STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00455454. Complaint IN00455454- No deficiencies related to the allegations are cited. Survey dates: March 12, 13, 14, 17, 18, 19, 2025 Facility number: 000164 Provider number: 155263 AIM number: 100289550 Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicare: 5 Medicaid: 21 Other: 9 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 28, 2025.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses to regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 5/01/2025 to the state findings of the Recertification and State Licensure Survey. We respectfully request paper compliance in leu of a post survey review. Please contact the facility if additional information is needed for a desk review.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity for 1 of 2 days during dining observations. Staff was feeding a resident but not engaged with the resident, a resident	F 0550	It is the practice of this facility that all residents are treated with respect and dignity. 1. What corrective actions will be accomplished for those residents	05/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Gladish	Health Facility Administrator	04/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	asked for water and staff did not get it for her, a resident was told she would get coffee and did not receive it, and food was not served in a timely manner. (Main dining room, East Hall tray pass, West Hall tray pass) Findings include: 1. During a random continuous observation on 3/12/25 at 12:34 P.M., a resident seated in the main dining room asked a staff member for water to drink and indicated they had been there for a long time waiting for their trays. The staff member indicated she would get the resident water, used hand sanitizer, and then left the dining room. The resident did not get water until she was given her tray at 12:46 P.M. 2. During a continuous observation of Resident 29 in the Main dining room on 3/12/25 the following was observed: At 12:46 P.M., Resident 29 was served her meal. At 12:54 P.M., Certified Nurse Aide (CNA) 26 sat by Resident 29 to feed her. The resident next to Resident 29 at the table dropped her roll. The CNA picked up the roll for the resident off the table, gave it to her, and then grabbed a spoon to feed Resident 29 again. At 12:56 P.M., CNA 26 cued another resident at the table to eat. At 12:57 P.M., CNA 26 used a knife to cut the resident's roll and then picked up spoon and gave Resident 29 a bite of food. At 12:59 P.M., a resident hollered that she dropped ice cream on her leg. CNA 26 left Resident 29, went to the kitchen window, and asked for a towel for the resident. The resident then asked CNA 26 to take her back to her room and the CNA indicated "I can't right now. I'm the only one in here and I'm trying to feed another		found to be affected by the deficient practice: a. Residents identified during survey were provided meals and consumption was documented. b. Staff involved were educated on 4/08/2025 regarding the importance of timely meal delivery, customer service, assisting residents with their meals, maintaining residents' dignity, and providing clothing protectors. c. Resident 8's order for serving the resident's food in individual bowls was clarified with Speech Therapist. Order updated to reflect speech's recommendations on 3/13/2025. The care plan reflects current order. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficiency. . b. An audit was conducted to determine the assistance level of residents during meal times. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. A dining room manager will be assigned to ensure timeliness of meal delivery time along with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident". At 1:00 P.M., CNA 26 sat back down to feed Resident 29. Immediately, another resident was trying to stand up, CNA 26 went over to that resident and got her to sit back down, and then sat down to feed Resident 29. At 1:02 P.M., a resident requested ice cream so CNA 26 got up to ask the kitchen staff for ice cream and then gave it to that resident before she sat down to feed Resident 29 again. At 1:04 P.M., CNA 26 cued another resident at the table to eat. At 1:07 P.M., CNA 26 cut up food for the resident next to Resident 29 at the table. During the entire observation, the CNA did not converse with Resident 29. 3. During a continuous observation on 3/12/25, the following was observed while the hall trays were passed: At 12:04 P.M., CNA 15 started passing trays on the West Hall. At 12:06 P.M., the East Hall food cart was pushed into the hallway by the kitchen staff. At 12:52 P.M., CNA 15 was observed passing the last tray on the East Hall. CNA 15 was the only staff member passing hall trays to both halls. There was a nurse sitting at the nurse's station. 4. During a continuous observation of the main dining room on 3/12/25, the following was observed: At 12:22 P.M., the first resident in the dining room was served by Licensed Practical Nurse (LPN) 7. At 12:25 P.M., the Dietary Manager was observed going into the Administrator's office. LPN 7 left the dining room to wash her hands. At that time, there were no staff members in the dining room passing trays. At 12:26 P.M., the Administrator was observed		providing assistance to residents. Along with ensuring residents' needs are promptly addressed. b. All staff will be provided with training to assist with serving meals during mealtimes as needed. c. An audit tool has been initiated that audits meal delivery, customer service, assisting residents with their meals, and maintaining residents' dignity. d. Conduct monthly resident council meetings to gather feedback on meal services and address concerns promptly. e. An in-service will be completed to all Staff regarding timely meal delivery, customer service, assisting residents with their meals, maintaining residents' dignity, and providing clothing protectors. 4. How corrective actions will be monitored to ensure the deficient practices will not occur: A performance improvement tool has been initiated that audits meal delivery, customer service, assisting residents with their meals, and maintaining residents' dignity. This Quality Assurance Audit Tool will be completed by the Administrator and/or Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	standing in the dining room but did not pass any trays. At 12:27 P.M., LPN 7 returned to the dining room. At that time, the Business Office Manager (BOM) came to help pass trays. At 12:34 P.M., Registered Nurse (RN) 28 was observed bringing a resident to the dining room but did not help pass trays. At 12:37 P.M., LPN 32 was observed coming into the dining room and passed one tray. LPN 4 came into the dining room and asked LPN 32 to go to lunch. LPN 32 left the dining room. LPN 4 left the dining room and did not help pass trays. At 12:42 P.M., CNA 26 brought a resident to the dining room and helped pass trays. At 12:47 P.M., two residents were observed leaving the dining room after they finished eating. At 12:49 P.M., the last tray was served in the main dining room. 5. During a continuous observation of Resident 1 in the main dining room on 3/12/25, the following was observed: At 12:32 P.M., Resident 1 was observed trying to stand from her wheelchair. Another resident told her to sit down. LPN 7 told Resident 1 they'd bring her some coffee. At 12:36 P.M., Resident 1 was observed trying to stand again from her wheelchair. No one had brought her coffee. At 12:40 P.M., Resident 1 was served her tray, but it did not have coffee on it. 6. During a continuous observation of Resident 8 in the main dining room on 3/12/25, the following was observed: At 12:22 P.M., Resident 8 was seated in a Broda chair with a bedside table in the dining room. At 12:48 P.M., LPN 7 set his food tray on a nearby dining room table and gave him one bowl of		through the facility QA program. Monitoring will continue as planned or will be increased by the QA committee if needed to obtain 100% compliance. Additional action will be taken by the QA committee if warranted based on the outcome of tools.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pureed food with a spoon. At 12:53 P.M., Resident 8 had finished what was in bowl. At that time, LPN 7 gave him another bowl. At 12:56 P.M., LPN 7 took bowl from Resident 8 and placed a napkin on his chest instead of a clothing protector. At 1:00 P.M., Resident 8 finished the bowl. At 1:05 P.M., LPN 7 gave Resident 8 his last bowl to eat. During an interview on 3/18/25 at 1:50 P.M., the Director of Nursing (DON) indicated there should always be at least two staff in the dining room while residents were eating. It should not have taken that long for the resident's meals to be served, for a resident to be fed after the meal was served, or for a resident to get a drink. When staff assisted a resident to eat, they should have been focused on that resident. On 3/18/25 at 4:00 P.M., a current Dignity Policy, revised August 2009, was provided by the DON and indicated, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect ... 'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth ... " On 3/19/25 at 8:35 A.M., a current Assistance with Meals Policy, revised July 2017, was provided by the DON and indicated, " ... Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity ... " On 3/19/25 at 8:35 A.M., the DON provided a Food and Nutrition Services policy, revised in October, 2017, which indicated "...5. The food and nutrition staff will be available and adequately			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staffed to assist residents with eating as needed. Nurse aides and feeding assistants will provide support to enhance the resident experience..." 3.1-3(a)(1) 3.1-3(t)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to clarify a code status for 1 of 1 residents reviewed for advance directives. A resident's current physician's order did not match the signed "Indiana Physician Orders for Scope of Treatment" form. (Resident 29) Finding includes: On 3/13/25 at 2:13 P.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behaviors and was admitted to the facility on 7/2/24. The most recent Significant Change Minimum Data Set (MDS) assessment, dated 12/4/24, indicated Resident 29's cognition was severely impaired. Current Physician's Orders included, but were not limited to, the following: cardiopulmonary resuscitation (CPR or full code indicated a patient's consent to receive all possible life-saving measures in the event of a cardiac or respiratory arrest), ordered 7/2/24 A current Code Status Care Plan, created and last reviewed on 7/26/24, indicated Resident 29 had a code status of Do Not Attempt Resuscitation (DNR) with an intervention including, but not limited to, the following:	F 0578	It is the practice of this facility to ensure Advance Directives are accurately reflected on the Physician's orders for all residents. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. Resident # 29 physician order for 7.2.2024 was immediately clarified with physician and corrected to DNR status. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the alleged deficient practice. A house wide audit had been conducted of all residents' current physician's orders related to code status. All residents' physician's orders were found to coincide with the residents' current choice related to code status.	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review DNR quarterly and/or at Resident 29 or family's request, initiated 7/26/24 The signed Indiana Physician Orders for Scope of Treatment (POST) form for Resident 29, dated 7/6/24, indicated DNR as the resident code status. A care plan meeting note, dated 10/17/24, indicated Resident 29's advance directive was reviewed at the care conference and was current. The most recent care plan meeting note, dated 12/10/24, indicated Resident 29's son attended via telephone call and did not indicate the advance directive was reviewed at the care conference. During an interview on 3/13/25 at 3:00 P.M., Registered Nurse (RN) 43 indicated to find a code status, she would look in the Electronic Health Record (EHR) at the top of the page. At that time, the EHR indicated Resident 29 was a full code. RN 43 indicated the current physician's order for code status of CPR was the information at the top of the resident's chart. So it did not get changed when the POST form was completed because the POST, code status care plan, and physician's order should match. During an interview on 3/18/25 at 10:56 A.M., the Social Services Director (SSD) indicated when she had care plan conferences, she would discuss the resident's advance directive. She indicated she checked that the code status care plan and the POST matched. On 3/18/25 at 4:00 P.M., a current Advance Directives Policy, revised December 2016) was provided by the Director of Nursing (DON) and indicated, "Information about whether or not the resident has executed an advance directive shall		3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. M.D.S. coordinator will confirm that the code status care plan aligns with the physician's orders and the residents' signed code status form. b. Medical records will audit clinical records after admission to ensure that POST form, physician order, and care plan are in place. c. Medical Records and/or Designee will complete an audit tool to ensure physician order reflect resident's code status per POST form. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur. A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that physician's orders accurately reflect resident's code status. This Quality Assurance Audit Tool will be completed by the Medical Records and/or Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be displayed prominently in the medical record ... the plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive ... " 3.1-4(l)(5)		compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to provide appropriate notice of charges for services covered and services not covered under Medicare for 2 of 2 residents reviewed for beneficiary notices. Resident's and/or their representative did not receive an Advanced Beneficiary Notice (ABN) when their Medicare Part A services terminated and they remained in the facility. (Resident 5, Resident 14) Findings include: 1. On 3/14/25 at 3:30 P.M., the Administrator provided a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. On 3/17/25 at 6:52 A.M., beneficiary notices given to Resident 5 were reviewed. Resident 5's discharge date from Medicare Part A benefits was 1/17/25. The resident remained in the facility. An ABN notice for future services was not provided. 2. On 3/14/25 at 3:30 P.M., the Administrator provided a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. On 3/17/25 at 6:52 A.M., beneficiary notices given to Resident 14 were reviewed. Resident 14's	F 0582	It is the practice of this facility to provide appropriate notice of charges for services covered and services not covered under Medicare. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. Resident # 5 and #14 identified during survey of not receiving an ABN when Medicare Part A services ended. The facility issued an ABN on 04/11/2025 as they are currently residing in the facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: a. Residents currently on Medicare or Insurance stays have the potential to be affected. b. An audit was conducted of all current residents' records in the last 30 days that had a Medicare or Insurance stay to verify that an SNF ABN was issued	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	discharge date from Medicare Part A benefits was 1/31/25. The resident remained in the facility. An ABN notice for future services was not provided. During an interview on 3/17/25 at 1:47 P.M., the Social Services Director (SSD) indicated the therapy department completed the ABN notices. During an interview on 3/18/35 at 11:20 A.M., the BOM indicated Resident 5 did not receive an ABN notice because she went to hospice services on 2/11/25. Resident 14 did not receive an ABN notice because she ended therapy services when her Medicare Part A services terminated. During an interview on 03/19/25 at 9:32 A.M., Occupational Therapy (OT) 2 and the Senior Administrator were unaware an ABN notice should have been issued for Resident 5 and Resident 14. During an interview on 3/19/25 at 10:22 AM, the Senior Administrator indicated there was no policy, but it would be their policy to follow the regulation for beneficiary notices. 3.1-4(f)(3)		appropriately. No other issues were identified. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. An in-service was completed to the Interdisciplinary Team on 4/11/2025 regarding issuing the SNF ABN along with the NOMNC. 4. How corrective actions will be monitored to ensure the deficient practices will not occur. a. A performance improvement tool has been initiated that audits to ensure that SNF ABN are properly issued and documented in the resident's file. This Quality Assurance Audit Tool will be completed by the Administrator and/or Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility QA program. Monitoring will continue as planned or will be increased by the QA committee if needed to obtain 100% compliance. Additional action will be taken by the QA committee if warranted based on the outcome of tools.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for 3 of 3 residents reviewed for physical restraints and 2 of 5 residents reviewed for unnecessary medications. Side (bed) rails used for mobility were marked as physical restraints, residents were marked as taking a hypnotic and an opioid but one was not administered. (Resident 7, Resident 23, Resident 25, Resident 28, Resident 30) Findings include: 1. During an observation on 3/12/25 at 10:26 A.M., Resident 7's bed was observed with half size side rails. On 3/13/25 at 2:10 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but was not limited to, dementia without behaviors. The most recent MDS assessment, dated 12/6/24, indicated Resident 7's cognition was severely impaired, she was independent for bed mobility, supervision for transfers, and used side rails daily as a physical restraint. Current Physician's Orders included, but were not limited to, the following: Half size side rails, ordered 9/4/24 The most recent Side Rail Assessment, dated 12/12/24, indicated side rails were indicated to enhance mobility, positioning, or promote independence. 2. During an observation on 3/12/25 at 10:28 A.M.,	F 0641	It is the practice of this facility to ensure MDS Assessments accurately reflect resident's status. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. 12.06.2024 M.D. S. quarterly assessment was revised to reflect no restraints for Resident # 7. b. 12.19.2024 M.D. S. quarterly assessment was revised to reflect no restraints or hypnotics on resident # 23. c. 12.19.2024 M.D. S. quarterly assessment was revised to reflect no restraints for resident #25. d. 12.10.2024 M.D.S. quarterly assessment was revised to reflect no restraints for resident # 28 e. 1.28.2025 M.D.S. quarterly assessment was revised to reflect no opioids assessment for resident #30 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficiency. b. An audit was conducted with no	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 23's bed was observed with half size side rails. On 3/14/25 at 1:10 P.M., Resident 23's clinical record was reviewed. Diagnoses included, but was not limited to, dementia with behaviors. The most recent Quarterly MDS assessment, dated 12/19/24, indicated Resident 23's cognition was severely impaired, independent for bed mobility and transfers, took a hypnotic, and used side rails daily as a physical restraint. Current Physician's Orders included, but were not limited to, the following: Half size side rails, ordered 12/2/24 The most recent Side Rail Assessment, dated 12/19/24, indicated side rails were indicated to enhance mobility, positioning, or promote independence. The December 2024 Medication Administration Record (MAR) from 12/1/24 through 12/31/24 was reviewed and lacked administration of a hypnotic to Resident 23. 3. During an observation on 03/12/25 10:53 A.M., Resident 25's bed was observed with half size side rails. On 3/17/25 at 1:22 P.M., Resident 25's clinical record was reviewed. Diagnoses included, but was not limited to, dementia with behaviors. The most recent Annual MDS assessment, dated 12/19/24, indicated Resident 25's cognition was moderately impaired, she was independent for bed mobility, supervision for transfers, and used side rails daily as a physical restraint.		further issues identified. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. The previous M.D.S. coordinator for the dates coded incorrectly is no longer an employee at Sycamore Care Strategies. The new M.D.S coordinator has been hired as of 3.24.2025. The M.D.S. coordinator reviewed all previous resident assessments to ensure accurate coding and compliance concerning restraints, hypnotic medications, and opioids. b. An audit tool will be completed by Regional M.D.S. Coordinator on 5 residents MDS Assessments to ensure completed accurately to reflect resident's status. The audit tool will be completed weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that patient's MDS Assessment is accurately completed to accurately reflect resident's status. This Quality Assurance Audit Tool will be completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Current Physician's Orders included, but were not limited to, the following: half size side rails, ordered 12/22/22 The most recent Side Rail Assessment, dated 12/19/24, indicated side rails were indicated to enhance mobility, positioning, or promote independence. 4. During an observation on 03/13/25 10:43 A.M., Resident 28's bed was observed with half size side rails. On 3/14/25 at 11:05 A.M., Resident 28's clinical records were reviewed. Diagnoses included, but were not limited to, non-ST elevation myocardial infarction, diabetes mellitus type II, and dementia. The most recent recent Quarterly MDS assessment, dated 12/10/24, indicated Resident 28 was unable to complete the Brief Interview for Mental Status (BIMS), and used side rails daily as a physical restraint. Current Physician's Orders included, but were not limited to, the following: half size side rails, dated 10/25/23 A current Fall Risk Care Plan, last revised on 4/17/24, included, but was not limited to, an intervention to provide the resident with a safe environment: (floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach), initiated 11/01/2023 The most recent Quarterly Side Rail assessment, dated 12/10/24, indicated the side rails were to enhance mobility, positioning, and promote		the Regional M.D.S Coordinator and/or Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	independence. 5. On 3/14/25 at 9:05 A.M., Resident 30's clinical records were reviewed. The diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, dementia, moderate with other behavioral disturbance, anxiety, and depression. The most recent Quarterly MDS assessment, dated 1/28/25, indicated Resident 30 had moderate cognitive impairment and took an opioid. Physician's Orders included, but were not limited to the following: Norco (pain medication) 5-325 MG (Milligram) tablet, Give one tablet by mouth two times a day for pain, ordered 10/1/24 and discontinued on 1/14/25 Morphine Sulfate (pain medication) 20 MG/5 ML (Milliliter) solution, Give one ml by mouth every 15 minutes as needed for pain, severe chronic pain, or SOB (shortness of breath), ordered 2/18/25 The January 2025 MAR was reviewed from 1/22/25 through 1/28/25 and indicated Resident 30 did not receive any opioid medication. During an interview on 3/18/25 at 1:50 P.M., the Director of Nursing (DON) indicated they have no physical restraints used on residents in the facility. They are only used for mobility and were marked in error on the MDS assessment. At that time, he indicated Resident 23 was not on a hypnotic in December 2024. She was taking Remeron (antidepressant) for insomnia and it was marked as a hypnotic and if a medication had been discontinued before the MDS assessment 7 day look back period, it should not be marked on the MDS assessment. These were marked in error. At			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that time, the DON indicated there was not a policy for completing MDS assessments but they would use the Resident Assessment Instrument (RAI) manual as their policy.			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to develop and implement a resident specific comprehensive care plan for 1 of 3 residents reviewed for falls, 1 of 5 residents reviewed for unnecessary medications, and 1 of 2 residents reviewed for nutrition. Resident's call light and reaching device were not within the resident's reach, a resident taking an antipyschotic did not have a care plan, and a resident that was an assist to feed was not assisted by staff. (Resident 9, Resident 30, Resident 1) Findings include: 1. On 3/12/25 at 10:34 A.M., Resident 9 was sitting in his wheelchair in his room. His reaching device and call light were on the bed behind him out of the resident's reach. On 3/13/25 at 10:01 A.M., staff left the resident's room. The reaching device was on the bed closest to the window and the call light was on the bed behind him out of the resident's reach. On 3/17/25 at 12:50 P.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, impaired mobility, weakness, balance deficit, and diabetes mellitus type II. The most recent Quarterly Minimum Data Set	F 0656	a. All nursing staff were educated on Resident # 9 care plan for personal assistance devices and call light to be in reach when resident is in his room. b. All the nursing staff were educated on Resident #30 nutrition care plan for assistance with eating. c. An antipsychotic care plan was created for Resident # 30. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficiency. An audit was conducted. No other issues identified. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The facility will implement a weekly schedule for care plan reviews and updates, ensuring involvement from the interdisciplinary team. This will be	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(MDS) assessment, dated 12/18/24, indicated Resident 9's cognition was intact and he was dependent on staff for transfers, showers, and toileting. Current Physician's Orders included, but were not limited to, the following: Reaching device to be within reach while in resident room every day and night shift, ordered 5/25/2024 A current Fall Risk Care Plan, created on 12/24/19 and last reviewed on 2/8/24, included, but was not limited to, an intervention to have a call light in reach. 2. On 3/13/25 at 12:04 P.M., Resident 1 was observed sitting in the Main dining room at a table in a wheelchair. Her chin was down to her chest, eyes closed, and a chair alarm was on back of the wheelchair. On 3/13/25 at 12:05 P.M., staff was observed bringing her meal tray to the table, set it up in front of Resident 1, tried to wake her up, and told her lunch was there. Resident 1 opened her eyes and went back to sleep. On 3/13/25 at 12:22 P.M., Resident 1 was observed sitting in the wheelchair at the dining room table, her meal tray untouched in front of her, and her eyes closed. Staff did not assist her to eat. On 3/17/25 at 8:01 A.M., Resident 1 was observed sitting up in wheelchair at dining room table, chair alarm in place on back of wheelchair, head bent down to chest, holding a small bowl in her hand down at her side, feeding herself very slowly. Staff was not assisting her. On 3/13/25 at 2:22 P.M., Resident 1's clinical		reviewed weekly by the Administrator and/or Designee. b. The Interdisciplinary Team will receive additional training on the importance of accurate and comprehensive care planning which order changes and new interventions to care. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that patient's Care plans are accurately completed to accurately reflect resident's status. This Quality Assurance Audit Tool will be completed by the Administrator and/or Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance, hallucinations, and depression. The most recent Annual MDS assessment, dated 12/5/24, indicated Resident 1 had severe cognitive impairment and needed partial to moderate assistance (staff performs less than half the effort) for eating. A current Nutrition Care Plan, last reviewed 4/26/24, indicated Resident 1 was at risk for potential problems with nutrition and needed assistance with eating d/t (due to) impaired mobility. Interventions included, but were not limited to, the following: Requires assistance with feeding, initiated 3/6/24 3. On 3/14/25 at 9:05 A.M., Resident 30's clinical records were reviewed. The diagnoses included, but were not limited to diabetes mellitus, hypertension, dementia, moderate with other behavioral disturbance, anxiety, and depression. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 1/28/25, indicated Resident 30 had moderate cognitive impairment and took an antipsychotic. Current Physician Orders included, but were not limited to, the following: Risperdal 0.25 mg (milligrams), give one by mouth two times a day related to dementia, moderate, with behavioral disturbance, ordered 1/14/25 The clinical record lacked a care plan for Resident 30 receiving an antipsychotic. During an interview on 3/13/25 at 10:01 A.M., Resident 9 indicated he would use the call light			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and reaching device but they were not always within his reach and he has trouble finding them. During an interview on 3/18/25 at 4:10 P.M., the Director of Nursing (DON) indicated if a person was on antipsychotic they should have a care plan for that medication. At that time, he indicated the staff knew what diet the residents were on but not if they needed assistance. He indicated all residents get assistance with setting up their food. He was unaware that Resident 1 had a care plan that indicated she needed assistance with eating and staff should follow the plan of care. On 3/19/25 at 8:35 A.M., the DON provided a Food and Nutrition Services policy, revised October, 2017, which indicated "...5. the food and nutrition staff will be available and adequately staffed to assist residents with eating as needed. Nurse aides and feeding assistants will provide support to enhance the resident experience..." On 3/19/25 at 10:22 A.M., the Senior Administrator indicated there was no policy, but it would be their policy to follow resident's plan of care and physician orders. 3.1-35(b)(1)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to ensure a resident who was diagnosed with dementia, received the appropriate treatment and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents reviewed for dementia care. A high risk to fall resident repeatedly trying to get out of her chair	F 0744	It is the practice of this facility to ensure a resident who is diagnosed with dementia receives the appropriate treatment and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being.	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was not offered an activity or change in environment. (Resident 1) Finding includes: On 3/13/25 at 2:52 P.M., Resident 1 was observed in a recliner next to the wall by the nurse's station, trying to get out of the recliner and the chair alarm going off. Licensed Practical Nurse (LPN) 32 told Resident 1 not to get up. On 3/13/25 at 2:58 P.M., Resident 1's chair alarm was going off. LPN 32 told Resident 1 to sit back down. Resident 1 was getting agitated and starting to raise her voice. On 3/13/25 at 3:01 P.M., Resident 1's chair alarm was going off. LPN 32 told Resident 1 to sit back in her chair and asked Resident 1 where she was going. Resident 1 was getting upset. LPN 32 asked Resident 1 if she wanted to get back in the wheelchair or sit still in the recliner. Resident 1 indicated she would sit still. On 3/13/25 at 3:09 P.M., Resident 1 asked for a drink of water for second time. LPN 32 told her just a minute. On 3/13/25 at 3:10 P.M., Resident 1's chair alarm was going off, and she was trying to get up. LPN 32 told Resident 1 "You have to sit down in the chair". Resident 1 indicated "I have to pee." LPN 32 told her to wait a minute, and she would get someone to take her to the bathroom. On 3/17/25 at 12:54 P.M., Resident 1's chair alarm was going off as she tried to get out of the recliner. LPN 4 called her name. On 3/17/25 at 12:56 P.M., Resident 1's chair alarm		1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. The staff involved were educated 04/09/2025 regarding the importance of dementia care best practices, including person-centered approaches, recognizing and addressing behavioral symptoms effectively and respectfully. b. Resident #1 plan of care was reviewed which included interventions for appropriateness and effectiveness. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken. a. All residents have the potential to be affected by the deficient practice. b. An audit was completed for residents with dementia which were classified at a high risk for falls to ensure appropriate and effective interventions were in place. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. All staff in-services will be completed regarding communication techniques, promoting resident dignity, activity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was going off. LPN 4 called her name. On 3/17/25 at 12:57 P.M., Resident 1's chair alarm was going off as she tried to get out of the recliner. LPN 4 told her to sit down. At that time, staff did not ask what she needed, offer her anything to distract her, or change her surroundings. On 3/13/25 at 2:22 P.M., Resident 1's clinical records were reviewed. Diagnoses included, but were not limited to, dementia with other behavioral disturbance, hallucinations, depression, fracture of right pubis (bones in front of pelvis), and presence of right artificial hip joint. The most current Annual Minimum Data Set (MDS) assessment, dated 12/5/24, indicated Resident 1 had severe cognitive impairment, needed partial to moderate assistance (helper performed less than half the effort) for eating and was dependent on staff for toilet use and transfers. A current Dementia Care Plan, initiated 1/9/24 and last reviewed 3/13/24, included, but were not limited to, the following interventions: Cue, reorient and supervise as needed, initiated 1/9/24 The Dementia Care Plan did not include Resident 1's like and dislikes. During an interview on 3/17/25 at 12:43 P.M., LPN 4 indicated Resident 1 had a diagnosis of dementia. She indicated Resident 1 could only do activities for a short period of time, liked mint ice cream sandwiches, and would be given coloring pages but her attention only lasted about 15-20 minutes. LPN 4 indicated Resident 1's husband		interventions, and interventions that will promote decreased behavior. b. The Interdisciplinary Team will review during clinical meeting Monday-Friday to ensure effectiveness or ineffectiveness of interventions and update plan accordingly. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: A performance improvement tool has been implemented to conduct random audits of dementia care interactions five (5) times per week, ensuring high-quality care while preserving residents' dignity. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and her granddaughter come to visit, and they would do things with her. LPN 4 indicated the Activity Director would probably know what kind of activities Resident 1 liked. During an interview on 3/18/25 at 9:16 A.M., the Activity Director indicated she did one on one activities with Resident 1. She liked to look at a family book, snacks, and coffee. Resident 1 liked music, but she was not able to do a lot of activities they did with their hands. On 3/18/25 at 4:00 P.M., the Director of Nursing (DON) provided a Quality of Life-Dignity policy, revised August, 2009, which indicated "...12. Staff shall treat cognitively impaired residents with dignity and sensitivity; for example: a. Addressing the underlying motives or root causes for behavior..." On 3/19/25 at 10:20 A.M., the Senior Administrator provided a Dementia-Clinical Protocol policy, revised November, 2018, that indicated "...Treatment/Management...4. Direct care staff will support the resident in initiating and completing activities and tasks of daily living. a. Bathing, dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed..." 3.1-37(a)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of communicable	F 0880	It is the practice of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diseases and infections for 2 of 2 residents observed for incontinence care, 1 of 1 reviewed for wound care, 2 of 2 residents getting vital signs during medication administration, and 1 random observation of 2 residents. Staff did not change gloves or sanitize her hands between soiled to clean tasks. Staff performed handwashing for less then 20 seconds before and after wound care. A blood pressure cuff and pulse oximeter were not disinfected between residents. Proper Personal Protective Equipment (PPE) was not worn when transferring a resident on Enhanced Barrier Precautions (EBP). (Resident 2, Resident 22, Resident 26, Resident 29, Resident 1, Resident 25, Resident 30) Findings include: 1. On 3/14/25 at 8:17 A.M., Licensed Practical Nurse (LPN) 4 was observed getting vital signs on Resident 2 with the West Hall wrist blood pressure cuff and pulse oximeter during the medication pass. LPN 4 indicated Resident 2 was the last resident she was giving medications to. On 3/14/25 at 8:58 A.M., Registered Nurse (RN) 16 was observed grabbing the West Hall wrist blood pressure cuff and pulse oximeter from LPN 4 because she was unable to find one in the East Hall Medication Cart. It was not disinfected by LPN 4 or RN 16 before it was used on Resident 22 to check his vitals during the medication pass. 2. During a random observation on 3/17/25 at 6:29 A.M., LPN 4 used a wrist blood pressure cuff and pulse oximeter to check vital signs on Resident 29 in the common area by the nurse's station. Without disinfecting the equipment, she then used the same equipment to check Resident 26's vital signs.		environment and to help prevent the development and transmission of communicable diseases and infections. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. Resident #2, #22, #29 identified during survey of medical equipment being shared have had no adverse effects identified. b. LPN #4 and RN #16 have received education 4/08/2025 on disinfecting on vital sign equipment between residents to help prevent the development and transmission of communicable disease and infections. c. Resident #1 and #26 identified during survey of staff not changing gloves and hand hygiene during personal care have had no adverse effects identified. d. C.N.A. #18 and C.N.A. #26 have received education 4/08/2025 on the importance of hand hygiene and glove use to help prevent the development and transmission of communicable disease and infections. And has successfully completed return demonstration. e. Resident #30 identified during survey continues on the EBP precautions. f. C.N.A. #26 has received education on 04/10/2025 regarding Enhanced Barrier Precautions to help prevent the development and transmission of communicable	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. On 3/17/25 at 8:24 A.M., incontinence care on Resident 1 was observed in the West Hall shower room. After sanitizing their hands, Certified Nurse Aide (CNA) 26 and CNA 18 put on gloves and assisted the resident to the toilet. CNA 26 took off Resident 1's soiled incontinence pad. She then put on a clean incontinence pad. CNA 18 grabbed wipes while CNA 26 grabbed uncovered toilet paper sitting on the back of the toilet to have the resident wipe her nose. After the resident urinated into the toilet, CNA 26 assisted the resident to stand while CNA 18 wiped the resident's perineal area from front to back, pulled up the resident's clean incontinence pad, pulled up her pants, and assisted her into the wheelchair using the same gloves. CNA 18 did not change gloves or sanitize her hands between dirty to clean tasks. 4. On 3/14/25 at 9:43 A.M., incontinence care on Resident 25 was observed in the shower room. CNA washed her hands, put on gloves, assisted the resident to stand from the wheelchair, pulled Resident 25's pants down and assisted her to sit on the toilet. CNA 26 removed the soiled incontinence pad and fastened one side of a clean incontinence pad on the resident. Resident 25 held on to the grab bar while CNA 26 assisted her to stand, wiped her perineal area from front to back three times, and discarded the wipes in the trash can. She pulled the clean incontinence pad up and fastened it, pulled the resident's pants up, assisted Resident 25 to turn and sit in the wheelchair, removed the gait belt, and then removed her gloves. CNA 26 did not change gloves or sanitize hands between dirty and clean tasks. 5. On 3/14/25 at 12:52 P.M., Resident 30 was in his wheelchair sitting in his room with the call light on and CNA 26 went into room without PPE on and		disease and infections. The staff member has successfully completed return demonstration. g. R.N. #16 has received education 04/08/2025 regarding the hand hygiene policy along with successfully completing return demonstration. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficient practice. b. Nursing staff will be in-serviced regarding proper hand hygiene, glove usage, PPE usage, medical equipment, and EBP precautions. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur. a. Nursing staff have been in-serviced (Date) regarding proper hand hygiene, glove usage, PPE usage, medical equipment, and EBP precautions. b. An audit will be completed by the Infection Preventionist and/or Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	closed the door. An EBP sign was observed on the wall next to the room. The PPE cart was outside the door. CNA 26 came out of Resident 30's room. Resident 30 was observed lying in bed on his left side and covered up. On 3/17/25 at 10:49 A.M., Resident 30 was laying in his bed and the call light was on. CNA 26 knocked on the door, entered the resident's room without putting on PPE, asked if he for sure wanted to sit up in the wheelchair since lunch wasn't for another hour, and closed the door. CNA 26 left the room. Resident 30 was observed sitting in his wheelchair. On 3/14/25 at 9:05 A.M., Resident 30's clinical records were reviewed. The diagnoses included, but were not limited to, a wound on his buttock and dementia, moderate with behavioral disturbance. The most recent Quarterly MDS assessment, dated 1/28/25, indicated Resident 30 had moderate cognitive impairment, needed supervision for toilet use and transfers, and no skin issues at that time. Physician Orders included, but were not limited to, the following: Cleanse wound on buttock with normal saline, pat dry, apply Calcium Alginate, cover with border gauze and as needed if becomes soiled or dislodged, every day shift, ordered 2/28/25 EBP in place: See sign outside of resident room, every day and night shift, ordered 2/19/25 On 3/14/25 at 2:52 P.M., Registered Nurse (RN) 28 and RN 16 performed wound care on the coccyx for Resident 30. After putting on proper PPE, RN 16 cleaned bedside table with wipe, cleaned		immediately addressed. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: A performance improvement tool has been implemented to conduct random audits of hand hygiene and glove usage, disinfecting vital sign equipment, and Enhance Barrier Precautions procedure. This Quality Assurance Audit Tool will be completed by the Infection Preventionist and/or Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	scissors with wipe, removed gloves, and washed hands at sink with 5 second lather, dried hands, and put on gloves. RN 28 washed hands and put on gloves. RN 16 uncovered resident, moved pillow from behind resident, turned resident to right side, unfastened brief, put disposable chucks pad under the resident, removed dressing, area was length (cm) (centimeters): 0.8, width (cm): 0.4, depth (cm): 0.1 in size, slightly red with very small opening in center. RN 16 removed gloves, put clean gloves on, without sanitizing hands, cleaned area with normal saline, dried area with gauze, removed gloves, washed hands with a 5 second lather, put on clean gloves, applied calcium alginate over wound, cut dressing, put small amount of normal saline on dressing and put it in open area, border gauze placed over dressing, put date and initials on dressing, reapplied brief, rolled to left side, placed pillow behind back, and covered resident. RN 16 cleaned up supplies and discarded them in trash, cleaned marker with wipes, removed trash bag, tied shut, and put a clean trash bag in trash can. RN 28 took trash bag, and removed PPE. RN 16 removed PPE and both cleaned hands with sanitizer in hall. During an interview on 3/18/25 at 10:36 A.M., the Director of Nursing (DON) indicated he would expect staff to sanitize the blood pressure cuff, pulse oximeter, and other equipment between residents and he would expect staff to change gloves and sanitize hands between dirty and clean tasks while doing incontinence care. At that time, he indicated if a resident was on EBP and staff were touching the resident for an extended period of time, they should be putting on proper PPE, including gown and gloves, and handwashing should last from 40-60 seconds. On 3/19/25 at 8:35 A.M., a current Cleaning and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Disinfection of Equipment Policy, revised October 2018, was provided by the DON and indicated, "Resident-care equipment ... will be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection ... " On 3/19/25 at 8:35 A.M., the DON provided a Hand Hygiene Policy, dated 12/1/21, indicated "...7. Use an alcohol-basedhand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...h. Before moving from a contaminated body site to a clean body site during resident care;...j. After contact with blood or bodily fluids;...Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer)...Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves...4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene. 3.1-18(b)(2) 3.1-18(l)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and homelike environment for residents for 1 of 1 shower rooms, 3 of 16 resident rooms/bathrooms observed for environment, and 3 random observations. The shower room grout was soiled and water was leaking from the hand held shower head, resident wheelchairs and a Broda chair had leather flaking off the arm rests,	F 0921	It is the practice of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice. a. The tile in shower room has	05/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	an entrance door to room had cracked, sharp plastic on the bottom, carpeting was loose causing an uneven floor surface, and a resident's recliner had a strong odor of urine. (Shower Room, Room 9A, Resident 29, Room 8, Room 5, Resident 7, Resident 8) Findings include: 1. On 3/14/25 at 9:17 A.M., the following was observed in the Shower Room: a missing tile at the entrance of the shower, grout was soiled on the floor and wall of shower, white build up on the floor and the hand rails in the shower, water dripping from the hand held shower head, the toilet paper holder was missing and the uncovered toilet paper was setting on back of the toilet, and the grout was soiled around the toilet. On 3/17/25 at 8:24 A.M., the same was observed. 2. On 3/13/25 at 9:29 A.M., the following was observed in Resident 29's Room 9A: the foot board had duct tape along the top edge and the door to enter the room had a cracked, sharp, plastic cover along the bottom. On 3/17/25 at 11:24 A.M., the same was observed. On 3/12/25 at 11:07 A.M., Resident 29 was sitting in her wheelchair in the living room of the facility and the left arm of her wheelchair was missing leather covering and the yellow foam pad was showing. On 3/13/25 at 10:13 A.M., the Resident was sitting in front of the nurse's station and the same was observed. 3. On 3/12/25 at 10:34 A.M., in Room 8, Resident 9 was sitting in his wheelchair in his room. The resident's recliner had a strong urine odor and stains on the cushion.		been replaced including cleaning of shower wall and floor. b. Handheld shower head has been replaced. c. The toilet paper holder has been replaced. d. The grout around the toilet has been cleaned. e. The duct tape on the foot board has been removed and fixed in Room 9. f. Plastic covered on room 9's door was replaced. g. Resident # 29 left arm on wheelchair was replaced. h. Resident # 9 recliner was removed from room. i. Room # 5 the carpet was replaced with new flooring. j. Resident # 7 right arm on wheelchair was replaced. k. Resident # 8 Broda chair was replaced. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents have the potential to be affected by the alleged deficient practice. b. Administrator, Maintenance, and Housekeeping/Laundry Supervisor completed facility rounding to identify needed cleaning and repairs. 3. Measures and systemic changes are put into place to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 3/17/25 at 11:20 A.M., the same was observed. 4. On 3/12/25 at 10:35 A.M., the following was observed in Room 5: the carpet on the floor was pulling away from under the door threshold and it made the carpeting have bumps causing an uneven floor throughout the room. On 3/18/25 at 12:01 P.M., the same was observed. 5. On 3/12/25 at 11:00 A.M., Resident 7 was sitting in her wheelchair in the living room of the facility and the right side arm rest leather was flaking off. On 3/17/25 at 11:39 A.M., the same was observed. 6. On 3/12/25 at 12:22 P.M., Resident 8 was observed in the dining room seated in his Broda chair. The left arm rest had the leather missing and the yellow foam pad was showing. On 3/13/25 at 12:36 P.M., the same was observed. During an interview on 3/18/25 at 1:50 P.M., the Director of Nursing (DON) indicated maintenance and/or housekeeping should be cleaning the shower room daily and as needed. It should be deep cleaned monthly. Room 9A should get a new foot board and replacing the plastic on the door. Maintenance would need to make rounds to look at all resident wheelchairs and equipment to replace the arm rests if needed because they should not have peeling leather. The recliner was owned by Resident 9 and housekeeping would be responsible for cleaning the recliner but they may end up having to replace it. Room 5 needed the carpeting removed and different flooring put in but it just hadn't been done. On 3/19/25 at 8:35 A.M., a current Homelike Environment Policy, revised May 2017, was		ensure that the alleged deficient practice does not recur. a. Maintenance added identified facility repairs to Preventative Maintenance log. The log and Administrator assistance will prioritize needed repairs. b. Housekeeping Supervisor and Administrator reviewed/revised cleaning checklist. c. Areas of repairs needed were placed on a repair schedule. d. An in-service will be completed with Housekeeping and Maintenance Supervisor regarding homelike environment. e. All staff have been instructed to complete repair orders to ensure timely repair. f. Administrator, Maintenance, Housekeeping/Laundry Supervisor will complete rounds and document results on the audit tool. Any identified repairs or cleaning will be immediately addressed. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: A performance improvement rounding tool has been implemented. This Quality Assurance Audit Tool will be completed by the Administrator and/or Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided by the DON and indicated, "Residents are provided with a safe, clean, comfortable, and homelike environment ... The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary, and orderly environment ... " 3.1-19(f)(5) 3.1-19(z)(bb)		outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	