STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155206	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brownsburg Health Care Center	1010 Hornaday Rd Brownsburg, IN 46112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record reviews, the facility failed to ensure residents were treated with respect and dignity by allowing staff to refer to residents using demeaning and task-oriented labels (feeds/feeders) during meal service and failed to ensure residents were provided the opportunity to accept or decline entry into their rooms when staff walked in without knocking or waiting for a reply. This deficient practice had the potential to affect 4 of 5 residents reviewed for dignity (Residents D, 48, 53, and 37). Findings include:1. During a dining observation on 1/5/26 at 11:59 p.m., a rolling lunch cart was brought to the secured memory care unit and Licensed Practical Nurse (LPN) 25 and Certified Nursing Aide (CNA) 15 began to pass lunch trays. As they began to pass trays out, CNA 15 asked, are there any feeds back here? LPN 25 indicated, there are three feeds, and pointed to Residents D, 48 and 53. All residents' meals were served on their plastic trays. The lunch plates, cups, and utensils were not removed and from the tray to be more homelike and less institutional. During an interview on 1/5/26 at 12:05 p.m., CNA 15 indicated, she had never worked in memory care and asked about feeds because she doesn't know the residents' names. On 1/9/26 at 3:05 p.m., the Administrator (ADM) provided a copy of current facility policy titled, Resident Rights, dated/revised 2/2025. The policy indicated, residents have the right to be treated with dignity, respect, and individuality at all times, including being free from degrading, demeaning, or disrespectful language and treatment by staff. On 1/9/26 at 3:05 p.m., the ADM provided a copy of current facility policy titled, Secure Care Neighborhood, dated/revised 7/2024. The policy indicated residents residing on the dementia unit are to receive person-centered care that preserves dignity, utilizes respectful communication, and prohibits labeling, stigmatizing, or dehumanizing language regardless of cognitive status. 2. During an interview on 1/5/26 at 11:00 a.m. Resident H indicated staff regularly barged into their room without knocking, or if they did knock, they came in right after knocking instead of waiting for the resident to invite them into the room. As the resident voiced their concerns, an unidentified staff member knocked twice and then proceeded to come into the room without waiting for a reply and invitation into the room from the resident. The staff member quickly set the resident's lunch tray down, apologized and walked out of the room. 3. During an interview with Resident K and the Ombudsman on 1/8/26 at 1:08 p.m. an unidentified (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff member knocked twice and then proceeded to open the door without waiting for a reply and invitation into the room from the resident. The staff member quickly apologized and closed the door. The Ombudsman indicated since she had been in the room talking with Resident K, three different staff members had also done what that unidentified staff member did. On 1/13/26 at 11:57 a.m. a copy of a current facility policy titled, Privacy and Dignity dated 6/2020 was provided. That policy indicated, .Purpose [of this policy is] To ensure that care and services provided by the Facility promote and/or enhance privacy, dignity and overall quality of life. The Facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect. V. The Facility promotes independence and dignity in dining. VI. The Facility respects the resident's private space and property. IX. The following rights to privacy are a part of the admission agreement and the resident is informed of these rights during the admission process A. Residents are afforded a right to privacy. 3.1-3(t) 3.1-32(a)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review and interview, the facility failed to identify repeated grievances and implement effective corrective actions to alleviate ongoing resident complaints related to personal care services, responsiveness to call lights, hygiene care, and staff interactions which demonstrated that corrective measures were ineffective and systemic issues were not addressed for 6 of 6 months of grievances reviewed. Findings include: On 1/9/26 at 1:14 p.m. the Director of Nursing provided copies of the previous 6 months of grievances. A review of grievances, dated July 2025 through December 2025, revealed multiple repeated complaints across residents demonstrating a pattern of unresolved systemic issues which included, but were not limited to: Call light response time and staff attitude, missed or delayed showers and complaints about ADL (activities of daily living) care, and short staffing or staffing concerns. 1. Call light response time and staff attitude. 14 of the 23 grievances were direct complaints about call lights response time and/or staff attitude. Grievances used for example included, but were not limited to the following: a. On 7/9/25 a resident complained that he had asked his morning shift aide to let the nurse know he was ready for his tube feed around 2:00 p.m. The Nurse never came. The resident asked the second time when his evening shift aide came on duty. The nurse never came. The resident resorted to calling a family member who came to the facility to help get him assistance. b. On 9/16/25 a family member complained on behalf of a resident that there was a long wait time for staff to check on the resident and help her to the bathroom and some staff had poor attitudes and would leave the resident on the toilet.c. On 9/25/25 a resident complained that she could not get help from her caregiver and wound up soaked. The aide would come in to clear the call light, say she would be right back, but never came back. d. On 11/6/25 a resident complained that her aide yelled at her and told her she had just been changed and she wasn't going to change her again that soon.e. On 11/13/25 a resident complained that at approximately 5:00 a.m., they pressed the call button to change their [brief]. The CNA responded and immediately started in yelling at me and accused the resident of knocking towels and pillows onto the floor. She said, she wasn't here to clean up my mess and then got louder by the minute and I feared for my safety and she accused the resident of pointing her finger in the CNA's face but I was just shielding myself. She went on and on and got louder about the resident's finger in her face. I could not get her to calm down. All I wanted was a [brief] change because I was soaking wet and freezing due to no heat. I was very fearful of her. Responses to these grievances redundantly referenced staff member was disciplined but did not include the documentation of alleged discipline and there was no evidence of monitoring or sustained measures for corrective action. 2. Grievances filed on 8/19/25, 8/28/25, 9/5/25, 9/13/25, 9/22/25, 9/27/25, and 10/22/25 alleged showers were not received, staff refused to give them showers, shower days were missed, or residents were told the facility was too short staffed to give the shower at the scheduled time. Responses to these grievances redundantly referenced education provided to staff without evidence of monitoring or sustained measures for corrective action. 3. Grievances filed on 8/28/25, 9/9/25, 9/18/25, 9/30/25, 10/22/25, and 11/12/25 identified ongoing concerns related to inadequate staffing, including statements that staff were unavailable, residents were told staff were too busy to assist, or care could not be provided as scheduled. These grievances were accompanied by repeated reports of missed or delayed ADL care, including bathing and toileting assistance, as well as prolonged call light response times, as noted above. The recurrence of delayed ADL care and call light response issues across multiple grievances served as indicators that staffing levels were insufficient to meet residents' needs. During an interview on 1/12/26 at 1:46 p.m., the Administrator (ADM) indicated the facility had experienced repeated grievance concerns related to staffing, staff (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attitude, delayed call light response times, missed showers, and unmet ADL care. He stated that these concerns had not yet been fully trended or systematically addressed due to recent turnover and his short tenure but acknowledged the need to incorporate grievances and staffing issues into the facility's QAPI process. The ADM indicated the facility must implement systemic corrective actions, including root cause analysis, tracking and trending of grievances, staffing oversight, and ongoing monitoring to ensure concerns are effectively addressed and do not continue to recur. On 1/9/26 at 2:30 p.m., the ADM provided a copy of current facility policy titled, Grievance/Complaints dated/revised 4/2017. The policy requires that all grievances be promptly investigated, documented in writing, reviewed by the Administrator, and that corrective actions be implemented to prevent further violations of resident rights. The policy further requires the facility to take immediate action to prevent ongoing concerns, communicate findings and actions to residents or representatives, and maintain grievance records for tracking and accountability. Had the facility adhered to this policy by trending grievances, performing root cause analysis, implementing effective corrective actions, and monitoring outcomes, repeated concerns related to staffing, delayed call light response, missed ADL care, and staff behavior may have been identified and addressed before recurring. This citation relates to Intake 2595596. 3.1-7(a)(2)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on observation, interview, and record review, the facility failed to ensure that a resident's advance directive documentation was accurate and consistent across her medical record and failed to ensure a physician's order was in place for a resident's advance directive wishes for 2 of 3 residents reviewed for advance directives (Residents 1 and 3). Findings include:1. On 1/6/26 at 11:47 a.m., Resident 1's medical record was reviewed. She had a Physician's Order for Scope of Treatment (POST) form, dated 10/23/25, which indicated she wished to have a DNR or Do Not Resuscitate advance directive status. The current physician's order, as of the record review on 1/6/26, listed her as a full code. A corresponding Advance Directive Comprehensive Care Plan, dated 10/17/25, indicated Resident 1 as a full code. During an interview on 1/7/2026 at 1:57 p.m., Registered Nurse (RN) 26 indicated she was certain Resident 1 was a full code resident. After her review of the POST, RN 26 indicated that was a big discrepancy and she would need to talk with the Director of Nursing to ensure the correct code status was updated across the resident's record. 2. On 1/6/26 at 10:02 a.m., a record review was completed for Resident 3. She had the following diagnoses which included but were not limited to fracture of right lower leg, fracture of left leg, type 2 diabetes mellitus, hypertension, chronic kidney disease, hyperlipidemia (high cholesterol), cerebral infarction with hemiplegia and hemiparesis affecting left non-dominant side (stroke with paralysis and weakness), and muscle weakness. Resident 3's record lacked an order for code status. Resident 3 had a care plan, dated 10/22/25, indicating Resident 3 had an order for Do Not Resuscitate (DNR). On 1/12/26 at 2:35 p.m., the Director of Nursing (DON) indicated an order was added for DNR. A policy titled, Advanced Directives was provided by the Executive Director (ED) on 1/8/26 at 3:27 p.m. It indicated, .At the time of admission, admission staff or designee will inquire about the existence of and Advanced Directive. The admission staff will inform and provide written information to all adult residents concerning the right to accept or refuse medical treatment. 3.1-4(d) 3.1-4(e) 3.1-38(f) 3.1-4(1)(4)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to prevent physical abuse between two dementia residents resulting in Resident D obtaining a laceration to the upper lip, nasal fracture, fractures to the 6th, 7th, and 8th ribs, and subsequent change in condition related to weakness from her hospitalization where she is no longer able to walk independently and requires staff assistance to be transported in a wheelchair (Residents D and E) for 1 of 6 residents reviewed for abuse. In addition to the residents in immediate jeopardy, the facility failed to implement effective supervision and interventions to prevent resident-to-resident sexual abuse when a cognitively impaired male resident, (Resident G) entered a cognitively impaired female resident's room (Resident F) removed her pants and briefs and began to masturbate while touching her. This resulted in harm that is not immediate jeopardy for 1 of 6 residents reviewed for abuse when Resident F was documented to have increased anxiety, reduced engagement, and a departure from her previously consistently happy demeanor. The immediate jeopardy began on 11/20/25 when Resident D, who resided on the secured memory care unit, wandered near the doorway of Resident E. Resident E purposely pushed Resident D, who lost her balance and fell, hitting her face on the handrail. Upon immediate assessment, Resident D sustained a laceration to her upper lip, had a nosebleed, and skin tears to the left hand. She was sent to the hospital for treatment where she was found to have a lip laceration, nasal fracture, and fractures of the 6th, 7th, and 8th ribs. Upon return to the facility, she declined from walking independently to requiring total dependence on staff for transfers and ambulation by staff in a wheelchair. Per staff interviews and resident medical record reviews, Resident E had a history of psychosis, delusional thinking, and aggressive behaviors, specifically targeted at Resident D, prior to the incident. Per staff interviews and resident medical record reviews, Resident D frequently paced the hall and intrusively wandered into other resident's rooms. Residents D's and E's records lack documentation of the targeting of Resident D by Resident E or interventions to prevent harm to either resident. Observations during the survey have found Resident D and Resident E to be left alone in common areas without staff supervision. The Administrator (ADM), the Director of Nursing (DON), and the Regional Nurse Consultant (RNC) were notified of the Immediate Jeopardy on 1/7/26 at 4:54 p.m. The immediate jeopardy was removed on 1/9/26 at 12:20 p.m., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:1. An Indiana Department of Health facility incident report, dated 11/20/25, indicated Resident E was involved in a resident-to-resident altercation. Resident D was intrusively wandering into Resident E's room when Resident E made open hand and extended arm contact with Resident D resulting in her losing her balance causing her to hit her mouth on the handrail as she fell. Resident D was assessed and noted to have a deep laceration to upper lip, nosebleed, skin tears to top of left hand and 2nd knuckle. The NP ordered to send Resident D to the hospital for evaluation and treatment. On 1/5/26 at 10:35 a.m., upon initial observation of the secured memory care unit, no staff were present in the main dining/activity room. Resident E was seated in a chair at a table and Resident D was seated in her wheelchair at a separate table with her back to Resident E. On 1/5/26 at 10:40 a.m., Qualified Medication Aide (QMA) 13 entered the unit in a hurry and indicated in general to the gathered residents in the dining room, let's see what they have going on for you guys. I have no idea, and stated she was just going to wing it, indicating she had been pulled to multiple assignments that morning. On 1/6/26 at 8:53 a.m., Certified Nursing Assistant (CNA) 15 indicated she did not normally work in the memory care unit, she had been pulled to help cover (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the previous day and was not familiar with the residents. On 1/6/26 at 9:00 a.m., the main dining/activity room of the secured memory care unit was observed. There were seven residents present, the TV was on, and an unidentified housekeeper was observed cleaning the floors. There were no direct care staff present. Resident D was seated in her wheelchair at a table with three peers. On 1/6/26 at 9:22 a.m., Resident E was observed at a table in the main dining room area. She was lightly engaged in a coloring activity. She only participated when encouraged and stopped her activity to watch the other residents. Resident D was seated at a separate table, not engaged in the activity. During this activity, staff were in and out of the dining room, as the nurse passed medications and the CNA provided incontinent/ADL care. On 1/7/26 at 8:42 a.m., Licensed Practical Nurse (LPN) 16 indicated she was assigned to the memory care unit that morning. She did not usually work on the unit and was not sure about the residents' routines, preferences, or behaviors. On 1/7/26 at 11:27 a.m., no staff were present in the main dining/activity room, where residents were seated with the Daily Chronicle and coloring materials. Resident D was seated in her wheelchair at a table with one peer. On 1/7/26 at 2:43 p.m., Resident E was observed unsupervised as she independently ambulated from her room, across the hall, into another resident's room, then walked into the dining room and asked when it was mealtime. During an interview on 1/6/26 at 10:40 a.m., Resident D's family member indicated Resident D had experienced three falls during the previous year, the most serious fall was a result of being pushed down by another resident. The family member indicated the other resident apparently didn't like Resident D and pushed her which caused her to fall and strike a rail. This incident resulted in a busted lip that required stitches. The family member indicated Resident D had been walking independently prior to the incident but became weak following the hospitalization and was no longer safe to walk independently. The family member confirmed Resident D sustained facial and rib fractures from the incident and expressed concern that Resident D was not protected from harm. During an interview on 1/7/26 at 12:15 p.m., CNA 14 indicated Resident E appeared to target Resident D more than the other residents. Resident E had a history of aggressive behaviors, particularly when residents wandered into her room, it made her mad. During an interview on 1/7/26 at 12:18 p.m., the Admissions Coordinator indicated she also helped as an activity aide on the memory care unit. She was not employed at the time of the incident between Resident D and E, but was later informed that Resident E had a history of delusional thinking and aggressive behavior. Resident E perceived Resident D as threat and often expressed more aggressive behaviors towards her because she thought Resident D was a man. Since the Admissions Coordinator started working on the memory care unit as an activity assistant, she had not seen or been made aware of specific interventions to prevent future altercations between Resident D and E and/or interventions to prevent other residents from wandering into Resident E's room. During an interview on 1/7/26 at 3:17 p.m., the Assistant Director of Nursing (ADON) was working as the nurse on the floor in the secured memory care unit. He indicated it was not his usual assignment to be in the memory care unit and he was not familiar with the residents. He could not speak to Resident D or Resident E's routines, preferences, behaviors and/or potential for altercations. During an interview on 1/7/26 at 3:20 p.m., CNA 18 demonstrated a significant language barrier and was unable to understand or respond to questions regarding resident behaviors and safety concerns. During a follow up interview on 1/7/26 at 3:23 p.m., QMA 14 reiterated, it was well known that Resident E did not like residents, particularly Resident D to enter her room. Resident D repeatedly intrusively wandered into Resident E's room, and on the day of the incident, Resident D had been walking by Resident E's room, when Resident E saw her in the frame of her doorway and shoved Resident D down, yelling at her, Get out of my room! QMA 14 was too far away to prevent the push/fall, but witnessed the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	incident. She immediately called for help and stayed with Resident D until the nurse came. QMA 14 indicated Resident D had blood coming from her nose and lip and lost a tooth at the time of the fall. During an interview on 1/7/26 at 3:30 p.m., QMA 19 indicated she had worked in the memory care unit before and knew that Resident E did not like when other residents came into her room. It made the resident mad and she would yell and scream for them to get out. QMA 19 indicated she had been working in the memory care unit on the day of the incident. At that time, she was next door helping another resident with a meal when she witnessed Resident D pass the room she was in, walking down the hall per her routine. Then QMA 19 heard a loud bang/crash. She rushed to see what happened and saw Resident D on the floor with blood around her nose and mouth. During an interview on 1/7/26 at 3:38 p.m., Activity Assistant 20 indicated she helped out in the memory care unit on a regular basis. She indicated it was well known that Resident E did not like other residents coming into her room and particularly did not like Resident D because she thought Resident D looked like a man, and perceived her as a threat. During an interview on 1/7/26 at 3:43 p.m., the Director of Nursing (DON) indicated she assumed the DON position in May 2025. The DON described Resident E as feisty and while she mostly had a history of being verbally aggressive, there had been one or two incidents of physical aggression towards her peers prior to the incident with Resident D. The DON indicated Resident D used to wear a hair piece, but when she stopped wearing it Resident E began to perceive Resident D as a man and remained fixated on her due to Resident D's appearance. a. Resident E's record was reviewed on 1/7/26 at 11:28 a.m. She was a long term care resident who resided in the secured memory care unit and had diagnoses which included, but were not limited to, vascular dementia, delusional disorder, and generalized anxiety disorder. A quarterly Minimum Data Set (MDS) assessment, dated 10/29/25, indicated Resident E was moderately cognitively impaired and there were no behaviors coded for the look back period. A Psychiatric progress note, dated 8/22/25, indicated Resident E had a prior psychiatric history of major depression, dementia, psychotic/delusional disorder. History of hallucinations ordelusions. History of inpatient psychiatric hospitalization. A summary of the visit indicated Resident E complained about a fellow resident who wandered into other rooms and touches her while laughing, Resident E cussed at her and demanded they should put her in jail. Staff were able to confirmed that Resident D did intrusively wander into other's rooms. Staff also reported that Resident E had been more anxious lately. The record lacked documentation of follow up, interventions and/or care plan revisions to address the resident's complaints about an intrusive peer and her increased anxiety. A Psychiatric progress note, dated 9/19/25, indicated Resident E required an emergent telehealth visit, due to a situation between [two] residents and was currently on 15 minute checks for safety. During the call, Resident E was calm and did not recall the incident from last night with another resident. She did not show signs of agitation, aggression or distress, and was determined appropriate to come off safety checks. The record lacked documentation of any incident between Resident E and another peer and/or follow up, interventions and/or care plan revisions to address to alleged incident. Resident E's progress notes were reviewed and lacked routine behavior monitoring and/or behavior documentation if occurred. The progress notes lacked documentation of Resident E's resident to resident concerns/fixation towards Resident D. A nursing progress note, dated 11/20/25 at 7:15 p.m., indicated Resident E had an altercation with another resident, [Resident D] was entering her doorway intrusively wandering into her room. With open hands and extended arms, Resident E made contact with Resident D which resulted in Resident D losing her balance and hitting her face on handrail as she fell. Resident D was sent to the emergency room for evaluation and treatment. Resident E was subsequently sent to an in-patient psychiatric hospital for evaluation. Resident E's comprehensive care plans were (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reviewed and lacked implementation/revision to include her concerns/fixation towards Resident D and or her preferences to keep peers out of her room. Her physician's orders were reviewed and did not include any behavior monitoring. A current CNA assignment sheet was provided by the DON on 1/7/26 at 3:47 p.m. The notes section for Resident E was blank. It did not include person-centered interventions for history of aggression and/or preferences to keep other residents out of her room. During an interview on 1/7/26 at 3:43 p.m., three psychiatric progress notes (noted above for the following dates 8/22/25, 9/17/25 and 9/26/25) were reviewed with the DON, who indicated she was unaware of the events leading up to these encounters and would look further into the records. During an interview on 1/7/26 at 4:25 p.m., the DON indicated she had not been able to locate or find additional information or documentation related to the three psychiatric progress notes from 8/22/25, 9/17/25, and 9/26/25. Throughout the survey observation period, no visual interventions were observed on or near Resident E's room to discourage her peers from intrusively wandering. b. On 1/7/26 at 2:51 p.m., Resident D's record was reviewed. She was a long term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, unspecified dementia, mild cognitive impairment, and unsteadiness on feet. A quarterly MDS, dated [DATE], indicated Resident D was severely cognitively impaired but was able to eat independently and walk up to 150 feet independently or with only minimal set up assistance. Resident D's progress notes were reviewed and lacked routine behavior monitoring and/or behavior documentation related to her repeated intrusive wandering. Resident D's comprehensive care plans were reviewed. She had a care plan that was not initiated until 11/16/25 which indicated she had behavior of wandering into other resident's rooms. An intervention for this plan of care included, Intervene as necessary to protect the rights and safety of others. Resident D's care plan lacked implementation/revision that she was often perceived by other residents as a man due to her appearance or that she was targeted because of her peers perceived threat. A nursing progress note, dated 11/20/25 at 7:26 p.m., indicated Resident D was involved in a resident-to-resident altercation at 5:42 p.m. Resident D was intrusively wandering into another resident's room when the other resident made open hands and extended arms contact with her resulting in her losing her balance causing her to hit her mouth on the handrail as she fell. At the time of the fall Resident D was assessed and found to have sustained, a deep laceration from her upper lip to her nose, skin tears to top of her left hand and 2nd knuckle. A hospital Discharge summary, dated [DATE], indicated Resident D was sent to the emergency room for evaluation and treatment and was subsequently found to have sustained a laceration to her upper lip which required sutures, a nasal bone fracture, and fractures of her 6th, 7th and 8th ribs. A significant change MDS, dated [DATE], was initiated upon her return from the hospital which indicated a decline in her ability to eat and walk. She required maximum assistance to eat, and maximum assistance to ambulate. A current CNA assignment sheet was provided by the DON on 1/7/26 at 3:47 p.m. The notes section for Resident D was not revised to change her ambulation status from walking to wheelchair and did not include person-centered interventions/approaches to address her peers often mistaking her for a man, due to her appearance. On 1/8/26 at 10:54 a.m., a copy of the incident investigation documentation was provided by the Administrator (ADM). The investigation was conducted by the DON but did not include a date the investigation was initiated or finalized. A Witness Statement from QMA 14 indicated, .I saw [Resident E] push [Resident D] right in front of her door . [Resident D] fell on her face flat, she had an upper lip split and was bleeding, she also had skin tear on her left hand. A description of the incident indicated Resident E and Resident D were involved in a resident-to-resident altercation. Resident D was intrusively wandering into Resident E's room when Resident E made open hand contact with extended arms resulting in (continued on next page)

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	155206	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident D losing her balance, falling, and hitting her face on the handrail. The residents were immediately separated and safety for all residents assured. The residents were assessed, and Resident D was noted to have a deep laceration to upper lip and skin tears to top of left hand and 2nd knuckle of left hand. Resident D showed no non-verbal signs of pain or distress. The spouse of Resident D was notified as well as Administrator and on call NP. Messages were left for family of Resident E. The NP ordered to send Resident D to the ER for evaluation and treatment. 911 called. Labs and urine were ordered for Resident E along with a psychiatric (psych) eval. Resident E was placed on one-to-one supervision until placement with psych confirmed. The investigation documents indicated the following recommendations: Resident D would be closely monitored for signs and symptoms of infection regarding stitches to upper lip. Lab monitoring in place. Resident D placed on therapy case load. Activities would meet with the resident and assess activity needs. Resident E was on one-to-one supervision and sent to psych for eval. The IDT [interdisciplinary team] would review care of residents. Education provided on resident safety. Both residents' care plans were updated. Resident D's record lacked documentation that monitoring of Resident D's lip for infection was implemented. Throughout the survey period, no visual interventions were observed in place such as a picture of Resident D, or her name in large letters on her door to help her identify her own room. Neither Resident E or D were reviewed by Activities nor were care plans for activities revised. No IDT notes were noted in the either residents' charts Neither Residents care plans were updated. On 1/5/26 at 10:00 a.m., the Administrator provided a copy of the facility current Abuse Prevention and Prohibition, dated 8/2020. The policy indicated, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. the facility is committed to protecting residents from abuse by anyone, including, but not limited to Facility staff, other residents. The immediate jeopardy that began on 11/20/25 was removed on 1/9/26 at 12:20 p.m., when the facility ensured a systemic plan to include staff education and monitoring of residents to ensure staff provided supervision. Resident D was moved to a new unit to ensure residents would not be in common areas together. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. 2. An Indiana Department of Health facility incident report, dated 7/27/25, indicated Resident G entered Resident F's room and started behaving socially inappropriately. Staff reported Resident G's pants were open. Staff redirected Resident G out of the room. Resident F did not recall anything happening or being fearful and denied knowing anything that happened. Resident safety was assured. Staff and neighborhood interviews were started. Resident G was placed on direct observation for 48 hours. The Police Department was notified. On 1/5/26 at 10:40 a.m., Resident F was initially observed. She was seated in a wheelchair in the main dining/activity room. She appeared to be watching the T.V. She smiled pleasantly, but did not engage in meaningful conversation. During the survey period, Resident G was observed on multiple occasions independently ambulating through the halls. During an interview on 1/6/26 at 11:06 a.m., Resident F's husband indicated, back in the summer, he was notified that another male resident had been found in her room and had removed her pants. He was not informed of any additional actions or outcomes from the incident which made him upset. He began to cry and indicated he felt helpless and that he had failed his wife and let her down. He indicated Resident F was confused and unable to understand or express what had occurred, and she was subsequently moved to the secured memory care unit following the assault. He expressed emotional distress while recalling the incident and Resident F was unable to communicate her feelings or distress related to the sexual assault. On 1/7/26 at 2:14 p.m., Resident G was observed in his room. He was seated (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in a recliner chair and watched TV. Resident G denied having a girlfriend in the facility and did not recall taking liberties, or having private time with another female resident. Resident G indicated he spent most of his time in his room, but sometimes like to walk through the facility to check things out, and go to the front to step outside and feel the weather. During an interview on 1/7/26 at 2:16 p.m., Qualified Medication Aide (QMA) 10 indicated Resident G was independently ambulatory, and that while he spent most of his time in his room, he would still walk through the building at his leisure. During an interview on 1/8/26 at 12:30 p.m., the Director of nursing indicated she was on vacation at the time of the incident, the Administrator (ADM) at the time had come in to address the situation. The DON had not conducted any additional or ongoing assessments or interventions upon her return as she was under the impression the ADM had taken care of it all. During a follow up interview on 1/8/26 at 1:13 p.m., the DON indicated after the sexual abuse between Resident F and G, Resident G had been placed on 15-minute checks, he had a psychotic consult and was placed on 48-hour close observation. Other than the psychotic consultation, the DON could not provide evidence of additional follow up. During an interview on 1/8/26 at 1:16 p.m., Certified Nursing Aide (CNA) 23 indicated, she had not been employed at the time of the incident, and no one had told her about Resident G's history of sexually inappropriate behavior. She did not know and had not been informed to be aware of this potential behavior as he continued to be able to and liked to walk through the building.' During an interview on 1/8/26 at 1:17 p.m., CNA 15 indicated, she had not been working the day of the abuse, but when she came back to work and found out about it, she was shocked to learn it had been Resident G because he was such a sweet guy. CNA 15 indicated there was no education or in-service after the incident, and since it was so out of character for Resident G, no one really considered monitoring him for it because it was so unlike him. CNA 15 indicated he did still walk through the facility as he pleased and she had never witnessed behavior like that from him. During an interview on 1/9/26 at 12:59 p.m., QMA 22 indicated she was the only witness to what happened between Resident F and G. She indicated it was around 3:30 p.m. when she realized she had not seen Resident F, which was unusual, as Resident F liked to be out of her room and attended activities. She decided to go check on Resident F and when she opened Resident F's door, she saw Resident G seated in a chair with his pants and underwear pulled down to his thighs, while Resident F was naked from the waist down and stood in front of Resident G. Resident G was masturbating with one hand, while his other hand was between Resident F's legs. QMA 22 indicated she immediately walked in and told Resident G to stop and pull his pants up. She removed Resident G from Resident F's room and went to get the nurse. The nurse immediately came and went to assess Resident F. QMA 22 stayed with Resident G who admitted to touching himself and Resident G, but he thought it was ok because she did not tell him to stop. During an interview on 1/9/26 at 1:29 p.m., Licensed Practice Nurse (LPN) 24 indicated she had been working on the secured memory care unit with QMA 22 came to her and explained what she saw. LPN 24 immediately went to assess Resident F, but Resident F was unable to recall what happened. LPN 24 conducted a skin and pain assessment and notified the ADM and the police were called. The ADM came right away and Resident G was moved to a new room. LPN and QMA gave their witness statements to the police. During an interview on 1/9/26 at 1:43 p.m., the Receptionist indicated Resident G liked to come up and get money out every now and then, he would come to the front desk to ask about weather and liked to step outside to check it out. Sometimes he sat in the lobby and other common areas. a. On 1/7/26 at 8:15 a.m., Resident F's record was reviewed. She was a long-term care resident who resided on the secured memory care unit at the time of the review. She was admitted in November of 2024 and had diagnoses which included, but were not limited to, unspecified dementia, recurrent major depressive disorder, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and cognitive impairment. A quarterly minimum data set (MDS) assessment dated , 5/19/25, current at the time of the following incident, indicated Resident F was moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 9 out of 15. A care plan progress note, dated 2/11/25 at 12:19 p.m., (and repeated throughout the record) indicated, she was followed by a psychiatric provider and had a history of sexual trauma, molested by brother when she was young. A review of Resident F's psychiatric consult progress notes revealed the following: From her admission on [DATE] through 7/10/25, she was routinely assessed as psychiatrically stable, alert and pleasant at baseline, with no documented increase in anxiety, agitation, or behavioral symptoms. Psychiatric progress notes dated 11/7/24, 11/14/24, 12/5/24, 12/26/24, 3/6/25, 5/15/25, and 7/10/25 repeatedly documented no significant changes in mood, sleep, appetite, or behavior, and an interdisciplinary team (IDT) approved gradual dose reduction of sertraline in May 2025 which further reflected clinical stability prior to July. A psychiatric consult, dated 7/11/25, indicated Resident F had allowed another resident into her room without supervision, during which the resident cut her hair. Resident F did not object at the time, but later expressed regret and distress, demonstrating impaired judgment and delayed emotional processing. The psychiatric note indicated, .during the session resident was cooperative and presented as upset, with incongruent. Resident described this as 'being okay' while touching her hair constantly. Resident was observed with a new haircut and when asked about it, resident referred 'hating her hair' and regretting the decision to cut her hair. Per SSD [Social Service Director] resident let a fellow resident cut her hair, although neither of them remember the full event . she was moved to another room to prevent further incidents. Resident F's assessments, nursing progress notes and care plan lacked documentation, follow up and/or interventions to address and prevent any further resident-to-resident incidents after she allowed her hair to be cut. Following the July 2025 sexual assault, psychiatric documentation, dated 7/27/25 and 7/31/25, identified a change in her psychiatric status, with providers noting new or increased anxiety, reduced engagement, and a departure from her previously consistently happy demeanor, which resulted in an increase in psychotropic medication. Resident F's record lacked physician notification and/or orders of increased behavior monitoring, such as additional supervisor related to poor decision making. Resident F's record lacked nursing IDT follow up for the hair cutting incident and the sexual assault incident to address the root cause of these behaviors and to implement new interventions to protect her from future incidents. Resident F's record lacked comprehensive care plans to address her history of sexual trauma endured in her youth, poor judgement and decision making related to allowing a peer to cut her hair, and poor judgement/decision making and not being able to stop another resident from sexually assaulting her. b. On 1/7/26 at 9:15 a.m., Resident G's record was reviewed. He was a long-term care resident who resided on the 400-hall at the time of the review. He was admitted to the facility on [DATE] and had diagnoses which included, but were not limited to, unspecified dementia. A quarterly MDS assessment, dated 5/16/26, indicated Resident G was moderately cognitively impaired with a BIMS score of 11 out of 15. A nursing progress note, dated 7/27/25 at 5:45 p.m., indicated Resident G was found to be socially inappropriate in another resident's room, and requiring staff to remove him for Resident F's safety. A Psychiatric progress note, dated 7/27/25, indicated nursing staff found Resident G had entered a female resident's room and began masturbating. Nursing staff redirected Resident G and provided education regarding facility policy and appropriate behaviors with other residents. During the psychiatric consultation, Resident G became agitated and did not understand why the behavior was inappropriate. Nursing staff reported this was believed to be the first incident of this nature and requested psychiatric involvement. On 8/01/25, a follow-up psychiatric services visit for Resident G (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was conducted at the request of the SSD, due to an inappropriate sexual incident involving a female resident, which resulted in Resident G being moved to another hall. Per Social Services recommendation, the incident was not explicitly discussed during the session, as Resident G had previously discussed the incident with other providers, expressed feelings of shame, and had demonstrated agitation when the topic was revisited. During the session, Resident G was cooperative, presented as neutral with congruent affect, and denied major concerns with mood, sleep, or appetite. When asked about the room change, Resident G stated he did not know why he was moved but reported being okay with the change. Resident G's record lacked physician notification and/or orders of increased behavior monitoring, such as additional supervisor related to sexually explicit behaviors. Resident G's record lacked nursing IDT follow up for the resident-to-resident sexual assault to discuss and address the root cause of the behavior and prevent future occurrences. Resident G's record lacked comprehensive care plans to address his history of or new behavior sexually explicit actions towards his peer, and lacked implementations to prevent future incidents. On 1/5/26 at 10:00 a.m., the Administrator provided a copy of the facility current Abuse Prevention and Prohibition, dated 8/2020. The policy indicated, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. the facility is committed to protecting residents from abuse by anyone, including, but not limited to Facility staff, other residents. This citation relates to Intake 2711282. 3.1-27(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to ensure that alleged violations involving resident to resident physical abuse, sexual abuse, and misappropriation of resident's funds were thoroughly investigated, appropriately documented, and followed up by effective corrective actions for 5 of 6 residents reviewed for abuse (Residents D, E, F, G, and J). Findings include:1. An Indiana Department of Health facility incident report, dated 11/20/25, indicated Resident E was involved in a resident-to-resident altercation. Resident D was intrusively wandering into Resident E's room when Resident E made open hand and extended arm contact with Resident D resulting in her losing her balance causing her to hit her mouth on the handrail as she fell. Resident D was assessed and noted to have a deep laceration to upper lip, nosebleed, skin tears to top of left hand and 2nd knuckle. The NP ordered to send Resident D to the hospital for evaluation and treatment. On 1/8/26 at 10:54 a.m., a copy of the incident investigation documentation was provided by the Administrator (ADM). The investigation was conducted by the DON but did not include a date the investigation was initiated or finalized. A Witness Statement from QMA 14 indicated, .I saw [Resident E] push [Resident D] right in front of her door . [Resident D] fell on her face flat, she had an upper lip split and was bleeding, she also had skin tear on her left hand. A description of the incident indicated Resident E and Resident D were involved in a resident-to-resident altercation. Resident D was intrusively wandering into Resident E's room when Resident E made open hand contact with extended arms resulting in Resident D losing her balance, falling, and hitting her face on the handrail. The residents were immediately separated and safety for all residents assured. The residents were assessed, and Resident D was noted to have a deep laceration to upper lip and skin tears to top of left hand and 2nd knuckle of left hand. Resident D showed no non-verbal signs of pain or distress. The spouse of Resident D was notified as well as Administrator and on call NP. Messages were left for family of Resident E. The NP ordered to send Resident D to the ER for evaluation and treatment. 911 called. Labs and urine were ordered for Resident E along with a psychiatric (psych) eval. Resident E was placed on one-to-one supervision until placement with psych confirmed. The investigation documents indicated the following recommendations: Resident D would be closely monitored for signs and symptoms of infection regarding stitches to upper lip. Lab monitoring in place. Resident D placed on therapy case load. Activities would meet with the resident and assess activity needs. Resident E was on one-to-one supervision and sent to psych for eval. The IDT [interdisciplinary team] would review care of residents. Education provided on resident safety. Both residents' care plans were updated. Resident D's record lacked documentation that monitoring of Resident D's lip for infection was implemented. Neither Resident E or D's indicated they were reviewed by Activities nor were care plans for activities revised. No IDT notes were noted in the resident charts. Neither residents' care plans were updated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The abuse investigation lacked documentation the facility thoroughly investigated, analyzed, and responded to an allegation of resident-to-resident abuse involving Residents D and E. Following the incident on 11/20/25, there was no evidence of a comprehensive IDT investigation, no documented analysis of the residents' known behaviors, and no meaningful follow-up or care plan interventions implemented to address the root causes or prevent recurrence. The facility failed to revise care plans, implement dementia-centered behavioral or environmental interventions, or ensure enhanced supervision upon the residents' return to the unit. 2. An Indiana Department of Health facility incident report, dated 7/27/25, indicated Resident G entered Resident F's room and started behaving socially inappropriately. Staff reported Resident G's pants were open. Staff redirected Resident G out of the room. Resident F did not recall anything happening or being fearful and denied knowing anything that happened. Resident safety was assured. Staff and neighborhood interviews were started. Resident G was placed on direct observation for 48 hours. The Police Department was notified. During an interview on 1/8/26 at 12:30 p.m., the Director of nursing indicated she was on vacation at the time of the incident, the Administrator (ADM) at the time had come in to address the situation. The DON had not conducted any additional or ongoing assessments or interventions upon her return as she was under the impression the ADM had taken care of it all. During a follow up interview on 1/8/26 at 1:13 p.m., the DON indicated after the sexual abuse between Resident F and G, Resident G had been placed on 15-minute checks, he had a psychotic consult and was placed on 48-hour close observation. Other than the psychotic consultation, the DON could not provide evidence of additional follow up. During an interview on 1/8/26 at 1:17 p.m., CNA 15 indicated, she had not been working the day of the abuse, but when she came back to work and found out about it, she was shocked to learn it had been Resident G because he was such a sweet guy. CNA 15 indicated there was no education or in-service after the incident, and since it was so out of character for Resident G, no one really considered monitoring him for it because it was so unlike him. CNA 15 indicated he did still walk through the facility as he pleased and she had never witnessed behavior like that from him. During an interview on 1/9/26 at 12:59 p.m., QMA 22 indicated she was the only witness to what happened between Resident F and G. She indicated it was around 3:30 p.m. when she realized she had not seen Resident F, which was unusual, as Resident F liked to be out of her room and attended activities. She decided to go check on Resident F and when she opened Resident F's door, she saw Resident G seated in a chair with his pants and underwear pulled down to his thighs, while Resident F was naked from the waist down and stood in front of Resident G. Resident G was masturbating with one hand, while his other hand was between Resident F's legs. QMA 22 indicated she immediately walked in and told Resident G to stop and pull his pants up. She removed Resident G from Resident F's room and went to get the nurse. The nurse immediately came and went to assess Resident F. QMA 22 stayed with Resident G who admitted to touching himself and Resident G, but he thought it was ok because she did not tell him to stop. During an interview on 1/9/26 at 1:29 p.m., Licensed Practice Nurse (LPN) 24 indicated she had been working on the secured memory care unit with QMA 22 came to her and explained what she saw. LPN 24 immediately went to assess Resident F, but Resident F was unable to recall what happened. LPN 24 conducted a skin and pain assessment and notified the ADM and the police were called. The ADM came right away and Resident G was moved to a new room. LPN and QMA gave their witness statements to the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	police. The abuse investigation lacked documentation the facility thoroughly investigated, analyzed, and responded to an allegation of resident-to-resident sexual abuse involving Residents F and G. Following the July 2025 sexual abuse incident, there was no documentation of a comprehensive IDT investigation, no documented analysis of supervision failures or resident vulnerabilities, and no meaningful follow-up or care plan interventions implemented to address root causes or prevent recurrence. Despite Resident F's dementia, impaired judgment, and prior vulnerability to unsupervised resident access, and despite Resident G's dementia, the facility failed to revise care plans, implement dementia-centered behavioral or environmental interventions, or ensure enhanced supervision for either resident. Cross reference F600, F656 and F744. 3. An Indiana Department of Health facility incident report, dated 12/22/25, indicated Resident J stated that he was missing his debit card and $20.00. The police were called. The accused employee was immediately suspended and an investigation was initiated. On 1/7/26 at 11:10 a.m. Resident J's medical record was reviewed. They were a long-term care Resident whose diagnoses included but were not limited to reduced mobility. Resident J's most recent Minimum Data Set (MDS) assessment, dated 11/20/25, indicated Resident J had a Brief Interview for Mental Status (BIMS) score of 13 which indicated they were cognitively intact. A progress note, dated 12/21/25 at 2:10 p.m., written by Licensed Practical Nurse (LPN) 12 indicated the police were called to Resident J's room by Resident J because they were missing their debit card and $20.00 in cash. LPN 12 indicated in the note that she attempted to help Resident J look for the missing card and cash, however Resident J indicated they knew where they had put the card and cash and that they were both gone. LPN 12 indicated in that note that the manager on duty was notified of the incident. On 1/7/26 at 11:00 a.m. a copy of a soft file regarding the above incident was provided. The contents of the file were as follows, a copy of a grievance form filled out by the former Social Worker (SW), a copy of the state reportable form filed for this incident, a statement from the former SW about the incident, several unrelated write ups for Certified Nursing Assistant (CNA) 28, a termination letter unsigned for CNA 28 and safe surveys (a survey questionnaire asking residents questions regarding abuse and misappropriation of belongings such as food, beverages, money, etc.) for the residents on the unit Resident J resided on. On 12/22/25 a grievance form was filled out by the former SW. That grievance form indicated Resident J was self-propelling in their wheelchair to the former SW's office while they were on the phone with the police. At that time Resident J indicated they had their debit card and $20.00 in cash stolen from their wallet. The former SW indicated she found a new inactive debit card in the resident's wallet, but not the cash or the original debit card the resident was missing. Safe surveys were done for all residents on the unit Resident J resided on. Two of the residents surveyed answered yes to the question asking if they had ever witnessed a staff member take anything that did not belong to them, even food or beverages. The soft file lacked follow up with those residents to investigate further what had been taken. Several safe surveys indicated the resident being surveyed was non-verbal and had no answers written in for the questions. The soft file lacked attempts to follow up with those (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-verbal residents' family members or Power of Attorney's (POAs) to survey them on behalf of those residents. During an interview on 1/8/26 at 11:05 a.m. LPN 12 indicated on 12/21/25 Resident J was very upset, yelling, and using inappropriate language towards staff. She indicated she asked Resident J what was wrong and they indicated their CNA from the previous night (12/20/25), CNA 28, had stolen their debit card and $20.00 cash from out of their wallet. LPN 12 indicated some staff members believe the Resident blamed CNA 28 for the missing things because he didn't like her, but she wasn't sure what happened. LPN 12 indicated she attempted to help the resident look for the missing things, but Resident J became even more agitated so she left the resident with the police in the room so they could talk privately. LPN 12 indicated after that incident she immediately notified the manager who was on call and the Director of Nursing (DON). On 1/12/26 at 2:25 p.m. the Corporate Registered Nurse (RN) indicated she had spoken with CNA 28 and the CNA indicated she was not aware that she had been terminated for this incident, she was under the impression she was only suspended pending the investigation into the incident with Resident J. The Corporate RN indicated the Assistant Director of Nursing (ADON) and the former SW at the time did not want CNA 28 to come back into the building, so they provided a verbal notification of termination to CNA 28. The medical record and soft file for the incident lacked documentation of the verbal notification of termination for CNA 28. On 1/12/26 at 4:20 p.m. the Corporate RN indicated the former SW had indicated that she reimbursed Resident J for the missing $20.00, but there was no documentation to support that, so they would be reimbursing that $20.00 to Resident J again to ensure the Resident was truly reimbursed and they would provide the resident with a lock box. On 1/13/26 at 11:57 p.m. a copy of a current facility policy titled, Incident Investigation dated 8/2020, was provided. That policy indicated, .Purpose [of this policy is] to ensure that the Facility tracks incidents that take place at the Facility in an effort to increase the quality of care provided to residents. I. The Facility will have a Licensed Nurse fill out the Incident/Accident Report as soon as possible. II. An incident includes but is not limited to the following.B. Abuse. D. Unusual occurrence; E. Bruises; F. Medication error.H. Property loss. Procedure. II. As appropriate, interviews with staff members and other witnesses will be documented. This citation relates to Intake 2711282. 3.1-28(d)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to reconcile a resident's medication at the time of discharge for 1 of 4 residents reviewed (Resident 86). Findings include:On 1/7/26 at 11:39 a.m., a record review was completed for Resident 86. She had the following diagnosis which included but were not limited to chronic kidney disease, hypertension (high blood pressure), hyperlipidemia (high cholesterol), and weakness. Resident 86's record lacked documentation her medication reconciliation after discharge. The discharged medications unaccounted for were as follows: lantus (insulin) 100 units per milliliter (u/ml), mirtazapine (antidepressant) 15 milligram (mg), torsemide (diuretic) 20 mg, trazodone (antidepressant) 50 mg, lorazepam (antianxiety medication) 0.5 mg, metoprolol (blood pressure medication) 25 mg, insulin Lispro Junior kwikpen, polymyxin B-trimethoprim (antibiotic eye drop) 10000-0.1 u/ml, acetaminophen (pain reliever) 325 mg, glucagon (medication to raise blood sugar) emergency injection 1mg, glucose oral gel 40% (medication to raise blood sugar), hydroxyzine (antihistamine) 25 mg, and refresh tears ophthalmic (hydrating eye drops) solution. On 1/8/26 at 11:39 a.m., during an interview, the Director of Nursing (DON) indicated she could not find record of Resident 86's discharged medications. A policy was not provided by the facility at the time of exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure residents' comprehensive care plans were implemented to address their individual needs for 6 of 18 residents reviewed for care plan implementation (Residents D, E, F, G, 3, and 70). Findings include: 1. An Indiana Department of Health facility incident report, dated 11/20/25, indicated Resident E was involved in a resident-to-resident altercation. Resident D was intrusively wandering into Resident E's room when Resident E made open hand and extended arm contact with Resident D resulting in her losing her balance causing her to hit her mouth on the handrail as she fell. Resident D was assessed and noted to have a deep laceration to upper lip, nosebleed, skin tears to top of left hand and 2nd knuckle. The NP ordered to send Resident D to the hospital for evaluation and treatment. On 1/7/26 at 2:51 p.m., Resident D's record was reviewed. She was a long term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, unspecified dementia, mild cognitive impairment, and unsteadiness on feet. A quarterly MDS, dated [DATE], indicated Resident D was severely cognitively impaired but was able to eat independently and walk up to 150 feet independently or with only minimal set up assistance. Resident D's comprehensive care plans were reviewed. She had a care plan that was not initiated until 11/16/25 which indicated she had behavior of wandering into other resident's rooms. An intervention for this plan of care included, Intervene as necessary to protect the rights and safety of others. Resident D's care plan lacked implementation/revision that she was often perceived by other residents as a man due to her appearance or that she was targeted because of her peers perceived threat. A nursing progress note, dated 11/20/25 at 7:26 p.m., indicated Resident D was involved in a resident-to-resident altercation at 5:42 p.m. Resident D was intrusively wandering into another resident's room when the other resident made open hands and extended arms contact with her resulting in her losing her balance causing her to hit her mouth on the handrail as she fell. At the time of the fall Resident D was assessed and found to have sustained, a deep laceration from her upper lip to her nose, skin tears to top of her left hand and 2nd knuckle. A hospital Discharge summary, dated [DATE], indicated Resident D was sent to the emergency room for evaluation and treatment and was subsequently found to have sustained a laceration to her upper lip which required sutures, a nasal bone fracture, and fractures of her 6th, 7th and 8th ribs. Resident D's record lacked documentation of care plan interventions related to Resident D's lip laceration implemented. Resident D's care plans were not updated after the incident. 2. An Indiana Department of Health facility incident report, dated 11/20/25, indicated Resident E was involved in a resident-to-resident altercation. Resident D was intrusively wandering into Resident E's room when Resident E made open hand and extended arm contact with Resident D resulting in her losing her balance causing her to hit her mouth on the handrail as she fell. Resident D was assessed and noted to have a deep laceration to upper lip, nosebleed, skin tears to top of left hand and 2nd knuckle. The NP ordered to send Resident D to the hospital for evaluation and treatment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/26 at 12:15 p.m., CNA 14 indicated Resident E appeared to target Resident D more than the other residents. Resident E had a history of aggressive behaviors, particularly when residents wandered into her room, it made her mad. During an interview on 1/7/26 at 3:43 p.m., the Director of Nursing (DON) indicated she assumed the DON position in May 2025. The DON described Resident E as feisty and while she mostly had a history of being verbally aggressive, there had been one or two incidents of physical aggression towards her peers prior to the incident with Resident D. The DON indicated Resident D used to wear a hair piece, but when she stopped wearing it Resident E began to perceive Resident D as a man and remained fixated on her due to Resident D's appearance. Resident E's record was reviewed on 1/7/26 at 11:28 a.m. She was a long term care resident who resided in the secured memory care unit and had diagnoses which included, but were not limited to, vascular dementia, delusional disorder, and generalized anxiety disorder. A quarterly Minimum Data Set (MDS) assessment, dated 10/29/25, indicated Resident E was moderately cognitively impaired and there were no behaviors coded for the look back period. A Psychiatric progress note, dated 8/22/25, indicated Resident E had a prior psychiatric history of major depression, dementia, psychotic/delusional disorder. History of hallucinations or delusions. History of inpatient psychiatric hospitalization. A summary of the visit indicated Resident E complained about a fellow resident who wandered into other rooms and touches her while laughing, Resident E cussed at her and demanded they should put her in jail. Staff were able to confirmed that Resident D did intrusively wander into other's rooms. Staff also reported that Resident E had been more anxious lately. The record lacked documentation of follow up, interventions and/or care plan revisions to address the resident's complaints about an intrusive peer and her increased anxiety. A nursing progress note, dated 11/20/25 at 7:15 p.m., indicated Resident E had an altercation with another resident, [Resident D] was entering her doorway intrusively wandering into her room. With open hands and extended arms, Resident E made contact with Resident D which resulted in Resident D losing her balance and hitting her face on handrail as she fell. Resident D was sent to the emergency room for evaluation and treatment. Resident E was subsequently sent to an in-patient psychiatric hospital for evaluation. Resident E's comprehensive care plans were reviewed and lacked implementation/revision to include her concerns/fixation towards Resident D and or her preferences to keep peers out of her room. 3. An Indiana Department of Health facility incident report, dated 7/27/25, indicated Resident G entered Resident F's room and started behaving socially inappropriately. Staff reported Resident G's pants were open. Staff redirected Resident G out of the room. Resident F did not recall anything happening or being fearful and denied knowing anything that happened. Resident safety was assured. Staff and neighborhood interviews were started. Resident G was placed on direct observation for 48 hours. The Police Department was notified. During an interview on 1/6/26 at 11:06 a.m., Resident F's husband indicated, back in the summer, he (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was notified that another male resident had been found in her room and had removed her pants. He was not informed of any additional actions or outcomes from the incident which made him upset. He began to cry and indicated he felt helpless and that he had failed his wife and let her down. He indicated Resident F was confused and unable to understand or express what had occurred, and she was subsequently moved to the secured memory care unit following the assault. He expressed emotional distress while recalling the incident and Resident F was unable to communicate her feelings or distress related to the sexual assault. During an interview on 1/9/26 at 12:59 p.m., QMA 22 indicated she was the only witness to what happened between Resident F and G. She indicated it was around 3:30 p.m. when she realized she had not seen Resident F, which was unusual, as Resident F liked to be out of her room and attended activities. She decided to go check on Resident F and when she opened Resident F's door, she saw Resident G seated in a chair with his pants and underwear pulled down to his thighs, while Resident F was naked from the waist down and stood in front of Resident G. Resident G was masturbating with one hand, while his other hand was between Resident F's legs. QMA 22 indicated she immediately walked in and told Resident G to stop and pull his pants up. She removed Resident G from Resident F's room and went to get the nurse. The nurse immediately came and went to assess Resident F. QMA 22 stayed with Resident G who admitted to touching himself and Resident G, but he thought it was ok because she did not tell him to stop. On 1/7/26 at 8:15 a.m., Resident F's record was reviewed. She was a long-term care resident who resided on the secured memory care unit at the time of the review. She was admitted in November of 2024 and had diagnoses which included, but were not limited to, unspecified dementia, recurrent major depressive disorder, and cognitive impairment. A quarterly minimum data set (MDS) assessment dated , 5/19/25, current at the time of the following incident, indicated Resident F was moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 9 out of 15. A care plan progress note, dated 2/11/25 at 12:19 p.m., (and repeated throughout the record) indicated, she was followed by a psychiatric provider and had a history of sexual trauma, molested by brother when she was young. A psychiatric consult, dated 7/11/25, indicated Resident F had allowed another resident into her room without supervision, during which the resident cut her hair. Resident F did not object at the time, but later expressed regret and distress, demonstrating impaired judgment and delayed emotional processing. The psychiatric note indicated, .during the session resident was cooperative and presented as upset, with incongruent. Resident described this as 'being okay' while touching her hair constantly. Resident was observed with a new haircut and when asked about it, resident referred 'hating her hair' and regretting the decision to cut her hair. Per SSD [Social Service Director] resident let a fellow resident cut her hair, although neither of them remember the full event . she was moved to another room to prevent further incidents. Resident F's record lacked comprehensive care plans to address her history of sexual trauma endured in her youth, poor judgement and decision making related to allowing a peer to cut her hair, and poor judgement/decision making and not being able to stop another resident from sexually assaulting her. 4. An Indiana Department of Health facility incident report, dated 7/27/25, indicated Resident G (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entered Resident F's room and started behaving socially inappropriately. Staff reported Resident G's pants were open. Staff redirected Resident G out of the room. Resident F did not recall anything happening or being fearful and denied knowing anything that happened. Resident safety was assured. Staff and neighborhood interviews were started. Resident G was placed on direct observation for 48 hours. The Police Department was notified. During an interview on 1/9/26 at 12:59 p.m., QMA 22 indicated she was the only witness to what happened between Resident F and G. She indicated it was around 3:30 p.m. when she realized she had not seen Resident F, which was unusual, as Resident F liked to be out of her room and attended activities. She decided to go check on Resident F and when she opened Resident F's door, she saw Resident G seated in a chair with his pants and underwear pulled down to his thighs, while Resident F was naked from the waist down and stood in front of Resident G. Resident G was masturbating with one hand, while his other hand was between Resident F's legs. QMA 22 indicated she immediately walked in and told Resident G to stop and pull his pants up. She removed Resident G from Resident F's room and went to get the nurse. The nurse immediately came and went to assess Resident F. QMA 22 stayed with Resident G who admitted to touching himself and Resident G, but he thought it was ok because she did not tell him to stop. On 1/7/26 at 9:15 a.m., Resident G's record was reviewed. He was a long-term care resident who resided on the 400-hall at the time of the review. He was admitted to the facility on [DATE] and had diagnoses which included, but were not limited to, unspecified dementia. A Psychiatric progress note, dated 7/27/25, indicated nursing staff found Resident G had entered a female resident's room and began masturbating. Nursing staff redirected Resident G and provided education regarding facility policy and appropriate behaviors with other residents. During the psychiatric consultation, Resident G became agitated and did not understand why the behavior was inappropriate. Nursing staff reported this was believed to be the first incident of this nature and requested psychiatric involvement. Resident G's record lacked comprehensive care plans to address his history of or new behavior sexually explicit actions towards his peer, and lacked implementations to prevent future incidents. 5. On 1/5/26 at 10:12 a.m., Resident 3 was observed lying in bed with her bedside table on her left side with fluids. Resident had left side hemiplegia (paralysis) and was unable to access her fluids. On 1/6/26 at 11:32 a.m., Resident 3 was observed in her room, lying in bed with her bedside table on her left side of the bed. On 1/6/26 at 10:02 a.m., a record review was completed for Resident 3. She had the following diagnoses which included but were not limited to fracture of right lower leg, fracture of left leg, cerebral infarction with hemiplegia and hemiparesis affecting left non-dominant side (stroke with paralysis and weakness), and muscle weakness. Her record lacked a care plan and care plan interventions to address the potential for dehydration. 6. On 1/5/26 at 9:45 a.m., Resident 70 was observed lying in bed. She was able to make eye contact but did not speak when spoken to. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/26 at 3:49 p.m., Resident 70 was lying in bed. She was non-verbal. She did not follow directions when she was asked to take a drink of fluids that was on her bedside to the left side of the bed. Her mouth appeared to be dry. On 1/7/26 at 2:02 p.m., a record review was completed for Resident 70. She had the following diagnoses which included but were not limited to hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke), hyperlipidemia (high cholesterol), and dysphagia (difficulty swallowing). Resident 70 was prescribed furosemide (diuretic) and spironolactone (diuretic) with a start date of 10/19/25. Her record lacked a care plan addressing the potential for dehydration related to taking diuretics. On 1/12/26 at 12:10 p.m., the Director of Nursing indicated the care plans were added to the resident's records. A policy titled, Care Planning with a revision date of 10/24/22 was provided by the Executive Director (ED) on 1/8/26 at 2:32 p.m. It indicated, .Each resident's comprehensive care plan will describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. 3.1-35(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure staff provided services according to professional standards of care when a resident's wound care orders were transcribed incorrectly or not transcribed at all (Resident 5), a resident's prophylactic antibiotics were not reordered resulting in a delay in surgery (Resident K), when staff failed to administer medications at appropriate times recommended by the manufacturer (Resident 31 and 69), and when an antidepressant had an inaccurate diagnosis for use (Resident 94) for 5 of 78 residents reviewed for professional standards of care concerns. Findings include: 1. On 1/7/26 at 11:22 a.m. Resident 5's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, a pressure ulcer to the sacral (tailbone) region. Resident 5 had a recently amputated fifth toe (pinky toe) on her left foot with sutures still intact. A progress note, dated 12/23/25, indicated during a dressing change a Deep Tissue Injury (DTI) was noted below the suture site. Resident 5's Medication Administration Record (MAR), as of 1/7/26, indicated the ordered wound care instructions for her left fifth digit were to cleanse the left foot fifth digit with normal saline, pat it dry, paint it with betadine, then apply silver alginate (a wound dressing combining absorbent alginate fibers with antimicrobial silver) to the wound bed, cover with an Abdominal (ABD) pad (a highly absorbent, multilayered medical dressing used for large, heavily draining wounds), and wrap with kerlix and secure with an ace wrap. A hospital health wound clinic note, dated 12/29/25, indicated Resident 5 had a wound to her lateral left foot (the outer edge of the left foot stretching from the heel to the little toe). The note indicated the wound care instructions for that wound were to cleanse the wound with wound cleaner, pat dry with a gauze, paint the eschar (dead scabbed skin) with betadine (a widely used topical antiseptic that kills bacteria, viruses, and fungi), apply moistened Acticoat (a silver-coated calcium alginate fabric) to the wound and sutures, apply an absorbent dressing, and secure with rolled gauze or kerlix and tape. Resident 5's MAR, as of 1/7/26, indicated the ordered wound care for her left heel should be done every three days and as needed for soilage or dislodgement, every dayshift, every other day for pressure on heels. A hospital health wound clinic note, dated 12/29/25, indicated Resident 5 had a wound to her left heel. The note indicated the wound care for that wound should be done every three days and as needed for soilage or dislodgment. A hospital health wound clinic note, dated 12/29/25, indicated Resident 5 was to off-load her sacrum completely by turning her every two hours side to side only, spending no time on her back while in bed. Resident 5's current MAR, as of 1/7/26, lacked an order to off-load her sacrum completely by turning her every two hours side to side only, spending no time on her back while in bed. During an interview on 1/12/26 at 12:44 p.m. the wound nurse indicated when the wound clinic sent over new wound care instructions, she was the person responsible for transcribing the orders into the medical record. She was unaware there were orders to only turn Resident 5 from side to side and for (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her to never be on her back while in bed. She indicated she was going to put that order in as well. 2. On 1/9/26 at 11:44 a.m. Resident K indicated the facility told them the prophylactic antibiotics they needed to take prior to their surgery had not come in from the pharmacy yet. The resident indicated it had been so long that their surgeon had to push their surgery back from Friday 1/9/26 to Monday 1/12/26. On 1/9/26 at 12:29 p.m. the Unit Manager (UM) indicated the surgery center originally ordered amoxicillin, but the resident had an allergy to that medication. The UM indicated she called, and they ordered ciprofloxacin that would be delivered that night ensuring Resident K's surgery would be able to move forward on Monday still. The UM indicated she didn't know why the new medication hadn't been ordered, or why no one followed up on it. 3. On 1/7/26 at 11:22 a.m., a record review was completed for Resident 31. She had the following diagnoses which included but were not limited to hypothyroidism, diabetes type 2, and depression. She had an order for levothyroxine 75 micrograms (mcg) one time daily for hypothyroidism. On 1/7/26 at 9:06 a.m., during medication administration observation, RN 26 administered levothyroxine to Resident 31 after she consumed breakfast and with her other medications. On 1/7/26 at 10:00 a.m., during an interview the Nurse Practitioner (NP) indicated residents should have levothyroxine prior to breakfast and by itself. Taking the medication after eating would alter the resident's thyroid levels. On 1/7/26 at 3:13 p.m., a message was received by the Pharmacist indicating levothyroxine should be administered consistently in the morning on an empty stomach at least 30 to 60 minutes before meals. On 1/7/26 at 2:14 p.m., the Director of Nursing (DON) indicated they do not have a policy regarding administration of levothyroxine. 4. On 1/7/26 at 12:36 p.m. a record review was completed for Resident 69. She had the following diagnoses which included but were not limited to anxiety disorder, hyperlipidemia (high cholesterol), major depressive disorder, and hypertension. On 1/7/26 at 8:45 a.m., during the medication administration observation, RN 26 administered omeprazole after the resident consumed breakfast and with her other medications. She had an order for omeprazole 20mg (milligram) one time daily for gastro-esophageal reflux disease (when stomach acid flows back up into the esophagus and causes heartburn). On 1/7/26 at 3:13 p.m., a message was received by the Pharmacist indicating omeprazole should be administered 30 to 60 minutes before a meal. On 1/7/26 at 2:14 p.m., the Director of Nursing (DON) indicated they do not have a policy regarding administration of omeprazole. 5. On 1/8/26 at 9:57 a.m., a record review was completed for Resident 94. She had the following (continued on next page)

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	155206	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses which included, but not limited to, type 2 diabetes, hypertension, chronic kidney disease, hyperlipidemia (high cholesterol), and restless leg syndrome (RLS). Resident 94 had an order, dated 12/31/25, for duloxetine HCl oral capsule delayed release sprinkle 60 milligrams (mg) one time daily for depression. The resident's record lacked documentation of a depression diagnosis. On 1/8/26 at 3:02 p.m., during an interview, the Director of Nursing (DON) indicated she would have to look into the resident's medication order. On 1/9/26 at 10:03 a.m., a note was received from the DON indicating the duloxetine was for RLS not depression. On 1/9/26 at 10:27 a.m., during an interview, the Unit Manager (UM) indicated the resident did not have a diagnosis of depression. The diagnosis for the order was changed to RLS verses depression. A policy titled, Psychotherapeutic Drug Management was provided by the Executive Director (ED) on 1/9/26 at 3:02 p.m. It indicated, .To ensure the resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition. 3.1-35(g) 3.1-35(l)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure non-pressure related wound dressings were changed appropriately and according to physician's orders for 1 of 1 residents (Resident K) reviewed for non-pressure related wound concerns.Findings include: On 1/8/26 at 12:48 p.m. Resident K's wound dressings were observed with the Director of Nursing (DON). Resident K had dressings just under their belly button and on their right outer ankle bone covering open blister wounds that were both dated 12/31/25. The dressing on their right outer ankle had visible bloody drainage on the outside of the dressing. Resident K also had dressings on his left elbow and left heel that had no date on them. On 1/9/26 at 1:16 p.m. Resident K's medical record was reviewed. He was a long-term care Resident whose diagnoses included but were not limited to non-pressure chronic ulcer of the right lower leg. Resident K had an active order to cleanse the wound on their left heel with normal saline, pat it dry and apply a foam dressing every Monday, Wednesday, Friday and every 8 hours as needed with a start date of 7/4/25. Resident K had an active order to cleanse the wound on their mid abdomen with normal saline, pat it dry, apply calcium alginate (a natural water-insoluble gel derived from seaweed) to the wound bed and apply a foam dressing daily and as needed for soilage or dislodgment with a start date of 12/24/25. Resident K had an active order to cleanse the wound on his left elbow with normal saline, pat dry, apply Santyl (a prescription medication used to remove dead skin tissue from chronic wounds to promote healing.) then calcium alginate and apply an adhesive dressing daily and as needed for soilage or dislodgment with a start date of 12/24/25. Resident K had an active order to cleanse the wound on his right outer ankle with normal saline, apply calcium alginate and Santyl to the wound bed and apply a foam dressing daily with a start date of 12/25/25. Resident K had an active order for behavior monitoring every shift. The target behaviors for this monitoring included but were not limited to refusing wound care. During an interview on 1/8/26 at 12:52 p.m. the DON indicated Resident K would often refuse his dressing changes, and he was away from the facility with family from 12/31/25 to 1/5/26, but that it was her expectation that those dressings would have been changed immediately upon the resident's return to the facility or as soon as the resident would allow them to. During an interview on 1/12/26 at 12:45 p.m. the Wound Nurse indicated she did weekly wound rounds where she did the dressing changes and associated tasks, outside of that it was the floor nurses' responsibility to do any other dressing changes as ordered. The Wound Nurse indicated Resident K's dressings should have been changed immediately upon their return to the facility however, she indicated Resident K did refuse dressing changes most of the time. Resident K's behavior monitoring for the months of December 2025 and January 2026 were reviewed and it lacked documentation that he had exhibited any of the target behaviors on the list, including refusing wound care. On 1/9/26 at 3:05 p.m. a copy of a current facility policy titled, Wound Management dated 6/2020 was provided. That policy indicated, .Purpose [of this policy is] to provide a system for the treatment and management of resident wounds including.non-pressure injury. A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection. This citation relates to 2638762 and 2595596. 3.1-37

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure proper wound care and positioning was done according to physician orders for 1 of 5 residents (Resident 5) reviewed for pressure ulcer concerns. Findings include:On 1/7/26 at 11:44 a.m. Resident 5's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to a pressure ulcer to the sacral (tailbone) region. Resident 5 had a recently amputated fifth toe (pinky toe) on her left foot with sutures still intact.A progress note, dated 12/23/25, indicated during a dressing change a Deep Tissue Injury (DTI) was noted below the left lateral suture site.An IU Health Wound Clinic note dated 12/29/25 indicated Resident 5 had a wound to her lateral left foot (the outer edge of the left foot stretching from the heel to the little toe). The note indicated the wound care instructions for that wound were to cleanse the wound with wound cleaner, pat dry with a gauze, paint the eschar (dead, scabbed skin) with betadine (a widely used topical antiseptic that kills bacteria, viruses, and fungi), apply moistened Acticoat (a silver-coated calcium alginate fabric) to the wound and sutures, and apply an absorbent dressing and secure with rolled gauze or kerlix and tape.A hospital Health Wound Clinic note, dated 12/29/25, indicated Resident 5 had a wound to her left heel. The note indicated the wound care instructions for that wound were to cleanse the wound with wound cleanser, pat dry with a gauze, put Iodosorb gel on a flat gauze over the wound bed, cover it with an absorbent dressing and secure with rolled gauze or kerlix and tape.A hospital Health Wound Clinic note, dated 12/29/25, indicated Resident 5 was to off-load her sacrum completely by turning her every two hours side to side only, spending no time on her back while in bed. On 1/9/26 at 9:08 a.m. the Wound Nurse, the Unit Manager and a visiting nurse there for training in wound care were observed as they started Resident 5's dressing changes. Upon entering the room, the Resident was observed laying on her back in bed with pressure relieving boots on both feet. When the Wound Nurse took the old dressing off it was observed that the old dressing covering Resident 5's heel and lateral left foot did not have ABD pads on them and her heel also did not have the gauze with Iodosorb gel on it. The Wound Nurse indicated that this was wrong and the floor nurse who did the dressing last must have done the dressing change wrong. When putting the new dressing on Resident 5's lateral left foot, the wound nurse tore a piece of silver alginate (a highly absorbent, antimicrobial wound dressing made from seaweed and silver) in half, using one half for the DTI and throwing the other piece away. No wound care was done directly to the sutures. At that time, two wedge pillows were observed sitting on the resident's dresser across the room from the bed. After finishing the dressing changes the Wound Nurse, Unit Manager, and visiting nurse left Resident 5 on her back before leaving the room.On 1/9/26 at 3:05 p.m. a copy of a current facility policy titled, Wound Management dated 6/2020 was provided. That policy indicated, .Purpose [of this policy is] to provide a system for the treatment and management of resident wounds including pressure and non-pressure injury. A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection. ll. Wound Management.F. Per attending physician order, the nursing staff will initiate treatment and utilize interventions for pressure redistribution and wound management.This citation relates to 2638762 and 2595596.3.1-40

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to remove a resident's supplements from his room and failed to ensure a resident's enabler bars were at a safe distance from her mattress for 2 of 5 residents reviewed for accidents (Resident 9 and 3).Findings include:1. On 1/5/25 at 10:13 a.m., Resident 9 was lying in his bed. He was unable to move his body. He used an eye gaze computer to communicate with others. On his table there was a large number of supplements. He indicated he took those supplements daily. The supplements included: IS [NAME], biocidin liquid, para 3, LB/GB Complex, Inflammatone, HM-ET Binder, ProbioMed 50, IS [NAME], primal multi, olive oil, vitamin D, Para 1, cyanocobalamin, menaquinone, argine (L argine), and magnesium.On 1/7/26 at 2:39 p.m., a record review was completed for Resident 9. He had the following diagnoses which included but were not limited to amyotrophic lateral sclerosis (ALS) (a progressive neurodegenerative disease that attacks motor neurons in the brain and spinal cord, causing them to die, which stops the brain from controlling voluntary muscles like those for walking, talking, swallowing, and breathing), dysphagia (difficulty swallowing), abnormal weight loss, and obstructive sleep apnea.His record lacked a self-administration assessment for medications.He had a care plan, dated 1/5/26, indicating he prefers to buy supplements online from Amazon and keep them in his room on the table in basket. MD (Medical Doctor) orders reflected on MAR (Medication Administration Record), however resident advises staff on how he would prefer to take them. On 1/8/26 at 9:55 a.m., during an interview with the Director of Nursing (DON), she indicated they removed his supplements from bedside.2. On 1/7/26 at 2:59 p.m., the DON was made aware of concerns with grab bars being too far away from the mattress leading to the potential for entrapment. The Regional Nurse Consultant, DON, Medical Records, and Unit Manager (UM) went to the room. The frame was a bariatric frame and was pulled in. Medical Records was under the bed adjusting the frame to a regular sized frame. The gaps between the grab bar and mattress on the left side was 2 inches. On the right, the gap was 3 inches. The UM lowered the grab bars in order to keep the resident safe.On 1/6/26 at 10:02 a.m., a record review was completed for Resident 3. She had the following diagnoses which included but were not limited to fracture of right lower leg, fracture of left leg, type 2 diabetes mellitus, hypertension, chronic kidney disease, hyperlipidemia (high cholesterol), cerebral infarction with hemiplegia and hemiparesis affecting left non-dominant side (stroke with paralysis and weakness), and muscle weakness.The resident's care plan lacked addressing the grab bars.A policy titled, Bedside Storage of Medications was provided by the Executive Director (ED) on 1/8/26 at 3:27 p.m. It indicated, .Bedside medication storage is permitted for sublingual and inhaled emergency medications and for residents who are able to self-administer upon the written order of the prescriber and when it is deemed appropriate in the judgement of the facilities assessment team.A policy for side rails was not provided by the facility at the end of exit. 3.1-45(a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, interviews and record review the facility failed to ensure a resident (Resident K) received their prescribed Oxycodone for 1 of 1 residents reviewed for pain management. Findings include: On 1/5/26 at 10:45 a.m. Resident K was observed as they sat in their recliner in their room. Resident K appeared to be very thin and frail but was in good spirits and able to have a conversation. Resident K spoke fondly of the dietary staff and indicated the floor staff were good for the most part but there were a few who he didn't care for. At the time of this observation Resident K did not elaborate on those staff members who he didn't care for. On 1/8/26 at 12:22 p.m. the Ombudsman indicated Resident K told her the facility had discontinued his pain medication and issued them a 30-day notice for discharge due to drug test results that the facility determined indicated Resident K had been abusing his opiate pain medication. On 1/8/26 at 12:48 p.m. Resident K was observed as they sat in their recliner in their room. The resident became tearful and indicated when we spoke previously, they had not been as forthcoming about their concerns as they should have been. The resident indicated they feared that staff may have been standing outside the door listening to our previous conversation and they feared retaliation from the facility if they spoke up about their concerns. Resident K indicated the facility performed a drug test on the resident due to suspicions of illegal drug use related to complaints of a marijuana smell coming from the hallway where their room resided. Resident K explained the blood drug test came back positive for THC (marijuana) but negative for Oxycodone, the opiate the resident was prescribed for pain. The resident had no idea how they could have tested negative for Oxycodone, but they did indicate sometimes they did not receive the medication as often as was prescribed. At the end of this interview Resident K was tearful and expressed a sense of relief after being honest about their concerns. On 1/9/26 at 1:16 p.m. Resident K's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to Chronic Obstructive Pulmonary Disease (COPD). Resident K had an active order for one tablet Oxycodone (opiate pain medication)15 milligrams (mg) tablets 4 times a day scheduled for moderate to severe pain with a start date of 6/10/25.A progress note, dated 12/23/25 at 3:49 p.m., written by the Director of Nursing (DON) indicated a visitor complained of a marijuana smell coming from the hallway Resident K's room was in. The note explains that the DON and Administrator noted the smell appeared to be stronger the closer to Resident K's room they got. Resident K was honest about their use of marijuana and agreed to be drug tested. A progress note, dated 12/23/25 at 4:25 p.m., indicated a urine drug test was obtained from Resident K and it was positive for THC and Oxycodone. Resident K's blood drug test results collected on 12/24/25 resulted on 1/2/26 indicated Resident K was positive for THC and negative for Oxycodone. On 12/17/25 Resident K's Electronic Medication Administration Record (EMAR) indicated they received their Oxycodone four times as prescribed. Resident K's narcotic sign off sheet indicated they only received 3 Oxycodone's on 12/17/25. On 12/18/25 Resident K's EMAR indicated they received their Oxycodone four times as prescribed. Resident K's narcotic sign off sheet indicated they only received 3 Oxycodone's on 12/18/25. On 12/19/25 Resident K's EMAR indicated they received their Oxycodone four times as prescribed. Resident K's narcotic sign off sheet indicated they only received 3 Oxycodone's on 12/19/25. On 12/22/25 Resident K's EMAR indicated they received their Oxycodone four times as prescribed. Resident K's narcotic sign off sheet indicated they only received 2 Oxycodone's on 12/22/25. On 12/23/25 Resident K's EMAR indicated they received their Oxycodone four times as prescribed. Resident K's narcotic sign off sheet indicated they only received 3 Oxycodone's on 12/23/25. On 12/24/25 Resident K's EMAR indicated they received their Oxycodone four times as prescribed. Resident K's narcotic sign off sheet indicated they only received 3 Oxycodone's on (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/24/25. On Resident K's narcotic sign off sheet there was a discrepancy where the remaining balance on 12/25/25 at 12:00p.m. had been changed from 17 to 13. Next to the remaining balance on 12/25/25 at 12:00 p.m. there was a note saying Sat (5) with illegible letters underneath.An EMAR note related to Resident K's Oxycodone, dated 12/25/25 at 1:30 p.m., indicated Resident K was out of the facility and that medication was sent with them. The note did not specify the amount of medication that was sent with the resident in the note. Resident K's narcotic sign off sheet indicated the Resident received one Oxycodone on 12/27/25 at 9:00 a.m. Resident K's progress notes indicated they were on a leave of absence from 12/25/25 at 12:15 p.m. until 12/29/25 at 6:32 a.m. On 12/29/25 Resident K's EMAR indicated they received their Oxycodone four times as prescribed. Resident K's narcotic sign off sheet indicated they only received 3 Oxycodone's on 12/29/25. On 12/30/25 Resident K's EMAR indicated they received their Oxycodone four times as prescribed. Resident K's narcotic sign off sheet indicated they only received 3 Oxycodone's on 12/30/25. Resident K's narcotic sign off sheet for the administration of their Oxycodone from 12/13/25 to 1/1/26 had a note at the bottom that indicated 3 Oxycodone 15mg [milligram] tabs received by [Resident K's father's signature] Residents father. That note was dated 1/1/26. Resident K's January EMAR indicated on 1/6/26 the Oxycodone order was discontinued. A progress note, dated 1/7/26, indicated Resident K and their father were informed of the need to be discharged 30 days from that day due to violating the illegal drug use policy. On 1/9/26 at 11:44 a.m. Resident K was observed as they sat in their recliner resting with their eyes closed. The resident had the lights off, their shoulders were drawn into themselves, and they appeared paler than the day before. Resident K's lunch tray was on their bedside table in front of them, but it had not been touched and there was a note on top indicating to leave it there for later because they were nauseated. Resident K indicated they had been feeling very sick since the previous night and became tearful, indicating they had not been able to keep anything down.During an interview on 1/9/26 at 2:20 p.m. the DON indicated the Nurse Practitioner (NP) discontinued Resident K's Oxycodone because they suspected the Resident was pocketing them in order to sell or trade them for marijuana. The DON indicated they had drug tested Resident K and he was positive for THC but negative for his prescribed opiate, so they assumed he had to be pocketing them. During an interview on 1/9/26 at 2:35 p.m. Registered Nurse (RN) 7 indicated on 1/1/26 Resident K's father came into the facility without the resident requesting more medications for Resident K because they were going to be away from the facility for longer than anticipated. RN 7 indicated she thought his behavior was strange, but she gave him the remaining 3 Oxycodone's and had him sign the bottom of the narcotic sheet as proof. The DON indicated they did not explore other explanations for the discrepancy between the urine and blood drug tests.The record lacked documentation of Resident K's father being in the facility to pick up medication on 12/25/25. During an interview on 1/12/26 at 11:55 a.m. the Corporate RN indicated there were some blood drug tests that allowed for a therapeutic level of certain medications if they were prescribed medications. She indicated that would mean if the resident was in the therapeutic range for Oxycodone, he should test negative for Oxycodone because that would mean the resident was not abusing the medication. During an interview on 1/13/26 at 9:19 a.m. the DON indicated she spoke with the nurse who signed the narcotic sheet on 12/27/25 and that nurse indicated Resident K's father had come into the facility to get more medications because they were going to be away from the facility longer than expected. The DON indicated the note to the side of the remaining balance on 12/25/25 at 12:00 p.m. was from the nurse who signed off that administration. She indicated that nurse wrote that because before Resident K left the facility for a leave of absence on 12/25/25 they were given 5 Oxycodone's to take with them. The DON indicated she would be doing education on appropriate medication (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	distribution when a resident went on a leave of absence, and they were starting an investigation into the confusion with the narcotic sign offs and potentially missing Oxycodones. The record lacked documentation of Resident K's father being in the facility to pick up medication on 12/27/25. On 1/13/26 at 11:57 a.m. a copy of a current facility policy titled, Pain Management dated 6/2020 was provided. That policy indicated, .ll. Pain Management A. The Licensed Nurse will administer pain medications as ordered. This citation relates to 2638762 and 2595596. 3.1-37(a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record reviews, the facility failed to provide RN coverage per the facility assessment, failed to ensure adequate staffing on the memory care (dementia) unit, and failed to ensure adequate staffing to answer call lights and provide showers. This deficient practice had the potential to affect 78 of 78 residents residing in the facility. Findings include:1. Upon the survey entrance on 1/5/26 at 10:00 a.m., the Executive Director (ED) provided a copy of the Facility Assessment. Per the assessment, the facility required a minimum PPD (how many hours are spent with a patient per day) for Registered Nurses (RN) of 0.54 hours daily. A copy of the schedules requested were provided by the Executive Director (ED) on 1/5/26 at 10:33 a.m. Upon reviewing the nursing staffing schedules, the facility did not meet its minimum RN coverage PPD on the following dates: 7/27/25, 11/20/25, 12/3/25, 12/4/25, 12/5/25, 12/6/25, 1/5/26, 1/6/26, 1/7/26, 1/8/26, and 1/9/26. On 1/12/26 at 1:42 p.m. The Regional Nurse Consultant (RNC) indicated there should be at least two staff members on the memory care unit at night. Upon review of the nursing staffing schedules, the facility did not staff the memory care unit with an adequate number of staff for night shift by using one Certified Nursing Assistant (CNA) or one Qualified Nursing Assistant (QMA) on the following dates: 7/27/25, 11/20/25, 12/3/25, 12/4/25, 12/5/25, 12/6/25, 12/7/25, 1/5/26, 1/6/26, 1/7/26, 1/8/26, 1/9/26. This staff member was to provide nursing and nursing assistant duties to a total of 14 residents on the night shift. 2. On 1/5/26 at 10:35 a.m., upon initial observation of the secured memory care unit, no staff were present in the main dining/activity room. Resident E was seated in a chair at a table and Resident D was seated in her wheelchair at a separate table with her back to Resident E. On 1/5/26 at 10:40 a.m., Qualified Medication Aide (QMA) 13 entered the unit in a hurry and indicated in general to the gathered residents in the dining room, let's see what they have going on for you guys. I have no idea, and stated she was just going to wing it, indicating she had been pulled to multiple assignments that morning. During an interview on 1/5/26 at 10:45 a.m., QMA 13 indicated she worked all over the building and sometimes helped out in memory care. She indicated they were short staffed that morning so she was pulled in a thousand different directions but had been asked to help with activities in the memory care unit. On 1/6/26 at 8:53 a.m., Certified Nursing Aide (CNA) 15 was observed working on the memory care hall. She indicated, usually helped with weights, for the long-term care halls, and had never worked in the memory care unit. She indicated she was pulled to help but was not provided a CNA assignment sheet, so she would just ask the nurse about the resident's as needed. On 1/6/26 at 9:00 a.m., the main dining/activity room of the secured memory care unit was observed. There were seven residents present, the TV was on, and an unidentified housekeeper was observed cleaning the floors. There were no direct care staff present. Resident D was seated in her wheelchair at a table with three peers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/6/26 at 9:22 a.m., Resident E was observed at a table in the main dining room area. She was lightly engaged in a coloring activity. She only participated when encouraged and stopped her activity to watch the other residents. Resident D was seated at a separate table, not engaged in the activity. During this activity, staff were in and out of the dining room, as the nurse passed medications and the CNA provided incontinent/ADL care. During an interview on 1/6/26 at 10:40 a.m., Resident D's family member indicated Resident D had experienced three falls during the previous year, the most serious fall was a result of being pushed down by another resident. The family member indicated the other resident apparently didn't like Resident D and pushed her which caused her to fall and strike a rail. This incident resulted in a busted lip that required stitches. The family member indicated Resident D had been walking independently prior to the incident but became weak following the hospitalization and was no longer safe to walk independently. The family member confirmed Resident D sustained facial and rib fractures from the incident and expressed concern that Resident D was not protected from harm. On 1/7/26 at 8:42 a.m., Licensed Practical Nurse (LPN) 16 indicated she was assigned to the memory care unit that morning. She did not usually work on the unit and was not sure about the residents' routines, preferences, or behaviors. On 1/7/26 at 11:27 a.m., no staff were present in the main dining/activity room, where residents were seated with the Daily Chronicle and coloring materials. Resident D was seated in her wheelchair at a table with one peer. On 1/7/26 at 2:43 p.m., Resident E was observed unsupervised as she independently ambulated from her room, across the hall, into another resident's room, then walked into the dining room and asked when it was mealtime. During an interview on 1/7/26 at 3:17 p.m., the Assistant Director of Nursing (ADON) was working as the nurse on the floor in the secured memory care unit. He indicated it was not his usual assignment to be in the memory care unit and he was not familiar with the residents. He could not speak to Resident D or Resident E's routines, preferences, behaviors and/or potential for altercations. During an interview on 1/7/26 at 3:20 p.m., CNA 18 demonstrated a significant language barrier and was unable to understand or respond to questions regarding resident behaviors and safety concerns. During an interview on 1/8/25 at 9:25 a.m., LPN 27 indicated there was usually only one Nurse or QMA in the memory care unit to pass medication, and only one CNA. She thought it would be helpful to have at least 2 CNAs and an activity aide. On 1/9/26 at 9:35 a.m., LPN 27 was observed repeatedly leaving her medication administration tasks to monitor residents in the dining room due to lack of staff supervision. On 1/9/226 at 10:58 a.m., Resident F indicated she needed to use the bathroom. LPN 27 was the only staff member on the unit and told her she would have to wait for someone else to come back to the unit to supervise the dining/activity room because staff could not leave the dining room unattended. Cross Reference F600 and F744. 3. A review of grievances, dated July 2025 through December 2025, revealed multiple repeated (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	complaints across residents demonstrating a pattern of unresolved systemic issues which included, but were not limited to: Call light response time and staff attitude, missed or delayed showers and complaints about ADL (activities of daily living) care, and short staffing or staffing concerns. Fourteen of the twenty-three grievances reviewed were direct complaints about call lights response time and/or staff attitude. Grievances filed on 8/19/25, 8/28/25, 9/5/25, 9/13/25, 9/22/25, 9/27/25, and 10/22/25 alleged showers were not received, staff refused to give them showers, shower days were missed, or residents were told the facility was too short staffed to give the shower at the scheduled time. Grievances filed on 8/28/25, 9/9/25, 9/18/25, 9/30/25, 10/22/25, and 11/12/25 identified ongoing concerns related to inadequate staffing, including statements that staff were unavailable, residents were told staff were too busy to assist, or care could not be provided as scheduled. These grievances were accompanied by repeated reports of missed or delayed ADL care, including bathing and toileting assistance, as well as prolonged call light response times. Cross reference F656. A policy titled, Secure Care Neighborhood with a revision date of 7/24 was provided by the Executive Director (ED) on 1/9/26 at 3:05 p.m. It indicated, .The secure care neighborhood will be staffed to meet the needs of the residents residing in the neighborhood.The facility who has a secure neighborhood (secure unit) will provide therapeutic staffing to meet the needs of the residents who reside in the secured area. A policy titled, Nursing Department-Staffing, Scheduling and Postings with a revision date of 1/25 was provided by the ED on 1/9/26 at 3:05 p.m. It indicated, .In staffing, an adequate number of nursing service personnel, scheduling will be done as needed to meet resident needs and will account for the number, acuity, and diagnoses the facilities resident populations. This citation relates to Intake 2611908. 3.1-17(a) 3.1-17(b)(1)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide consistent, knowledgeable staffing, adequate supervision, and meaningful dementia appropriate activities on the Memory Care (MC) unit. This deficient practice had the potential to affect 14 of 14 residents residing on the Memory Care Unit. Findings include: 1. Upon initial entrance into the memory care unit on 1/5/26 at 10:30 a.m., seven residents were seated in the MC dining room with no staff present. On 1/5/26 at 10:40 a.m., Qualified Medication Aide (QMA) 13 entered the unit in a rush and indicated to the several residents gathered in the main dining/activity room, let's see what they have going on for you guys, I have no idea. She briefly looked at the posted activity calendar, then went to the nurses station and returned with a rolling cart. She indicated she was, just going to wing it, as she started passing coffee and snacks and visiting with residents. During an interview on 1/5/26 at 10:45 a.m., QMA 13 indicated she worked all over the building and sometimes helped in memory care. She indicated they were short staffed that morning. So she was pulled in a thousand different directions but had been asked to help with activities in the memory care unit. On 1/6/26 at 8:53 a.m., Certified Nursing [NAME] (CNA) 15 was observed working on the memory care hall. She indicated she usually helped with weights, for the long-term care halls, and had never worked in the memory care unit. She indicated she was pulled to help but was not provided a CNA assignment sheet. So, she would just ask the nurse about the resident's as needed. On 1/7/26 at 8:42 a.m., Licensed Practical Nurse (LP) 16 indicated she was assigned that morning to the memory care unit and that she did not normally work on the unit. She did not know the residents very well the nurse assigned to Memory Care. On 1/7/26 at 11:27 a.m., several residents were seated in the MC's main dining/activity room with no staff supervision. On 1/7/26 at 2:43 p.m., Resident C exited her room and entered another resident's room unsupervised. During an interview on 1/8/25 at 9:25 a.m., LPN 27 indicated there was usually only one Nurse or QMA in the memory care unit to pass medication, and only one CNA. She thought it would be helpful to have at least two CNAs and an activity aide. On 1/9/26 at 9:35 a.m., LPN 27, was observed repeatedly leaving her medication administration tasks to monitor residents in the dining room due to lack of staff supervision. On 1/9/26 at 10:30 a.m., the admission Coordinator left the unit for a pre-scheduled meeting while the nurse was passing medications and the CNA was giving showers. This left seven residents unsupervised in the main dining/activity room. On 1/9/226 at 10:58 a.m., Resident F indicated she needed to use the bathroom. LPN 27 was the only staff member on the unit and told her she would have to wait for someone else to come back to the unit to supervise the dining/activity room because staff could not leave the dining room unattended. On 1/12/26 at 10:50 a.m., the nurse was off the unit and the CNA was in a resident's room providing care. This left five residents in the main dining/activity room unsupervised and with no structured activity occurring. 2. Throughout the survey period, activities on the MC unit were largely limited to, repetitive coloring pages, daily Chronicle readings, and television, regardless of resident interest or engagement. On 1/5/26 at 10:40 a.m., Qualified Medication Aide (QMA) 13 entered the unit in a rush and indicated to the several residents gathered in the main dining/activity room, let's see what they have going on for you guys, I have no idea. She briefly looked at the posted activity calendar, then went to the nurses station and returned with a rolling cart. She indicated she was, just going to wing it, as she started passing coffee and snacks and visiting with residents. On 1/6/26 between 9:22 a.m. and 9:30 a.m., Residents 35 and 20 repeatedly indicated they did not want to color, yet staff continued placing coloring pages in front of them and coloring themselves while residents remained disengaged. On 1/7/2026 at 8:47 a.m., Resident 48 was observed (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	falling asleep at the table with a crayon in her hand, while others sat disengaged with the television on. During an interview on 1/9/26 at 9:25 a.m., LPN 27 indicated the Activity Director was out sick, and activities were usually limited to coloring and reading, and that several residents just sleep a lot and did not enjoy the activities being offered. The activity calendar was reviewed and revealed the following:No structured activities were scheduled or implemented on the unit after 3:00 p.m., and there was no evidence of a routine, therapeutic programming, or alternative interventions in place to address residents with dementia who may experience Sundowning, (increased confusion, agitation, or agitation during the late afternoon and evening hours). On 1/8/26 an Afternoon Stroll was scheduled for 3:00 p.m. Even with repeated staff and resident remarks about how nice the weather was, no one was available or attempted to take the residents outside. An Arts & Crafts type activity was schedule on 1/5/26, 1/6/26, and 1/7/26. Each day, the same coloring activity was repeatedly offered. On On 1/9/26 at 2:30 p.m., the ADM provided a copy of current facility policy titled, Secured Care Neighborhood, dated/revised, 7/2024. The policy indicated, The goal of the Secure Care Neighborhood is to meet the individual needs of residents with cognition or dementia related illness and are at risk for elopement. The Secure Care Neighborhood will provide a safe environment that maximizes independence and provides an activity intensive atmosphere. The facility who has a Secure Care Neighborhood (Secured Unit) will provide therapeutic staffing to meet the needs of the residents who reside in the Secured Area. Trained staff will provide residents consistent staff members that promote an active environment designed to meet the individual needs of the residents. A comprehensive activity program will be designed to enhance the ability to espresso feelings, maintain social skills, develop a sense of belonging, improve self-esteem, self-confidence and quality of life for the residents who reside in the neighborhood. 3.1-37

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to date and remove expired medications from use for 3 of 4 medication carts observed for medication storage and 1 of 1 medication room observed for medication storage.Findings include:On 1/5/26 at 12:07 p.m., the 1,2 and 3 hall medication cart was observed. Resident 38 had an albuterol inhaler 0.83% in the cart with no date to indicate when it was opened. Hydrocortisone (steroid)cream was in the medication cart. The 400-hall medication cart was observed. Hydrocortisone cream was in the medication cart. Resident 8 had an insulin pen, Lantus in the cart with a date of 11/26/25. It expired. Diclofenac (nonsteroidal anti-inflammatory pain reliever) cream was stored with Miralax (laxative) oral powder. Resident 6 had hydrocortisone cream in the medication cart. He had a Novolog (insulin) kwikpen in the cart dated 12/1/25. It was expired. The 7 and 8 hall medication room had a normal saline bottle in the refrigerator. It lacked a date to indicate when it was opened. The Unit Manager indicated the saline was expired and removed the saline from use.RN 7 indicated the insulin pens were expired and removed the expired insulin pens from use.The facility did not provide a policy for medication storage at the time of exit. 3.1-25(j)3.1-25(m)3.1-25(n)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) program to identify, analyze, and correct systemic quality and safety issues. This failure resulted in the facility's inability to prevent recurrence of known problems and contributed to harm-level and Immediate Jeopardy deficiencies. This deficient practice had the potential to affect 78 of 78 residents who resided in the facility. Findings include:During interview on 1/12/26 at 11:21 a.m., the Regional Director of Operation (RDO) and the Regional Nurse Consultant, (RNC) indicated the faculty had failed to effectively incorporate a QAPI program to help mitigate deficiencies that were identified during the survey period. The Regional Director of Operation (RDO) and the Regional Nurse Consultant, (RNC) acknowledged that under the prior administration, required corporate and facility processes for incident reporting, investigation, and interdisciplinary team (IDT) oversight were not followed. They confirmed that adverse incidents and reportable events were frequently managed in a vacuum, without IDT involvement, administrative awareness, or appropriate investigation, tracking, or follow-up. Leadership stated that the facility failed to utilize the corporate Adverse Incident Reporting (AIR) process, resulting in incidents not being reported, tracked, or reviewed through required quality assurance mechanisms. During the previous administrator's employment, there had been increased leadership turnover and administrative leave without effective transition plans or delegation of responsibilities put into place to ensure continuity of oversight. Incoming administrative and clinical leaders reported they were unaware of ongoing incidents, investigations, or regulatory requirements until after survey activity occurred. Leadership acknowledged that previous training, onboarding, and supervision of key personnel, including the Director of Nursing and Administrator, had been insufficient, and moving forward both the RDO and RNC would be working closely with IDT to correct these deficiencies. The RDO and RNC indicated that these administrative failures resulted in a lack of timely investigations, inadequate care planning, insufficient staff education, and failure to identify and correct systemic issues related to abuse allegations, staffing concerns, pressure injuries, and resident-to-resident altercations. During interview on 1/12/26 at 1:46 p.m., the Administrator (ADM) indicated he was interim and had only been in the building about a week prior to survey. He had the opportunity to briefly review the QAPI documentation and although QAPI meetings were convened on a regular basis, he was unable to identify effective actions to mitigate many concerns that had been identified during the survey period. Ad hoc quality reviews had recently been initiated (e.g., boiler safety, resident smoking practices, medication storage, housekeeping concerns), but these reviews were reactive, limited in scope, and not part of a comprehensive, data-driven QAPI program. The Administrator confirmed that identified concerns were not consistently subjected to formal root cause analysis, measurable action plans, or ongoing effectiveness monitoring prior to survey involvement. The Administrator indicated grievances related to staffing, call light response times, staff attitude, showers, and basic care needs had been recurring but were not consistently trended, analyzed, or incorporated into QAPI for systemic correction and that the facility failed to utilize its QAPI program to proactively identify, prioritize, and correct systemic issues, resulting in repeated deficiencies. During a follow up interview on 1/13/26 at 9:38 a.m., the Administrator (ADM) acknowledged that despite staffing concerns being identified at least three times within the previous 12 months, no formal action plan or Performance Improvement Project (PIP) had been initiated. During the survey entrance conference on 1/5/26 at 10:00 a.m., the ADM provided a current copy blank QAPI documents as an example of how potential issues were identified and addressed. He indicated that the facility policy was for each department to (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reflect on its services and programming to identify potential issues that would require proactive action plans to help identify and prevent deficient practices. 3.1-52