As a measure of ongoing	3		
	disease unless the v	accine is medically			compliance, audit results will t	e		
	contraindicated, or	the resident has already been			submitted to the campus			
		receiving vaccinations, the			administrator, or designee, for			
	resident or legal representative will be provided				review by the Quality Assuran			
		acation regarding the benefits			Performance Improvement (Q	API)		
	_	ffects of the vaccinationsAll			Committee until substantial			
		be assessed evaluated for			compliance is achieved. The 0			
	current vaccinations	s status upon admission"			committee has the right to mo	dify		
	A current facility no	olicy, titled "Vaccines and			or extend monitoring times according to the outcomes of			
		ted as last revised on 11/14/24			audits.			
		Clinical Support Nurse on			audits.			
		n., indicated "Minimize the risk						
	of residents acquiri							
	-	lications from communicable						
		munizations by following the						
	CDC Guidance"							
	3.1-18(b)(5)							
L 0002	400.00(3)/0)/// "							
F 0887 SS=D	483.80(d)(3)(i)-(vii	•						
	COVID-19 Immunization							
Bldg. 00	Based on interview and record review, the facility		E 6/	207	4 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	.:11	02/02/2025	
		and record review, the facility VID-19 vaccinations were	F 08	887	1 What corrective action w	'III	03/03/2025	
					be accomplished for those			
	offered to residents for 3 of 5 residents reviewed for immunizations. (Resident 53, 139 and 23)				residents found to have been	n t		
					affected by the alleged deficient			
			1		practices.		l	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155378	B. W	ING _		02/17/2025		
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF	PROVIDER OR SUPPLIEI	3			GRANT ST			
SIGNIAT	URE HEALTHCARE	E AT PARKWOOD			ON, IN 46052			
JIGINAI		- ALLAMOOD		LLDAN	UIN, IIN 7000Z			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DATE			
	Findings include:				23			
				were affected. Residents we		-		
		records for Residents 53, 139,			assessed with no concerns, a	nd		
		ved, on 2/14/25 at 9:02 a.m., and	at 9:02 a.m., and		immunizations consents completed.			
	indicated the following:							
						sidents having		
		received the COVID-19			the potential to be affected by			
	•	and 2022. There was no			same deficient practices will be			
		ndicate Resident 53 was			identified and what corrective			
	offered the COVID	-19 vaccination after 2022.			action will be taken:			
					a All residents have the			
		d received the COVID-19			potential to be affected by alle	eged		
		. There was no documentation			deficient practice.			
		t 139 was offered the			b Facility wide audit was	,		
	COVID-19 vaccination after 2021.			completed to ensure all residents				
	D 11 . 221 11 11 11 GOVED 10				had immunizations consents	n		
	c. Resident 23 had declined the COVID-19				place per facility guidelines.	4		
	vaccination in 2024 on admission. There was no				3 What measures will be p	out		
	documentation to indicate Resident 23 was offered the COVID-19 vaccination after admission.				into place and what systemic			
	offered the COVID	-19 vaccination after admission.			changes will be made to ensu			
	During an interview	v, on 2/14/25 at 10:52 a.m., the			that the alleged deficient practions does not recur:	uce		
		eated vaccine status and						
		was part of the admission			a As measure of ongoing	uroo		
	_	ility. There was a fault in the			compliance Market Liaison, N Managers, and Nursing Staff	I		
					re-educated on the facility's	Weie		
	follow-through with ensuring each resident signed or declined the vaccination consent forms				vaccine policy.			
	and the administration of the vaccinations.				b DON and/or designee w	vill		
	and the administration of the vaccinations.				audit 5 residents weekly times			
	During an interview	v, on 2/17/25 at 1:14 p.m., the			weeks, twice monthly times 2	I		
	_	eated the facility had no further			months, then monthly times 3			
	information to prov	-			months to ensure residents ha			
	provi				immunization consents and			
	A current facility policy, titled "Vaccination of			vaccines given as appropriate.				
	Resident," dated as last revised on 1/31/25 and			4 How the corrective action				
	received by the Clinical Support Nurse on 2/12/25			will be monitored to ensu				
	at 10:20 a.m., indicated "All residents will be							
		at aid in preventing infections		alleged deficient practice will r recur, what quality assurance				
	disease unless the vaccine is medically				I			
	disease unless the v	accine is medically			program will be put into place	:		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155378	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/17/2025		
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE AT PARKWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 1001 N GRANT ST LEBANON, IN 46052					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	vaccinatedPrior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinationsAll new residents shall be assessed evaluated for current vaccinations status upon admission" A current facility policy, titled "Vaccines and Immunizations," dated as last revised on 11/14/24 and received by the Clinical Support Nurse on 2/17/25 at 11:28 a.m., indicated "Minimize the risk of residents acquiring, transmitting, or experiencing complications from communicable diseases through immunizations by following the CDC Guidance"			si a re P C c c c	compliance, audit results will be submitted to the campus administrator, or designee, for eview by the Quality Assurance Improvement (Quality Committee until substantial compliance is achieved. The Committee has the right to more extend monitoring times according to the outcomes of audits.	ce API) QAPI		

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