

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND<br>PLAN OF CORRECTIONS   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                      |                                  | (X2) MULTIPLE<br>CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING | (X3) DATE SURVEY<br>COMPLETED<br><br>09/02/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>VITA OF GREENFIELD |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP<br>CODE<br><br>1683 COMMUNITY WAY, GREENFIELD, ,<br>46140 |                                  |                                                                 |                                                 |
| (X4) ID<br>PREFIX TAG                                  | SUMMARY STATEMENT OF<br>DEFICIENCIES...                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION... | (X5)<br>COMPLETION<br>DATE                                      |                                                 |
| R 0000                                                 | <p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Intake 471699, 471602, 471107, 471049, 470578, 470134, 470085, 470086, 469971, 469929, 469679, 469146, and 468978</p> <p>Intake 471699 - State deficiencies related to the allegations are cited at R0052 and R0091</p> <p>Intake 471602 - State deficiencies related to the allegations are cited at R0091.</p> <p>Intake 471107 - State deficiencies related to the allegations are cited at R0091.</p> <p>Intake 471049- State deficiencies related to the allegations are cited at R0052</p> <p>Intake 470578- State deficiencies related to the</p> | R 0000                                                                                     |                                  |                                                                 |                                                 |

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allegations are cited at R0052.

Intake 470134- State  
deficiencies related to the  
allegations are cited at R0091.

Intake 470085- State  
deficiencies related to the  
allegations are cited at R0091.

Intake 470086- State  
deficiencies related to the  
allegations are cited at R0091.

Intake 469971 - State  
deficiencies related to the  
allegations are cited at R0052  
and R0091.

Intake 469929 - State  
deficiencies related to the  
allegations are cited at R0091.

Intake 469679- No deficiencies  
related to the allegations are  
cited.

Intake 469146 - No deficiencies  
related to the allegations are  
cited.

Intake 468978- State  
deficiencies related to the  
allegations are cited at R0091.

Survey dates: August 31,  
September 1,2,and 3, 2026.

Facility number: 016063

Residential Census: 91

These State Residential  
Findings are cited in accordance

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|        | <p>with 410 IAC (Indiana Administrative Code) 16.2-5.</p> <p>Quality review completed 9/14/26.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        |  |            |
| R 0029 | <p>Residents' Rights - Deficiency</p> <p>410 IAC 16.2-5-1.2(d)</p> <p>(d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.</p> <p>Based on interview and record review, the facility failed to ensure residents' dignity were maintained with staff not being respectful for 3 of 12 residents interviewed. (Residents' P, SS, and R)</p> <p>Findings include:</p> <p>1. The clinical record for Resident P was reviewed on 9/1/26 at 9:00 a.m. The resident's diagnosis included, but was not limited to, elevated blood pressure.</p> <p>An interview was conducted with Resident P on 9/1/26 at 9:47 a.m. She indicated the Dietary Manager (DM) was rude and disrespectful. She had went down to the dining room and requested for a sandwich from the kitchen. She had been waiting for a while and had asked a dietary staff person that</p> | R 0029 |  | 09/18/2026 |

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had come out of the kitchen how many people were working and what they were assigned to do in the kitchen. She had also asked what the DM was doing in there. Resident P had questioned why the DM would choose to order food supplies during a lunch meal when the staff were behind with providing the lunch meal. The resident felt it could have waited until after the lunch meal. After eating her meal, the resident had returned back to her apartment and laid down. Apparently, the dietary staff person the resident had spoken to in the dining room had reported to the DM what the resident had said about her. Soon after she laid down, someone started knocking "loudly" on her door. She had planned to ignore the person, but then the person started calling her name and continued to knock loudly on her door. After hearing the rattle of the keys, she decided to get up cause the person was going to unlock the door and come into her apartment. She opened the door to the DM and the Memory Care Director (MCD). The DM had asked, "what my problem was earlier in the dining room." The DM and the MCD were very rude during the discussion. She filed a grievance with the former Executive Director (ED).

A grievance binder was

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provided by the Regional ED on 9/1/26 at 2:30 p.m. It included a grievance that had been filed by Resident P. It indicated, on 7/21/26, during a lunch meal, Resident P had asked staff why it was taken so long to receive a sandwich after requesting for one from the kitchen. The resident had inquired how many staff members were working in the kitchen including the Dietary Manager (DM). The staff member had reported to Resident P the DM was ordering the food supplies and was not assisting with preparing the lunch meal. Resident P had asked the staff member why couldn't the DM wait until after the lunch meal to do the food supply ordering. Resident P had went back to her apartment to lay down after eating her meal. Shortly after, someone began knocking loudly on her door. She was going to ignore the person at the door, but the knocking continued while calling of her name at the door. The resident then heard keys rattling, so she got up from the bed to answer the door due to the person on the other side was going to use the keys to unlock her door. The DM and the Memory Care Director (MCD) were the staff members on the other side of the door. The DM wanted to know about Resident P's concerns. The grievance investigation report

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indicated Resident P was "most" concerned the staff had come to her apartment.

An interview was conducted with the DM on 9/1/26 at 3:05 p.m. She indicated she had been told Resident P was "irate" in the dining room. She was name calling the dietary staff. She and the MCD had went up to her apartment and knocked on her door. Some residents are hard hearing, so they did knock loudly. MCD did have keys to the resident's apartment. As MCD unlocked the resident's apartment; Resident P had met them at the door of the apartment. She had given permission to enter. The DM was trying to find out what had happened and see if she was able to fix whatever the resident was unhappy about. During the conversation, the resident was "very nasty in her tone." The DM wanted to explain to her why it was taking so long for to get her sandwich.

An interview was conducted with the MCD on 9/1/26 at 3:10 p.m. She indicated she was asked by the DM to go with her as a witness to Resident P's apartment to see what had upset her in the dining room earlier. The MCD did have keys to the resident's apartment. They had knocked on the resident's door, and she did

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|  | <p>unlocked the resident's apartment door with her keys. The resident had met them at the door. She did not speak during their conversation between DM and Resident P. The resident and the DM's conversation was pleasant. Neither one was agitated or disrespectful to each other. The conversation was pleasant. After, the resident filed a grievance about the visit to her apartment. She had not said anything to the resident during the visit to her apartment that day, so she was unsure why the resident was upset with her. The MCD had decided she was no longer going to speak to the resident.</p> <p>2. The clinical record for Resident SS was reviewed on 9/2/26 at 2:00 p.m. The resident's diagnosis included, but was not limited to, depression (mood disorder feeling of sadness).</p> |  |  |  |
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|  | <p>A grievance binder was provided by the Regional ED on 9/1/26 at 2:30 p.m. It included a grievance that had been filed by Resident SS. The resident's concern was the noise level from the staff outside his apartment between the hours 5:00 a.m. to 7:30 a.m. The staff were rude and disrespectful when he requested for them to lower their voices.</p> <p>An interview was conducted with Resident SS on 9/2/26 at 1:59 p.m. He indicated every morning approximately 6:00 a.m., during shift change the staff were coming up to the nurse's station laughing having a good time while getting report. The walls were thin, so it woke him up, because they were so loud. He had told an electric site had to be installed downstairs, so the nurse's station was suppose to be moved downstairs. It still has not happened. It has been going on for months.</p> <p>3. The clinical record for Resident R was reviewed on 9/2/26 at 9:00 a.m. The resident's diagnosis included, but was not limited to, elevated blood pressure.</p> <p>A grievance binder was provided by the Regional ED on 9/1/26 at 2:30 p.m. It included a grievance that had been filed</p> |  |  |  |
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about Resident R. On 7/4/26, a staff person had indicated Resident R had eaten her breakfast that included 4 scrambled eggs, 3 pieces of bacon and a English muffin. After, the resident had requested for 2 banana pancakes. The staff person had reported she told the resident "no that is two meals"...She kept throwing a fit and I sent her 1 banana pancake to calm her down."

An interview was conducted with Resident R on 9/1/26 at 11:33 a.m. She indicated some of the staff are rude.

During a Confidential Interview 5 from 8/31/26 through 9/2/26, they indicated there were some Certified Nursing Assistants that are disrespectful when speaking to the residents.

During a Confidential Interview 6 from 8/31/26 through 9/2/26, they indicated the staff are disrespectful to the residents; if the residents are disrespectful to them. They have observed it. The residents need to learn how to speak to the staff respectfully, so the residents are in return respected.

During an interview with the Director of Nursing (DON), the Regional Executive Director (RGD), and the Assisted Director of Nursing (ADON) on

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|  | <p>9/2/26 at 4:35 p.m., The DON indicated the former ED had told Resident R about the an electric site needing to be placed and then the nurses' station would move downstairs. That was untrue. The RGD indicated they have been working with staff being respectful.</p> <p>A dignity policy was provided by the RGD on 9/2/26 at 9:36 a.m. It indicated, "Purpose: The purpose of the Resident Rights Policies is to ensure that all residents of the facility are treated with dignity, respect, and consideration, and that their fundamental rights are fully protected in accordance with Indiana State regulations. These policies establish the framework for promoting resident autonomy, privacy, and participation in decisions</p> <p>regarding their care and daily life. The policies aim to safeguard residents from abuse, neglect, exploitation, involuntary seclusion, and any form of discrimination or mistreatment. They provide clear guidance to staff, residents, and families regarding the rights of residents and the facility ' s obligations to uphold these rights, thereby fostering a</p> <p>safe, supportive, and person-centered environment consistent with ISDH licensing</p> |  |  |  |
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|        | <p>requirements. Procedure:</p> <p>Each resident of a licensed residential care facility has the right to:...6. Be treated with consideration, respect, and full recognition of the resident ' s dignity and individuality, including privacy in treatment and in care of the resident ' s personal needs..."</p>                                                                                                                                                                                                                                                                                                                                                      |        |  |            |
| R 0052 | <p>Residents' Rights - Offense</p> <p>410 IAC 16.2-5-1.2(v)(1-6)</p> <p>(v) Residents have the right to be free from:</p> <p>(1) sexual abuse;</p> <p>(2) physical abuse;</p> <p>(3) mental abuse;</p> <p>(4) corporal punishment;</p> <p>(5) neglect; and</p> <p>(6) involuntary seclusion.</p> <p>A. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect and ensure an elopement prevention device was provided to a cognitively impaired resident after an initial elopement for 13 days in accordance with service plan, failed to provide adequate supervision to prevent further</p> | R 0052 |  | 09/18/2026 |

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elopements, failed to ensure the alarm receiver on the nurse's cart computer was effectively monitored to ensure staff were aware of alarm activation for 1 of 1 resident reviewed for elopement (Resident B). These deficient practices resulted in the resident eloping twice without staff knowledge to a facility parking lot near a retention pond and corn fields.

B. Based on interview and record review, the facility failed to protect the residents' right to be free from sexual abuse by a resident for 4 of 5 residents reviewed for abuse (Residents B, C, M, and R).

A 1. The clinical record for Resident B was reviewed on 9/1/26 at 9:27 a.m. The resident's diagnosis included, but was not limited to, Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks).

A Comprehensive Evaluation, dated 2/17/26, indicated Resident B was severely cognitively impaired and was at moderate risk for elopement. The resident could not effectively communicate their needs and were able to independently move around the locked unit without an assistive

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|  | <p>device.</p> <p>An Individualized Service Plan, dated 2/16/26, indicated Resident B needed elopement monitoring. The goal was for the resident to remain safely inside the community. The intervention was the staff would monitor the resident for elopement risk, and redirect and reassure regularly and as needed.</p> <p>On 7/24/26, an Incident Report submitted to the Indiana Department of Health (IDOH) indicated Resident B had pushed on the southwest exit door of the memory care unit and exited the building at 9:00 a.m. Resident B was outside for approximately three minutes and returned safely to the memory care main entrance doors at 9:03 a.m. Resident B had no injuries. The preventative measures added were to place Resident B on 15-minute checks and a wander guard (a safety monitoring network used in senior care facilities to alert staff when an at-risk resident approaches an exit or restricted area) was to be assigned to Resident B. Maintenance would address any concerns regarding the facility memory care southwest exit door to prevent further occurrences.</p> <p>An observation note, dated</p> |  |  |  |
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|  | <p>8/6/26 at 1:27 p.m., indicated a Wander guard device activated and applied to Resident B's right ankle. The device placement and function were verified following application. The staff would continue to monitor the device for proper placement and function and report concerns as appropriate.</p> <p>On 8/21/26, an Incident Report, submitted to IDOH, indicated Resident B had exited the southwest door of the memory care unit. The camera system was reviewed and showed that Resident B had exited the door at 5:53 p.m. The family of another resident had observed Resident B attempting to re-enter the door at 5:55 p.m. and made staff aware. The staff immediately went to get Resident B and assisted the resident back into the memory care unit at 5:57 p.m. The resident had no injuries. The preventative actions taken were to add additional staff to the memory care unit. Resident B was placed on 15-minute checks. The maintenance director notified the alarm/ door company of issue with door and requested emergency service. The follow-up to the incident, dated 8/24/26, indicated the magnetic lock had malfunctioned due to a bracketing issue. The alarm/door company completed</p> |  |  |  |
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|  | <p>the service to the door on the same day as the elopement.</p> <p>On 8/31/26 at 9:30 a.m., the outside of the facility was observed. The secured memory care unit was located on the south side of the building. There was a pond with water in it at the southwest corner of the memory care parking lot. The east side of the property is bordered by a field of fully grown field corn. The field corn was over six foot tall. The north side of the building had a field of fully grown field corn across the parking lot in front of the building.</p> <p>On 8/31/26 at 10:30 a.m., an observation of the secured memory care unit was done with the Memory Care Coordinator (MMC). Resident B was observed dressed in street clothes and walking without an assistive device in the hallway. The MMC indicated Resident B did not have behaviors unless the resident had a urinary tract infection (an infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra).</p> <p>On 9/1/25 at 11:05 a.m., the Regional Executive Director (RED) provided the invoice for the secured memory care unit southwest door repair, completed 7/24/26. The invoice</p> |  |  |  |
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|  | <p>indicated the electronic strike plate (an access control device installed in a door frame that replaces a standard fixed plate to let people open a door using electronic signals instead of a key) was faulty and was replaced with a new device.</p> <p>On 9/1/26 at 12:30 p.m., the RED provided the invoice for the secured memory care unit southwest door repair, completed 8/21/26. The invoice indicated emergency service was requested due to an elopement. The system was operational upon arrival and wander system had no control over door locks. The server was reset because remote service was very slow, but access was operating normally. The memory care unit was walked with the Director of Maintenance (DOM) and tested wander tag operations. The sensitivity was turned up on several doors to increase tag range. Also discovered wander alerts were only going to the nurse cart personal computer and not devices carried by staff. The escalation was changed to include alarming to phones carried by staff.</p> <p>On 9/1/26 at 2:36 p.m., Resident B was observed sitting at a table with other residents in the secured memory care unit's activity room. A wander guard</p> |  |  |  |
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alert was present on her right ankle.

On 9/2/26 at 2:40 p.m., the secured memory care unit was observed with the DOM. The DOM indicated the wander guard system was different from the traditional wander guard systems. The facilities wander guard system was set up through an outside company and was electronical. The DOM was unsure who checked that the system was functioning properly.

During an interview on 9/2/26 at 5:10 p.m., the Director of Nursing (DON) indicated that Resident B's wander guard device was placed on 8/6/26. Resident B did not have a wander guard device until 8/6/26. The wander guard devices should be checked daily, and the facility was in the process of developing a system to ensure the devices were checked daily.

During an interview on 9/2/26 at 5:15 p.m., the RED and the Regional Vice President of Operations (RVPO) indicated the DOM should be testing the wander guard system and checking the functionality of the exit doors on the secured memory care unit daily. The wander guard system does not have physical keypads at the

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|  | <p>exit doors. If a wander guard is activities, an alarm sounds in the vicinity of the door the resident wearing the wander guard is close to and an alert goes to the staff phones. The ED and the RVPO would prefer the alarm to be louder and sound throughout the unit, instead of just by the door that is affected.</p> <p>During an interview on 9/3/26 at 11:56 a.m., the RED indicated the DOM had not been made aware of the need to do daily checks of the secured memory care units doors. The wander guard system is an online system. The RED was unsure what would happen if power or Wi-Fi was lost. The volume of the wander guard doors had not been made louder. All the phones the Certified Nurses' Aides carry had been updated to receive alerts if the wander guard system was activated and does indicate which door is alarming. A system to check the wander guards function had not been put into place. A Wander Guard monitoring system needed to be put into place immediately.</p> <p>On 9/3/26 at 12:16 p.m., the RED provided the current Elopement Policy, last revised June 2026, that read "...the purpose of this policy is to establish guidelines for</p> |  |  |  |
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preventing, managing, and responding to elopement incidents involving residents. Residents in Assisted Living may be at risk of elopement due to cognitive or physical impairment. Vita Management properties are committed to identifying at-risk residents, implementing preventative measures, and ensuring an immediate and coordinating response to elopement incidents. Definitions: Elopement: The act of a resident leaving the premises unsupervised or unnoticed posing a risk to their safety. At-Risk Resident: A resident who has a cognitive, behavioral, or physical condition that increase the likelihood of elopement. Procedure: Resident Assessment: All residents will be assessed for elopement risk upon admission and during regular care plan reviews. This assessment includes: Cognitive impairments (e.g., Dementia, Alzheimer's) Behavioral history (e.g., past elopement attempts, documented exit-seeking) Physical ability to exit the premises unsupervised Documentation of risk assessments and individualized care plans for at risk residents will be maintained in the residents' record ... Preventative Measures: Exit doors will be equipped with alarms, locks,

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keypads, and wander guards as allowed by Indiana State regulations. Security cameras will monitor entry and exit points..."

B 1. The clinical record for Resident C was reviewed on 8/31/26 at 2:50 p.m. The resident's diagnosis included, but was not limited to, cognitive impairment (trouble with mental functions like thinking, learning, remembering, and making decisions).

A physician's order, dated 3/12/26, indicated the resident received Medroxyprogesterone acetate (long-acting progestin hormone used to treat hypersexuality in men) 150 milligram (mg) inject 150 mg for one dose as directed. This order was discontinued on 7/1/26.

A Comprehensive Evaluation for Resident C, dated 8/25/26, indicated Resident C had moderate cognitive impairment and was at moderate risk for elopement. Resident C used a walker or a wheelchair for mobility and could effectively communicate their needs verbally.

An Individual Service Plan for Resident C, dated 8/25/26, indicated Resident C was ambulatory using a rolling walker, and needed cognitive assistance with reminders and

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|  | <p>redirection. The goal was for staff to be aware of the residents cognitive needs and redirect as needed to maintain happiness and safety for themselves and others. The Individualized Service Plan did not include a service plan addressing sexual behaviors towards others.</p> <p>The clinical record for Resident B was reviewed on 9/1/26 at 9:27 a.m. The resident's diagnosis included, but was not limited to, Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks).</p> <p>A Comprehensive Evaluation, dated 2/17/26, indicated Resident B was severely cognitively impaired and was at moderate risk for elopement. The resident could not effectively communicate their needs and were able to independently move around the locked unit without an assistive device.</p> <p>Resident C's clinical record contained an incident note, dated 6/30/26 at 3:40 p.m., that indicated a Certified Nursing Aide (CNA) had entered the activity room and observed Resident C standing behind another resident who was seated in a chair. Resident C</p> |  |  |  |
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was touching the other resident inappropriately while leaning down and whispering into the other resident's ear. The seated resident did not appear visibly upset or in distress at the time of the incident and was observed looking down toward the floor without verbalizing or demonstrating signs of resistance. The CNA immediately intervened and redirected Resident C away from the other resident and out of the activity room. Resident C was cooperative with redirection and walked with staff to his apartment to prepare for an appointment. Resident C was placed on 15-minute safety checks. Incident was immediately reported to the Executive Director and Director of Nursing.

An Incident Report submitted to the IDOH on 6/30/26, indicated Resident C was observed inappropriately touching Resident B. Both residents live in the memory care unit. A CNA immediately intervened and redirected Resident C away from Resident B. Resident C was escorted from the activity room. Resident B displayed no signs of distress. The follow-up, added 7/9/26, indicated the psychiatric nurse practitioner had assessed Resident C and adjusted medications. Resident C had not displayed similar

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behaviors.

A physician's order, dated 7/3/26, indicated Resident C was to receive Medroxyprogesterone acetate 150 mg, inject 150 mg intramuscularly (IM) every 3 months.

B 2 The clinical record for Resident M was reviewed on 9/2/26 at 10:30 a.m. The resident's diagnosis included, but was not limited to, Alzheimer's disease.

A Comprehensive Evaluation, dated 6/23/26, indicated Resident M was severely cognitively impaired.

Resident C's clinical record contained an incident note, dated 8/23/26 at 6:50 p.m. The incident note indicated a CNA reported upon entering the T.V. room of the memory care unit, Resident C was observed sitting with Resident M on the couch. Resident C's hand was rubbing Resident M's peri area (area between legs). Staff immediately separated residents. Resident M was assessed with no injury noted and not in psychosocial distress. Resident C was placed on 15-minute checks. The Director of Nursing and Memory Care Director were notified.

An incident Report submitted to

IDOH on 8/23/26, indicated a staff member had witnessed Resident C touching Resident M in an inappropriate manner. The residents were immediately separated. Resident C was placed on 15-minute checks.

A General Investigation Form, dated 8/23/26, indicated CNA 6 had entered the area and noted Resident C hand was right on top of Resident M's pubic area. Resident M's hand was on top of Resident C's hand. The residents were immediately separated, and CNA 6 notified the "medication passer".

B 3. The clinical record for Resident R was reviewed on 9/2/26 at 10:30 a.m. The resident's diagnosis included, but was not limited to, Severe Vascular Dementia (reduced blood flow damage causes profound loss of cognitive, physical, and functional abilities).

A Comprehensive Evaluation, dated 6/3/26, indicated Resident R was severely cognitively impaired

An incident report submitted to IDOH on 8/25/26 at 9:45 a.m., indicated a brief description of incident was during the review of prior days incident, clinical documentation was discovered of a possible inappropriate touching by Resident C. The

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|  | <p>secondary resident was not identified at the time. The preventive measures taken were to extend Resident C's 15-minute checks for an additional 72 hours.</p> <p>A General Investigation Form dated 8/24/26, indicated Licensed Practical Nurse (LPN) 7 had been interviewed by the DON. The witness statement indicated associate stated that Resident C was observed touching another resident's breast. Resident C was redirected immediately. The DON had instructed associate that Resident C was not to be left alone with female residents, and staff was to continue to monitor Resident C every 15 minutes.</p> <p>On 9/1/26 at 2:43 p.m., an interview was conducted with CNA 6. CNA 6 indicated they had witnessed the incident between Resident C and Resident M on 8/23/26. CNA 6 had gone to the T.V. area to get Resident M for bed. Resident C was sitting on the couch beside Resident M with his hand in Resident M's peri area. CNA 6 removed Resident C's hand from Resident M. Resident C became upset with CNA 6 for removing his hand from Resident M's peri area. CNA 6 reported the incident to the nurse on duty. CNA 6 indicated</p> |  |  |  |
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|  | <p>they had witnessed the incident that happened the next evening between Resident C and Resident R. On the evening of 8/24/26, CNA 6 sat in the TV room to keep an eye on Resident C. CNA 6 had walked away from the TV area for a minute to help another resident. When CNA 6 returned, Resident C was standing in the hallway and touching Resident R's breast. Resident R told Resident C that he had better not do that again or Resident C would be in trouble. Resident C was normally ambulatory and able to get around well. Resident C normally used a walker. CNA 6 had reported the incident to the nurse or Qualified Medication Aide who was on duty. CNA 6 could not remember the name of the staff member they had reported the incident too.</p> <p>On 9/2/26 at 12:05 p.m., Resident C was observed sitting at a table in the dinning room. There were several other residents sitting in the dinning room, waiting for lunch service.</p> <p>On 8/31/26 at 10:55 a.m., the RED provided the Abuse, Neglect, and Misappropriation Policy, last revised June 2026, that read " ...Purpose ...It is the policy of this facility to ensure that all residents are free from abuse, neglect, involuntary seclusion, and misappropriation</p> |  |  |  |
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|        | <p>of property ... Definitions ... Sexual Abuse refers to any unwelcome sexual advance, request for sexual favors, or other verbal, non-verbal, or physical conduct of a sexual nature that creates an intimidating, hostile, or offensive environment. Sexual harassment can occur between individuals of any gender and may be perpetrated by supervisors, coworkers, residents, clients, or others ...".</p> <p>This citation was related to Intake 471699, 471049, 470578, and 469971.</p> |        |  |            |
| R 0091 | <p>Administration and Management - Noncompliance</p> <p>410 IAC 16.2-5-1.3(h)(1-4)</p> <p>(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following:</p> <p>(1) The range of services offered.</p> <p>(2) Residents' rights.</p> <p>(3) Personnel administration.</p> <p>(4) Facility operations.</p> <p>The policies shall be made available to residents upon request.</p>          | R 0091 |  | 09/18/2026 |

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|  | <p>C The clinical record for Resident R was reviewed on 9/2/26 at 10:30 a.m. The resident's diagnosis included, but was not limited to, Severe Vascular Dementia (reduced blood flow damage causes profound loss of cognitive, physical, and functional abilities).</p> <p>A Comprehensive Evaluation, dated 6/3/26, indicated Resident R was severely cognitively impaired</p> <p>The clinical record for Resident C was reviewed on 8/31/26 at 2:50 p.m. The resident's diagnosis included, but was not limited to, cognitive impairment (trouble with mental functions like thinking, learning, remembering, and making decisions).</p> <p>A Comprehensive Evaluation for Resident C, dated 8/25/26, indicated Resident C had moderate cognitive impairment and was at moderate risk for elopement. Resident C used a walker or a wheelchair for mobility and could effectively communicate their needs verbally.</p> <p>An incident report submitted to IDOH on 8/25/26 at 9:45 a.m., indicated a brief description of incident was during the review of prior days incident, clinical documentation was discovered</p> |  |  |  |
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of a possible inappropriate touching by Resident C. The secondary resident was not identified at the time. The preventive measures taken were to extend Resident C's 15-minute checks for an additional 72 hours.

A General Investigation Form dated 8/24/26, indicated Licensed Practical Nurse (LPN) 7 had been interviewed by the DON. The witness statement indicated associate stated that Resident C was observed touching another resident's breast. Resident C was redirected immediately. The DON had instructed associate that Resident C was not to be left alone with female residents, and staff was to continue to monitor Resident C every 15 minutes.

On 9/1/26 at 2:43 p.m., an interview was conducted with CNA 6. CNA 6 indicated they had witnessed an incident between Resident C and Resident R. On the evening of 8/24/26, CNA 6 sat in the TV room to keep an eye on Resident C. CNA 6 had walked away from the TV area for a minute to help another resident. When CNA 6 returned, Resident C was standing in the hallway and touching Resident R's breast. Resident R told Resident C that he had better not do that

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|  | <p>again or Resident C would be in trouble. Resident C was normally ambulatory and able to get around well. Resident C normally used a walker. CNA 6 had reported the incident to the nurse or Qualified Medication Aide who was on duty. CNA 6 could not remember the name of the staff member they had reported the incident too.</p> <p>On 9/2/26 at 4:55 p.m., the DON was interviewed. The DON indicated LPN 7 had informed the DON Resident C had touched Resident B's breast on 8/24/26. The DON had not interviewed CNA 6 about the 8/24/26 incident and was unaware that Resident R had been touched by Resident C.</p> <p>During an interview on 9/2/26 at 5:10 p.m., the Regional Executive Director (RED) indicated incidents of abuse should be reported to the Executive Director immediately. The incident between Resident C and Resident R should have been reported to the RED when it happened.</p> <p>On 8/31/26 at 10:55 a.m., the RED provided the Abuse, Neglect, and Misappropriation Policy, last revised June 2026, that read "...All employees are considered mandatory reporters under Indiana law. Any employee who, during</p> |  |  |  |
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employment, examines, attends, counsels, or treats a resident and reasonably believes that the resident has suffered abuse, neglect, or misappropriation must immediately report the allegation to the Executive Director or designated representative. Failure to promptly report suspected abuse may result in civil or criminal penalties and disciplinary action..."

This residential tag relates to 471699, 471602, 471107, 471049, 470134, 470578, 470085, 470086, 469971, 469929, and 468978.

2.5-1.3(h)(4)

A. Based on interview and record review, the facility failed to ensure their policies regarding bedbugs were followed, specific to provision of consistent staff education, lack of inspection of items brought into the facility, lack of documentation of steps taken for bedbug eradication and lack of timely notification to staff, residents and resident's responsible parties regarding the identification of bedbugs in the facility which affected over 20 rooms within the facility. (Rooms 207, 208, 209, 211, 212, 214, 215, 307, 323, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 413, 415,

422, and 423)

B. Based on observation, interview and record review, the facility failed to ensure the facility's policies and procedures were implemented for falls for 1 of 3 residents reviewed for falls, including but not limited to the documentation of the fall being a witnessed or unwitnessed event, details of the time, location and general circumstances of the fall, any assessments of the resident after the fall and any notifications of the resident's fall to the appropriate persons and any follow-up of the fall.  
(Resident D)

C. Based on interview and record review, the facility failed to timely implement the Abuse, Neglect, and Misappropriation Policy by not immediately reporting suspected sexual abuse to the administrator or designee for 2 of 5 residents reviewed for abuse (Resident C and Resident R).

Findings include:

A. In an interview on 9-1-26 at 3:26 p.m., with the Activities Director, she indicated she became aware of bedbugs in the building earlier this year with one resident's room and has expanded since then. "The big burst seemed to be sometime in the spring, maybe April or May.

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The management team received information, can't remember if it was in person or email regarding how to identify bedbugs. We were given spray bottles of alcohol to spray on the floors and on chairs and furniture. At the time, if a resident was identified with bedbugs, we moved them to a different room. We had an all-staff meeting where we talked about bedbugs and what to look for and who to report the bedbugs problem to. This was done for the staff prior to giving out information to residents and sent them out to families and/or responsible parties and this was done sometime in June." The Activities Director shared, "One of the biggest problems we had was rumors. We had any number of residents that would claim they had bedbugs, but when we would check their rooms, we would not find anything."

In an interview on 9-1-26 at 1:20 p.m., with the current Executive Director (ED), she indicated her information indicates the initial bedbug identification was at or around 2-5-26, for Room 403. She added at the time, she was not the acting ED, but was in a Corporate capacity. She shared a canine inspection was conducted on 2-9-26, which included all rooms being inspected and all common areas

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by the contracted pest control company. She noted by 3-30-26, there was an increase in reportings of bedbugs in the building. She added by 6-2-26, she (the current ED, who started in this capacity at this building in 8-10-26) was made aware via email of the bedbug situation and "I emailed the [former] ED to begin the aggressive treatment, as outlined in the bedbug policy." She indicated since she was not in the building at the time, she can only assume the former ED would have provided education to themselves and the maintenance director, which would include the bedbug policies and procedures and the checklist. She explained the checklist would provide information on what to do if staff see or suspect something. She indicated the former ED should have explained to the former maintenance director to start checklists on any suspected bedbug problems and for the former ED and the former Maintenance Director to keep her updated on any findings related to the bedbug situation. "I don't know if the previous Maintenance Director was actually doing what I had told them." She indicated the facility provided a blacklight piece of equipment that helps to more easily detect bedbug. She added she was aware that

bedbug education had been provided to the Resident Council President, Vice-President, Sargent of Arms and their Treasurer, but was not certain of the date of occurrence. She clarified since the Resident Council does not provide the meeting minutes to the facility, she was uncertain if that information was shared with the other residents.

The current ED indicated she had requested for all items brought into the facility to be checked/inspected by the former Maintenance Director for bedbugs prior to admission and this was requested prior to the current ED coming to the facility on or around 8-10-26, but is uncertain if this was being done, "but I presume the previous Maintenance Director was not doing this." She indicated she was not in this building's ED capacity when the current Maintenance Director began employment. She indicated he was provided with the bedbug policies and procedures and the facility's expectations for his position.

The current ED was queried regarding lack of documentation related to education of staff, residents and families and/or responsible parties. She provided inservice education conducted on 6-3-26, for staff

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on bedbugs. "I guess it is a good question as to why there was a delay in providing education to the staff." The current ED was unable to provide documentation of steps taken during the time of initial identification of the bedbugs until when she resumed the current ED position, with the exception of pest control logs from the two companies used by the facility. The pest control logs did not provide resident names, only the room numbers for any pest treatments conducted in the facility.

The facility provided documentation on 9-2-26, of an all-staff inservice education, conducted on 6-3-26, regarding what bedbugs are, where they may be found or located, their means of transmission and treatments for the person and the environment. Additional documentation was provided on 9-2-26, of notifications made to residents and responsible parties of the facility having bedbugs in the facility on 6-5-26.

In an interview with the current ED on 9-2-26 at 1:55 p.m., she did not begin her tenure as the interim ED until 8-10-26. "I am having problems locating some of the records from the previous ED and the Maintenance Director, so I cannot tell you

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exactly what may have been done in regards to how the policies and procedures for bedbugs were implemented. I will try and find some of the documentation for that, but not sure what, if anything, I can find."

In an interview on 9-1-26 at 9:50 a.m., with the current Maintenance Director, he indicated he began employment with the facility on 7-31-26. He specified he was not aware of any training or education regarding bedbugs that had been provided to himself, other staff or residents. He clarified he was not familiar with any of the facility's issues with bedbugs prior to being hired. He clarified the issue of the presence of bedbugs in the facility was not provided to him until after hire. He shared the last time he had dealt with any bedbugs issues was at a previous place of employment about 10 years ago.

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In an interview on 9-1-26 at 10:20 a.m., with Resident BB, she recalled she had heard about the facility having bedbugs, but was not aware of any associated problems as a result of the bedbugs. Resident BB could not recall receiving any educational information or materials regarding bedbugs from the facility.

In an interview with Resident CC on 9-1-26 at 10:30 a.m., he indicated he has resided at the facility for over one year. He noted he was unable to recall the exact date, but earlier this year he awoke with his right arm itching, which was abnormal for him. He recalled reporting this to the facility staff and was moved to a different room for several days while his room was being treated and then returned to his same room. Resident CC did mention he

has heard peers discussing the bedbug situation and he assumes the problem has been resolved. He was unable to remember receiving any verbal or written information from the facility regarding what bedbugs are, what concerns or signs and/or symptoms to look for and what to expect with treatment for bedbugs.

In an interview on 9-1-26 at 10:40 a.m. with Resident DD,

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|  | <p>she indicated she has resided for over one year in the same room. She was unable to recall the date, but stipulated she did have an incident in which bedbugs were found in her room by staff and found the staff were very helpful in getting all of her belongings boxed up to be treated but "not sure if the staff did it or they got somebody else to treat the room. All I know is that we had to be gone for the whole day. I was told they sprayed something and did some kind of heat treatment." Indicated the facility did provide her bedbug education, specific to what bedbugs are, but she could not recall if the facility provided any information on signs and symptoms or what to look for or report or what kinds of treatment are available.</p> <p>In an interview with Resident EE on 9-1-26 at 11:30 a.m., he indicated he has been at the facility for less than one week, but has seen no evidence of any pests or rodents in his room or been informed of any such issues in the facility.</p> <p>A review of the pest control logs from the facility's contracted pest control company since November, 2025, provided the following information:</p> <p>11-11-25: routine pest control visit with no mention of bedbug</p> |  |  |  |
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|  | <p>issues</p> <p>12-9-25: routine pest control visit with no mention of bedbug issues</p> <p>1-22-26: routine pest control visit with no mention of bedbug issues</p> <p>2-23-26: routine pest control visit with no mention of bedbug issues</p> <p>2-25-26 bedbug visit, treatment and inspection of rooms 211, 403, 405</p> <p>3-10-26 routine pest control visit with identification of no bedbug activity and treatment for same to rooms 403 and 405</p> <p>3-27-26: bedbug visit, treat and inspect room 409</p> <p>4-7-26: routine visit &amp; bedbug visit without mention of what rooms/areas were checked</p> <p>4-10-26: bedbug visit, treat and inspect visit for first floor only and common areas with no evidence of any live bedbug found</p> <p>4-14-26: routine pest control visit with no mention of bedbug issues</p> |  |  |  |
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|  | <p>5-12-26: routine pest control visit with no mention of bedbug issues</p> <p>6-15-26: routine pest control visit with no mention of bedbug issues</p> <p>7-16-26 bedbug visit areas sprayed for bedbug and routine pest control visit; no mention of specific areas sprayed or treated for bedbug</p> <p>8-26-26: routine pest control visit with no mention of bedbug issues</p> <p>A review of the pest control logs from contracted pest control company which uses heat for bedbug treatment was as follows:</p> <p>"1.May 29: Heat-based Bed Bug Treatment for unit 215.</p> <p>2.May 29: Heat-based Bed Bug Treatment for unit 401.</p> <p>3.June 5: 1 week Follow up chemical spray for units 215 and 401.</p> <p>4.June 5: Heat-based Bed Bug Treatment for unit 410.</p> <p>5.June 5: Heat-based Bed Bug Treatment for unit 323.</p> <p>6.June 9: Heat-based Bed Bug Treatment for unit 208.</p> |  |  |  |
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| <p>7.June 9: Heat-based Bed Bug Treatment for unit 415.</p> <p>8.June 12: 1 week Follow up chemical spray for units 323 and 410.</p> <p>9.June 16: Heat-based Bed Bug Treatment for units 409 and 413.</p> <p>10.June 16: Heat-based Bed Bug Treatment for units 407 and 408.</p> <p>11.June 16: 1 week Follow up chemical spray for units 208 and 415.</p> <p>12.June 17: Heat-based Bed Bug Treatment for units 402 and 403.</p> <p>13.June 17: Heat-based Bed Bug Treatment for units 404, 405 and 406.</p> <p>14.June 18: 1 week Follow up chemical spray for units 415 and 208.</p> <p>15.June 18: Heat-based Bed Bug Treatment for units 207 and 209.</p> <p>16.June 18: Heat-based Bed Bug Treatment for units 212 and 214.</p> <p>17.June 18: Inspection and chemical spray for unit 307. Sprayed all baseboards, mattresses and furniture. No live</p> |  |  |  |
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activity found.

18.June 18: Heat-based Bed Bug Treatment for unit 322.

19.June 25: 1 week Follow up chemical spray for units 403, 405, 406, 407, 408, 409,

411, 212, 214, 402, 207, 209, 322.

20.June 25: Heat-based Bed Bug Treatment for units 422 and 423.

21.June 25: IBBA Steam and Spray Warranty for unit 323.

22.July 1: 1 week Follow up chemical spray for unit 404.

23.July 7: IBBA Steam and Spray Warranty for unit 207.

24.July 7: IBBA Steam and Spray Warranty for unit 401.

25.July 7: 1 week Follow up chemical spray for units 413 and 423.

26.July 8: Heat-based Bed Bug Treatment for unit 206.

27.July 15: 1 week Follow up chemical spray for unit 206.

28.Aug 10: IBBA Steam and Spray Warranty for unit 410.

29.Aug 28: Inspection and chemical spray treatment for unit 28 for a therapeutic chair.

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|  | <p>No live activity found.</p> <p>Heat Treatment Summary</p> <p>1. Interior spray of entire home with Crossfire, and dusting of outlets with powder pesticide</p> <p>2. 1-Day, 100% Remediation, Heat-Based Treatment (8am-5pm) 3. 1-Week Follow Up Precautionary Spray and Inspection</p> <p>4. 60-day Guaranteed Warranty on the entire home Chemical Summary</p> <p>All of the spray-based work above was completed with one of two chemicals*** 1. MGK Crossfire Bed Bug Concentrate</p> <p>2. Alpine WSG"</p> <p>The following rooms were treated by the contracted pest control companies: 207, 208, 209, 211, 212, 214, 215, 307, 322, 323, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 413, 415, 422, 423, and other rooms or areas not clearly identified in the companies' documentation.</p> <p>The facility's "Bed Bug Policy," dated 6-2025, was received via email on 9-2-26. This policy indicated, "The purpose of this policy is to establish and maintain clear and effective procedures for the prevention,</p> |  |  |  |
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|  | <p>early detection, and management of bed bug infestations within the community...The intent is to safeguard the health, comfort, and well-being of all residents, staff and visitors by implementing evidence-based prevention methods, prompt reporting, and appropriate professional remediation. Through consistent staff education, timely intervention, and adherence to established procedures, the community aims to minimize the risk of infestation, prevent spread, protect resident belongings, and maintain a clean, safe and sanitary environment...Furniture, beds, couches, and personal items should be inspected for signs of infestation prior to allowing items into the community...Any suspicion of bed bugs must be reported immediately to the Maintenance Director, the Maintenance Director shall make appropriate notification to the Executive Director, Director of Nursing, and/or designated representative. In the event of suspected bed bugs the following procedure shall be followed: Immediately, staff must wear gloves when encountering an affected resident, linens, furniture, or personal items until the resident has showered and items have been treated (with confirmation</p> |  |  |  |
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|  | <p>no bed bugs remain) or removed. Nothing may be removed from the resident's room and transported unless it has first been sealed completely in a plastic bag or trash bag. Maintenance Director shall arrange for a licensed professional exterminator to provide treatment as quickly as possible. The exterminator shall treat the resident's room and adjacent rooms, including those above, below, and directly next door (left and right). All items in the affected room (as applicable) shall be bagged, sealed, and removed using proper PPE guidelines. Heavily infested items shall be sealed and discarded immediately in the outdoor trash receptacle. Treatment of clothing shall be as follows: placed and sealed in plastic bags or trash bags; clean clothing may be treated in a dryer at or above 113 [degrees] F (45 [degrees] C). Soiled clothing and linens must remain sealed until placed directly in the washer; bags must be immediately discarded outdoors. Items that cannot be laundered must be sealed and sent for dry cleaning or commercial laundering at the expense of the resident; upholstered furniture which may include but is not limited to, mattresses, box springs, chairs, cushions, and sofas must be entirely wrapped in plastic, sealed, and taped.</p> |  |  |  |
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|  | <p>Replacement is highly recommended for heavily infested upholstery items; wooden furniture items may include but are not limited to, bedside tables, bookcases, chests, etc., must be wrapped sealed and taped for appropriate removal. Discard is required for heavily infested wooden furniture items; for proper resident management please provide the following: a complete and thorough shower, removing soiled linens immediately to place in proper bags for sealing, provide a clean set of clothing that does not originate from the infested room, relocation of the resident shall commence, if the resident refuses to relocate or relocation is not possible, the resident must shower and change into clean clothing not originating from the infested room each time they choose to leave the infested room until professional treatment has been completed; once treatment from a licensed professional exterminator has been completed on the infested room, the resident may return to the room and resume normal activities following any instruction from the exterminator; the treated room must be inspected 3x weekly for 2 weeks following the finalization of extermination; aggressive bed bug procedures supercede all current bed bug</p> |  |  |  |
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|  | <p>checklists."</p> <p>B. The clinical record of Resident D was reviewed on 9-2-26 at 9:52 a.m. Her diagnoses included, but were not limited to, cognitive decline. It indicated she resided on the secured memory care unit (MCU) and her most recent evaluation and service plan, dated 6-24-26, identified Resident D as severely cognitively impaired and was a fall risk with the need for frequent staff supervision.</p> <p>A review of the nursing progress notes reflected on 8-6-26 with no time listed, QMA 5 was notified of Resident D having a black eye. It indicated, "writer went to see and noticed it was [a] knot and some swelling above the eyebrow with slight bruising, before hand [sic] resident was sitting in the back tv area with writer and several other residents, engaging in conversation but did not witness any falls." A notation, dated 8-8-26 at 11:35 a.m., specified the Memory Care Director notified Resident D's son of the fall and the resident's current condition. A review of the nursing progress notes failed to locate any documentation related to the circumstances of the fall, such as time and date of the fall, if the fall was a witnessed or unwitnessed, any</p> |  |  |  |
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|  | <p>notification to the nurse on duty in order to conduct an assessment of the resident after the fall, timely (within 24 hours) notification and any follow-up of the resident status after the fall, until an entry dated 8-13-26.</p> <p>An observation of Resident D was conducted on 10:35 a.m., in which she was seated in her wheelchair in the activity room with two staff present who were providing nail care to her. No bruising was observed to her face or arms. Resident D's speech was of a single syllable word fashion that did not make sense, almost word-salad type speech.</p> |  |  |  |
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In an interview on 9-2-26 at 10:40 a.m., with QMA 2, she shared she was not present when Resident D's fall occurred. "When I came back to work, she had two black eyes." She indicated when a resident has a fall, "Normally...they are placed on a 72-hour monitoring. [Name of Resident D] is usually seated near staff because she has a tendency to just try to get up out of her wheelchair and is a high fall risk. She does have poor balance, but she is not safe by herself to walk. She can speak, but more like a word salad. She seemed to heal up fairly well." QMA 2 confirmed Resident D receives "[a] blood thinner of Eliquis 5 milligrams daily."

In an interview on 9-2-26 at 10:45 a.m., with QMA 5, she recalled on the day of Resident D's fall, she was present in the building, but not on the unit when she fell. "I learned about her fall later that evening. [I] Gave her meds that evening and it did not appear bruised at that time. Was about the next day that the bruising started."

In an interview with the Memory Care Director on 9-2-26 at 12:01 p.m., she indicated she was not in the facility when she was told about Resident D's fall. "If I remember right, she had fallen and was starting to show a bruise around her right eye. As

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|  | <p>time went on, the bruise extended to both eyes. I talked to the evening shift staff and told them to keep an eye on her. She is a fall risk. I think she was using her walker at the time, but she also has a wheelchair and if I remember, the foot pedals were down on it. My guess was it was an unwitnessed fall. She seems to be able to understand things much better than she can communicate back to you."</p> <p>In at interview on 9-2-26 at 11:50 a.m. with the Director of Nursing (DON), she specified, "I'm not sure that all the documentation was done with [name of Resident D]'s fall, it's something we need to work on."</p> <p>In an interview with the current Executive Director (ED) on 9-2-26 at 2:10 p.m., she indicated, "As far as I can see, there is no documentation of when or where the fall occurred, no assessment by a nurse, no notification at the time of the fall to the doctor, ED, DON, Memory Care Director or the family. Any unwitnessed fall should have an assessment done by a licensed nurse, or sent out by 911 if there was not a nurse available to do an assessment. If a resident has a fall with any type of a possible head injury, a nurse should check them out. I don't see much of any kind of</p> |  |  |  |
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|  | <p>documentation of what happened or what type of follow up was done with the resident after the fall."</p> <p>On 9-2-26, the facility emailed a copy of a policy entitled, "Fall Prevention Policy," with a revision date of 8-2026. This policy indicated, "The purpose of this policy is to establish consistent processes for reviewing, responding, documenting, and following up on resident falls while still providing the appropriate care and supervision based on person-centered care guidelines. If a resident's fall is witnessed or reported, staff shall remain with the resident and shall not move the resident unless necessary due to immediate safety or emergency risk. The nurse on staff shall be notified immediately for proper assessment of resident including but not limited to, injury (visible or reported), pain, and vital signs as appropriate. If the resident condition warrants immediate emergency medical intervention, 9-1-1 shall be contacted. In a situation in which a nurse is unable to assess the residents, 9-1-1 shall be contacted, if applicable. Clinical staff shall make the following individuals aware of a fall: Director of Nursing, Memory Care Director (for Memory Care Unit falls), Executive Director,</p> |  |  |  |
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|        | <p>Power-of-Attorney/Guardian, Resident Provider, 9-1-1, if applicable. Following a resident fall, in applicable instances, the resident shall be placed on 72-hour fall monitoring protocol. This decision shall be based on condition, assessment findings, injury and/or suspected injury, change in condition, fall history, risk factors, and clinical judgement. Resident care plan [sic] shall be reviewed and updated as applicable. This facility shall evaluate the circumstances surrounding the fall and address all identified environmental, equipment, supervision, or care-related factors to reduce fall risk."</p> |        |  |            |
| R 0092 | <p>Administration and Management - Noncompliance</p> <p>410 IAC 16.2-5-1.3(i)(1-2)</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and</p>   | R 0092 |  | 09/18/2026 |

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|  | <p>emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on interview and record review, the facility failed to have monthly fire drills for 2 of 9 months reviewed. This had a potential to affect 91 of 91 residents that resided in the facility.</p> <p>Findings include:</p> <p>A binder that contained the monthly fire drills that were conducted was provided by the Regional Executive Director (ED) on 8/31/26 at 10:15 a.m. The binder did not include fire drills that had been conducted June 2026 and July 2026.</p> <p>An interview was conducted with the ED on 8/31/26 at 10:30 a.m. She indicated she was unable to provide fire drills that had been conducted monthly for the year. There were a couple months missing.</p> |  |  |  |
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|  | <p>A fire drill policy was provided by the ED on 9/3/26 at 12:25 p.m. It indicated, "Purpose: The purpose of this policy is to establish a procedure to ensure all employees are prepared to appropriately respond during a fire emergency by completing routine fire drills. Fire drills shall provide staff with an opportunity to practice fire emergency procedures, demonstrate knowledge of RACE and PASS procedures, and ensure the safety of residents and visitors in accordance with Indiana Department of Health regulations and the facility Emergency Preparedness Plan.</p> <p>Procedure: Fire drills shall be conducted in accordance with the Indiana Department of Health Residential Care Facility regulations and Life Safety Code Requirements. The facility shall conduct a monthly fire drill. Throughout the year, fire drills shall be conducted on all shifts to ensure all employees are afforded the opportunity to participate..."</p> |  |  |  |
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| R 0149 | <p>Sanitation and Safety Standards - Deficiency</p> <p>410 IAC 16.2-5-1.5(f)</p> <p>(f) The facility shall have a pest control program in operation in compliance with 410 IAC 7-24.</p> <p>Based on observation and interview and record review, the facility failed to have pest control program in place. This had a potential to affect 91 of 91 residents that eat food prepared in the kitchen.</p> <p>Findings include:</p> <p>A kitchen tour was conducted on 8/31/2026 at 10:30 a.m. Dietary Manager conducted the tour. During the tour, multiple flying insects observed to be flying in the dry storage area. DM indicated Exterminator was in the kitchen last Thursday to address the gnats. She indicated the gnats were coming up from the drains. The drains were observed throughout the kitchen. Dry spaghetti was observed to be in the drain by the prep area. Assistant Dietary Manager indicated that the spaghetti was served the previous Friday. A large bowl of ripe bananas was also observed on the bottom shelf of a prep table.</p> <p>An interview was conducted with the Exterminator Staff</p> | R 0149 |  | 09/18/2026 |
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|        | <p>Person on 9/2/26 at 2:00 p.m. She indicated the facility's contract did not include flying pests. Gnats were caused by poor sanitation with left out produce. She indicated they did not treat flying pests at this time.</p> <p>An interview was conducted with Regional Executive Director on 9/2/26 at 4:20 p.m. She indicated she wasn't aware that flying pests were not in the contract.</p> <p>The Food Service Sanitation Policy was provided by the Regional Executive Director on 8/31/2026 at 4:37 p.m. It indicated, " ... The facility shall maintain an effective pest control program to prevent insects and rodents from entering food service areas. Evidence of pest activity shall be reported immediately, and corrective action shall be taken promptly ..."</p> |        |  |            |
| R 0216 | <p>Evaluation - Noncompliance</p> <p>410 IAC 16.2-5-2(c)(1-4)(d)</p> <p>(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:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                       | R 0216 |  | 09/18/2026 |

- (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.

Based on interview and record review, the facility failed to ensure self medication assessments were conducted timely and service plans were updated for residents that self administer their medications for 2 of 5 residents records reviewed. (Resident G and Resident L)

Findings include:

1. The clinical record for Resident G was reviewed on 9/2/26 at 11:00 a.m. The resident's diagnosis included, but was not limited to, elevated blood pressure.

An evaluation for Resident G, dated 7/30/26, indicated the staff administer all medications.

A self medication assessment, dated 7/30/26, indicated the resident was unable to self administer her medications.

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|  | <p>A physician order, dated 11/24/25, indicated Resident G was to receive estradiol cream applied vaginally (hormone replacement medication) Mondays, Wednesdays and Fridays.</p> <p>The August 2026 Medication/Treatment Record (MAR/TAR) indicated Resident G had self administered the estradiol cream every Monday, Wednesday and Friday in August expect 8/24/26.</p> <p>2. The clinical record for Resident L was reviewed on 9/1/26 at 1:00 p.m. The resident's diagnosis included, but was not limited to, elevated blood pressure.</p> <p>A 7/21/26 evaluation for Resident L indicated the staff administer the resident's medications.</p> <p>A self medication assessment, dated 7/21/26, indicated Resident L was unable to administer her medications.</p> <p>A physician order, dated 7/24/26, indicated Resident L was to receive 20 percent zinc oxide to her buttocks three times a day.</p> |  |  |  |
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The August 2026 MAR/TAR indicated Resident L had self administered the 20 percent zinc oxide to her buttocks:

8/2/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

8/4/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

8/6/26 - 12:00 p.m.,

8/8/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

8/9/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

8/11/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

8/14/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

8/17/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

8/18/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

8/22/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m., and

8/23/26 - 8:00 a.m., 12:00 p.m., and 4:00 p.m.,

An interview was conducted with the Director of Nursing on 9/2/26 at 5:30 p.m. She indicated residents that choose to self medicate their medications should have a self medication assessments that

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|        | indicate they are able. She had assessed Resident L and updated her self medications assessment that day to indicate she was able to self medicate her creams.                                                                                                                                                                                                                                                                                                                                                                                                              |        |  |            |
| R 0240 | <p>Health Services - Deficiency</p> <p>410 IAC 16.2-5-4(d)</p> <p>(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on interview and record review, the facility failed to ensure medications were administered as ordered for 1 of 5 residents records reviewed. (Resident G)</p> <p>Findings include:</p> <p>The clinical record for Resident G was reviewed on 9/2/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, elevated blood pressure.</p> | R 0240 |  | 09/18/2026 |

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|  | <p>A physician order, dated 12/1/25, indicated Resident G was to receive 6.25 milligrams of coreg once a day. The staff was to hold the blood pressure medication if the resident's systolic blood pressure reading (the top number of the blood pressure reading) was less than 100.</p> <p>The August 2026 Medication Administration Record (MAR) for Resident G indicated the following days the staff did not administer the 6.25 milligrams of coreg and the 10 milligrams of the toseamide due to the resident's blood pressure reading was low:</p> <p>6.25 milligrams of coreg:</p> <p>8/2/26 - blood pressure reading was 101/52,</p> <p>8/21/26 - blood pressure reading was 100/56 and</p> <p>8/25/26 - blood pressure reading was 105/61</p> <p>Resident G's medical chart did not include documentation the medical provider was contacted to hold the blood pressure reading on 8/2/26, 8/21/26 and 8/25/26.</p> <p>An interview was conducted with the Director of Nursing on 9/2/26 at 5:30 p.m. She indicated she was unsure why</p> |  |  |  |
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|        | the blood pressure medications were held on 8/2/26, 8/21/26 and 8/25/26.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |  |            |
| R 0273 | <p>Food and Nutritional Services - Deficiency</p> <p>410 IAC 16.2-5-5.1(f)</p> <p>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to keep food stored in a safe manner, cleanliness of ceiling, and ensure dishwasher was functioning properly. This had the potential to affect 91 of 91 residents that eat food prepared in the kitchen.</p> <p>Findings include:</p> <p>The kitchen tour was conducted on 8/31/2026 at 10:30 a.m., with the Dietary Manager (DM) and Assisted Dietary Manager (ADM). During the tour, the dishwasher cycle was completed. Dietary Manager indicated the dishwasher was a low temperature dishwasher and was only 2 months old. The temperature of the dishwasher wash cycle was 138 degrees Fahrenheit, and the rinse cycle was noted to be 75 degrees</p> | R 0273 |  | 09/18/2026 |

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Fahrenheit. DM completed the chemical test strip check. The strip did not match the indicator. The dishwasher temperature log indicated all high wash temperatures, and Parts Per Million (PPM) portion was blank for the month of August. She indicated she would be calling the company to have someone come out to check the dishwasher.

The stand alone freezer was observed with the ADM. The freezer had the following items that were open to air and without dates:

A bag of chicken tenders that was open to air with no date,

A bag of fish that was closed with no date,

A bag of onion rings that was sealed with no date,

A bag of chicken nuggets that was open to air with no date,

A bag of French fries that was open to air with no date,

A bag of chicken breast with no date, and

A bag of crab Rangoon with no date.

The vent on the ceiling by the juice machine was observed to have a layer of grey-brown

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|  | <p>substance. Assistant Dietary Manager indicated he had been employed for a year, and no one had cleaned it. He was unsure whose responsibility it was.</p> <p>A kitchen tour was conducted on 9/1/2026 at 3:00 p.m. The dishwasher was observed with a Service Technician (ST). The ST had indicated the hose for the cleaning agent was damaged, and it was replaced. DM indicated she had received the new test strips from the technician.</p> <p>The dishwasher temperature log was provided by the DM on 8/31/26 at 11:00 a.m. It indicated the staff were not documenting the temperatures after test strips.</p> <p>The Food Storage Policy and Food Service Sanitation Policy was provided by the Regional Executive Director on 8/31/2026 at 4:37 p.m. It indicated, " ... opened food items and prepared food items shall be labeled and dated in accordance with facility policy and manufacturer ..." The food service sanitation policy indicated, " ... The kitchen, food preparation areas, storage rooms, serving areas, dining rooms, and all food service equipment shall be maintained in a clean, sanitary, and orderly</p> |  |  |  |
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|        | condition always ..." It also indicated, "...ventilation systems and exhaust hoods shall be maintained in clean condition ..." Furthermore, it indicated, "...verify and regularly test dishwashers reach required wash and rinse temperatures or maintain correct sanitizer concentration ..."                                                                                                                                                                                                                                                                                                                                                                                                                                                            |        |  |            |
| R 0349 | <p>Clinical Records - Noncompliance</p> <p>410 IAC 16.2-5-8.1(a)(1-4)</p> <p>(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:</p> <p>(1) Complete.</p> <p>(2) Accurately documented.</p> <p>(3) Readily accessible.</p> <p>(4) Systematically organized.</p> <p>A. Based on interview and record review, the facility failed to document the various steps taken by the facility related to the facility's policies and procedures for presence of bedbugs which included steps taken by facility for eradication of bedbugs, lack of timely education to staff and timely</p> | R 0349 |  | 09/18/2026 |

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notification to residents and RP regarding having active bedbugs within the facility which affected over 20 resident rooms. (Rooms 207, 208, 209, 211, 212, 214, 215, 307, 322, 323, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 413, 415, 422, 423)

B. Based on interview and record review, the facility failed to ensure documentation was completed for 1 of 3 residents reviewed for falls, including but not limited to the documentation of the fall being a witnessed or unwitnessed fall, details of time, location and general circumstances of the fall, any assessment of the resident, notification of the fall to the appropriate persons and follow-up of the fall. (Resident D)

Findings include:

A. In an interview on 9-1-26 at 3:26 p.m., with the Activities Director, she indicated she became aware of bedbugs in the building earlier this year with one resident's room and has expanded since then. "The big burst seemed to be sometime in the spring, maybe April or May. The management team received information, can't remember if it was in person or email regarding how to identify bedbugs. We were given spray

bottles of alcohol to spray on the floors and on chairs and furniture. At the time, if a resident was identified with bedbugs, we moved them to a different room. We had an all-staff meeting where we talked about bedbugs and what to look for and who to report the bedbugs problem to. This was done for the staff prior to giving out information to residents and sent them out to families and/or responsible parties and this was done sometime in June." The Activities Director shared, "One of the biggest problems we had was rumors. We had any number of residents that would claim they had bedbugs, but when we would check their rooms, we would not find anything."

In an interview on 9-1-26 at 1:20 p.m., with the current Executive Director (ED), she indicated her information indicates the initial bedbug identification was at or around 2-5-26, for Room 403. She added at the time, she was not the acting ED, but was in a Corporate capacity. She shared a canine inspection was conducted on 2-9-26, which included all rooms being inspected and all common areas by the contracted pest control company. She noted by 3-30-26, there was an increase in reportings of bedbugs in the building. She added by 6-2-26,

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she (the current ED, who started in this capacity at this building in 8-10-26) was made aware via email of the bedbug situation and "I emailed the [former] ED to begin the aggressive treatment, as outlined in the bedbug policy." She indicated since she was not in the building at the time, she can only assume the former ED would have provided education to themselves and the maintenance director, which would include the bedbug policies and procedures and the checklist. She explained the checklist would provide information on what to do if staff see or suspect something. She indicated the former ED should have explained to the former maintenance director to start checklists on any suspected bedbug problems and for the former ED and the former Maintenance Director to keep her updated on any findings related to the bedbug situation. "I don't know if the previous Maintenance Director was actually doing what I had told them." She indicated the facility provided a blacklight piece of equipment that helps to more easily detect bedbug. She added she was aware that bedbug education had been provided to the Resident Council President, Vice-President, Sargent of Arms and their Treasurer, but was not

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certain of the date of occurrence. She clarified since the Resident Council does not provide the meeting minutes to the facility, she was uncertain if that information was shared with the other residents.

The current ED indicated she had requested for all items brought into the facility to be checked/inspected by the former Maintenance Director for bedbugs prior to admission and this was requested prior to the current ED coming to the facility on or around 8-10-26, but is uncertain if this was being done, "but I presume the previous Maintenance Director was not doing this." She indicated she was not in this building's ED capacity when the current Maintenance Director began employment. She indicated he was provided with the bedbug policies and procedures and the facility's expectations for his position.

The current ED was queried regarding lack of documentation related to education of staff, residents and families and/or responsible parties. She provided inservice education conducted on 6-3-26, for staff on bedbugs. "I guess it is a good question as to why there was a delay in providing education to the staff." The current ED was unable to

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|  | <p>provide documentation of steps taken during the time of initial identification of the bedbugs until when she resumed the current ED position, with the exception of pest control logs from the two companies used by the facility. The pest control logs did not provide resident names, only the room numbers for any pest treatments conducted in the facility.</p> <p>The facility provided documentation on 9-2-26, of an all-staff inservice education, conducted on 6-3-26, regarding what bedbugs are, where they may be found or located, their means of transmission and treatments for the person and the environment. Additional documentation was provided on 9-2-26, of notifications made to residents and responsible parties of the facility having bedbugs in the facility on 6-5-26.</p> <p>In an interview with the current ED on 9-2-26 at 1:55 p.m., she did not begin her tenure as the interim ED until 8-10-26. "I am having problems locating some of the records from the previous ED and the Maintenance Director, so I cannot tell you exactly what may have been done in regards to how the policies and procedures for bedbugs were implemented. I will try and find some of the</p> |  |  |  |
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documentation for that, but not sure what, if anything, I can find."

In an interview on 9-1-26 at 9:50 a.m., with the current Maintenance Director, he indicated he began employment with the facility on 7-31-26. He specified he was not aware of any training or education regarding bedbugs that had been provided to himself, other staff or residents. He clarified he was not familiar with any of the facility's issues with bedbugs prior to being hired. He clarified the issue of the presence of bedbugs in the facility was not provided to him until after hire. He shared the last time he had dealt with any bedbugs issues was at a previous place of employment about 10 years ago.

In an interview on 9-1-26 at 10:20 a.m., with Resident BB, she recalled she had heard about the facility having bedbugs, but was not aware of any associated problems as a result of the bedbugs. Resident BB could not recall receiving any educational information or materials regarding bedbugs from the facility.

In an interview with Resident CC on 9-1-26 at 10:30 a.m., he indicated he has resided at the facility for over one year. He

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noted he was unable to recall the exact date, but earlier this year he awoke with his right arm itching, which was abnormal for him. He recalled reporting this to the facility staff and was moved to a different room for several days while his room was being treated and then returned to his same room. Resident CC did mention he

has heard peers discussing the bedbug situation and he assumes the problem has been resolved. He was unable to remember receiving any verbal or written information from the facility regarding what bedbugs are, what concerns or signs and/or symptoms to look for and what to expect with treatment for bedbugs.

In an interview on 9-1-26 at 10:40 a.m. with Resident DD, she indicated she has resided for over one year in the same room. She was unable to recall the date, but stipulated she did have an incident in which bedbugs were found in her room by staff and found the staff were very helpful in getting all of her belongings boxed up to be treated but "not sure if the staff did it or they got somebody else to treat the room. All I know is that we had to be gone for the whole day. I was told they sprayed something and did some kind of heat treatment."

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|  | <p>Indicated the facility did provide her bedbug education, specific to what bedbugs are, but she could not recall if the facility provided any information on signs and symptoms or what to look for or report or what kinds of treatment are available.</p> <p>In an interview with Resident EE on 9-1-26 at 11:30 a.m., he indicated he has been at the facility for less than one week, but has seen no evidence of any pests or rodents in his room or been informed of any such issues in the facility.</p> <p>A review of the pest control logs from the facility's contracted pest control company since November, 2025, provided the following information:</p> <p>11-11-25: routine pest control visit with no mention of bedbug issues</p> <p>12-9-25: routine pest control visit with no mention of bedbug issues</p> <p>1-22-26: routine pest control visit with no mention of bedbug issues</p> <p>2-23-26: routine pest control visit with no mention of bedbug issues</p> |  |  |  |
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2-25-26 bedbug visit, treatment and inspection of rooms 211, 403, 405

3-10-26 routine pest control visit with identification of no bedbug activity and treatment for same to rooms 403 and 405

3-27-26: bedbug visit, treat and inspect room 409

4-7-26: routine visit & bedbug visit without mention of what rooms/areas were checked

4-10-26: bedbug visit, treat and inspect visit for first floor only and common areas with no evidence of any live bedbug found

4-14-26: routine pest control visit with no mention of bedbug issues

5-12-26: routine pest control visit with no mention of bedbug issues

6-15-26: routine pest control visit with no mention of bedbug issues

7-16-26 bedbug visit areas sprayed for bedbug and routine pest control visit; no mention of specific areas sprayed or treated for bedbug

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8-26-26: routine pest control visit with no mention of bedbug issues

A review of the pest control logs from contracted pest control company which uses heat for bedbug treatment was as follows:

"1.May 29: Heat-based Bed Bug Treatment for unit 215.

2.May 29: Heat-based Bed Bug Treatment for unit 401.

3.June 5: 1 week Follow up chemical spray for units 215 and 401.

4.June 5: Heat-based Bed Bug Treatment for unit 410.

5.June 5: Heat-based Bed Bug Treatment for unit 323.

6.June 9: Heat-based Bed Bug Treatment for unit 208.

7.June 9: Heat-based Bed Bug Treatment for unit 415.

8.June 12: 1 week Follow up chemical spray for units 323 and 410.

9.June 16: Heat-based Bed Bug Treatment for units 409 and 413.

10.June 16: Heat-based Bed Bug Treatment for units 407 and 408.

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11.June 16: 1 week Follow up chemical spray for units 208 and 415.

12.June 17: Heat-based Bed Bug Treatment for units 402 and 403.

13.June 17: Heat-based Bed Bug Treatment for units 404, 405 and 406.

14.June 18: 1 week Follow up chemical spray for units 415 and 208.

15.June 18: Heat-based Bed Bug Treatment for units 207 and 209.

16.June 18: Heat-based Bed Bug Treatment for units 212 and 214.

17.June 18: Inspection and chemical spray for unit 307. Sprayed all baseboards, mattresses and furniture. No live activity found.

18.June 18: Heat-based Bed Bug Treatment for unit 322.

19.June 25: 1 week Follow up chemical spray for units 403, 405, 406, 407, 408, 409, 411, 212, 214, 402, 207, 209, 322.

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20.June 25: Heat-based Bed Bug Treatment for units 422 and 423.

21.June 25: IBBA Steam and Spray Warranty for unit 323.

22.July 1: 1 week Follow up chemical spray for unit 404.

23.July 7: IBBA Steam and Spray Warranty for unit 207.

24.July 7: IBBA Steam and Spray Warranty for unit 401.

25.July 7: 1 week Follow up chemical spray for units 413 and 423.

26.July 8: Heat-based Bed Bug Treatment for unit 206.

27.July 15: 1 week Follow up chemical spray for unit 206.

28.Aug 10: IBBA Steam and Spray Warranty for unit 410.

29.Aug 28: Inspection and chemical spray treatment for unit 28 for a therapeutic chair. No live activity found.

#### Heat Treatment Summary

1.Interior spray of entire home with Crossfire, and dusting of outlets with powder pesticide

2.1-Day, 100% Remediation, Heat-Based Treatment (8am-5pm) 3. 1-Week Follow Up Precautionary Spray and

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|  | <p>Inspection</p> <p>4. 60-day Guaranteed Warranty on the entire home Chemical Summary</p> <p>All of the spray-based work above was completed with one of two chemicals*** 1. MGK Crossfire Bed Bug Concentrate</p> <p>2. Alpine WSG"</p> <p>The following rooms were treated by the contracted pest control companies: 207, 208, 209, 211, 212, 214, 215, 307, 322, 323, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 413, 415, 422, 423, and other rooms or areas not clearly identified in the companies' documentation.</p> <p>The facility's "Bed Bug Policy," dated 6-2025, was received via email on 9-2-26. This policy indicated, "The purpose of this policy is to establish and maintain clear and effective procedures for the prevention, early detection, and management of bed bug infestations within the community...The intent is to safeguard the health, comfort, and well-being of all residents, staff and visitors by implementing evidence-based prevention methods, prompt reporting, and appropriate professional remediation. Through consistent staff</p> |  |  |  |
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| <p>education, timely intervention, and adherence to established procedures, the community aims to minimize the risk of infestation, prevent spread, protect resident belongings, and maintain a clean, safe and sanitary environment...Furniture, beds, couches, and personal items should be inspected for signs of infestation prior to allowing items into the community...Any suspicion of bed bugs must be reported immediately to the Maintenance Director, the Maintenance Director shall make appropriate notification to the Executive Director, Director of Nursing, and/or designated representative. In the event of suspected bed bugs the following procedure shall be followed: Immediately, staff must wear gloves when encountering an affected resident, linens, furniture, or personal items until the resident has showered and items have been treated (with confirmation no bed bugs remain) or removed. Nothing may be removed from the resident's room and transported unless it has first been sealed completely in a plastic bag or trash bag. Maintenance Director shall arrange for a licensed professional exterminator to provide treatment as quickly as possible. The exterminator shall treat the resident's room and</p> |  |  |  |
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|  | <p>adjacent rooms, including those above, below, and directly next door (left and right). All items in the affected room (as applicable) shall be bagged, sealed, and removed using proper PPE guidelines. Heavily infested items shall be sealed and discarded immediately in the outdoor trash receptacle. Treatment of clothing shall be as follows: placed and sealed in plastic bags or trash bags; clean clothing may be treated in a dryer at or above 113 [degrees] F (45 [degrees] C). Soiled clothing and linens must remain sealed until placed directly in the washer; bags must be immediately discarded outdoors. Items that cannot be laundered must be sealed and sent for dry cleaning or commercial laundering at the expense of the resident; upholstered furniture which may include but is not limited to, mattresses, box springs, chairs, cushions, and sofas must be entirely wrapped in plastic, sealed, and taped. Replacement is highly recommended for heavily infested upholstery items; wooden furniture items may include but are not limited to, bedside tables, bookcases, chests, etc., must be wrapped sealed and taped for appropriate removal. Discard is required for heavily infested wooden furniture items; for proper resident management</p> |  |  |  |
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|  | <p>please provide the following: a complete and thorough shower, removing soiled linens immediately to place in proper bags for sealing, provide a clean set of clothing that does not originate from the infested room, relocation of the resident shall commence, if the resident refuses to relocate or relocation is not possible, the resident must shower and change into clean clothing not originating from the infested room each time they choose to leave the infested room until professional treatment has been completed; once treatment from a licensed professional exterminator has been completed on the infested room, the resident may return to the room and resume normal activities following any instruction from the exterminator; the treated room must be inspected 3x weekly for 2 weeks following the finalization of extermination; aggressive bed bug procedures supercede all current bed bug checklists."</p> <p>This residential tag relates to Intakes 468978, 469929, 469971, 470085, 470086 and 471699.</p> <p>2.5-8.1(a)(1)</p> <p>2.5-8.1(a)(2)</p> <p>2.5-8.1(a)(4)</p> |  |  |  |
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|  | <p>B. The clinical record of Resident D was reviewed on 9-2-26 at 9:52 a.m. Her diagnoses included, but were not limited to, cognitive decline. It indicated she resided on the secured memory care unit (MCU) and her most recent evaluation and service plan, dated 6-24-26, identified Resident D as severely cognitively impaired and was a fall risk with the need for frequent staff supervision.</p> <p>A review of the nursing progress notes reflected on 8-6-26, with no time listed, QMA 5 was notified of Resident D having a black eye. It indicated, "writer went to see and noticed it was [a] knot and some swelling above the eyebrow with slight bruising, before hand [sic] resident was sitting in the back tv area with writer and several other residents, engaging in conversation but did not witness any falls." A notation, dated 8-8-26 at 11:35 a.m., specified the Memory Care Director notified Resident D's son of the fall and the resident's current condition. A review of the nursing progress notes failed to locate any documentation related to the circumstances of the fall, such as time and date of the fall, if the fall was a witnessed or unwitnessed, any notification to the nurse on duty in order to conduct an</p> |  |  |  |
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assessment of the resident after the fall, timely (within 24 hours) notification and any follow-up of the resident status after the fall, until an entry dated 8-13-26.

An observation of Resident D was conducted on 10:35 a.m., in which she was seated in her wheelchair in the activity room with two staff present who were providing nail care to her. No bruising was observed to her face or arms. Resident D's speech was of a single syllable word fashion that did not make sense, almost word-salad type speech.

In an interview on 9-2-26 at 10:40 a.m., with QMA 2, she shared she was not present when Resident D's fall occurred. "When I came back to work, she had two black eyes." She indicated when a resident has a fall, "Normally...they are placed on a 72-hour monitoring. [Name of Resident D] is usually seated near staff because she has a tendency to just try to get up out of her wheelchair and is a high fall risk. She does have poor balance, but she is not safe by herself to walk. She can speak, but more like a word salad. She seemed to heal up fairly well." QMA 2 confirmed Resident D receives "[a] blood thinner of Eliquis 5 milligrams daily."

In an interview on 9-2-26 at

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10:45 a.m., with QMA 5, she recalled on the day of Resident D's fall, she was present in the building, but not on the unit when she fell. "I learned about her fall later that evening. [I] Gave her meds that evening and it did not appear bruised at that time. Was about the next day that the bruising started."

In an interview with the Memory Care Director on 9-2-26 at 12:01 p.m., she indicated she was not in the facility when she was told about Resident D's fall. "If I remember right, she had fallen and was starting to show a bruise around her right eye. As time went on, the bruise extended to both eyes. I talked to the evening shift staff and told them to keep an eye on her. She is a fall risk. I think she was using her walker at the time, but she also has a wheelchair and if I remember, the foot pedals were down on it. My guess was it was an unwitnessed fall. She seems to be able to understand things much better than she can communicate back to you."

In at interview on 9-2-26 at 11:50 a.m. with the Director of Nursing (DON), she specified, "I'm not sure that all the documentation was done with [name of Resident D]'s fall, it's something we need to work on."

In an interview with the current

Executive Director (ED) on 9-2-26 at 2:10 p.m., she indicated, "As far as I can see, there is no documentation of when or where the fall occurred, no assessment by a nurse, no notification at the time of the fall to the doctor, ED, DON, Memory Care Director or the family. Any unwitnessed fall should have an assessment done by a licensed nurse, or sent out by 911 if there was not a nurse available to do an assessment. If a resident has a fall with any type of a possible head injury, a nurse should check them out. I don't see much of any kind of documentation of what happened or what type of follow up was done with the resident after the fall."

On 9-2-26, the facility emailed a copy of a policy entitled, "Fall Prevention Policy," with a revision date of 8-2026. This policy indicated, "The purpose of this policy is to establish consistent processes for reviewing, responding, documenting, and following up on resident falls while still providing the appropriate care and supervision based on person-centered care guidelines. If a resident's fall is witnessed or reported, staff shall remain with the resident and shall not move the resident unless necessary due to

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|  | <p>immediate safety or emergency risk. The nurse on staff shall be notified immediately for proper assessment of resident including but not limited to, injury (visible or reported), pain, and vital signs as appropriate. If the resident condition warrants immediate emergency medical intervention, 9-1-1 shall be contacted. In a situation in which a nurse is unable to assess the residents, 9-1-1 shall be contacted, if applicable. Clinical staff shall make the following individuals aware of a fall: Director of Nursing, Memory Care Director (for Memory Care Unit falls), Executive Director, Power-of-Attorney/Guardian, Resident Provider, 9-1-1, if applicable. Following a resident fall, in applicable instances, the resident shall be placed on 72-hour fall monitoring protocol. This decision shall be based on condition, assessment findings, injury and/or suspected injury, change in condition, fall history, risk factors, and clinical judgement. Resident care plan [sic] shall be reviewed and updated as applicable. This facility shall evaluate the circumstances surrounding the fall and address all identified environmental, equipment, supervision, or care-related factors to reduce fall risk."</p> <p>2.5-8.1(a)(1)</p> |  |  |  |
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|        | <p>2.5-8.1(a)(2)</p> <p>2.5-8.1(a)(4)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        |  |            |
| R 0414 | <p>Infection Control - Deficiency</p> <p>410 IAC 16.2-5-12(k)</p> <p>(k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>Based on observation, interview and record review, the facility failed to maintain infection control with proper handwashing during medication administrations for 5 of 5 residents reviewed for medication administrations. (Resident 1, Resident 6, Resident 63, Resident 74, and Resident 75)</p> <p>Findings include:</p> <p>1.The clinical record was reviewed for Resident 1 on 9/1/2026 at 3 p.m. The diagnosis for Resident 1 includes, but are not limited to, Alzheimer's dementia without behavioral disturbance (a clinical state where a person experiences cognitive decline and memory loss without showing disruptive actions like aggression).</p> <p>An observation was made of a</p> | R 0414 |  | 09/18/2026 |

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OMB NO. 0938-0391

medication administration with License Practical Nurse (LPN) 1 for Resident 1 on 9/1/26 at 12:00 p.m. LPN 1 was observed preparing the medication administration. During that time, she touched the following items: computer, mouse, medication cart handle, package of medications. Then, approached resident at dining room table, and administered medications. There was no observation of hand hygiene utilized before or after medication administration.

2. The clinical record was reviewed for Resident 6 on 9/1/2026 at 3 p.m. The diagnoses for Resident 6 include, but are not limited to, A-fib (a heart condition where the upper chambers of the heart beat irregularly and fast).

An observation was made of a medication administration with LPN 1 for Resident 6 on 9/1/26 at 12:00 p.m. LPN 1 was observed preparing the medication administration. During that time, she touched the following items: computer, mouse, medication cart handle, package of medications, medicine cup, water pitcher, and plastic cup for water. Then, approached resident at the dining room table, and administered medications. There was no observation of hand hygiene utilized before or

after medication administration.

3. The clinical record was reviewed for Resident 63 on 9/1/26 at 3:05 p.m. The diagnoses for Resident 63 include, but are not limited to, dementia ( a continuous decline in mental ability that disrupts daily life and independence).

An observation was made of a medication administration with LPN 1 for Resident 63 on 9/1/26 at 12:02 p.m. LPN 1 was observed preparing the medication administration. During that time, she touched the following items: computer, mouse, medication cart handle, package of medications, medicine cup, water pitcher, and plastic cup for water. Then, approached the resident at the dining room table, and administered medications. There was no observation of hand hygiene utilized before or after medication administration.

4. The clinical record was reviewed for Resident 74 on 9/2/2026 at 3 p.m. The diagnosis for Resident 74 include, but are not limited to, dementia (a continuous decline in mental ability that disrupts daily life and independence).

An observation was made of a medication administration with Qualified Medication Aide (QMA) 2 for Resident 74 on

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9/2/2026 at 11:50 a.m. QMA 2 was observed preparing the resident's medication administration. During that time, QMA 2 touched the following items: computer, mouse, medication cart, medication cart drawer handle, medication packet, pill cup, water pitcher, and plastic cup for water. She then entered the resident's room, assisted the resident to sit on the edge of the bed, and administered the medications. There was no observation of hand hygiene before or after the medication administration to Resident 74.

5. The clinical record was reviewed for Resident 75 at 9/2/2026 at 3:05 p.m. The diagnosis for Resident 75 includes, but are not limited to, dementia (a continuous decline in mental ability that disrupts daily life and independence).

An observation was made of a medication administration with QMA 2 for Resident 75 on 9/2/2026 at 11:53 a.m. During that time, QMA 2 touched the following items: medication cart, computer, mouse, medication cart drawer handle, medication packet, pill cup, water pitcher, and plastic cup for water. She then entered the resident's room and administered the medications. There was no observation of hand hygiene

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before or after the medication administration to resident 75.

An Interview conducted was conducted with the Director of Nursing (DON) on 9/2/2026 at 4:15 p.m. The DON indicated that hand hygiene is to be completed prior to medication pass, and upon completion of medication pass.

The hand hygiene policy was provided on 9/3/2026 at 9:21 a.m. by Regional Executive Director. It indicated, " ... Hand hygiene shall be performed at the following times: prior to handling medications ..."

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