STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beech Grove Meadows	2002 Albany St Beech Grove, IN 46107

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a self-administration of medication assessment was completed for medications left at bedside of 1 of 32 resident rooms. (Resident 79)Finding includes: During initial tour on 2/17/26 at 10:28 a.m., Resident 79 was observed to have a bottle of [NAME] nasal spray and a bottle of Refresh eye drops on the over the bed table. Resident 79's clinical record was reviewed on 2/17/26 at 11:00 a.m. The diagnosis included, but was not limited to, acute respiratory failure. The admission Minimum Data Set assessment, dated 2/7/26, indicated Resident 79 had no cognitive impairment. Resident of 79's clinical record lacked a self-administration of medication assessment. On 2/18/26 at 8:29 a.m., Resident 79 was observed to have a bottle of [NAME] Nasal Spray and a bottle of Refresh eye drops on the over the bed table. During an interview on 2/18/26 at 8:33 a.m., the Director of Nursing indicated Resident 79 did not have a self-administration of medication assessment and should have had one completed. On 2/19/26 at 8:10 a.m., the Director of Nursing provided a policy titled Self Administration of Medications, American Senior Services, with revision date of 1/2015 and indicated that the policy is currently being observed by the facility. A review of the policy indicated if a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the Self-Administration of Medication Assessment observation. 3.1-11(a)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure clinical information was kept confidential and located in a secure location for 13 of 93 residents who reside in the facility reviewed for confidentiality of records. (Residents 9, Resident 58, Resident 62, Resident 74, Resident 76, Resident 86, Resident 96, Resident 101, Resident 103, Resident 104, Resident 105, Resident 115, Resident 116) Finding includes: On 2/17/26 at 8:20 a.m., resident documents were observed unattended and spread out face up on a low table. The table was located in front of a couch just inside the front entrance of facility between the receptionist's desk and the Executive Director's (ED) office. No staff were visible in the area at the time. The unsecure and unattended documents included, but were not limited to: - Resident 9 (name), room (number), code status do not resuscitate (DNR), medication allergies listed out as follows: aspirin (ASA), Demerol, gemfibrozil, Lasix, Statins-HMG-CoA Reductase Inhibitors, Zetia, consistent carb (carbohydrate) diet, care in pairs, and listed assistance required for aspects of resident's activities of daily living (ADLs). - Resident 58 (name), room (number), code status full code, no known allergies (NKA), check every 2 hours for incontinence, regular diet, and listed assistance required for aspects of resident's ADLs. - Resident 62 (name), room (number), code status DNR/hospice, NKA, listed as a high fall risk with numerous fall interventions, behavioral symptom, Resident will at times become verbally aggressive with peers. Staff will offer the resident earplugs or noise cancelling headphones. Separate residents into different activities., check every 2 hours for incontinence, regular diet with ground meat, was receiving (Name of) Hospice care, and listed assistance required for aspects of resident's ADLs. - Resident 74 (name), room (number), code status full code, medication allergy listed out for codeine sulfate, additional information, Resident may at times place [Resident 74's] wet or soiled clothing in [Resident 74's] closet and not inform staff., and listed assistance required for aspects of resident's ADLs. - Resident 76 (name), room (number), code status full code, NKA, regular diet, wander guard (a device that alarms at exits for residents with high elopement risk) in place, elopement risk, additional information, Resident has a right glass eye, and listed assistance required for aspects of resident's ADLs. - Resident 86 (name), room (number), code status full code, medication and environmental allergies listed out as follows: Clozaril, Soap, regular diet with ground meat double portions, presence of a catheter device, and listed assistance required for aspects of resident's ADLs. - Resident 96 (name), room (number), code status full code, food and medication allergies listed out as follows: Nuts, vancomycin, presence of paraplegia (impairment of motor or sensory function), presence of a catheter device, resident on enhanced barrier precautions, care in pairs, presence of wound on coccyx, and listed assistance required for aspects of resident's ADLs. - Resident 101 (name), room (number), code status full code, NKA, regular diet, and listed assistance required for aspects of resident's ADLs. - Resident 103 (name), room (number), code status full code, NKA, regular diet, on a toileting assistance program, use of compression stockings, and listed assistance required for aspects of resident's ADLs. - Resident 104 (name), room (number), code status full code, medication allergies listed out as follows: amoxicillin-pot clavulanate, diphenhydramine HCL, metformin, Sulfa (Sulfonamide Antibiotics), regular diet, presence of enhanced barrier precautions, presence of a wound to right foot, on a toileting assistance program, and listed assistance required for aspects of resident's ADLs. - Resident 105 (name), room (number), code status DNR, medication allergy drug class listed as follows: Opioid Analgesics (Narcotics/Opiates), regular diet, no male caregivers preference, and listed assistance required for aspects of resident's ADLs. - Resident 115 (name), room (number), code status full code, antibiotic medication allergy listed out as follows: azithromycin, and listed assistance required for aspects of (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's ADLs. - Resident 116 (name), room (number), code status full code, medication allergy listed out as follows: iodine, presence of left below knee amputation, dialysis appointments three times weekly, use of brace to left stump, and listed assistance required for aspects of resident's ADLs. During an interview on 2/17/26 at 8:30 a.m., the Executive Director (ED), indicated that the resident documents should not have been left out on the table. On 2/23/26 at 10:20 a.m., the ED provided a policy titled HIPAA and Privacy Compliance and Complaint Policy, dated October 2018, and indicated it was the policy currently in use by the facility. A review of the policy indicated that the facility is required to maintain the privacy, security, and confidentiality of residents' Protected health Information (PHI) in compliance with state and federal laws and regulations and with ASC Policies.which. includes any information about health status, provision of care, or payment that can be linked to an individual. 3.1-3(o)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure resident care plans were revised to reflect accurate code status for 2 of 22 residents reviewed for care plan accuracy. (Resident 12 and Resident 60)Finding includes:1. The clinical record for Resident 12 was reviewed on 2/17/26 at 2:20 p.m. The diagnoses included, but were not limited to, pressure ulcers and congestive heart failure.An active physician's order, initiated 12/8/25, indicated resident's code status was DNR (Do Not Resuscitate)An Indiana Physician Orders for Scope of Treatment form, or POST form, dated 12/8/25, indicated Resident 12 had elected a DNR code status.A care plan, dated 10/20/25, regarding the resident as a new admission to the facility included an approach with a start date of 10/20/25 which stated, Honor resident wishes including discharge goal: Return to community/possibly long term care, code status: Full.A care plan, dated 12/8/25, indicated resident had a preferred code status of DNR.2. The clinical record for Resident 60 was reviewed on 2/17/26 at 12:05 p.m. The diagnoses included, but were not limited to, acute kidney failure and cerebral infarction (where blood flow to part of the brain is blocked or reduced, also called an ischemic stroke).An active physician's order, dated 1/23/24, indicated resident's code status was DNR.An Indiana Out of Hospital Do Not Resuscitate Declaration and Order form, was signed by the resident and witnessed on 2/15/22 and signed by the physician on 2/16/22.A care plan, dated 1/19/24 regarding the resident as a new admission to the facility included an approach with a start date of 1/19/24 which stated, Honor resident wishes including discharge goal: Remain in Long term, code status: Full.A care plan, dated 1/24/24 indicated resident had a preferred code status of DNR.During an interview on 2/23/26 at 8:50 a.m., the Executive Director (ED) and Director of Nursing Services (DNS) indicated that Resident 12 and Resident 60's care plans indicated both a full code and a DNR code status. Both care plans should have been revised to reflect only the current code status preferences of DNR for each of the two residents.On 2/23/26 at 8:45 a.m., the ED provided a copy of a policy titled IDT Comprehensive Care Plan Policy, and indicated it was the policy currently in use by the facility. A review of the policy indicated that, Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each OBRA MDS assessment.3.1-35(d)(2)(B)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to implement Enhanced Barrier Precaution infection control practices for 1 of 4 residents reviewed for wounds. (Resident 45). Finding includes: On 2/23/26 at 8:25 a.m., Resident 45's clinical record was reviewed. The diagnoses included, but were not limited to, osteomyelitis, left ankle and foot (a slowly progressive bone infection, often lasting over two weeks). An Annual Minimum Data Set assessment, dated 1/23/26, indicated Resident 45 had moderate cognitive impairment. On 2/19/26 at 2:04 p.m., observed License Practical Nurse (LPN) 2 provide wound care. LPN 2 gathered supplies for Resident 45's left ankle. Upon entering Resident 45's room there were no indications that Enhanced Barrier Precautions (EBP) should be followed. Resident 45's wound care was observed including the removal of a light brown crusted covering which exposed a silver metal screw head that protruded from the skin just above the skin surface on Resident 45's left ankle. LPN 2 was observed wearing gloves during the care, but was not observed to wear a gown. During an interview on 2/19/26 at 2:15 p.m., LPN 2 indicated that there were no signs indicating that nursing staff should follow Enhanced Barrier Precautions but would check records to clarify if Resident 45's wound care required Enhanced Barrier Precautions. On 2/19/26 at 2:20 p.m., Resident 45's clinical record was reviewed. A wound assessment, dated 10/24/25, indicated old hardware/screw coming through the skin. The facility lacked an order to follow Enhanced Barrier Precautions. During an interview on 2/19/26 at 2:50 p.m., the Director of Nursing indicated that Resident 45's left ankle wound was from an old surgery, and the skin was not open therefore the Interdisciplinary Team did not feel Resident 45's wound met Enhanced Barrier Precaution criteria. On 2/19/26 at 2:50 p.m., the Administrator provided a copy of policy titled, American Senior Communities Policy Title: Enhanced Barrier Precautions (EBP), revised 3/2025 and indicated it was the current policy in use by the facility, A review of the policy indicated: Enhanced Barrier Precautions are used for: .Resident (s) with chronic wound and or indwelling medical devices regardless of their MDRO status and Resident(s) who have an infection or colonization with a CDC-targeted MDRO when contact precautions do not apply . 3.1-18(b)(1)