STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE MEMORY CARE OF ANDERSON	2101 N MADISON AVENUE, ANDERSON, , 46011

(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 Intake 469215. Intake 469215 - State deficiencies related to the allegations are cited at R029, R090, and R217. Unrelated deficiencies are cited. Survey dates: April 29 and 30, 2026 Facility number: 013811 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review May 11, 2026.	R 0000		
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect,	R 0029		05/13/2026

	and recognition of their dignity and individuality. Based on interview and record review, the facility failed to ensure a staff member treated a resident with respect and dignity for 1 of 3 residents reviewed for quality of care. (LPN 6 and Resident B) Findings include: An anonymous allegation of mistreatment and neglect of Resident B was received by Indiana Department of Health on 4/16/26. Resident B's clinical record was reviewed on 4/29/26 at 11:50 a.m. Diagnoses included repeated falls and left knee pain, unsteadiness, repeated falls, unspecified symptoms and signs involving cognitive functions and awareness, dementia, cognitive communication deficit, and rib fractures. A current 30-day service plan, dated 9/22/25, indicated she was severely cognitively impaired. A progress note, dated 12/28/25 at 5:31 a.m., indicated staff heard someone yelling for help and found Resident B sitting on floor by entry door when the door was opened. She indicated			

	that she had a knot on her head. She was assessed and lifted to standing position by two staff members. Her walker was positioned by the recliner and given to her to ambulate to the recliner. Her range of motion (ROM) and all extremities moved as before. She was noted to have 2.2 centimeter (cm) round knot on her left posterior head. She could not state what occurred, but indicated the walker was in the bathroom. A late entry progress note for 12/31/25, dated 1/2/26 at 9:58 a.m. indicated she was asked if anyone had been mean to her. She denied that anyone had been mean to her and that everyone was nice. She was asked if helped her when needed, and she indicated that she loved living at the facility and that everyone was so helpful. A summary of an investigation, provided by the Executive Director on 4/30/26 at 9:28 a.m., indicated it was reported to the ADON that a staff member was verbally inappropriate with Resident B on 12/28/25 at 5:00 a.m. The staff member was immediately removed from the floor and sent home. The staff member did not return and was terminated. Resident B was assessed to ensure that she			

	exhibited no emotional distress related to the alleged incident. A 29-seconds long video of the incident was provided by the Memory Care Director on 4/30/26 at 10:31 a.m. The video depicted LPN 6 standing beside Resident B's recliner while Resident B ambulated backwards using her walker to sit. Resident B moved the walker to her right, and LPN 6 asked gruffly, "So tell me why this (pointing at the walker) is over here (pointing in the living room) and you're over there (motioning towards the bathroom)." Resident B replied "Well, because it was in the bathroom." LPN stated, "No, it was right there (pointing in the living room)." Resident B said "No," and LPN 6 stated, "Yes ma'am." Resident B then said, "Yes, it was." She touched the back of her head with her right hand and began to say that she had a knot on the back of her head, but LPN 6 interrupted her and stated, "So what." Resident B repeated, "I have a knot on the back of my head." LPN 6 again stated, "So what," and the video ended. The Memory Care Director provided the facility's investigative statements on 4/30/26 at 10:51 a.m., which included the following:			

	The previous ADON's written statement indicated that she spoke with Resident B's family on 12/30/25 around 2:00 p.m. and reported concerns of Resident B lying on the floor for 20 minutes after a fall on 12/24/25. On 12/28/25, a lady who assisted Resident B was very rude and explained the incident. Resident B's family sent the ADON a picture of the lady in question. The ADON apologized to Resident B's family repeatedly and indicated they didn't take these things lightly and they would be looking into it. An undated handwritten statement signed by LPN 6 indicated that she had been a nurse for 43 years and that, regardless of her residents' diagnoses, she always attempted to do her best and within her scope of practice to keep them safe. She had reminded Resident B numerous times not to forget her walker on the date of the incident. Resident B was adamant that she left her walker in the bathroom and it was sitting by the recliner. If it was recorded on the smart speaker device that she told Resident B "I don't care," it was only in reference to where Resident B left her walker or where she thought she left it. She further indicated that she cared deeply for every resident			

	she cared for and provided safety suggestions for Resident B. During an interview, on 4/30/26 at 12:51 p.m., the Memory Care Director indicated, after the video was reviewed, LPN 6 was suspended pending an investigation. The Memory Care Director denied the video constituting abuse but acknowledged that the way LPN 6 spoke to Resident B was inappropriate. LPN 6's education was provided by the Memory Care Director on 4/30/26 at 12:06 p.m. LPN 6 was educated on Abuse 10/27/25 and Resident Rights 10/27/25. A current facility policy, revised 8/4/23, titled "Resident Rights," provided by the Memory Care Director on 4/30/26 at 1:53 p.m. indicated the following: "...Policy Statement: Community is dedicated to upholding and respecting the rights of all residents. This policy outlines the rights and privileges of residents, ensures their awareness of these rights, and provides guidelines for maintaining residents' dignity, autonomy, and quality of life...." This citation relates to Intake 469215.			

R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.	R 0090		05/13/2026

	(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the State Agency (Indiana Department of Health) for 1 of 1 reportable abuse allegation reviewed. (LPN 6 and Resident B) Findings include:			

	An anonymous allegation of mistreatment and neglect of Resident B was received by Indiana Department of Health on 4/16/26. Resident B's clinical record was reviewed on 4/29/26 at 11:50 a.m. Diagnoses included repeated falls and left knee pain, unsteadiness, repeated falls, unspecified symptoms and signs involving cognitive functions and awareness, dementia, cognitive communication deficit and rib fractures. A current 30-day service plan dated 9/22/25 indicated she was severely cognitively impaired. A progress note, dated 12/28/25 at 5:31 a.m., indicated staff heard someone yelling for help and found Resident B sitting on floor by the entry door when the door was opened. She indicated that she had a knot on her head. She could not state what occurred but indicated the walker was in the bathroom. A late entry progress note for 12/31/25, dated 1/2/26 at 9:58 a.m. indicated she was asked if anyone had been mean to her. She denied that anyone had been mean to her and that everyone was nice. She was asked if helped her when needed, and she indicated that she loved living at the facility			

	and that everyone was so helpful. A summary of the investigation provided by the Executive Director on 4/30/26 at 9:28 a.m. indicated it was reported to the ADON that a staff member was verbally inappropriate with Resident B on 12/28/26 at 5:00 a.m. The staff member was immediately removed from the floor and sent home. ADON reported the allegation to the DON and Executive Director. The Regional DON and Regional Operations Manager were also notified. The family and physician were contacted and statements were obtained from staff. The staff member did not return and was terminated. Resident B was assessed to ensure that she exhibited no emotional distress related to the alleged incident. Other residents were assessed and questioned whether they felt fearful of any caregivers. No concerns were reported and it was documented in their observations. Memory care staff were in-serviced regarding the Abuse/Neglect/Exploitation policy. Based on Resident B's assessment showing no emotional distress related to the alleged incident, it was determined that he incident was not a reportable incident per facility policy.			

	The 29-seconds long video of the incident was provided by the Memory Care Director on 4/30/26 at 10:31 a.m. The video depicted LPN 6 standing beside Resident B's recliner while Resident B ambulated backwards using her walker to sit. Resident B moved the walker to her right, and LPN 6 asked gruffly, "So tell me why this (pointing at the walker) is over here (pointing in the living room) and you're over there (motioning towards the bathroom)." Resident B replied "Well, because it was in the bathroom." LPN stated, "No, it was right there (pointing in the living room)." Resident B said "No," and LPN 6 stated, "Yes ma'am." Resident B then said, "Yes, it was." She touched the back of her head with her right hand and began to say that she had a knot on the back of her head, but LPN 6 interrupted her and stated, "So what." Resident B repeated, "I have a knot on the back of my head." LPN 6 again stated, "So what," and the video ended. The Memory Care Director provided the investigative statements on 4/30/26 at 10:51 a.m. which indicated the following: The previous ADON's written statement indicated that she spoke with Resident B's family			

	on 12/30/26 around 2:00 p.m. and reported concerns of Resident B lying on the floor for 20 minutes after a fall on 12/24/25. On 12/28/25, a lady who assisted Resident B was very rude and explained the incident as observed. Resident B's family sent the ADON a picture of the lady in question. The ADON apologized to Resident B's family repeatedly and indicated they didn't take these things lightly and they would be looking into it.			

	An undated handwritten statement signed by LPN 6 indicated that she had been a nurse for 43 years and that, regardless of her residents' diagnoses, she always attempted to do her best and within her scope of practice to keep them safe. She had reminded Resident B numerous times not to forget her walker on the date of the incident. Resident B was adamant that she left her walker in the bathroom and it was sitting by the recliner. If it was record on the Alexa device that she told Resident B "I don't care," it was only in reference to where Resident B left her walker or where she thought she left it. She further indicated that she cared deeply for every resident she cared for and provided safety suggestions for Resident B. During an interview, on 4/30/26 at 9:37 a.m., the Memory Care Director indicated that the incident with LPN 6 and Resident B was not reported to the State Agency, because after the interview with Resident B, they didn't feel it emotionally affected her and the employee resigned and no longer worked in the community. During an interview, on 4/30/26 at 12:51 p.m., the Memory Care Director indicated after the video			

	was reviewed, LPN 6 was suspended pending an investigation. The Memory Care Director denied the video constituting abuse but acknowledged that the way LPN 6 spoke to Resident B was inappropriate. The current facility policy, effective date 1/1/15, titled "Abuse/Neglect/Exploitation," provided by the Executive Director on 4/30/26 at 9:28 a.m. indicated the following: "Procedure...8. Upon instructions from your Executive Director, follow your state specific reporting requirements...13. Any staff members may notify the appropriate state agency of suspected/alleged abuse, neglect, or exploitation without fear of retribution. It is the responsibility of each employee to assure compliance with state abuse report regulations...." This citation relates to Intake 469215.			
R 0145	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(b) (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.	R 0145		05/13/2026

Based on observation, interview, and record review, the facility failed to ensure a memory care unit janitorial closet containing potentially hazardous materials and chemicals was locked during a random observation.

Findings include:

During a tour of the facility, on 4/29/26 at 9:30 a.m., accompanied by the Memory Care Director, a janitorial closet was located across from the central common area lounge. The door to the janitorial closet was slightly open. A female resident was nearby self propelling in her wheelchair and two residents were seated in facility chairs in common area lounge with walkers in front of them. The closest contained containers of Heavy Duty Bowl Cleaner, Revitize Miracle Spotter, Rapid Surface Disinfectant Cleaner, 73 Disinfectant Acid Bathroom Cleaner, Dawn dishsoap, and Krud Kutter (kitchen degreaser). The Memory Care Director indicated the door could be opened by a key fob and should be closed and locked.

During an interview on 4/29/26 at 10:00 a.m., Housekeeper 11 indicated that she normally pushed the door shut but may

	not have. She would normally shut and lock the janitorial closet to keep residents out of the closet. A current facility policy, titled "Safety Procedures provided by the Executive Director on 4/29/26 at 2:41 p.m., indicated the following: "...Procedures...4. Do not leave cords, ladders, chemicals and other equipment in any area unattended. Properly store all supplies and equipment in locking cupboards, cabinets and storage areas...9. Never leave chemicals or cleaning agents unattended. When cleaning resident apartments, take the housekeeping cart (or caddy with chemicals) into the apartment. Do not leave it in the hallway unattended. 10. Lock up all soaps, laundry detergents and disinfectants used for whirlpool bath when not in use or when a staff member is not present...."			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an 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	R 0217		05/13/2026

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 be provided.

Based on interview and record review, the facility failed to ensure service plans were reviewed and revised with

individualized interventions to prevent further falls, per facility policy, for 2 of 3 residents reviewed for falls. (Resident B and C) This deficiency resulted in Resident B experiencing multiple falls, including a hospitalization requiring critical care support for injuries sustained in a fall.

Findings include:

1. Resident B's clinical record was reviewed on 4/29/26 at 11:50 a.m. Diagnoses included repeated falls and left knee pain, unsteadiness, repeated falls, unspecified symptoms and signs involving cognitive functions and awareness, dementia, cognitive communication deficit and rib fractures.

A 30-day service plan, dated 9/22/25, indicated she was severely cognitively impaired. She was at a high risk for falls and required regular staff interventions to prevent falls. Her fall risk assistance intervention, dated 9/22/25, indicated staff were to regularly perform interventions with the resident, who was at a high risk for falls.

Resident B's progress notes included the following falls:

On 1/18/26 at 12:18 a.m., staff heard a thump and performed a

room check. Staff observed her on the floor. She indicated she was trying to check her door.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 1/24/26 at 1:32 a.m., she was found on the floor in front of her recliner and indicated she slipped on a slick spot. She hit her ribs, spine and shoulder. A red line of bruising was noted on her left backside.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 1/30/26 at 9:59 p.m., she pushed her call light pendant, and she was observed lying on the floor on her left side. A purplish bruise on the left side of her face, and she complained of left side rib pain. A small skin tear on her left lower shin. She was transferred to the emergency room.

A discharge evaluation progress note from the rehabilitation facility, dated 2/25/26, indicated she was post-fall with a level-2 trauma and required a transfer to a local trauma center for left fractured ribs (ribs 8 through 12) with a hemothorax (blood in chest cavity), a pericardial effusion (fluid around the heart),

and a grade-2 splenic laceration (a tear in the spleen) requiring a chest-tube placement (to drain accumulated blood) with Intensive Care Unit (ICU) management.

A current change of condition service plan, dated 2/26/26, indicated Resident B had severe cognitive impairment and was at a high risk for falls. She required regular staff interventions to prevent falls. Her fall risk assistance interventions, dated 2/26/26, indicated staff were to regularly perform interventions with her due to being at high risk for falls. Her spot check interventions indicated staff would provide welfare checks on her to promote safety and ensure her needs were being met (12 times daily).

On 2/27/26 at 3:16 p.m., she returned to the facility.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 3/4/26 at 12:53 p.m., she fell while getting up in the dining room.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 3/5/26 at 9:48 a.m., staff

found her on the floor in her bathroom on her left side when they went to get her up for breakfast.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 3/26/26 at 10:21 p.m., she was found lying on her left side outside the bathroom, yelling for help.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 3/28/26 at 10:14 p.m., a CNA responded to her call light pendant and found her sitting on her buttocks behind the door. She indicated she was getting up to come to the door but could not state why.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 4/9/26 at 5:41 a.m., staff heard that someone was yelling for help and found her on the floor on her left side next to the bed. She indicated she rolled out of bed.

The clinical record lacked a review of the fall and did not include an intervention added to

	the service plan. On 4/9/26 at 5:42 p.m., the nurse heard a noise, and Resident B was on the floor. She hit her head on wall as she fell and indicated she had pain. The nurse reminded her to use her call light pendant when getting up from her chair. When the nurse returned, the resident was coming out of her bathroom with her walker. She was again reminded to use her call light pendant for assistance. The clinical record lacked a review of the fall and did not include an intervention added to the service plan. On 4/9/26 at 6:24 p.m., the nurse received call from a family member indicating that Resident B had a fall that was observed on camera. Resident B indicated she was going for a walk when she fell. The nurse later observed Resident B walking around the facility twice and redirected her to her room. Resident B refused to go to her room, indicating she was going for a walk. The clinical record lacked a review of the fall and did not include an intervention added to the service plan. On 4/11/26 at 5:08 p.m., a CNA reported to the nurse that Resident B had fallen outside of			

the bathroom door. Resident B indicated she parked her walker to get into bed. The nurse reminded her of the sign on wall where she normally parked her walker that instructed her not to, as well as using her call light pendant when assistance was needed. She complained of pain in her left shoulder. Bruising was noted from previous falls, as well as bruising on her thigh and face.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 4/26/26 at 10:12 p.m., she pressed her call light pendant and was found on lying on her left side behind her recliner. Her walker was in front of her feet by her bed. She used the call light pendant after the fall occurred and was continued to press the pendant when the CNA and nurse arrived. She indicated she had to use the bathroom as the reason she got out of bed by herself. She was assisted to the toilet and back in bed.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

2. Resident C's clinical record was reviewed on 4/29/26 at 12:48 p.m. Diagnoses included hypertension, migraine,

Parkinson's disease, and dementia.

A move-in care plan, dated 2/9/26, indicated he was cognitively intact. He was at a high risk for falls and required regular staff interventions to prevent falls. His fall risk assistance intervention, dated 2/9/26, indicated that staff were to regularly perform interventions with him, who was at a high risk for fall. His spot check interventions were that staff would provide welfare checks on him to promote safety and ensure his needs were being met during the day (12 times daily).

Resident C's progress notes included the following falls:

On 3/5/26 at 1:59 p.m., he was found sitting on his buttocks in the entry way to his room.

A 30-day care plan, dated 3/11/26, indicated he was severely cognitively impaired. . He was at a high risk for falls and requires regular staff interventions to prevent falls. His fall risk assistance interventions, dated 3/11/26, was staff were to regularly perform interventions with the resident, who was at a high risk for fall. His spot check interventions were that staff would provide welfare checks on him to promote safety and

ensure his needs were being met during the day (12 times daily).

On 3/26/26 at 10:06 p.m., he was sitting on his buttocks on the floor of his bathroom when the CNA entered the room. He indicated he was trying to use the bathroom and the floor was slippery. The nurse reminded him to use his call light pendant and wait for assistance when needing to go to the bathroom.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

On 4/20/26 at 11:34 p.m., a CNA reported finding him on the floor next to his bed during rounding.

The clinical record lacked a review of the fall and did not include an intervention added to the service plan.

During an interview, on 4/29/26 at 1:34 p.m. CNA 23 indicated Resident B tripped over her own feet, staff could be sitting right there, and she would be walking normal and fall. There was not much you could do for her, they tried to keep an eye on her. If she walked to her room, they would walk with her and once she was in her room they would check on her frequently. Resident C was unable to toilet

	himself. He used his call light or he called his daughter and she would call the facility to let them know that they needed to check on him. He used a wheelchair and had tremors. During an interview, on 4/29/26 at 2:01 p.m. CNA/Activities Assistant 2 indicated Resident B sat down too fast and fell out of her chair, she will leave her the walker and "freelances," she had a bad leg and doesn't want to pick her leg up to turn. She pushed her call light a lot, she was kind of impatient and would not remember to ask for help. Resident C needed quite a lot of assistance he had Parkinson's disease and was not to toilet himself and pushed his call light. During an interview, on 4/29/26 at 2:10 p.m., LPN 27 indicated Resident B's fall interventions included frequently checking on her, keeping her involved and engaged in activities. Resident C was in that phase of dementia where he thought he could do things independently and he forgets to use the call light.			

During an interview, on 4/29/26 at 3:38 p.m., the DON indicated that Resident B was on every two-hour check. The high-risk interventions tied back to the two hour monitoring. They kept her in activities and engaged with other residents and tried to get to her as quick as possible.

During an interview with the Memory Care Director and the DON, on 4/30/36 at 12:51 p.m., the Memory Care Director indicated they discussed falls at the monthly quality assurance meetings and services plans were updated with a change of condition and every six months a reassessment was completed. The DON indicated that the falls were documented in the electronic health records and reviewed in morning meetings. At the last meeting they had, they decided that going forward they would be putting a new intervention into place with every fall.

A current facility policy, revised on 8/1/23, titled "Resident Fall Prevention," and provided by the Memory Care Director on 4/29/26 at 3:35 p.m., indicated the following:"...Procedure...5. Developing a Personalized Fall Prevention Plan: Based on the assessment findings, staff shall discuss fall prevention strategies with the resident and/or responsible party. A

	personalized plan shall be developed and incorporated into the resident's Service Plan...10. Ongoing Monitoring and Evaluation: After implementing the fall prevention plan, staff shall closely monitor its effectiveness and any subsequent fall incidents. Regular re-evaluations and adjustments to the plan shall be made as needed to ensure continued effectiveness...." This citation relates to Intake 469215.			

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 SIGNATURE	TITLE	(X6) DATE