STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT HOBART	1420 ST MARYS CIRCLE, HOBART, , 46342

(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 the Investigation of Intakes 465370, 465908, 466055, 466132, 466139, 466620, 466646, 467186, and 467340. Intake 465370 - State deficiencies related to the allegations are cited at R0240. Intake 465908 - State deficiencies related to the allegations are cited at R0086, R0144 and R0177. Intake 466055 - State deficiencies related to the allegations are cited at R0086, R0144 and R0177. Intake 466132 - State deficiencies related to the allegations are cited at R0052, R0216, and R0349. Intake 466139 - State deficiencies related to the allegations are cited at R0086, R0144 and R0240.	R 0000	The submission of this plan of correction does not indicate an admission by Brentwood at Hobart that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Brentwood at Hobart. The community hereby maintains it is in substantial compliance with the requirements of participation in residential care facilities. Please accept this plan of correction as the credible allegation of compliance with all state and federal requirements governing the management of this facility. Brentwood at Hobart respectfully request from the department a desk review/paper compliance for these tags.	

	Intake 466620 - State deficiencies related to the allegations are cited at R0116 and R0240. Intake 466646 - State deficiencies related to the allegations are cited at R0116. Intake 467186 - State deficiencies related to the allegations are cited at R0036, R0086, R0144, R0216, R0240, and R0349. Intake 467340 - No deficiencies related to the allegations are cited at R0086, R0144, R0217, and R0240. Survey dates: February 2, 3, and 4, 2026 Facility number: 002627 Residential Census: 118 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/9/26.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:	R 0036	This facility will ensure clinical recordsare complete and accurately documented, including notifying the MD of any changes in conditions. All residents have the potential to be affected by this deficient practice. No adverse effects were noted for any other	03/01/2026

	(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the resident's physician was notified after a change in status for 1 of 3 residents reviewed for a change in condition. (Resident E) Finding includes: The record for Resident E was reviewed on 2/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and anxiety. The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident had moderate dementia with significant short term memory and possibly long term memory loss. A Nurse's Note, dated 1/17/26 at 10:10 a.m., indicated discoloration to the left forearm and hand were observed while the CNA was getting the resident dressed for breakfast.		residents. The DON/Designee will audit all chartingusing an audit form. Audits will be completed twice per week for 2 months, then weekly for 2 months, then monthly for 2 months. All results will be reviewed during our monthly QA meeting.	

	The resident was unable to explain how it happened. All necessary parties were notified. A Health Status Note, dated 1/17/26 at 9:40 p.m., indicated the resident was noted with bruising to the left forearm and mild swelling to the wrist area. The affected wrist was warm to touch. The resident complained of pain and discomfort with movement. Range of motion intact with no deformity noted. The hospice nurse was notified and evaluated the resident. The hospice nurse advised to monitor the extremity for any increased swelling or decreased movement and report the changes. PRN (as needed) Morphine (a narcotic pain medication) was administered for pain. A Health Status Note, dated 1/18/26 at 9:25 p.m., indicated the resident remained in bed the whole second shift, and refused to come out for dinner. The resident's left forearm remained bruised and swollen at the wrist. Decreased movement on the affected arm was noted. The hospice nurse was notified and stated would visit the resident tomorrow for assessment. A Health Status Note, dated 1/19/26 at 11:33 p.m., indicated the resident had an x-ray to the forearm performed and staff			

	were waiting for the x-ray results. A Communication with Physician Note, dated 1/20/26 at 11:05 a.m., indicated the left forearm x-ray results showed no acute fractures or dislocation. No new orders from the physician at that time. This was the first documented entry since 1/17/26 of the physician being contacted. During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated the physician should have been notified as well, not just hospice. This citation relates to Intake 467186. Based on record review and interview, the facility failed to ensure the resident's physician was notified after a change in status for 1 of 3 residents reviewed for a change in condition. (Resident E) Finding includes: The record for Resident E was reviewed on 2/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and anxiety. The Service Plan, dated 4/29/25 and reviewed on 2/2/26,			

	indicated the resident had moderate dementia with significant short term memory and possibly long term memory loss. A Nurse's Note, dated 1/17/26 at 10:10 a.m., indicated discoloration to the left forearm and hand were observed while the CNA was getting the resident dressed for breakfast. The resident was unable to explain how it happened. All necessary parties were notified. A Health Status Note, dated 1/17/26 at 9:40 p.m., indicated the resident was noted with bruising to the left forearm and mild swelling to the wrist area. The affected wrist was warm to touch. The resident complained of pain and discomfort with movement. Range of motion intact with no deformity noted. The hospice nurse was notified and evaluated the resident. The hospice nurse advised to monitor the extremity for any increased swelling or decreased movement and report the changes. PRN (as needed) Morphine (a narcotic pain medication) was administered for pain. A Health Status Note, dated 1/18/26 at 9:25 p.m., indicated the resident remained in bed the whole second shift, and refused to come out for dinner. The			

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R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from:	R 0052	This facility will ensure residents are free from abuse.All residents have the potential to be affected by this deficient practice. No adverse effects were noted for any other residents.All staff were educated	03/01/2026

	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, record review and interview, the facility failed to ensure a resident was free from abuse, related to staff being physically aggressive with a resident with dementia for 1 of 3 residents reviewed for abuse. (Resident H) Finding includes: The record for Resident H was reviewed on 2/3/25 at 1:26 a.m. Diagnoses included, but were not limited to, dementia, anemia, high blood pressure, and depression. A 12/19/25 Service Plan indicated the resident required support to make appropriate decisions about her care and environment. A Incident Note, dated 12/29/25 at 11:55 p.m., indicated staff were notified Resident H had a fall during care. The resident was observed lying on her back, alert and conscious, no bleeding, bruising, or lacerations		on the abuse policy. Any suspected abuse will be reported to the Stateboardof Health. All employees involved will be immediatelysuspended pending investigationandappropriate disciplinaryactionup to and including termination will apply according to the results of investigation. All staff will complete Relias abuse training upon hire and annually. The ED/Designee will audit all abuse training to ensure compliance monthly for 6 months using the audit tool. All results will be reviewed during our monthly QA meeting.	

	were observed during assessment. Vital signs were obtained and within normal limits. Resident H was assisted up to her feet with no complaints. All parties were notified. On 12/29/25, a facility reported incident indicated Resident H, a Memory Care resident, was having ADL care provided by CNA 1. CNA 1 was noted to have forcefully pulled the resident's left arm while trying to have her stand. This caused the resident to stumble and fall. Resident H was assessed with no injury noted and was placed on 72-hour safety checks. CNA 1 was immediately suspended pending investigation. The facility's investigation indicated CNA 1 was interviewed via telephone, staff who were present during the incident were inserviced on abuse and all other staff members were assigned an online abuse education module. A skin and fall assessment were completed post fall and 72 hours safety checks were completed. CNA 1's statement, dated 12/30/25, indicated CNA 1 had "tried to take her to the bathroom, but she kept walking away. She sat on her bed with brief hallway down while she			

	was having a bowel movement. I tried to pick her up so that I could pull up her brief, but she slid to the floor". During an interview on 2/3/26 at 3:06 p.m., the Director of Nursing (DON) indicated she reviewed the camera footage that gets initiated whenever there is a change of plane in a room. Resident H had consent for that surveillance to be activated if a fall was detected. The DON had reviewed the footage of the fall which recorded 1 minute prior to a change in plane and 1 minute post change of plane. The video showed CNA 1 roughly grab Resident H off her bed which caused her to fall. She was terminated via telephone after the surveillance was reviewed. This citation relates to Intake 466132. Based on observation, record review and interview, the facility failed to ensure a resident was free from abuse, related to staff being physically aggressive with a resident with dementia for 1 of 3 residents reviewed for abuse. (Resident H) Finding includes: The record for Resident H was reviewed on 2/3/25 at 1:26 a.m. Diagnoses included, but were not limited to, dementia,			

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R 0086	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(a)(1-2) The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on record review and interview, the facility corporation and administration displayed an ongoing lack of supervision/ management of the facility operations regarding an elevator and front door which had been broken for many months. This had the potential to affect all 118 residents residing in the facility. Finding includes: The elevator had been out of service since March 2025, and the shunt work/wires were	R 0086	It is the procedure andintentof the corporation tosupervise and schedule any maintenance issue that may arise in terms of building services.The state inspectortagged out the working elevators and requested upgraded service to the elevators.The community followed the directive of the state inspector who tagged out theelevators, butalso allowed us to use other working elevators, locatedonoppositesides of the communityuntil the requested upgrades were completed. The elevators that were placed under lock out/tag outof service by the inspectorhave been upgradedper code. We have workedwith several vendors working to satisfy the requirements of the statefor several months.The community has provided oversight and supervision since thetagout and continueto do so.Other elevators in the community are functioning and have been availableforuse byresidents,staff and families.We understand it may be inconvenient for some of the residents, butit isnot a deficient practice to have 2 working elevators.All residents have the potential to be affected.All residents may use the other two working elevators while thetagged-outelevators areclearedto begin operation	03/01/2026

	completed, and the elevator was ready for inspection in October 2025. The front doors have been broken since October 2025. The doors do not lock, and the handicap mechanism does not work. During an interview on 2/2/26 at 3:08 p.m., Resident D indicated the elevator had been out since he was admitted back in August 2025. He was a mechanical engineer, and he measured 150 feet from his room to the elevator and 100 additional feet to the dining room. That was a 500 feet round trip for anyone on his hall. During an interview on 2/3/26 at 11:55 a.m., the family member of Residents L and M indicated the elevator had been out since March of 2025 and was a gross disservice to the residents. During an interview on 2/4/26 at 11:37 a.m., the Division Chief of Fire Prevention indicated he shut down the elevators in March of 2025, related to a fire alarm system not working properly. He indicated the work had been completed fully and was done and ready for permit to operate in October 2025. He indicated he became aware the elevator was still not operating by a complaint that was called into the mayor's office on		again.The community is committed to resolving and satisfyingthe upgradedwork requestedby the State inspector. We have been working with our vendors since this time andcoordinatedtheir servicesforeachtocomplete a specific task, which has been completed.Our ElevatorVendor has requested the state inspector to come outseveral times to inspect the elevators. The communityremains responsive and will continue to work with our vendors (Elevator vendor,Fire panel vendors, and other vendors) needed to perform this requested work.All requested work by vendors have beencompletedthe elevator vendor has reached out to the State of Indiana inspector tocome inspect the elevators. Our elevatorvendorhas submittedthe request again for the State of Indiana inspectorfor a date and time of the inspection. Thecommunity'selevatorvendor hasrequestedthe state inspector tomakeaonsite inspectionand allow us to use the elevators again.The date of the inspection iscompletelyup to the state inspectorto schedule a date and time with the community.We will let the residents, family, and staff know once the State inspector allows us tooperatethe	

	1/30/26. During an interview on 2/4/26 at 11:55 a.m., the Director of Maintenance indicated he was waiting on the state people to come and put the elevator back in service. He indicated the fire chief was coming to tell him what was going on. He could not provide follow up documentation indicating he was checking on the permit status of the elevator. During an interview on 2/4/25 at 12:01 p.m., the Administrator indicated she was recently hired in January and was not aware the elevator had been shut down since March 2025. She was also unaware the front door had been broken since October 2025. This citation relates to Intakes 465908, 466055, 466139, 467186, and 467340. Based on record review and interview, the facility corporation and administration displayed an ongoing lack of supervision/ management of the facility operations regarding an elevator and front door which had been broken for many months. This had the potential to affect all 118 residents residing in the facility. Finding includes:		tagged-outelevators.As of now, the State of Indiana inspector is scheduled to come out by the end of February2026.	

	The elevator had been out of service since March 2025, and the shunt work/wires were completed, and the elevator was ready for inspection in October 2025. The front doors have been broken since October 2025. The doors do not lock, and the handicap mechanism does not work. During an interview on 2/2/26 at 3:08 p.m., Resident D indicated the elevator had been out since he was admitted back in August 2025. He was a mechanical engineer, and he measured 150 feet from his room to the elevator and 100 additional feet to the dining room. That was a 500 feet round trip for anyone on his hall. During an interview on 2/3/26 at 11:55 a.m., the family member of Residents L and M indicated the elevator had been out since March of 2025 and was a gross disservice to the residents. During an interview on 2/4/26 at 11:37 a.m., the Division Chief of Fire Prevention indicated he shut down the elevators in March of 2025, related to a fire alarm system not working properly. He indicated the work had been completed fully and was done and ready for permit to operate in October 2025. He indicated he became aware the			

	elevator was still not operating by a complaint that was called into the mayor's office on 1/30/26. During an interview on 2/4/26 at 11:55 a.m., the Director of Maintenance indicated he was waiting on the state people to come and put the elevator back in service. He indicated the fire chief was coming to tell him what was going on. He could not provide follow up documentation indicating he was checking on the permit status of the elevator. During an interview on 2/4/25 at 12:01 p.m., the Administrator indicated she was recently hired in January and was not aware the elevator had been shut down since March 2025. She was also unaware the front door had been broken since October 2025. This citation relates to Intakes 465908, 466055, 466139, 467186, and 467340.			
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The	R 0116	This facility will ensure that all staff are properly screened prior to working in the building. An audit of all employee files was completed. All staff who were noted without reference checks completed were identified. Reference checks have been completed for all employees noted. This facility will not allow staff to work until all on-boarding	03/01/2026

	facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to properly screen employees hired in the past four months, related to failure to obtain reference checks for 5 of 5 new employees reviewed. (LPN 1, CNA 3, CNA 4, CNA 5, and QMA 1) Finding includes: The Employee Files were reviewed on 2/4/26 at 9:30 a.m. The following employee's files did not have reference checks: LPN 1 - start date 8/27/25 CNA 3 - start date 9/12/25 CNA 4 - start date 9/16/25 CNA 5 - start date 10/1/25 QMA 1 - start date 11/3/25 During an interview on 2/4/26 at 11:26 a.m., the Administrator indicated the reference checks had not been completed for the above employees. This citation relates to Intake 466620 and 466646. Based on record review and		including referencechecksare completed. The ED/Designee will auditall newemployee files prior to their start date to ensure on-boardingiscompletedincluding reference checks. All findings will be reviewed during our monthly QA meeting.	

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R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good	R 0144	This facility willmaintainaclean and safe environment. Please see the attached door lock audit forms. All residents have the potential to be affected by this deficient practice. The building was audited by the management team for compliance.	03/01/2026

	repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain an environment that was clean and in good repair related to dirt, food, and debris on the floors, pillows without pillowcases, food-stained chairs, laundry falling out of opened dresser drawers and on the floor, foul odors, elevator not working, and front doors did not lock. (Memory Care, front door, and north side elevator) This had the potential to affect all 118 residents residing in the facility. Findings include: 1. The following was observed on 2/2/25: a. At 11:41 a.m., Room 424 had a foul urine odor, food, and debris on the floor, under the bed, and on the recliner. There were three pillowcases that did not have a pillowcase on them. There were crumbs in both chairs in the room as well as stains. b. At 11:50 a.m., Room 426 had trash, food, and debris on the floor, under the bed, and on the recliner. The recliner had a used chuck pad still on the seat and the resident had been in the		All problem areas wereidentified. Cleaning schedules weremodified, and housekeeping staff were made aware of the changes. The housekeepingmanagerwill audit compliance twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. All findings will be reviewed during our monthly QA meeting.	

	hospital since 1/6/26. There were stains on the recliner, laundry was on the floor surrounding the dresser, and clothes was falling out of open drawers. c. The north side elevator had not been in service since March 2025 and was still not in operation. d. The front entry doors were not locked and could not be locked when demonstrated. These had been broken since October 2025. Cross reference R0086. During an interview on 2/2/26 at 3:08 p.m., Resident D indicated the elevator had been out since he was admitted back in August 2025. He was a mechanical engineer, and he measured 150 feet from his room to the elevator and 100 additional feet to the dining room. That was a 500 feet round trip for anyone on his hall. During an interview on 2/3/26 at 11:55 a.m., the family member of Resident L and M indicated the elevator had been out since March of 2025 and was a gross disservice to the residents. During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated she was aware of the conditions, and			

	they had a meeting this morning on their course of action. During an interview on 2/4/26 at 12:20 p.m., the Administrator indicated the maintenance director was unable to lock the doors. Their wires were taken down, and he needed to rewire the front door. She reported, "The front door does not currently lock". This citation relates to Intakes 465908, 466055, 466139, 467186, and 467340. Based on observation and interview, the facility failed to maintain an environment that was clean and in good repair related to dirt, food, and debris on the floors, pillows without pillowcases, food-stained chairs, laundry falling out of opened dresser drawers and on the floor, foul odors, elevator not working, and front doors did not lock. (Memory Care, front door, and north side elevator) This had the potential to affect all 118 residents residing in the facility. Findings include: 1. The following was observed on 2/2/25: a. At 11:41 a.m., Room 424 had a foul urine odor, food, and debris on the floor, under the bed, and on the recliner. There			

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	During an interview on 2/2/26 at 3:08 p.m., Resident D indicated the elevator had been out since he was admitted back in August 2025. He was a mechanical engineer, and he measured 150 feet from his room to the elevator and 100 additional feet to the dining room. That was a 500 feet round trip for anyone on his hall. During an interview on 2/3/26 at 11:55 a.m., the family member of Resident L and M indicated the elevator had been out since March of 2025 and was a gross disservice to the residents. During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated she was aware of the conditions, and they had a meeting this morning on their course of action. During an interview on 2/4/26 at 12:20 p.m., the Administrator indicated the maintenance director was unable to lock the doors. Their wires were taken down, and he needed to rewire the front door. She reported, "The front door does not currently lock". This citation relates to Intakes 465908, 466055, 466139, 467186, and 467340.			
R 0177	Physical Plant Standards -	R 0177	Physical and Plant standards. It	03/22/2026

	Deficiency 410 IAC 16.2-5-1.6(a) (a) The facility shall make provisions for the handicapped as required by state or federal codes. Based on observation and interview, the facility failed to maintain and make provisions for handicapped residents related to broken handicap door buttons on the front entry doors. Finding includes: The following was observed on 2/2/25: At 8:35 a.m., the front door handicap buttons were observed to be broken. During an interview on 2/4/26 at 10:52 a.m., the Maintenance Director indicated the contractors had not completed the work on the front door and that's why the handicap function did not work.		is the policy of Brentwood of Hobart tomonitorand make repairs to building equipment such as doors anddevicessuch ashandicapaccessibleopen door assist whethercompletedin houseor contracted out services.All residents had the potential to be affected. All doors will be inspectedby maintenance department for proper function specifically focused on handicap accessible buttons functioning properly. The maintenancedepartment has secured two quotes for an outside vendor to repair the handicap accessible button. Once this work has been completed, thewiring will allow the restoration of the magnetic locks. Themaintenance director and or designee will check all exteriordoorstwice a week for 4 weeks then weekly thereafter. Community has receivedtwo quotes from vendorsto perform this work. One vendorwill be selected to perform thework by 2/21/26and we will ask the vendor tocomplete therepair and installwithin30 days. The community would like to ask for anextensionto have the contracted work completed by March 222026.	

	During an interview on 2/4/25 at 12:01 p.m., the Administrator provided quotes from a contractor service from January 2026. She indicated she was recently hired in January and was not aware the front door handicap buttons had been broken since October 2025. Quotes should have been obtained earlier. This citation relates to Intakes 465908 and 466055. Based on observation and interview, the facility failed to maintain and make provisions for handicapped residents related to broken handicap door buttons on the front entry doors. Finding includes: The following was observed on 2/2/25: At 8:35 a.m., the front door handicap buttons were observed to be broken. During an interview on 2/4/26 at 10:52 a.m., the Maintenance Director indicated the contractors had not completed the work on the front door and that's why the handicap function did not work. During an interview on 2/4/25 at 12:01 p.m., the Administrator provided quotes from a contractor service from January			

	2026. She indicated she was recently hired in January and was not aware the front door handicap buttons had been broken since October 2025. Quotes should have been obtained earlier. This citation relates to Intakes 465908 and 466055.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. 2. The record for Resident D was reviewed on 2/2/26 at 10:07 a.m. The resident's	R 0216	This facility will ensure only residents who are able to self-administer havemedications in their possession. All residents have the potential to be affected by this deficient practice.Staff members who were negligent in this practice were given disciplinary action.An audit was completed for all residents todetermine appropriateness for self-administration. All nursing staff were educated on proper medication administration and self-administrationpolicies. DON/Designee will complete monthly self-administration assessments forappropriate residentsindefinitely. All findings will be reviewed during our monthly QA meeting.	03/01/2026

	diagnoses included, but were not limited to, type 2 diabetes, and hypertension (high blood pressure). On 2/2/26 at 3:08 p.m., Resident D was observed holding a packet containing several pills that was labeled with his name. The resident indicated the day nurse had left his evening pills for him "because they would be short staffed later." A Service Plan, reviewed on 11/12/25, indicated the resident required support to communicate and help make his needs known. A Service Plan, revised on 8/14/25 and reviewed on 9/8/25, indicated the resident required assistance with medications due to cognitive loss and required daily supervision of medication. The February 2026 Physician's Order Summary (POS) indicated the resident did not have an order to self-administer his medications. There was no self-administer of medications assessment completed for the resident. During an interview on 2/2/26 at 3:55 p.m., the Administrator indicated the resident did not self-administer his medications and the nurse should not have			

left the resident with his evening medications.

During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated the nurse stated she knew she shouldn't have given the resident pills early and was already under corrective action.

This citation relates to Intakes 466132 and 467186.

Based on record review and interview, the facility failed to ensure residents had the ability to self-administer medications for 2 of 2 residents reviewed for self-administration of medications. (Residents N and D)

Findings include:

1. During an observation on 2/3/26 at 8:32 a.m., QMA 2 entered Resident N's room to administer his morning medications. The resident's medications were in a plastic medication cup. The resident was overheard telling the QMA that he would take the pills with his breakfast. Upon exiting the room, the QMA did not have the medication cup. During an interview at that time, the QMA indicated that she left the pills in the resident's room so he could take them with his breakfast.

The record for Resident N was

	reviewed on 2/3/26 at 4:05 p.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbance, type 2 diabetes, atrial fibrillation (an irregular heartbeat), and hypertension (high blood pressure). A Service Plan, reviewed on 11/25/25, indicated the resident had mild to moderate disorientation or difficulty recalling/retaining information and he needed cueing. A Service Plan, dated 8/15/25 and reviewed on 11/25/25, indicated the facility was to administer the resident's medications due to cognitive loss and daily supervision of medication was required. The February 2026 Physician's Order Summary (POS) indicated the resident did not have an order to self-administer his medications. There was no self-administer of medications assessment completed for the resident. During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated the resident did not self-administer his medications and the QMA should not have left the medications with the resident. 2. The record for Resident D			

	was reviewed on 2/2/26 at 10:07 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes, and hypertension (high blood pressure). On 2/2/26 at 3:08 p.m., Resident D was observed holding a packet containing several pills that was labeled with his name. The resident indicated the day nurse had left his evening pills for him "because they would be short staffed later." A Service Plan, reviewed on 11/12/25, indicated the resident required support to communicate and help make his needs known. A Service Plan, revised on 8/14/25 and reviewed on 9/8/25, indicated the resident required assistance with medications due to cognitive loss and required daily supervision of medication. The February 2026 Physician's Order Summary (POS) indicated the resident did not have an order to self-administer his medications. There was no self-administer of medications assessment completed for the resident. During an interview on 2/2/26 at 3:55 p.m., the Administrator indicated the resident did not			

	self-administer his medications and the nurse should not have left the resident with his evening medications. During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated the nurse stated she knew she shouldn't have given the resident pills early and was already under corrective action. This citation relates to Intakes 466132 and 467186. Based on record review and interview, the facility failed to ensure residents had the ability to self-administer medications for 2 of 2 residents reviewed for self-administration of medications. (Residents N and D) Findings include:			

	1. During an observation on 2/3/26 at 8:32 a.m., QMA 2 entered Resident N's room to administer his morning medications. The resident's medications were in a plastic medication cup. The resident was overheard telling the QMA that he would take the pills with his breakfast. Upon exiting the room, the QMA did not have the medication cup. During an interview at that time, the QMA indicated that she left the pills in the resident's room so he could take them with his breakfast. The record for Resident N was reviewed on 2/3/26 at 4:05 p.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbance, type 2 diabetes, atrial fibrillation (an irregular heartbeat), and hypertension (high blood pressure). A Service Plan, reviewed on 11/25/25, indicated the resident had mild to moderate disorientation or difficulty recalling/retaining information and he needed cueing. A Service Plan, dated 8/15/25 and reviewed on 11/25/25, indicated the facility was to administer the resident's medications due to cognitive loss and daily supervision of medication was required. The February 2026 Physician's			

	Order Summary (POS) indicated the resident did not have an order to self-administer his medications. There was no self-administer of medications assessment completed for the resident. During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated the resident did not self-administer his medications and the QMA should not have left the medications with the resident. 2. The record for Resident D was reviewed on 2/2/26 at 10:07 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes, and hypertension (high blood pressure). On 2/2/26 at 3:08 p.m., Resident D was observed holding a packet containing several pills that was labeled with his name. The resident indicated the day nurse had left his evening pills for him "because they would be short staffed later." A Service Plan, reviewed on 11/12/25, indicated the resident required support to communicate and help make his needs known. A Service Plan, revised on 8/14/25 and reviewed on 9/8/25,			

	indicated the resident required assistance with medications due to cognitive loss and required daily supervision of medication. The February 2026 Physician's Order Summary (POS) indicated the resident did not have an order to self-administer his medications. There was no self-administer of medications assessment completed for the resident. During an interview on 2/2/26 at 3:55 p.m., the Administrator indicated the resident did not self-administer his medications and the nurse should not have left the resident with his evening medications. During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated the nurse stated she knew she shouldn't have given the resident pills early and was already under corrective action. This citation relates to Intakes 466132 and 467186. Based on record review and interview, the facility failed to ensure residents had the ability to self-administer medications for 2 of 2 residents reviewed for self-administration of medications. (Residents N and D)			

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	A Service Plan, dated 8/15/25 and reviewed on 11/25/25, indicated the facility was to administer the resident's medications due to cognitive loss and daily supervision of medication was required. The February 2026 Physician's Order Summary (POS) indicated the resident did not have an order to self-administer his medications. There was no self-administer of medications assessment completed for the resident. During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated the resident did not self-administer his medications and the QMA should not have left the medications with the resident. 2. The record for Resident D was reviewed on 2/2/26 at 10:07 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes, and hypertension (high blood pressure).			

	On 2/2/26 at 3:08 p.m., Resident D was observed holding a packet containing several pills that was labeled with his name. The resident indicated the day nurse had left his evening pills for him "because they would be short staffed later." A Service Plan, reviewed on 11/12/25, indicated the resident required support to communicate and help make his needs known. A Service Plan, revised on 8/14/25 and reviewed on 9/8/25, indicated the resident required assistance with medications due to cognitive loss and required daily supervision of medication. The February 2026 Physician's Order Summary (POS) indicated the resident did not have an order to self-administer his medications. There was no self-administer of medications assessment completed for the resident. During an interview on 2/2/26 at 3:55 p.m., the Administrator indicated the resident did not self-administer his medications and the nurse should not have left the resident with his evening medications. During an interview on 2/3/26 at 3:00 p.m., the Director of			

	Nursing indicated the nurse stated she knew she shouldn't have given the resident pills early and was already under corrective action. This citation relates to Intakes 466132 and 467186. Based on record review and interview, the facility failed to ensure residents had the ability to self-administer medications for 2 of 2 residents reviewed for self-administration of medications. (Residents N and D) Findings include: 1. During an observation on 2/3/26 at 8:32 a.m., QMA 2 entered Resident N's room to administer his morning medications. The resident's medications were in a plastic medication cup. The resident was overheard telling the QMA that he would take the pills with his breakfast. Upon exiting the room, the QMA did not have the medication cup. During an interview at that time, the QMA indicated that she left the pills in the resident's room so he could take them with his breakfast. The record for Resident N was reviewed on 2/3/26 at 4:05 p.m. The resident's diagnoses included, but were not limited to, dementia with behavior disturbance, type 2 diabetes,			

	atrial fibrillation (an irregular heartbeat), and hypertension (high blood pressure). A Service Plan, reviewed on 11/25/25, indicated the resident had mild to moderate disorientation or difficulty recalling/retaining information and he needed cueing. A Service Plan, dated 8/15/25 and reviewed on 11/25/25, indicated the facility was to administer the resident's medications due to cognitive loss and daily supervision of medication was required. The February 2026 Physician's Order Summary (POS) indicated the resident did not have an order to self-administer his medications. There was no self-administer of medications assessment completed for the resident. During an interview on 2/3/26 at 3:00 p.m., the Director of Nursing indicated the resident did not self-administer his medications and the QMA should not have left the medications with the resident.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an	R 0217	This facility will ensure that we follow service plans as written. All residents have the potential to be affected by this deficient practice. All service plans werereviewedand	03/01/2026

	evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to		residents requiring cueing or encouragement to eat were identified. Staff were educated on the proper way to encourage/cue a resident to eat and how to properly document any refusals. Family members and MD will be notified of refusals with proper documentation in the resident electronic records. DON/Designee will audit records to ensure compliance twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. All findings will be reviewed during our monthly QA meeting.	

	be provided. Based on observation, record review, and interview, the facility failed to provide services in the resident's service plan related to not encouraging a resident to eat for 1 of 3 residents reviewed for dietary / nutrition. (Resident G) Finding includes: During an observation on 2/2/26 at 12:04 p.m., CNA 2 entered Resident G's room, placed her lunch tray on the table, and exited. At 12:07 p.m., the food remained on the table untouched. The resident was in bed sleeping. At that time, the Unit Director told the resident her lunch was there and left the room. She did not wait to see if the resident got out of bed to eat. At 12:55 p.m., Resident G remained in bed sleeping. Her lunch tray remained on her table, not touched. No staff had been in her room since 12:07 p.m. The resident's record was reviewed on 2/2/26 at 11:20 a.m. Diagnoses included, but were not limited to, dementia.			

	A Service Plan, revised on 6/26/25, indicated the resident needed encouragement with eating. Interventions included encouraging food consumption. During an interview on 2/3/26 at 3:15 p.m., the Administrator was informed of the finding and offered no further information. This citation relates to Intake 467340. Based on observation, record review, and interview, the facility failed to provide services in the resident's service plan related to not encouraging a resident to eat for 1 of 3 residents reviewed for dietary / nutrition. (Resident G) Finding includes:			

	During an observation on 2/2/26 at 12:04 p.m., CNA 2 entered Resident G's room, placed her lunch tray on the table, and exited. At 12:07 p.m., the food remained on the table untouched. The resident was in bed sleeping. At that time, the Unit Director told the resident her lunch was there and left the room. She did not wait to see if the resident got out of bed to eat. At 12:55 p.m., Resident G remained in bed sleeping. Her lunch tray remained on her table, not touched. No staff had been in her room since 12:07 p.m. The resident's record was reviewed on 2/2/26 at 11:20 a.m. Diagnoses included, but were not limited to, dementia. A Service Plan, revised on 6/26/25, indicated the resident needed encouragement with eating. Interventions included encouraging food consumption. During an interview on 2/3/26 at 3:15 p.m., the Administrator was informed of the finding and offered no further information. This citation relates to Intake 467340.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d)	R 0240	This facility will ensure that ADL care is provided as scheduled. All residents have the potential to be affected by this deficient practice.	03/01/2026

	(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. 2. The record for Resident G was reviewed on 2/2/26 at 11:20 a.m. Diagnoses included, but were not limited to, dementia. A Service Plan, dated 3/26/25, indicated the resident required assistance with bathing. Interventions included the following tasks to be completed twice weekly: assisting with transfers in / out of shower, cueing to wash self, shampooing / drying hair, applying lotion, and reporting any changes in skin to the nurse. A review of the resident's record lacked documentation of resident showers from 11/1/25 to 2/2/26. During an interview on 2/3/26 at 9:04 a.m., the Administrator indicated the resident required prompting / reminding for bathing, and that no showers were documented from 11/1/25 to 2/2/26. 3. The record for Resident B was reviewed on 2/2/26 at 2:30 p.m. Diagnoses included, but were not limited to, anemia, bradycardia (slow heart rate), and atrial fibrillation (irregular		No other residents were identified as being affected. Care staff were educated on proper ADL documentation and compliance. Shower schedules were updated for the facility. Failure to provide scheduled ADL care will result in disciplinary action. The DON/Designee will audit all ADL charting to ensure compliance. Audits will be completedtwice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. All findings will be reviewed during our monthly QA meeting.	

	heartbeat). A Quarterly Assessment, dated 12/10/25, indicated the resident required assistance with incontinence management 6 times a day. A Hospice Significant Change in Status note, dated 12/24/25, indicated the resident's coccyx (tailbone area) wound had increased in size from 1 cm (centimeter) to 1.5 cm. Intervention included to keep the resident turned off of her back, support her with pillows, and provide frequent incontinence care. A review of the resident's record lacked documentation of incontinence care from 11/1/26 to 2/2/26. During an interview on 2/2/26 at 2:00 p.m., Resident B's family member indicated staff provided incontinence care every 5 to 6 hours, at best. She indicated she had to call the facility to ask them to change the resident because based on room surveillance camera footage, it had been nearly 15 hours since she had been changed.			

	During an interview on 2/3/26 at 9:33 a.m., the Administrator indicated there was no documentation of incontinence care for the resident from 11/1/26 to 2/2/26. 4. The record for Resident M was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and congestive heart failure. A Service Plan, dated 4/28/25, indicated the resident required assistance with bathing twice per week, on Monday and Friday. A review of the resident's record from 11/1/25 to 2/3/26 indicated showers were completed only on 11/2/25, 12/7/25, 12/14/25, 12/28/25, and 1/6/26. During an interview on 2/3/26 3:03 p.m., the Administrator indicated the resident should have received, and the aide should have documented, two showers per week. Based on record review and interview, the facility failed to ensure activities of daily living (ADLs) related to bathing and incontinence care were provided for residents requiring assistance for 5 of 5 residents reviewed for ADLs. (Residents L, G, B, M and F)			

	Findings include: 1. The record for Resident L was reviewed on 2/3/26 at 11:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and need for assistance with personal care. The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident required assistance with bathing related to transferring in and out of the shower, washing and drying his lower body, back shampooing, rinsing and drying his hair, and applying lotion. The resident also required assistance with toileting related to needing assistance with peri care, help with clothing after toileting, and assistance to and from the bathroom. The Documentation Survey Report for the month of November 2025, provided by the Director of Nursing, indicated the resident received a shower on 11/2/25. Documentation related to showering on 11/9/25 and 11/25/25 was coded as "N/A." There was no documentation related to assistance with toileting for the day shift on 11/15, 11/16, and 11/26/25. The evening shift on 11/7, 11/10, 11/20, and 11/29/25. The night shift on 11/4, 11/13, 11/14,			

	11/15, 11/22, 11/29, and 11/30/25. The Documentation Survey Report for the month of December 2025 indicated the resident received three showers for the month on 12/7, 12/14, and 12/28/25. December 21, 2025 was coded as "N/A." There was no documentation related to assistance with toileting for the evening shift on 12/14/25 and the night shift on 12/6, 12/19, 12/20, and 12/26/25. During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated showers were to be provided twice a week and assistance with toileting was to be provided at least once a shift and documented on the Documentation Survey Report. 5. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes. A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care. A Service Plan, dated 8/18/25, indicated the resident required assistance with bathing twice			

	per week and required assistance changing incontinence product and peri care. A review of the resident's shower record from November 2025 to January 2026 indicated showers were completed only on 11/9/25, 11/23/25, 12/12/25, and 12/16/25. There were no documented showers in January 2026. A review of the resident's incontinence/toileting record from November 2025 indicated the following dates were left blank with no documentation: Evening shift: 11/6, 11/8, 11/ 9, 11/19, 11/26/2025 Night shift: 11/13, 11/15, 11/22, 11/27, 11/30/2025 During an interview on 2/3/26 at 3:03 p.m., the Director of Nursing (DON) indicated they had a problem with documentation and she had been working on it. The showers should have been completed and documented twice a week, and there should have been no blanks on the toileting record. This citation relates to Intakes 465370, 466139, 466620, 467186, and 467340. 2. The record for Resident G was reviewed on 2/2/26 at			

	11:20 a.m. Diagnoses included, but were not limited to, dementia. A Service Plan, dated 3/26/25, indicated the resident required assistance with bathing. Interventions included the following tasks to be completed twice weekly: assisting with transfers in / out of shower, cueing to wash self, shampooing / drying hair, applying lotion, and reporting any changes in skin to the nurse. A review of the resident's record lacked documentation of resident showers from 11/1/25 to 2/2/26. During an interview on 2/3/26 at 9:04 a.m., the Administrator indicated the resident required prompting / reminding for bathing, and that no showers were documented from 11/1/25 to 2/2/26. 3. The record for Resident B was reviewed on 2/2/26 at 2:30 p.m. Diagnoses included, but were not limited to, anemia, bradycardia (slow heart rate), and atrial fibrillation (irregular heartbeat).			

	A Quarterly Assessment, dated 12/10/25, indicated the resident required assistance with incontinence management 6 times a day. A Hospice Significant Change in Status note, dated 12/24/25, indicated the resident's coccyx (tailbone area) wound had increased in size from 1 cm (centimeter) to 1.5 cm. Intervention included to keep the resident turned off of her back, support her with pillows, and provide frequent incontinence care. A review of the resident's record lacked documentation of incontinence care from 11/1/26 to 2/2/26. During an interview on 2/2/26 at 2:00 p.m., Resident B's family member indicated staff provided incontinence care every 5 to 6 hours, at best. She indicated she had to call the facility to ask them to change the resident because based on room surveillance camera footage, it had been nearly 15 hours since she had been changed. During an interview on 2/3/26 at 9:33 a.m., the Administrator indicated there was no documentation of incontinence care for the resident from 11/1/26 to 2/2/26. 4. The record for Resident M			

	was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and congestive heart failure. A Service Plan, dated 4/28/25, indicated the resident required assistance with bathing twice per week, on Monday and Friday. A review of the resident's record from 11/1/25 to 2/3/26 indicated showers were completed only on 11/2/25, 12/7/25, 12/14/25, 12/28/25, and 1/6/26. During an interview on 2/3/26 3:03 p.m., the Administrator indicated the resident should have received, and the aide should have documented, two showers per week. Based on record review and interview, the facility failed to ensure activities of daily living (ADLs) related to bathing and incontinence care were provided for residents requiring assistance for 5 of 5 residents reviewed for ADLs. (Residents L, G, B, M and F) Findings include: 1. The record for Resident L was reviewed on 2/3/26 at 11:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and need for			

	assistance with personal care. The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident required assistance with bathing related to transferring in and out of the shower, washing and drying his lower body, back shampooing, rinsing and drying his hair, and applying lotion. The resident also required assistance with toileting related to needing assistance with peri care, help with clothing after toileting, and assistance to and from the bathroom. The Documentation Survey Report for the month of November 2025, provided by the Director of Nursing, indicated the resident received a shower on 11/2/25. Documentation related to showering on 11/9/25 and 11/25/25 was coded as "N/A." There was no documentation related to assistance with toileting for the day shift on 11/15, 11/16, and 11/26/25. The evening shift on 11/7, 11/10, 11/20, and 11/29/25. The night shift on 11/4, 11/13, 11/14, 11/15, 11/22, 11/29, and 11/30/25. The Documentation Survey Report for the month of December 2025 indicated the resident received three showers for the month on 12/7, 12/14,			

	and 12/28/25. December 21, 2025 was coded as "N/A." There was no documentation related to assistance with toileting for the evening shift on 12/14/25 and the night shift on 12/6, 12/19, 12/20, and 12/26/25. During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated showers were to be provided twice a week and assistance with toileting was to be provided at least once a shift and documented on the Documentation Survey Report. 5. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes. A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care. A Service Plan, dated 8/18/25, indicated the resident required assistance with bathing twice per week and required assistance changing incontinence product and peri care. A review of the resident's shower record from November 2025 to January 2026 indicated			

	showers were completed only on 11/9/25, 11/23/25, 12/12/25, and 12/16/25. There were no documented showers in January 2026. A review of the resident's incontinence/toileting record from November 2025 indicated the following dates were left blank with no documentation: Evening shift: 11/6, 11/8, 11/ 9, 11/19, 11/26/2025 Night shift: 11/13, 11/15, 11/22, 11/27, 11/30/2025 During an interview on 2/3/26 at 3:03 p.m., the Director of Nursing (DON) indicated they had a problem with documentation and she had been working on it. The showers should have been completed and documented twice a week, and there should have been no blanks on the toileting record. This citation relates to Intakes 465370, 466139, 466620, 467186, and 467340. 2. The record for Resident G was reviewed on 2/2/26 at 11:20 a.m. Diagnoses included, but were not limited to, dementia. A Service Plan, dated 3/26/25, indicated the resident required assistance with bathing. Interventions included the			

	following tasks to be completed twice weekly: assisting with transfers in / out of shower, cueing to wash self, shampooing / drying hair, applying lotion, and reporting any changes in skin to the nurse. A review of the resident's record lacked documentation of resident showers from 11/1/25 to 2/2/26. During an interview on 2/3/26 at 9:04 a.m., the Administrator indicated the resident required prompting / reminding for bathing, and that no showers were documented from 11/1/25 to 2/2/26. 3. The record for Resident B was reviewed on 2/2/26 at 2:30 p.m. Diagnoses included, but were not limited to, anemia, bradycardia (slow heart rate), and atrial fibrillation (irregular heartbeat). A Quarterly Assessment, dated 12/10/25, indicated the resident required assistance with incontinence management 6 times a day. A Hospice Significant Change in Status note, dated 12/24/25, indicated the resident's coccyx (tailbone area) wound had increased in size from 1 cm (centimeter) to 1.5 cm. Intervention included to keep			

	the resident turned off of her back, support her with pillows, and provide frequent incontinence care. A review of the resident's record lacked documentation of incontinence care from 11/1/26 to 2/2/26. During an interview on 2/2/26 at 2:00 p.m., Resident B's family member indicated staff provided incontinence care every 5 to 6 hours, at best. She indicated she had to call the facility to ask them to change the resident because based on room surveillance camera footage, it had been nearly 15 hours since she had been changed. During an interview on 2/3/26 at 9:33 a.m., the Administrator indicated there was no documentation of incontinence care for the resident from 11/1/26 to 2/2/26. 4. The record for Resident M was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and congestive heart failure. A Service Plan, dated 4/28/25, indicated the resident required assistance with bathing twice per week, on Monday and Friday. A review of the resident's record			

	from 11/1/25 to 2/3/26 indicated showers were completed only on 11/2/25, 12/7/25, 12/14/25, 12/28/25, and 1/6/26. During an interview on 2/3/26 3:03 p.m., the Administrator indicated the resident should have received, and the aide should have documented, two showers per week. Based on record review and interview, the facility failed to ensure activities of daily living (ADLs) related to bathing and incontinence care were provided for residents requiring assistance for 5 of 5 residents reviewed for ADLs. (Residents L, G, B, M and F) Findings include: 1. The record for Resident L was reviewed on 2/3/26 at 11:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and need for assistance with personal care. The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident required assistance with bathing related to transferring in and out of the shower, washing and drying his lower body, back shampooing, rinsing and drying his hair, and applying lotion. The resident also required assistance with toileting related to needing			

	assistance with peri care, help with clothing after toileting, and assistance to and from the bathroom. The Documentation Survey Report for the month of November 2025, provided by the Director of Nursing, indicated the resident received a shower on 11/2/25. Documentation related to showering on 11/9/25 and 11/25/25 was coded as "N/A." There was no documentation related to assistance with toileting for the day shift on 11/15, 11/16, and 11/26/25. The evening shift on 11/7, 11/10, 11/20, and 11/29/25. The night shift on 11/4, 11/13, 11/14, 11/15, 11/22, 11/29, and 11/30/25. The Documentation Survey Report for the month of December 2025 indicated the resident received three showers for the month on 12/7, 12/14, and 12/28/25. December 21, 2025 was coded as "N/A." There was no documentation related to assistance with toileting for the evening shift on 12/14/25 and the night shift on 12/6, 12/19, 12/20, and 12/26/25. During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated showers were			

	to be provided twice a week and assistance with toileting was to be provided at least once a shift and documented on the Documentation Survey Report. 5. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes. A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care. A Service Plan, dated 8/18/25, indicated the resident required assistance with bathing twice per week and required assistance changing incontinence product and peri care. A review of the resident's shower record from November 2025 to January 2026 indicated showers were completed only on 11/9/25, 11/23/25, 12/12/25, and 12/16/25. There were no documented showers in January 2026. A review of the resident's incontinence/toileting record from November 2025 indicated the following dates were left blank with no documentation: Evening shift: 11/6, 11/8, 11/ 9,			

	11/19, 11/26/2025 Night shift: 11/13, 11/15, 11/22, 11/27, 11/30/2025 During an interview on 2/3/26 at 3:03 p.m., the Director of Nursing (DON) indicated they had a problem with documentation and she had been working on it. The showers should have been completed and documented twice a week, and there should have been no blanks on the toileting record. This citation relates to Intakes 465370, 466139, 466620, 467186, and 467340. 2. The record for Resident G was reviewed on 2/2/26 at 11:20 a.m. Diagnoses included, but were not limited to, dementia. A Service Plan, dated 3/26/25, indicated the resident required assistance with bathing. Interventions included the following tasks to be completed twice weekly: assisting with transfers in / out of shower, cueing to wash self, shampooing / drying hair, applying lotion, and reporting any changes in skin to the nurse.			

	A review of the resident's record lacked documentation of resident showers from 11/1/25 to 2/2/26. During an interview on 2/3/26 at 9:04 a.m., the Administrator indicated the resident required prompting / reminding for bathing, and that no showers were documented from 11/1/25 to 2/2/26. 3. The record for Resident B was reviewed on 2/2/26 at 2:30 p.m. Diagnoses included, but were not limited to, anemia, bradycardia (slow heart rate), and atrial fibrillation (irregular heartbeat). A Quarterly Assessment, dated 12/10/25, indicated the resident required assistance with incontinence management 6 times a day. A Hospice Significant Change in Status note, dated 12/24/25, indicated the resident's coccyx (tailbone area) wound had increased in size from 1 cm (centimeter) to 1.5 cm. Intervention included to keep the resident turned off of her back, support her with pillows, and provide frequent incontinence care.			

	A review of the resident's record lacked documentation of incontinence care from 11/1/26 to 2/2/26. During an interview on 2/2/26 at 2:00 p.m., Resident B's family member indicated staff provided incontinence care every 5 to 6 hours, at best. She indicated she had to call the facility to ask them to change the resident because based on room surveillance camera footage, it had been nearly 15 hours since she had been changed. During an interview on 2/3/26 at 9:33 a.m., the Administrator indicated there was no documentation of incontinence care for the resident from 11/1/26 to 2/2/26. 4. The record for Resident M was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and congestive heart failure. A Service Plan, dated 4/28/25, indicated the resident required assistance with bathing twice per week, on Monday and Friday. A review of the resident's record from 11/1/25 to 2/3/26 indicated showers were completed only on 11/2/25, 12/7/25, 12/14/25, 12/28/25, and 1/6/26.			

	During an interview on 2/3/26 3:03 p.m., the Administrator indicated the resident should have received, and the aide should have documented, two showers per week. Based on record review and interview, the facility failed to ensure activities of daily living (ADLs) related to bathing and incontinence care were provided for residents requiring assistance for 5 of 5 residents reviewed for ADLs. (Residents L, G, B, M and F) Findings include: 1. The record for Resident L was reviewed on 2/3/26 at 11:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and need for assistance with personal care. The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident required assistance with bathing related to transferring in and out of the shower, washing and drying his lower body, back shampooing, rinsing and drying his hair, and applying lotion. The resident also required assistance with toileting related to needing assistance with peri care, help with clothing after toileting, and assistance to and from the bathroom.			

	The Documentation Survey Report for the month of November 2025, provided by the Director of Nursing, indicated the resident received a shower on 11/2/25. Documentation related to showering on 11/9/25 and 11/25/25 was coded as "N/A." There was no documentation related to assistance with toileting for the day shift on 11/15, 11/16, and 11/26/25. The evening shift on 11/7, 11/10, 11/20, and 11/29/25. The night shift on 11/4, 11/13, 11/14, 11/15, 11/22, 11/29, and 11/30/25. The Documentation Survey Report for the month of December 2025 indicated the resident received three showers for the month on 12/7, 12/14, and 12/28/25. December 21, 2025 was coded as "N/A." There was no documentation related to assistance with toileting for the evening shift on 12/14/25 and the night shift on 12/6, 12/19, 12/20, and 12/26/25.			

	During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated showers were to be provided twice a week and assistance with toileting was to be provided at least once a shift and documented on the Documentation Survey Report. 5. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes. A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care. A Service Plan, dated 8/18/25, indicated the resident required assistance with bathing twice per week and required assistance changing incontinence product and peri care. A review of the resident's shower record from November 2025 to January 2026 indicated showers were completed only on 11/9/25, 11/23/25, 12/12/25, and 12/16/25. There were no documented showers in January 2026. A review of the resident's incontinence/toileting record from November 2025 indicated the following dates were left			

	blank with no documentation: Evening shift: 11/6, 11/8, 11/ 9, 11/19, 11/26/2025 Night shift: 11/13, 11/15, 11/22, 11/27, 11/30/2025 During an interview on 2/3/26 at 3:03 p.m., the Director of Nursing (DON) indicated they had a problem with documentation and she had been working on it. The showers should have been completed and documented twice a week, and there should have been no blanks on the toileting record. This citation relates to Intakes 465370, 466139, 466620, 467186, and 467340. 2. The record for Resident G was reviewed on 2/2/26 at 11:20 a.m. Diagnoses included, but were not limited to, dementia. A Service Plan, dated 3/26/25, indicated the resident required assistance with bathing. Interventions included the following tasks to be completed twice weekly: assisting with transfers in / out of shower, cueing to wash self, shampooing / drying hair, applying lotion, and reporting any changes in skin to the nurse. A review of the resident's record			

	lacked documentation of resident showers from 11/1/25 to 2/2/26. During an interview on 2/3/26 at 9:04 a.m., the Administrator indicated the resident required prompting / reminding for bathing, and that no showers were documented from 11/1/25 to 2/2/26. 3. The record for Resident B was reviewed on 2/2/26 at 2:30 p.m. Diagnoses included, but were not limited to, anemia, bradycardia (slow heart rate), and atrial fibrillation (irregular heartbeat). A Quarterly Assessment, dated 12/10/25, indicated the resident required assistance with incontinence management 6 times a day. A Hospice Significant Change in Status note, dated 12/24/25, indicated the resident's coccyx (tailbone area) wound had increased in size from 1 cm (centimeter) to 1.5 cm. Intervention included to keep the resident turned off of her back, support her with pillows, and provide frequent incontinence care. A review of the resident's record lacked documentation of incontinence care from 11/1/26 to 2/2/26.			

	During an interview on 2/2/26 at 2:00 p.m., Resident B's family member indicated staff provided incontinence care every 5 to 6 hours, at best. She indicated she had to call the facility to ask them to change the resident because based on room surveillance camera footage, it had been nearly 15 hours since she had been changed. During an interview on 2/3/26 at 9:33 a.m., the Administrator indicated there was no documentation of incontinence care for the resident from 11/1/26 to 2/2/26. 4. The record for Resident M was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and congestive heart failure. A Service Plan, dated 4/28/25, indicated the resident required assistance with bathing twice per week, on Monday and Friday. A review of the resident's record from 11/1/25 to 2/3/26 indicated showers were completed only on 11/2/25, 12/7/25, 12/14/25, 12/28/25, and 1/6/26. During an interview on 2/3/26 3:03 p.m., the Administrator indicated the resident should have received, and the aide should have documented, two			

	showers per week. Based on record review and interview, the facility failed to ensure activities of daily living (ADLs) related to bathing and incontinence care were provided for residents requiring assistance for 5 of 5 residents reviewed for ADLs. (Residents L, G, B, M and F) Findings include: 1. The record for Resident L was reviewed on 2/3/26 at 11:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and need for assistance with personal care. The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident required assistance with bathing related to transferring in and out of the shower, washing and drying his lower body, back shampooing, rinsing and drying his hair, and applying lotion. The resident also required assistance with toileting related to needing assistance with peri care, help with clothing after toileting, and assistance to and from the bathroom. The Documentation Survey Report for the month of November 2025, provided by the Director of Nursing, indicated the resident received a			

	shower on 11/2/25. Documentation related to showering on 11/9/25 and 11/25/25 was coded as "N/A." There was no documentation related to assistance with toileting for the day shift on 11/15, 11/16, and 11/26/25. The evening shift on 11/7, 11/10, 11/20, and 11/29/25. The night shift on 11/4, 11/13, 11/14, 11/15, 11/22, 11/29, and 11/30/25. The Documentation Survey Report for the month of December 2025 indicated the resident received three showers for the month on 12/7, 12/14, and 12/28/25. December 21, 2025 was coded as "N/A." There was no documentation related to assistance with toileting for the evening shift on 12/14/25 and the night shift on 12/6, 12/19, 12/20, and 12/26/25. During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated showers were to be provided twice a week and assistance with toileting was to be provided at least once a shift and documented on the Documentation Survey Report. 5. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety,			

	stroke, dementia, and diabetes. A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care. A Service Plan, dated 8/18/25, indicated the resident required assistance with bathing twice per week and required assistance changing incontinence product and peri care. A review of the resident's shower record from November 2025 to January 2026 indicated showers were completed only on 11/9/25, 11/23/25, 12/12/25, and 12/16/25. There were no documented showers in January 2026. A review of the resident's incontinence/toileting record from November 2025 indicated the following dates were left blank with no documentation: Evening shift: 11/6, 11/8, 11/ 9, 11/19, 11/26/2025 Night shift: 11/13, 11/15, 11/22, 11/27, 11/30/2025 During an interview on 2/3/26 at 3:03 p.m., the Director of Nursing (DON) indicated they had a problem with documentation and she had			

	been working on it. The showers should have been completed and documented twice a week, and there should have been no blanks on the toileting record. This citation relates to Intakes 465370, 466139, 466620, 467186, and 467340. 2. The record for Resident G was reviewed on 2/2/26 at 11:20 a.m. Diagnoses included, but were not limited to, dementia. A Service Plan, dated 3/26/25, indicated the resident required assistance with bathing. Interventions included the following tasks to be completed twice weekly: assisting with transfers in / out of shower, cueing to wash self, shampooing / drying hair, applying lotion, and reporting any changes in skin to the nurse. A review of the resident's record lacked documentation of resident showers from 11/1/25 to 2/2/26. During an interview on 2/3/26 at 9:04 a.m., the Administrator indicated the resident required prompting / reminding for bathing, and that no showers were documented from 11/1/25 to 2/2/26. 3. The record for Resident B			

	was reviewed on 2/2/26 at 2:30 p.m. Diagnoses included, but were not limited to, anemia, bradycardia (slow heart rate), and atrial fibrillation (irregular heartbeat). A Quarterly Assessment, dated 12/10/25, indicated the resident required assistance with incontinence management 6 times a day. A Hospice Significant Change in Status note, dated 12/24/25, indicated the resident's coccyx (tailbone area) wound had increased in size from 1 cm (centimeter) to 1.5 cm. Intervention included to keep the resident turned off of her back, support her with pillows, and provide frequent incontinence care. A review of the resident's record lacked documentation of incontinence care from 11/1/26 to 2/2/26. During an interview on 2/2/26 at 2:00 p.m., Resident B's family member indicated staff provided incontinence care every 5 to 6 hours, at best. She indicated she had to call the facility to ask them to change the resident because based on room surveillance camera footage, it had been nearly 15 hours since she had been changed. During an interview on 2/3/26 at			

	9:33 a.m., the Administrator indicated there was no documentation of incontinence care for the resident from 11/1/26 to 2/2/26. 4. The record for Resident M was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and congestive heart failure. A Service Plan, dated 4/28/25, indicated the resident required assistance with bathing twice per week, on Monday and Friday. A review of the resident's record from 11/1/25 to 2/3/26 indicated showers were completed only on 11/2/25, 12/7/25, 12/14/25, 12/28/25, and 1/6/26. During an interview on 2/3/26 3:03 p.m., the Administrator indicated the resident should have received, and the aide should have documented, two showers per week. Based on record review and interview, the facility failed to ensure activities of daily living (ADLs) related to bathing and incontinence care were provided for residents requiring assistance for 5 of 5 residents reviewed for ADLs. (Residents L, G, B, M and F)			

	Findings include: 1. The record for Resident L was reviewed on 2/3/26 at 11:48 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and need for assistance with personal care. The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident required assistance with bathing related to transferring in and out of the shower, washing and drying his lower body, back shampooing, rinsing and drying his hair, and applying lotion. The resident also required assistance with toileting related to needing assistance with peri care, help with clothing after toileting, and assistance to and from the bathroom. The Documentation Survey Report for the month of November 2025, provided by the Director of Nursing, indicated the resident received a shower on 11/2/25. Documentation related to showering on 11/9/25 and 11/25/25 was coded as "N/A." There was no documentation related to assistance with toileting for the day shift on 11/15, 11/16, and 11/26/25. The evening shift on 11/7, 11/10, 11/20, and 11/29/25. The night shift on 11/4, 11/13, 11/14,			

	11/15, 11/22, 11/29, and 11/30/25. The Documentation Survey Report for the month of December 2025 indicated the resident received three showers for the month on 12/7, 12/14, and 12/28/25. December 21, 2025 was coded as "N/A." There was no documentation related to assistance with toileting for the evening shift on 12/14/25 and the night shift on 12/6, 12/19, 12/20, and 12/26/25. During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated showers were to be provided twice a week and assistance with toileting was to be provided at least once a shift and documented on the Documentation Survey Report. 5. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes. A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care. A Service Plan, dated 8/18/25, indicated the resident required assistance with bathing twice			

	per week and required assistance changing incontinence product and peri care. A review of the resident's shower record from November 2025 to January 2026 indicated showers were completed only on 11/9/25, 11/23/25, 12/12/25, and 12/16/25. There were no documented showers in January 2026. A review of the resident's incontinence/toileting record from November 2025 indicated the following dates were left blank with no documentation: Evening shift: 11/6, 11/8, 11/ 9, 11/19, 11/26/2025 Night shift: 11/13, 11/15, 11/22, 11/27, 11/30/2025 During an interview on 2/3/26 at 3:03 p.m., the Director of Nursing (DON) indicated they had a problem with documentation and she had been working on it. The showers should have been completed and documented twice a week, and there should have been no blanks on the toileting record. This citation relates to Intakes 465370, 466139, 466620, 467186, and 467340.			

R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to follow-up documentation after a fall, bruising, incident charting, and documentation of vital signs after a change in condition for 3 of 13 sampled residents. (Residents E, J, and F) Findings include: 1. The record for Resident E was reviewed on 2/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and anxiety. The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident had	R 0349	This facility will complete follow up documentation post falls, change in condition, andmonitoringorders with vitals. An audit of all records for the past90 dayshas been completed. No other residents were identified as being affected by this deficient practice.Nursing staff were educated on proper documentation for all changes in conditions.The DON/Designee will audit records for compliancetwice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. All findings will be reviewed during our monthly QA meeting.	03/01/2026

moderate dementia with significant short term memory and possibly long term memory loss.

A Skin/Wound Note, dated 12/7/25 at 1:49 p.m., indicated a skin tear from 12/4/25 remained to the left upper arm. The was no documentation on 12/4/25 of the initial incident. The next documented entry in the nursing progress notes after 12/7/25 was 12/18/25.

A State Reportable Incident, dated 1/13/26, indicated the resident had slapped another resident in the face. There was no documentation of the incident in the nursing progress notes.

An Incident Note, dated 1/21/26 at 11:42 p.m., indicated the resident was observed sitting on her buttocks next to her bed. The resident indicated that she fell trying to get out of her bed. The resident pointed to a scratch on the inside of her right arm and she stated that it hurt a little. The resident denied any pain or discomfort anywhere else. The resident indicated that she was not in any pain. The next documented entry in the nursing progress notes was on 1/23/26 at 3:37 p.m.

During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated the incident

	related to the resident to resident altercation on 1/13/26 should have been documented in the nursing progress notes as an incident note. She also indicated it was her expectation for follow-up documentation to be completed for 72 hours after a fall, bruising, or skin tear. 3. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes. A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care.			

A Incident Note, dated 1/6/26 at 9:01 a.m., indicated the writer was called to the resident's room by the CNA. Upon arrival the resident was observed with a blanket over her. When the writer said good morning to the resident, the resident had difficulty speaking. The writer then observed swelling of the resident's tongue. The nurse was notified and assessed the resident. The nurse advised the writer to call 911. The resident was transferred to the hospital for further evaluation. The Power of Attorney (POA), Director of Nursing (DON), and the Nurse Practitioner were notified.

During an interview 2/3/26, at 9:04 a.m., The DON indicated the resident was sent out on to the hospital because she had a swollen tongue and it was affecting her airway. She indicated they did not know if it was an allergic reaction, just that her airway was affected. She reported the assessment and vitals were in their incident report.

During an interview on 2/3/26 at 9:33 a.m., the DON indicated there were no vitals completed on Resident F prior to sending her to the hospital.

This citation relates to Intakes 466132 and 467186.

2. The record for Resident J was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and dementia.

The record indicated the resident returned to the facility from a hospitalization on 1/5/26.

A Skin Assessment, dated 1/5/26, indicated the resident had bruising to the following areas: right antecubital (front side of elbow area), left antecubital, right elbow, left elbow, right thigh, and left thigh. The record lacked another assessment of the bruising until 1/13/26.

During an interview on 2/3/26 at 3:25 p.m., the Administrator indicated the bruises should have been monitored and documented every shift for 72 hours.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to follow-up documentation after a fall, bruising, incident charting, and documentation of vital signs after a change in condition for 3 of 13 sampled residents. (Residents E, J, and F)

Findings include:

1. The record for Resident E

was reviewed on 2/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and anxiety.

The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident had moderate dementia with significant short term memory and possibly long term memory loss.

A Skin/Wound Note, dated 12/7/25 at 1:49 p.m., indicated a skin tear from 12/4/25 remained to the left upper arm. The was no documentation on 12/4/25 of the initial incident. The next documented entry in the nursing progress notes after 12/7/25 was 12/18/25.

A State Reportable Incident, dated 1/13/26, indicated the resident had slapped another resident in the face. There was no documentation of the incident in the nursing progress notes.

An Incident Note, dated 1/21/26 at 11:42 p.m., indicated the resident was observed sitting on her buttocks next to her bed. The resident indicated that she fell trying to get out of her bed. The resident pointed to a scratch on the inside of her right arm and she stated that it hurt a little. The resident denied any pain or discomfort anywhere

else. The resident indicated that she was not in any pain. The next documented entry in the nursing progress notes was on 1/23/26 at 3:37 p.m.

During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated the incident related to the resident to resident altercation on 1/13/26 should have been documented in the nursing progress notes as an incident note. She also indicated it was her expectation for follow-up documentation to be completed for 72 hours after a fall, bruising, or skin tear.

3. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes.

A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care.

A Incident Note, dated 1/6/26 at 9:01 a.m., indicated the writer was called to the resident's room by the CNA. Upon arrival the resident was observed with a blanket over her. When the writer said good morning to the resident, the resident had difficulty speaking. The writer then observed swelling of the resident's tongue. The nurse

was notified and assessed the resident. The nurse advised the writer to call 911. The resident was transferred to the hospital for further evaluation. The Power of Attorney (POA), Director of Nursing (DON), and the Nurse Practitioner were notified.

During an interview 2/3/26, at 9:04 a.m., The DON indicated the resident was sent out on to the hospital because she had a swollen tongue and it was affecting her airway. She indicated they did not know if it was an allergic reaction, just that her airway was affected. She reported the assessment and vitals were in their incident report.

During an interview on 2/3/26 at 9:33 a.m., the DON indicated there were no vitals completed on Resident F prior to sending her to the hospital.

This citation relates to Intakes 466132 and 467186.

2. The record for Resident J was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and dementia.

The record indicated the resident returned to the facility from a hospitalization on 1/5/26.

A Skin Assessment, dated

1/5/26, indicated the resident had bruising to the following areas: right antecubital (front side of elbow area), left antecubital, right elbow, left elbow, right thigh, and left thigh. The record lacked another assessment of the bruising until 1/13/26.

During an interview on 2/3/26 at 3:25 p.m., the Administrator indicated the bruises should have been monitored and documented every shift for 72 hours.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to follow-up documentation after a fall, bruising, incident charting, and documentation of vital signs after a change in condition for 3 of 13 sampled residents. (Residents E, J, and F)

Findings include:

1. The record for Resident E was reviewed on 2/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and anxiety.

The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident had moderate dementia with significant short term memory

and possibly long term memory loss.

A Skin/Wound Note, dated 12/7/25 at 1:49 p.m., indicated a skin tear from 12/4/25 remained to the left upper arm. The was no documentation on 12/4/25 of the initial incident. The next documented entry in the nursing progress notes after 12/7/25 was 12/18/25.

A State Reportable Incident, dated 1/13/26, indicated the resident had slapped another resident in the face. There was no documentation of the incident in the nursing progress notes.

An Incident Note, dated 1/21/26 at 11:42 p.m., indicated the resident was observed sitting on her buttocks next to her bed. The resident indicated that she fell trying to get out of her bed. The resident pointed to a scratch on the inside of her right arm and she stated that it hurt a little. The resident denied any pain or discomfort anywhere else. The resident indicated that she was not in any pain. The next documented entry in the nursing progress notes was on 1/23/26 at 3:37 p.m.

During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated the incident related to the resident to resident altercation on 1/13/26

should have been documented in the nursing progress notes as an incident note. She also indicated it was her expectation for follow-up documentation to be completed for 72 hours after a fall, bruising, or skin tear.

3. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes.

A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care.

A Incident Note, dated 1/6/26 at 9:01 a.m., indicated the writer was called to the resident's room by the CNA. Upon arrival the resident was observed with a blanket over her. When the writer said good morning to the resident, the resident had difficulty speaking. The writer then observed swelling of the resident's tongue. The nurse was notified and assessed the resident. The nurse advised the writer to call 911. The resident was transferred to the hospital for further evaluation. The Power of Attorney (POA), Director of Nursing (DON), and the Nurse Practitioner were notified.

During an interview 2/3/26, at

9:04 a.m., The DON indicated the resident was sent out on to the hospital because she had a swollen tongue and it was affecting her airway. She indicated they did not know if it was an allergic reaction, just that her airway was affected. She reported the assessment and vitals were in their incident report.

During an interview on 2/3/26 at 9:33 a.m., the DON indicated there were no vitals completed on Resident F prior to sending her to the hospital.

This citation relates to Intakes 466132 and 467186.

2. The record for Resident J was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and dementia.

The record indicated the resident returned to the facility from a hospitalization on 1/5/26.

A Skin Assessment, dated 1/5/26, indicated the resident had bruising to the following areas: right antecubital (front side of elbow area), left antecubital, right elbow, left elbow, right thigh, and left thigh. The record lacked another assessment of the bruising until 1/13/26.

During an interview on 2/3/26 at

3:25 p.m., the Administrator indicated the bruises should have been monitored and documented every shift for 72 hours.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to follow-up documentation after a fall, bruising, incident charting, and documentation of vital signs after a change in condition for 3 of 13 sampled residents. (Residents E, J, and F)

Findings include:

1. The record for Resident E was reviewed on 2/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and anxiety.

The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident had moderate dementia with significant short term memory and possibly long term memory loss.

A Skin/Wound Note, dated 12/7/25 at 1:49 p.m., indicated a skin tear from 12/4/25 remained to the left upper arm. The was no documentation on 12/4/25 of the initial incident. The next documented entry in the nursing progress notes after 12/7/25

was 12/18/25.

A State Reportable Incident, dated 1/13/26, indicated the resident had slapped another resident in the face. There was no documentation of the incident in the nursing progress notes.

An Incident Note, dated 1/21/26 at 11:42 p.m., indicated the resident was observed sitting on her buttocks next to her bed. The resident indicated that she fell trying to get out of her bed. The resident pointed to a scratch on the inside of her right arm and she stated that it hurt a little. The resident denied any pain or discomfort anywhere else. The resident indicated that she was not in any pain. The next documented entry in the nursing progress notes was on 1/23/26 at 3:37 p.m.

During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated the incident related to the resident to resident altercation on 1/13/26 should have been documented in the nursing progress notes as an incident note. She also indicated it was her expectation for follow-up documentation to be completed for 72 hours after a fall, bruising, or skin tear.

3. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included,

	but were not limited to, anxiety, stroke, dementia, and diabetes. A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care. A Incident Note, dated 1/6/26 at 9:01 a.m., indicated the writer was called to the resident's room by the CNA. Upon arrival the resident was observed with a blanket over her. When the writer said good morning to the resident, the resident had difficulty speaking. The writer then observed swelling of the resident's tongue. The nurse was notified and assessed the resident. The nurse advised the writer to call 911. The resident was transferred to the hospital for further evaluation. The Power of Attorney (POA), Director of Nursing (DON), and the Nurse Practitioner were notified.			

During an interview 2/3/26, at 9:04 a.m., The DON indicated the resident was sent out on to the hospital because she had a swollen tongue and it was affecting her airway. She indicated they did not know if it was an allergic reaction, just that her airway was affected. She reported the assessment and vitals were in their incident report.

During an interview on 2/3/26 at 9:33 a.m., the DON indicated there were no vitals completed on Resident F prior to sending her to the hospital.

This citation relates to Intakes 466132 and 467186.

2. The record for Resident J was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and dementia.

The record indicated the resident returned to the facility from a hospitalization on 1/5/26.

A Skin Assessment, dated 1/5/26, indicated the resident had bruising to the following areas: right antecubital (front side of elbow area), left antecubital, right elbow, left elbow, right thigh, and left thigh. The record lacked another assessment of the bruising until 1/13/26.

During an interview on 2/3/26 at 3:25 p.m., the Administrator indicated the bruises should have been monitored and documented every shift for 72 hours.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to follow-up documentation after a fall, bruising, incident charting, and documentation of vital signs after a change in condition for 3 of 13 sampled residents. (Residents E, J, and F)

Findings include:

1. The record for Resident E was reviewed on 2/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and anxiety.

The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident had moderate dementia with significant short term memory and possibly long term memory loss.

A Skin/Wound Note, dated 12/7/25 at 1:49 p.m., indicated a skin tear from 12/4/25 remained to the left upper arm. The was no documentation on 12/4/25 of the initial incident. The next documented entry in the nursing

progress notes after 12/7/25 was 12/18/25.

A State Reportable Incident, dated 1/13/26, indicated the resident had slapped another resident in the face. There was no documentation of the incident in the nursing progress notes.

An Incident Note, dated 1/21/26 at 11:42 p.m., indicated the resident was observed sitting on her buttocks next to her bed. The resident indicated that she fell trying to get out of her bed. The resident pointed to a scratch on the inside of her right arm and she stated that it hurt a little. The resident denied any pain or discomfort anywhere else. The resident indicated that she was not in any pain. The next documented entry in the nursing progress notes was on 1/23/26 at 3:37 p.m.

During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated the incident related to the resident to resident altercation on 1/13/26 should have been documented in the nursing progress notes as an incident note. She also indicated it was her expectation for follow-up documentation to be completed for 72 hours after a fall, bruising, or skin tear.

3. The record for Resident F was reviewed on 2/2/26 at

10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes.

A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care.

A Incident Note, dated 1/6/26 at 9:01 a.m., indicated the writer was called to the resident's room by the CNA. Upon arrival the resident was observed with a blanket over her. When the writer said good morning to the resident, the resident had difficulty speaking. The writer then observed swelling of the resident's tongue. The nurse was notified and assessed the resident. The nurse advised the writer to call 911. The resident was transferred to the hospital for further evaluation. The Power of Attorney (POA), Director of Nursing (DON), and the Nurse Practitioner were notified.

During an interview 2/3/26, at 9:04 a.m., The DON indicated the resident was sent out on to the hospital because she had a swollen tongue and it was affecting her airway. She indicated they did not know if it was an allergic reaction, just that her airway was affected. She reported the assessment and vitals were in their incident

report.

During an interview on 2/3/26 at 9:33 a.m., the DON indicated there were no vitals completed on Resident F prior to sending her to the hospital.

This citation relates to Intakes 466132 and 467186.

2. The record for Resident J was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and dementia.

The record indicated the resident returned to the facility from a hospitalization on 1/5/26.

A Skin Assessment, dated 1/5/26, indicated the resident had bruising to the following areas: right antecubital (front side of elbow area), left antecubital, right elbow, left elbow, right thigh, and left thigh. The record lacked another assessment of the bruising until 1/13/26.

During an interview on 2/3/26 at 3:25 p.m., the Administrator indicated the bruises should have been monitored and documented every shift for 72 hours.

Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately

documented related to follow-up documentation after a fall, bruising, incident charting, and documentation of vital signs after a change in condition for 3 of 13 sampled residents. (Residents E, J, and F)

Findings include:

1. The record for Resident E was reviewed on 2/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder and anxiety.

The Service Plan, dated 4/29/25 and reviewed on 2/2/26, indicated the resident had moderate dementia with significant short term memory and possibly long term memory loss.

A Skin/Wound Note, dated 12/7/25 at 1:49 p.m., indicated a skin tear from 12/4/25 remained to the left upper arm. The was no documentation on 12/4/25 of the initial incident. The next documented entry in the nursing progress notes after 12/7/25 was 12/18/25.

A State Reportable Incident, dated 1/13/26, indicated the resident had slapped another resident in the face. There was no documentation of the incident in the nursing progress notes.

An Incident Note, dated 1/21/26 at 11:42 p.m., indicated the resident was observed sitting on her buttocks next to her bed. The resident indicated that she fell trying to get out of her bed. The resident pointed to a scratch on the inside of her right arm and she stated that it hurt a little. The resident denied any pain or discomfort anywhere else. The resident indicated that she was not in any pain. The next documented entry in the nursing progress notes was on 1/23/26 at 3:37 p.m.

During an interview on 2/3/26 at 3:30 p.m., the Director of Nursing indicated the incident related to the resident to resident altercation on 1/13/26 should have been documented in the nursing progress notes as an incident note. She also indicated it was her expectation for follow-up documentation to be completed for 72 hours after a fall, bruising, or skin tear.

3. The record for Resident F was reviewed on 2/2/26 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety, stroke, dementia, and diabetes.

A Service Plan, dated 10/8/24 and revised on 1/8/25, indicated the resident had memory loss and required support to make appropriate decisions about her care.

A Incident Note, dated 1/6/26 at 9:01 a.m., indicated the writer was called to the resident's room by the CNA. Upon arrival the resident was observed with a blanket over her. When the writer said good morning to the resident, the resident had difficulty speaking. The writer then observed swelling of the resident's tongue. The nurse was notified and assessed the resident. The nurse advised the writer to call 911. The resident was transferred to the hospital for further evaluation. The Power of Attorney (POA), Director of Nursing (DON), and the Nurse Practitioner were notified.

During an interview 2/3/26, at 9:04 a.m., The DON indicated the resident was sent out on to the hospital because she had a swollen tongue and it was affecting her airway. She indicated they did not know if it was an allergic reaction, just that her airway was affected. She reported the assessment and vitals were in their incident report.

During an interview on 2/3/26 at 9:33 a.m., the DON indicated there were no vitals completed on Resident F prior to sending her to the hospital.

This citation relates to Intakes 466132 and 467186.

	2. The record for Resident J was reviewed on 2/3/26 at 10:00 a.m. Diagnoses included, but were not limited to, hypertension and dementia. The record indicated the resident returned to the facility from a hospitalization on 1/5/26. A Skin Assessment, dated 1/5/26, indicated the resident had bruising to the following areas: right antecubital (front side of elbow area), left antecubital, right elbow, left elbow, right thigh, and left thigh. The record lacked another assessment of the bruising until 1/13/26. During an interview on 2/3/26 at 3:25 p.m., the Administrator indicated the bruises should have been monitored and documented every shift for 72 hours.			

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 SIGNATURESearfeeair Sutherland	TITLEDON	(X6) DATE02/20/2026