STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS FELLOWSHIP COMMUNITY	2030 CHESTER BLVD, RICHMOND, , 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a Residential Licensure Survey. This visit included a State Licensure Survey. This visit included the Investigation of Intake IN00464441. Intake IN00464441 - State deficiencies related to the allegations are cited at R240. Survey dates: September 11, 12, 14, 15, and 16, 2025 Facility number: 001128 Residential Census: 80 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 25, 2025.	R 0000	**Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Facility cordially requests paper compliance.**	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d)	R 0240	Showers: Immediate Actions:	11/03/2025

	(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to assist residents with showers as scheduled for 2 of 3 residents reviewed for Activities of Daily Living (ADLs). (Resident C and Resident E) Findings include: 1.) During an interview with Confidential Staff 3 on 9/14/25 at 12:55 p.m., they indicated showers were not being completed for residents due to low staffing. Confidential Staff 3 indicated Resident C had not had a shower for months, the resident did not refuse showers and was able to be interviewed. Confidential Staff 3 indicated she had a staff member come from another unit, on 9/13/25, to provide the resident with a shower. Confidential Staff 3 provided Resident C's ADL documentation for showers, Resident C had no showers documented for July 2025, August 2025 or September 2025. Confidential Staff 3 indicated Resident C was good about washing himself up at the sink, but did have odorous feet when she put lotion on them. During an interview with		The DON or designee will review shower sheets 2 times per week for 4 weeks, to make sure all showers are completed as scheduled., Identification of other residents at risk: The staff nurse will ensure all residents ADL needs are being met on their shift. Any resident observed having unmet needs will be reported to the DON for appropriate intervention. Ongoing Monitoring: The DON or designee will review shower sheets 2 times per week for 4 weeks, to make sure all showers are completed as scheduled. The resident's will be showered according to their schedule. The administrator will ensure compliance. • Any deficient practice will be forwarded to the QAPI committee for further intervention. Compliance Date: • Shower schedules will be reviewed and updated as indicated by October 27, 2025. • The DON or designee will conduct a mandatory staff in-service to be held on October 29, 2025 at 7am and 2pm to review required nursing services to attain and maintain the highest practicable physical, mental and psychosocial well being of each resident. This will include but is not limited to the following:	

	Resident C on 9/15/25 at 11:04 a.m., he indicated he received showers whenever the staff provided them. Review of the record of Resident C, on 9/16/25 at 11:46 a.m., indicated the resident's diagnoses included, but were not limited to, chronic respiratory failure, inflammatory arthritis, dementia without behaviors, and chronic obstructive pulmonary disease. The service plan for Resident C, dated 6/3/25, indicated the resident required limited assistance with bathing. The staff were to assist the resident weekly with showers and document the care. 2.) During an interview with Resident E on 9/15/25 at 10:08 a.m., she indicated she was supposed to get assistance with two showers a week, and she was not receiving them. Resident E indicated sometimes she would receive one shower per week. Review of the record of Resident E, on 9/16/25 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, hypertension, diabetes, osteoarthritis, and vertigo. The service plan for Resident E, undated, indicated the resident			

	required limited assistance with bathing. The staff would provide a shower weekly. During an interview with Qualified Medication Aide (QMA) 10 on 9/16/25 at 12:25 p.m., they verified Resident E had one shower documented on her ADL documentation, indicating Resident E receiving one shower, on 9/4/25, for September 2025. During an interview with Medical Records on 9/16/25 at 1:56 p.m., they indicated Resident E did have a shower documented on the 24-hour report for 9/11/25. The ADL policy was provided by the Director of Nursing on 9/16/25 at 9:30 a.m. It indicated the purpose was to assist residents in achieving maximum function, provide assistance to residents as necessary, and improve quality of life. This citation is related to Intake IN00464441.			
S 0000	INITIAL COMMENTS This visit was for a State Licensure Survey. This visit included a Residential Licensure Survey. This visit included the Investigation of Intakes IN00463737 and IN00464441.	S 0000	**Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it**	

	Intake IN00463737 - State deficiencies related to the allegations are cited at F9999. Intake IN00464441 - State deficiencies related to the allegations are cited at F9999. Survey Dates: September 11, 12, 14, 15, and 16, 2025 Facility number: 001128 Census bed type: NCC: 51 Residential: 80 Total: 131 Census Payor type: Other: 131 Total: 131 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 25, 2025.		**is required by the provisions of federal and state law. Facility cordially requests paper compliance.**	
S 9999	FINAL OBSERVATIONS 410 IAC 16.2-5-1.2 Residents' rights Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 4-21.5; IC	S 9999	**<u>410 IAC 16.2-5-1.2 Residents' rights</u>** Getting out of Bed and Dressing:	11/03/2025

	12-10-5.5; IC 12-10-15-9; IC 16-28-5-1 Sec. 1.2. (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents' rights and responsibilities. A copy of the residents' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to		Immediate Actions: Resident H will be reviewed for ADL needs by the DON or designee. Resident H receives hospice services and requires maximum/total assist with all ADL needs. Individual interventions will be put into place to meet resident H’s needs. The DON updated the Plan of Care with new interventions on 10/20/25. Identification of other residents at risk: The staff nurse will ensure all residents ADL needs are being met on their shift. Any resident observed having unmet needs will be reported to the DON for appropriate intervention. Ongoing Monitoring:• The DON or designee will make rounds 5 times per week for 4 weeks to ensure resident’s ADL needs are met. DON or designee will monitor ADL completion on Point Click Care 5 times weekly x 4 weeks. System Changes and Staff Education:	

	exercise their rights as a resident of the facility and as a citizen or resident of the United States. (c) Residents have the right to exercise any or all of the enumerated rights without: (1) restraint; (2) interference; (3) coercion; (4) discrimination; or (5) threat of reprisal; by the facility. These rights shall not be abrogated or changed in any instance, except that, when the resident has been adjudicated incompetent, the rights devolve to the resident's legal representative. When a resident is found by his or her physician to be medically incapable of understanding or exercising his or her rights, the rights may be exercised by the resident's legal representative. (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. Based on interview and record review, the facility failed to promote a dignified atmosphere by not assisting a resident to get dressed and attend church, not		assessment and Plan of Care and those identified as needing additional help will be reported to the DON for appropriate intervention. • The administrator will ensure compliance. • Any deficient practice will be forwarded to the QAPI committee for further intervention. • The DON or designee will hold mandatory staff in-service on October 29, 2025 at 7am and 2pm to review required nursing services to attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident. This will include but is not limited to the following: transfers, eating, dressing, bathing, toileting and answering call lights timely. Call Lights Immediate Actions No immediate actions available. Identification of other residents at risk: All residents have the potential to be affected.	

	assisting a resident off the toilet for 45 minutes, and not assisting a resident to the restroom resulting in the resident becoming incontinent of his bladder for 3 of 3 residents reviewed for dignity (Resident H, Resident J, and Resident K). Findings include: A.) During an interview with Resident H's family member on 9/12/25 at 11:15 a.m., they indicated, on 8/3/25 around 10:30 a.m., he came to the resident's unit to take her to church. Resident H was still in bed, not dressed, and had not eaten breakfast. Resident H's family member indicated it was disrespectful to Resident H not assisting her to get ready for church. The resident had been going to church for 70 years. During an interview with Confidential Staff 1 on 9/14/25 at 12:27 p.m., she indicated she was working, on 8/3/25, when Resident H could not go to church. Confidential Staff 1 indicated the memory care unit did not have enough staff to assist the resident to get up and get her dressed for church. Review of the record of Resident H, on 9/16/25 at 11:38 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease,		System Changes and Staff Education: The DON or designee will educate nursing staff on promptly responding to call lights. Ongoing Monitoring: • The DON or designee will conduct call light audits, 5 lights per week, per shift for 4 weeks and randomly thereafter to ensure compliance. • The administrator will ensure compliance. • Any deficient practice will be forwarded to the QAPI committee for further intervention. • Call light response audit will be initiated on week of 10/20/25 • Completed call light response report will be reviewed at the December 10, 2025 QAPI committee meeting. Grievances Immediate Actions	

	heart failure, arthritis, and dementia. The care plan for activities of interest for Resident H, dated 3/24/21, indicated the resident enjoyed church. The Admission Minimum Data Set (MDS) assessment for Resident H, dated 6/30/25, indicated the resident was severely impaired for daily decision making. It was very important for Resident H to participate in religious services and practices. The care plan for Resident H, dated 7/28/25, indicated the resident required maximum assistance with dressing and hygiene. B.) During an interview with Resident J on 9/15/25 at 1:18 p.m., she indicated she had to sit on the toilet for 45 minutes before she was assisted off the toilet. The resident indicated the staff tell her that her call light does not work. The call light was observed working at the time of the interview. The resident indicated she timed how long she had to sit on the toilet by the clock in her room. The resident was observed to have a large digital clock with the right time in her room. Review of the record of Resident J, on 9/16/25 at 12:57		The administrator or designee will address resident H and I grievances. Note: Resident I expired on 10/1/25. Identification of other residents at risk: Any resident or family member with a grievance has the potential to be affected. System Changes and Staff Education: • The grievance policy will be reviewed and updated. (Need to attach) • The Administrator or designee will educate the Social Service Director and all nursing staff on the updated policy for grievances. • Grievances will be collected and documented on a log by the social services designee. Ongoing Monitoring: Grievances Immediate Actions The administrator or designee will address resident H and I grievances. Note: Resident I expired on 10/1/25. Identification of other residents at risk: Any resident or family	

	p.m., indicated the resident's diagnoses included, but were not limited to, hypertension, coronary artery disease, and depression. The care plan for Resident J, dated 7/16/25, indicated the resident required moderate assistance with toileting. The Quarterly MDS assessment for Resident J, dated 7/16/25, indicated the resident was cognitively intact for daily decision making. The resident required moderate assistance with toileting and transferring to and from the toilet. C.) During an interview with Resident K's family member on 9/15/25 at 10:08 a.m., they indicated Resident K and the family member had returned to his room after dinner, on 9/9/25 at 6:00 p.m., and Resident K put his call light on to have help going to the restroom. The family member indicated Confidential Staff 6 entered the room and indicated the aide was giving a resident a shower and had another shower to do after that, so it would be a long time. Resident K's family member indicated she watched the clock, and it took staff one hour to assist Resident K to the restroom which caused him to be incontinent. The family member indicated Resident K frequently waits up to thirty		member with a grievance has the potential to be affected. System Changes and Staff Education: • The grievance policy will be reviewed and updated. • The Administrator or designee will educate all staff on the updated policy for grievances. • Grievances will be collected and documented on a log by the • The administrator will review the log weekly for 4 weeks and then monthly, to ensure resident’s grievances have been addressed and compliance with the grievance policy is maintained. • The administrator will ensure compliance. • Any deficient practice will be forwarded to the QAPI committee for further intervention. • Grievance policy updated on October 1, 2025 by Administrator **410 IAC 16.2-3.1-17 Nursing services** Sufficient Nursing Staffing	

	minutes for his call light to be answered and was frequently incontinent of his bladder because of having to wait so long for assistance. Resident K's family member indicated they felt this was disrespectful to their family member. The clinical record for Resident K was reviewed on 9/16/25 at 11:45 a.m. The diagnoses included, but were not limited to, coronary artery disease, anxiety, and Parkinson's disease. The Annual MDS assessment, dated 8/13/25, indicated Resident K was moderately cognitively impaired, used a walker/wheelchair for ambulation, needed supervision/touching assistance with toileting, and was frequently incontinent. The plan of care for Resident K, dated 8/13/25, indicated the resident needed supervision to moderate assistance for toileting hygiene. The interventions included, but were not limited to, staff will supervise to moderately assist for toileting hygiene and assist with toileting and hygiene needs. The plan of care for Resident K, dated 10/20/24, indicated the resident was at risk for incontinence and complications of incontinence. The		Immediate Actions The facility staffing pattern will be reviewed and minimum staffing standards to be set. Identification of other residents at risk: All residents have the potential to be affected. System Changes and Staff Education: • Minimum staffing levels per census updated. Staffing requirements are being met to meet the residents physical, mental and psychosocial well-being. The DON or designee will educate the ADON to minimum staffing requirements and any time there is a potential to drop below that threshold, a report to the DON and/or the administrator for further instruction. Ongoing Monitoring: • The DON or designee will review the daily PPD staffing report to assure, that the staffing is not below agreed upon minimums. • The administrator will ensure compliance.	

	interventions included, but were not limited to, assisting to go to the bathroom every two hours or after meals and to assist with toileting as needed. The Resident Rights policy was provided by the Director of Nursing (DON) on 9/16/25 at 9:45 a.m. It indicated "...A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 410 IAC 16.2-5-1.2 Residents' rights Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 4-21.5; IC 12-10-5.5; IC 12-10-15-9; IC 16-28-5-1 (o) Residents have the right to form and participate in a resident council, and families of residents have the right to form a family council, to discuss alleged grievances, facility operation, residents' rights, or other problems and to participate in the resolution of these matters as follows:		• Any deficient practice will be forwarded to the QAPI committee for further intervention. • Minimum staffing guidelines per daily census updated 10/3/25 Falls, Failure to Supervise Resident to Prevent Falls Immediate Action: The DON or designee will assess resident “D” and determine the cause of the fall. Physical therapy will screen resident “D” and orders will be obtained as indicated. Appropriate individualized intervention will be put into place for Resident “D” and the plan of care will be updated with this new intervention. Identification of other residents at risk: The DON or designee will assess all other residents with like conditions Immediate Action: The DON or designee will assess resident “D” and determine the cause of the fall. Physical therapy will screen resident “D” and orders will be obtained as	

	(1) Participation is voluntary. (2) During resident or family council meetings, privacy shall be afforded to the extent practicable unless a member of the staff is invited by the resident council to be present. (3) The licensee shall provide space within the facility for meetings and assistance to residents or families who desire to attend meetings. (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or both; (C) a family member; (D) family groups; or (E) other individuals.		indicated. Appropriate individualized intervention will be put into plans, put appropriate interventions into place and document the interventions on the plan of care. System Changes and Staff Education: • The DON or designee will in-service all staff on fall prevention measures and supervision of those identified as being at risk for falls, immediate assessment and intervention after a fall occurs. • The IDT will review post fall residents at the next morning meeting to review the immediate intervention, identify root cause, change intervention as necessary and document on the plan of care. • The DON or designee will review falls weekly with Therapy to discuss potential new interventions or therapy evaluations. Ongoing Monitoring: • The DON or designee will review the fall log weekly to ensure compliance.	

Based on interview and record review, the facility failed to investigate and address grievances for 2 of 2 residents reviewed for grievances (Resident H and Resident I).

Findings include:

A.) During an interview with Resident H's family member on 9/12/25 at 11:15 a.m., they indicated, on 8/3/25 around 10:30 a.m., he came to the memory care unit to get Resident H and take her to church. Resident H was still in bed, not dressed and had not eaten breakfast. The family member came back, at 11:00 a.m., and the resident was eating breakfast. The family member indicated the resident's lunch would be served soon and she was just now eating breakfast. The family member indicated there were two days last week he came to the memory care unit and there was no staff feeding Resident H. Resident H was attempting to feed herself pudding with her fingers. The family member indicated he reported all his concerns to the Executive Director (ED), and no one had followed up with him on any of these issues. The family member indicated the ED did not offer for him to file a formal grievance on paper.

Review of the record of

thereafter to verify fall prevention interventions are in place.

• The QAPI committee will review falls quarterly. Residents with multiple falls and residents with significant falls will be reviewed at this time. Interventions will be reviewed with the QAPI committee for residents who have had multiple falls.

The administrator will ensure compliance.

• Any deficient practice identified will be forwarded to the QAPI committee for further interventions.

• Fall risk assessments, updated care plans and requests for therapy screens completed for residents on October 20, 2025.

Eating:

Immediate Actions:

Residents I, H, M and N will be evaluated and potentially treated by Occupational Therapy to identify each one’s ADL needs related to eating. Resident I expired on 10/1/25. Resident H and M receive hospice services for senile degeneration and require maximum/total assist with eating. Those that require

	Resident H, on 9/16/25 at 11:38 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, arthritis, and dementia. The care plan for activities of interest for Resident H, dated 3/24/21, indicated the resident enjoyed church. The Admission MDS assessment for Resident H, dated 6/30/25, indicated the resident was severely impaired for daily decision making. The resident required moderate assistance with eating and transfers and required maximal assistance with dressing. The care plan for Resident H, dated 7/28/25, indicated the resident required maximum assistance with dressing and hygiene. The memory care unit feeding and transfer documentation was provided by the Director of Nursing (DON) on 9/16/25 at 10:50 a.m. It indicated Resident H was total assistance with eating and required a mechanical sit to stand lift for transfers. B.) The clinical record for Resident I was reviewed on 9/16/25 at 12:00 p.m. The diagnoses included, but were		assistance or adaptive equipment will have the individualized interventions put into place to meet their needs. These interventions will be documented in the resident’s plan of care. Identification of other residents at risk: The staff nurses will observe residents during mealtime to identify those needing additional assistance with eating and report to DON or designee for appropriate intervention. Ongoing Monitoring: • The DON or designee will make rounds 5 times a week, over different dining rooms and individual resident rooms, during meal times, to make sure residents are being assisted as needed, for 4 weeks. System Changes and Staff Education: The DON or designee will in-service the nursing staff regarding meeting residents ADL needs according to their assessment and Plan of Care and those identified as needing additional help will be reported to the DON for appropriate intervention.	

not limited to, anemia, anxiety, dementia, and depression.

The Admission MDS assessment, dated 6/30/25, indicated Resident I was severely cognitively impaired.

During an interview with Resident I's family member on 9/12/25 at 10:08 a.m., they indicated another family member had emailed a list of concerns regarding Resident I's care to the Director of Sales on 9/5/25 at 9:35 a.m. Resident I's family member indicated, on 9/6/25, they were at the facility council meeting and after the meeting, the family member spoke with the Executive Director (ED) and asked if he had received the letter that was emailed to the facility about concerns regarding Resident I's care. The family member indicated the ED told them that, yes, he had received the letter and would be in contact with them by September 11, 2025 at 3:00 p.m. Resident I's family member indicated they never received a phone call from the ED to follow-up on concerns the family had about Resident I's care.

During an interview with the ED on 9/15/25 at 2:48 p.m., they indicated it was social services who were responsible for filling out a grievance for a resident or family member and social

• The administrator will ensure compliance.

• Any deficient practice will be forwarded to the QAPI committee for further intervention.

Dining Room Observations will begin October 20, 2025 and continue 5x/week for 4 weeks.

410 IAC 16.2-3.1-19 Environment and physical standards

Clean, Homelike Environment HCC Patio

Immediate Actions:

The environmental services director and/or maintenance director or designee will clean patio and repair all environmental deficiencies identified and removing any clutter and unnecessary materials.

Identification of Other Areas:

The environmental services director will conduct audits in all similar spaces to identify and correct any related deficiencies.

System Changes and Staff Education:

• The Environmental Director

	services would then determine what department head to forward the grievance to so concerns can be identified and addressed. The ED indicated if he received a grievance, he would fill out a form and follow-up. During an interview with the Social Service Director (SSD) on 9/16/25 at 9:38 a.m., they indicated they were not aware of Resident H's family member reporting concerns to the ED about lack of care for Resident H. The SSD also indicated they were unaware there was a grievance related to Resident I sent to the ED regarding care concerns for Resident I. The SSD indicated the ED nor Director of Sales had reported any care concerns regarding Resident I to her. The SSD indicated anyone can fill out the forms but she had to be aware of it so she could follow-up. During an interview with the Director of Sales on 9/16/25 at 10:16 a.m., they indicated they did receive an email from Resident I's family member, on 9/5/25, and forwarded the email to the ED to let him know they had concerns and requested that he reach out to them. The Director of Sales indicated if they received a complaint from a family member or resident, they always notify and send the		will assign a staff member to inspect and clean the patio daily. • The Environmental Service Director or designee will educate all environmental service staff on Clean Homelike Environment. Ongoing Monitoring: • The environmental Services Director or designee will complete an audit 2 times a week for 4 weeks to ensure compliance and randomly thereafter. • The administrator will review for compliance. • Any deficient practice identified will be forwarded to the QAPI committee for further intervention. • Initial repairs completed and corrected on October 10, 2025. New patio doors ordered on October 21, 2025 and will be installed upon receipt. • Cleaning completed and corrected on September 18, 2025. **410 IAC 16.2-3.1-38 Activities of daily living** Activities:	

	information to the ED. A Policy and Procedure Complaint Resolution policy was provided by the Social Service Director (SSD) on 9/12/25 at 10:30 a.m. It indicated " ...it is the policy of Friends Fellowship Community to thoroughly address all complaints and grievances made by: residents, family members ...F. Investigation and follow up must be completed within 48 hours of receiving the complaint". The SSD indicated zero grievance forms were received by the facility from January 2025 through June 2025. 410 IAC 16.2-3.1-17 Nursing services Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1 Sec. 17. (a) The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. (b) The facility must provide services by sufficient number of		Immediate Actions: Resident “H” will be assessed for activity needs. The activity staff will ensure resident attends church as is her preference. Identification of other residents at risk: Residents activity assessments will be reviewed by the Activity Director or designee to ensure accuracy. System Changes and Staff Education: The DON and Activity Director or designee will educate the nursing and activity staff on daily activities and the resident’s preference to attend. Ongoing Monitoring: • An activity staff member will take attendance at activities held. 2 times a week for 4 weeks, the Activity Director or designee will review the activity logs to ensure compliance with resident’s activity needs. • The Administrator will ensure compliance. • Any deficient practice will be forwarded to the QAPI committee for further	

	each of the following types of personnel on a twenty-four (24) hour basis to provide nursing care to all residents in accordance with resident care plans: (1) Except when waived under subsection (f), the facility shall provide a licensed nurse hour-to-resident ratio of five-tenths (.5) licensed nurse hour per resident per day, averaged over a one (1) week period. The hours worked by the director of nursing shall not be counted in the staffing hours. (2) Except when waived under subsection (f), the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (3) Except when waived under subsection (f), the facility must use the services of a registered nurse for at least eight (8) consecutive hours a day, seven (7) days a week. (4) Except as waived in subsection (f), the facility must designate a registered nurse who has completed a nursing		intervention Care plan updated on September 24, 2025 DON or designee will educate nursing staff on October 29, 2025 with residents activity preferences. Showers: Immediate Actions: The DON or designee will review the shower schedules and make sure Residents D, E and J are on the schedule. The resident's will be showered according to their schedule. Identification of other residents at risk: The DON or designee will review the shower schedule to make sure all residents are on the shower schedule are getting showers per schedule. Ongoing Monitoring:• The DON or designee will review shower sheets 2 times per week for 4 weeks, to make sure all showers are completed as scheduled. The DON or designee will review shower status of residents in Point Click Care 2 times weekly for 4 weeks.	

	management course with a clinical component or who has at least one (1) year of nursing supervision in the past five (5) years to serve as the director of nursing on a full-time basis. (c) The director of nursing will also function in the following duties: (1) Communication to the administrator and, where appropriate, the physician, the status of the residents, the occurrence of incidents, and accidents and unresolved administrative problems of the nursing department. (2) Plan for and direct nursing care services in accordance with the physicians' orders and to meet the needs of the residents. (3) Provide for the training of nursing staff. (4) Supervise nursing personnel to assure that preventive and restorative nursing procedures for each resident are initiated and performed so as to attain and maintain the highest practicable physical, mental, and		Staff Education: The DON or designee will in-service the nursing staff regarding meeting residents ADL needs according to their assessment and Plan of Care and those identified as needing additional help will be reported to the DON for appropriate intervention. • The DON or designee will review shower sheets 2 times per week for 4 weeks, to make sure all showers are completed as scheduled. • The administrator will ensure compliance. • Any deficient practice will be forwarded to the QAPI committee for further intervention. • Shower schedules will be reviewed and updated as indicated by October 27, 2025.	

	psychosocial well-being in accordance with the comprehensive assessment and care plan. (5) Assure that the clinical records are maintained in accordance with the facility policies and procedures and in compliance with this rule. (d) The director of nursing shall have, in writing, and shall exercise administrative authority, responsibility, and accountability for nursing services within the facility and shall serve only one (1) facility at a time in this capacity, and confer with the administrator on the evaluation of prospective residents to assure that only those residents whose physical, mental, and psychosocial needs can be met by the facility or through community resources are admitted to and retained by the facility. (e) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of sixty (60) or fewer residents. These hours		eating, dressing, bathing, toileting and answering call lights timely. **410 IAC 16.2-3.1-45 Accidents** Falls, Failure to Supervise Resident to Prevent Falls Immediate Action: The DON or designee will assess resident “D” and determine the cause of the fall. Physical therapy will screen resident “D” and orders will be obtained as indicated. Appropriate individualized intervention will be put into place for Resident “D” and the plan of care will be updated with this new intervention. Identification of other residents at risk: The DON or designee will assess all other residents with like conditions, put appropriate interventions into place and document the interventions on the plan of care. System Changes and Staff Education: • The DON or designee will in-service all nursing staff on fall prevention measures and	

worked may be counted toward staffing requirements.

Based on observation, interview, and record review, the facility failed to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, provide assistance with transfers, eating, dressing and toileting needs, answer call lights timely, and failed to monitor and supervise a resident who was at high risk for falls resulting in the resident falling and acquiring a mouth laceration requiring stitches for 5 of 5 residents reviewed for staffing. This had the potential to affect 25 of 25 residents residing on memory care unit 1 and memory care unit 2 (Resident H, Resident I, Resident M, Resident N, and Resident D).

Findings include:

A.) During an interview with Resident H's family member on 9/12/25 at 11:15 a.m., they indicated, on 8/3/25 around 10:30 a.m., he came to the memory care unit to get Resident H and take her to church. Resident H was still in bed, not dressed, and had not eaten breakfast. The family member came back at 11:00 a.m., and the resident was eating breakfast. The family

supervision of those identified as being at risk for falls, immediate assessment and intervention after a fall occurs.

• The IDT will review post fall residents at the next morning meeting to review the immediate intervention, identify root cause, change intervention as necessary and document on the plan of care.

• The DON or designee will review falls weekly with Therapy to discuss potential new interventions or therapy evaluations.

Ongoing Monitoring:

• The DON or designee will review the fall log weekly to ensure compliance.

• The DON or designee will make rounds 2 times a week for 4 weeks and randomly thereafter to verify fall prevention interventions are in place.

• The QAPI committee will review falls quarterly. Residents with multiple falls and residents with significant falls will be reviewed at this time. Interventions will be reviewed with the QAPI committee for residents who have had multiple falls.

• The administrator will ensure

	member indicated the resident's lunch would be served soon and she was just now eating breakfast. The family member indicated there were two days last week that he came to the memory care unit and there was no staff feeding Resident H. Resident H was attempting to feed herself pudding with her fingers. Resident H's family member indicated there were not enough staff on the memory care unit to assist the resident. During an interview with Confidential Staff 1 on 9/14/25 at 12:27 p.m., they indicated she was working, on 8/3/25, when Resident H could not go to church. Confidential Staff 1 indicated the memory care unit did not have enough staff to assist the resident to get up and get her dressed for church. Confidential Staff 1 indicated the memory care unit did not have enough staff to assist residents to transfer out of bed, assist them with eating, provide incontinence care timely, and residents were not assisted to the restroom timely. The Confidential Staff 1 indicated there were 12-14 residents who required assistance with eating and there were 5-6 residents who required a mechanical lift to transfer. During an interview with Confidential Staff 2 on 9/14/25		compliance. • Any deficient practice identified will be forwarded to the QAPI committee for further intervention. • Fall risk assessments, updated care plans and requests for therapy screens will be completed for residents completed on October 20, 2025	

at 12:43 p.m., they indicated there were not enough staff on the memory care unit to assist the residents with eating and not enough staff to spend one-on-one interaction with the residents.

During an interview with Confidential Staff 4 on 9/14/25 at 1:06 p.m., they indicated there were not enough staff to provide resident's showers as scheduled. The Confidential Staff 4 indicated it took up to 30 minutes for call lights to be answered.

During an interview with Confidential Staff 5 on 9/14/25 at 1:18 p.m., they indicated there was not enough staff to provide residents with good timely care. Confidential Staff 5 indicated residents were not being transferred out of bed until almost lunch time, residents were not assisted with dressing timely and not being assisted with eating timely.

Review of the record of Resident H, on 9/16/25 at 11:38 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, arthritis, and dementia.

The care plan for activities of interest for Resident H, dated 3/24/21, indicated the resident

enjoyed church.

The Admission MDS assessment for Resident H, dated 6/30/25, indicated the resident was severely impaired for daily decision making. It was very important for Resident H to participate in religious services and practices.

The memory care unit feeding and transfer documentation was provided by the Director of Nursing (DON) on 9/16/25 at 10:50 a.m. It indicated there were six residents who required total assistance with eating and eight residents who at any meal or time may need more assistance with eating. There were eight residents who required a mechanical lift for transfers, and two residents who required a mechanical sit to stand lift for transfers.

B.) During an interview with Resident I's family member on 9/12/25 at 2:10 p.m., they indicated they were in the facility on Saturday, September 6, 2025 at 11:30 a.m., and Resident I had just been brought out of their room for breakfast. The family member indicated by that time her food was cold and had to be heated up, and right after that lunch was served between 11:30 a.m. and 12:00 p.m. Confidential Staff 1 indicated Resident I just got out of bed because she

required a Hoyer lift (a medical device designed to safely lift and transfer individuals with limited ability, from one surface to another) to get up and there were not enough staff to get her up earlier. Resident I's family member indicated the resident did not get fed on Saturday.

The clinical record for Resident I was reviewed on 9/16/25 at 12:00 p.m. The diagnoses included, but were not limited to, anemia, anxiety, dementia, and depression.

The Admission MDS assessment, dated 6/30/25, indicated Resident I was severely cognitively impaired.

During an interview with Confidential Staff 14, they indicated medications were being given late, showers were not being done, residents were being left soiled in urine and feces, and this was all due to lack of staff.

C.) During an interview with Resident M's family member on 9/12/25 at 1:20 p.m., they indicated they were concerned Resident M was not getting fed for meals when they were not there because they did not have enough staff to assist. Resident M's family member indicated they were in the facility three to four times a week and observe residents not getting out of bed

and assisted timely for meals and observe residents going without meals or being assisted with feeding regularly due to lack of staff.

During an interview with Confidential Staff 11 on 9/14/25 at 12:33 p.m., they indicated a lot of times residents were not getting breakfast because staff were doing baths and it took two staff members to get residents up, which leaves one nurse for the entire unit who would pass medications and tried to feed residents at the same time.

The clinical record for Resident M was reviewed on 9/16/25 at 10:00 a.m. The diagnoses included, but were not limited to, dementia, diabetes mellitus, and hypertension.

An Admission MDS assessment, dated 6/30/25, indicated Resident M was severely cognitively impaired and was dependent with feeding.

D.) The clinical record for Resident N was reviewed on 9/16/25 at 12:15 p.m. The diagnoses included, but were not limited to, Down syndrome, depression, and dementia.

An Admission MDS assessment, dated 6/30/25, indicated Resident N was severely cognitively impaired,

used a walker/wheelchair, and required partial/moderate assistance with eating.

During an interview with Resident N's family member on 9/12/25 at 1:20 p.m., they indicated they were concerned Resident N was not getting assisted with meals when they were not there because they did not have enough staff to assist. Resident N's family member indicated they were in the facility three to four times a week and observe residents not getting out of bed and assisted timely for meals and observe residents going without meals or being assisted with feeding regularly due to lack of staff.

During an observation on 9/14/25 at 12:35 p.m., Resident N and Resident M were being assisted with eating lunch. A male Certified Nurse Aide (CNA) got up from the table and helped another resident, leaving both at the table alone and not feeding themselves.

E.) During an interview with Confidential Staff 1 on 9/14/25 at 12:27 p.m., they indicated Resident D had a fall on memory care unit 1 when there were no staff over on that unit, and Resident D had busted her lip and required stitches from that fall.

During an interview with

Confidential Staff 13 on 9/15/25 at 1:30 p.m., they indicated she worked the night of 8/4/25, when Resident D fell. Confidential Staff 13 indicated Resident D was on memory care unit 1 by herself when she fell. Confidential Staff 13 indicated the fall was not witnessed and she and two CNAs were on memory care unit 2 at the time of the fall. Confidential Staff 13 indicated a resident from memory care unit 1 came over to memory care unit 2 to alert her that there was a lady on the ground bleeding.

The clinical record for Resident D was reviewed on 9/16/25 at 11:07 a.m. The diagnoses included, but were not limited to, dementia and hyperthyroidism.

An Admission MDS assessment, dated 8/18/25, indicated Resident D was severely cognitively impaired.

The memory care unit feeding and transfer documentation was provided by the Director of Nursing (DON) on 9/16/25 at 10:50 a.m. It indicated Resident H was total assistance with eating and required a mechanical sit to stand lift for transfers.

A Certified Nurse Aide Job Description policy was provided by the DON on 9/16/25 at 10:28 a.m. It indicated "...Residential

	Support: 1. Respect and protect resident's dignity, resident's rights and resident's right to choose...7. Assist residents to prepare for meals and if needed, ensure proper positioning during meal...8. Serve food promptly...Provide assistance and/or feed resident as necessary, sitting at eye level and communicating with the resident...9. Assume the responsibility for the care of assigned residents, providing complete bed bath, shower, or tub bath, twice a week and as needed...10. Provide assistance with daily care...12. Assist resident to bathroom according to need..." 410 IAC 16.2-3.1-19 Environment and physical standards Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1 Sec. 19. (a) The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.			

(b) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection

Association, which is incorporated by reference. This section applies to all facilities initially licensed on or after the effective date

of this rule.

(c) Each facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and

building safety commission (675 IAC) where applicable to health facilities.

(d) An emergency electrical power system must supply power adequate at least for lighting all entrances and exits, equipment

to maintain the fire detection, alarm, and extinguishing systems, and life support systems in the event the normal electrical supply

is interrupted.

(e) When life support systems are used, the facility must provide emergency electrical power with an emergency generator

	that is located on the premises. (f) The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The facility must do the following: (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. (2) Have adequate outside ventilation by means of windows or mechanical ventilation, or a combination of the two (2). (3) Equip corridors with firmly secured handrails. (4) Maintain an effective pest control program so that the facility is free of pests and rodents. (5) Provide a home-like environment for residents. (g) Personnel shall handle, store, process, and transport linen in a manner that prevents the spread of infection as follows: (1) Soiled linens shall be securely contained at the source where it is generated and handled in a manner that protects workers			

and precludes contamination of clean linen.

Based on observation and interview, the facility failed to provide a clean and homelike environment of an indoor patio for 2 of 2 observations of the indoor patio. (Facility)

Findings include:

During an interview with Resident P and Resident Q's family members on 9/12/25 at 10:40 a.m., they indicated the enclosed indoor patio on the healthcare side was filthy, in disrepair, and no one could go out there and enjoy it because of the poor conditions.

During an observation of the healthcare indoor patio on 9/12/25 at 1:28 p.m., there were two torn screens, the tile was dirty and had a lot of debris throughout the room. The trashcan was overflowing, the cushions were in disarray and not on the chairs, and there were cobwebs throughout the indoor patio. Peeling paint was also observed on both doors.

During an observation of the indoor patio on 9/15/25 at 11:36 a.m., there were two screens that were torn, floors were dirty, two trash cans were sitting in the middle of the room with lids on them, paint was peeling on both doors, cobwebs were

noted throughout the patio, and two padded benches were dirty with chair cushions stacked on top.

During an interview with the Director of Nursing (DON) on 9/16/25 at 1:00 p.m., she indicated it was environmental staff and maintenance who were responsible to make sure the patio was kept clean and in good repair.

The Residents Rights policy was provided by the DON on 9/16/25 at 9:45 a.m. It indicated " ...Environment: The facility must provide- a. A safe, clean, comfortable, and homelike environment ..."

410 IAC 16.2-3.1-38 Activities of daily living

Authority: IC 16-28-1-7; IC 16-28-1-12

Affected: IC 16-28-5-1

Sec. 38. (a) Based on the comprehensive assessment of a resident and the care plan, the facility must ensure the following:

(1) The resident's abilities in activities of daily living (ADL) do not diminish unless circumstances of the resident's clinical

condition demonstrate that

	diminution was unavoidable. Conditions demonstrating unavoidable diminution in ADL's include the following: (A) The natural progression of the resident's disease. (B) Deterioration of the resident's physical condition associated with the onset of a physical or mental disability while receiving care to restore or maintain functional abilities. (2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities, including, but not limited to, the following: (A) Bathing, dressing, and grooming. (B) Transfer and ambulation. (C) Toileting. (D) Eating. (E) Speech, language, or other functional communication systems.			

(3) A resident who is unable to carry out ADL receives the necessary services to maintain good nutrition, grooming, and

personal and oral hygiene. Each resident shall show evidence of good personal hygiene, including, but not limited to, the

following:

(A) Care of the skin.

(B) Shampoo and grooming of the hair.

(C) Oral hygiene and care of the lips to prevent dryness and cracking.

(D) Shaving and beard trimming.

(E) Cleaning and cutting of the fingernails and toenails.

Based on observation, interview, and record review, the facility failed to provide assistance for residents with activities of daily living (ADLs) of dressing, grooming, toileting, eating and showers for 7 of 7 residents reviewed for ADL assistance (Resident D, Resident H, Resident J, Resident E, Resident I, Resident M, and Resident N).

Findings include:

A.) During an interview with

	Resident H's family member on 9/12/25 at 11:15 a.m., they indicated, on 8/3/25 around 10:30 a.m., he came to the memory care unit to get Resident H and take her to church. Resident H was still in bed, not dressed, and had not eaten breakfast. The family member came back at 11:00 a.m., and the resident was eating breakfast. The family member indicated the resident's lunch would be served soon and she was just now eating breakfast. The family member indicated there were two days last week that he came to the memory care unit and there were no staff feeding Resident H. Resident H was attempting to feed herself pudding with her fingers. The family member indicated he reported all his concerns to the Executive Director (ED) and no one had followed up with him on any of these issues. The family member indicated the ED did not offer for him to file a formal grievance on paper.			

During an interview with Confidential Staff 1 on 9/14/25 at 12:27 p.m., they indicated she was working, on 8/3/25, when Resident H could not go to church. Confidential Staff 1 indicated the memory care unit did not have enough staff to assist the resident to get up and get her dressed for church.

Review of the record of Resident H, on 9/16/25 at 11:38 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, arthritis, and dementia.

The Admission MDS assessment for Resident H, dated 6/30/25, indicated the resident was severely impaired for daily decision making. The resident required moderate assistance with eating and transfers and required maximal assistance with dressing.

The care plan for Resident H, dated 7/28/25, indicated the resident required maximum assistance with dressing and hygiene.

The memory care unit feeding and transfer documentation was provided by the Director of Nursing (DON) on 9/16/25 at 10:50 a.m. It indicated Resident H was total assistance with eating and required a

	mechanical sit to stand lift for transfers. B.) During an interview with Confidential Staff 4 on 9/14/25 at 1:06 p.m., they indicated there were not enough staff to provide resident's showers as scheduled. The Confidential Staff 4 indicated it took up to 30 minutes for call lights to be answered. Confidential Staff 4 indicated Resident J was not receiving her showers. Confidential Staff 4 provided Resident J's ADL documentation and the resident received one shower on August 25, 2025 and one shower on September 5, 2025. This indicated the resident received two showers in the last two months. During an interview and observation with Resident J on 9/15/25 at 1:18 p.m., she indicated she had to sit on the toilet for 45 minutes before she was assisted off the toilet. The resident indicated the staff tell her that her call light does not work. The call light was observed working at the time of the interview. The resident indicated she timed how long she had to sit on the toilet by the clock in her room. The resident was observed to have a large digital clock with the right time in her room. The resident indicated she was supposed to			

receive a shower two times a week on Monday and Thursday and she was not getting her showers.

Review of the record of Resident J, on 9/16/25 at 12:57 p.m., indicated the resident's diagnoses included, but were not limited to, hypertension, coronary artery disease, and depression.

The care plan for Resident J, dated 7/16/25, indicated the resident required moderate assistance with toileting and bathing. The interventions included, but were not limited to, staff would provide moderate assistance with toileting and two full baths a week.

The Quarterly MDS assessment for Resident J, dated 7/16/25, indicated the resident was cognitively intact for daily decision making. The resident required moderate assistance with toileting and transferring to and from the toilet.

C.) The clinical record for Resident D was reviewed on 9/16/25 at 11:07 a.m. The diagnoses included, but were not limited to, dementia, and hyperthyroidism.

An Admission MDS assessment, dated 8/18/25, indicated Resident D was severely cognitively impaired

and required supervision/touching assistance with showering.

During a review of Resident D's ADL forms, it indicated Resident D had not received a shower for the dates of 8/23/25-8/29/25, 8/30/25-9/5/25, and 9/6/25-9/12/25.

The plan of care for Resident D, dated 8/16/25, indicated the resident was able to complete bathing and hygiene with set up assistance. The interventions included, but were not limited to, performing all bathing needs with set up help, staff supervise while in the shower room, and take a full bath two times weekly, and partial bath five times weekly.

D.) The clinical record for Resident E was reviewed on 9/16/25 at 11:40 a.m. The diagnoses included, but were not limited to, hypertension and peripheral neuropathy.

The Nursing Admission Assessment, dated 9/2/25, indicated Resident E was alert with adequate short and long term memory, pleasant, calm, and cooperative.

During an interview with Resident E on 9/11/25 at 12:50 p.m., they indicated they had been back in the facility from the hospital for nine days and hadn't

received a shower nor have her hair washed. Resident E indicated she had washed herself from the waistline up every other day. Resident E indicated she needed help with the bottom half of her body. Resident E indicated she had asked several staff members for a shower and to wash her hair, but no one would ever follow through with it.

During an interview with Resident E on 9/14/25 at 1:23 p.m., she indicated she had washed her hair that morning herself in the sink with a washcloth.

During a review of Resident E's ADL forms on 9/15/25 at 2:00 p.m., they indicated Resident E had a partial bath documented for 9/6/25 and 9/13/25. During an interview with Confidential Staff 12, they indicated a partial bath consisted of washing the face, underarms, and peri-area. Confidential Staff 12 indicated each hallway had a shower paper that indicated what days which residents received showers. They indicated it was standard for resident to receive showers/baths two times per week or more often if care planned as such.

An Interdisciplinary Care Plan, dated 9/2/25, indicated Resident E was at risk for complications related to recent surgery. The

interventions included, but were not limited to, provide Resident E with the appropriate level of assistance for bathing.

E.) The clinical record for Resident I was reviewed on 9/16/25 at 12:00 p.m. The diagnoses included, but were not limited to, anemia, anxiety, dementia, and depression.

The Admission MDS assessment, dated 6/30/25, indicated Resident I was severely cognitively impaired, used a walker/wheelchair, and required set up/clean up assistance with meals.

During an interview with Resident I's family member on 9/12/25 at 2:10 p.m., they indicated on Saturday, 9/6/25 at 11:30 a.m., they arrived to see their family member just getting up out of her bedroom and brought out to the dining area for breakfast. Resident I's family member indicated her food was cold and needed to be heated up, and at that time they were beginning to serve residents lunch. The family member indicated Resident I did not get fed, on 9/6/25, and was frequently not getting fed or missing meals. Resident I's family member indicated Confidential Staff 1 informed her that Resident I had just gotten out of bed because she required a Hoyer lift (a medical device

designed to safely lift and transfer individuals with limited ability, from one surface to another) to get up and there were not enough staff to get her up earlier.

The plan of care for Resident I, dated 7/24/25, indicated the resident was able to complete ADLs with moderate to maximal assistance. The interventions included, but were not limited to, provide moderate assistance for bathing, dressing, and hygiene needs.

F.) The clinical record for Resident M was reviewed on 9/16/25 at 10:00 a.m. The diagnoses included, but were not limited to, dementia, diabetes mellitus, and chronic kidney disease.

An Admission MDS assessment, dated 6/30/25, indicated Resident M was severely cognitively impaired and was dependent with eating.

During an interview with Resident M's family member on 9/12/25 at 1:20 p.m., they indicated they were concerned Resident M was not getting fed for meals when they were not there because they did not have enough staff to assist. Resident M's family member indicated they were in the facility three to four times a week and observed residents not getting out of bed

and assisted timely for meals and observe residents going without meals or not being assisted with feeding regularly due to lack of staff.

During an observation on 9/14/25 at 12:35 p.m., Resident N and Resident M were being assisted with eating lunch. A male CNA got up from the table and helped another resident, leaving both at the table alone and not feeding themselves.

The plan of care for Resident M, dated 6/23/25, indicated the resident has the potential for decline in ADL function. The interventions included, but were not limited to, staff will provide assist with eating as needed.

G.) The clinical record for Resident N was reviewed on 9/16/25 at 12:15 p.m. The diagnoses included, but were not limited to, Down syndrome, depression, and dementia.

An Admission MDS assessment, dated 6/30/25, indicated Resident N was severely cognitively impaired, used a walker/wheelchair, and required partial/moderate assistance with eating.

During an interview with Resident N's family member on 9/12/25 at 1:20 p.m., they indicated they were concerned Resident N was not getting

assisted with meals when the family was not there because they did not have enough staff to provide assistance. Resident N's family member indicated they were in the facility three to four times a week and observed residents not getting out of bed and assisted timely for meals and observed residents going without meals or being assisted with feeding regularly due to lack of staff.

During an observation on 9/14/25 at 12:35 p.m., Resident N and Resident M were being assisted with eating lunch. A male CNA got up from the table and helped another resident, leaving both at the table alone and not feeding themselves.

The ADL policy was provided by the DON on 9/16/25 at 9:30 a.m. It indicated the purpose was to assist residents in achieving maximum function, provide assistance to residents as necessary, supervise and assist and improve quality of life.

410 IAC 16.2-3.1-45 Accidents

Authority: IC 16-28-1-7; IC 16-28-1-12

Affected: IC 16-28-5-1

Sec. 45. (a) The facility must ensure the following:

(1) The resident's environment remains as free of accident hazards as is reasonably possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

(b) For purposes of IC 16-28-5-1, a breach of subsection (a) is a deficiency. (Indiana State Department of Health; 410 IAC

16.2-3.1-45; filed Jan 10, 1997, 4:00 p.m.: 20 IR 1557, eff Apr 1, 1997; readopted filed Jul 11, 2001, 2:23 p.m.: 24 IR 4234)

Based on observation, interview, and record review, the facility failed to prevent a fall by adequately supervising an at risk resident for falls for 1 of 1 resident reviewed for falls. (Resident D)

Findings include:

The clinical record for Resident D was reviewed on 9/16/25 at 11:07 a.m. The diagnoses included, but were not limited to, dementia and hyperthyroidism.

An Admission Minimum Data Set (MDS) assessment, dated 8/18/25, indicated Resident D was severely cognitively impaired.

A fall risk assessment, dated 6/7/25, indicated Resident D was at high risk for falls.

During an interview with Confidential Staff 1 on 9/14/25 at 12:27 p.m., they indicated Resident D had a fall on memory care unit 1 when no staff was over on that unit and Resident D had busted her lip and required stitches from that fall.

A nurse's note for Resident D, dated 8/4/25 at 8:15 p.m., indicated Confidential Staff 13 was alerted by another resident that Resident D had fallen on the floor and was bleeding. Confidential Staff 13 indicated Resident D had an open laceration through her upper lip and missing most of a tooth. A nurse's note for Resident D, on 8/4/25 at 9:00 p.m., indicated Resident D was sent to the hospital for further evaluation.

During an interview with Confidential Staff 13 on 9/15/25 at 1:30 p.m., she indicated she worked the night of 8/4/25 when Resident D fell. Confidential Staff 13 indicated Resident D was on memory care unit 1 by herself when she fell. Confidential Staff 13 indicated the fall was not witnessed and she and two Certified Nurse Aides (CNAs) were on memory care unit 2 at the time of the fall. Confidential Staff 13 indicated a

	resident from memory care unit 1 came over to memory care unit 2 to alert her that there was a lady on the ground bleeding. A plan of care for Resident D, dated 4/23/21, indicated the resident was at risk for falls. The interventions included, but were not limited to, staff bringing resident closer to the nurses station to provide increased monitoring. A Fall Prevention policy was provided by the Director of Nursing on 9/16/25 at 9:30 a.m. It indicated " ...4. To supervise and assess resident function ..." This citation relates to Intakes IN00463737 and IN00464441.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREMelissa Harrison	TITLEDirector of Nursing	(X6) DATE10/24/2025