STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER Brickyard Healthcare - Brookview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21st Street Indianapolis, IN 46219	

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide an ongoing activity program for 2 of 4 residents reviewed for activities (Resident C and Resident B). Findings include:1.During an observation, on 1/21/26 at 11:38 a.m., Resident C was lying in bed with his eyes open. There was no music or television on in the resident's room. During an observation, on 1/22/26 at 11:56 a.m., Resident C was lying in bed with his eyes open. There was no music or television on in the resident's room.During an observation, on 1/23/26 at 11:18 a.m., Resident C was sitting in his room in a high back wheelchair with his eyes open. There was no music or television on in his room. Review of the clinical record of Resident C, on 1/23/26 at 2:09 p.m., indicated the resident's diagnoses included, but were not limited to, anoxic brain damage (the brain was completely deprived of oxygen, leading to severe physical, cognitive, and emotional issues), persistent vegetative state (consciousness resulting from sever brain damage where awake but showing no signs of awareness), muscle weakness, and sleep disorder (conditions that impair the amount of sleep resulting in daytime distress).The care plan for Resident C, dated 7/24/25, indicated the resident was in a persistent vegetative state and was unable to communicate. The resident was dependent on staff to anticipate his needs. The resident's family indicated the resident enjoyed music and being read to. The interventions included, but were not limited to, leave music and television on for the resident to hear during the day. During an interview with the Activity Director, on 1/23/26 at 1:34 p.m., she indicated she thought the CNA's were responsible to ensure Resident C's television or radio was on. 2.During an observation and interview with Resident B on 1/21/26 at 11:59 a.m., Resident B was sitting in her room with no self initiated activities occurring. The resident indicated the facility did not have enough activities and there was no variety of activities offered. The resident indicated she stayed in her room most of the time because there was no activities occurring. The resident indicated the facility did have bingo.During an observation and interview with Resident B on 1/23/26 at 10:50 a.m., Resident B was sitting in her room watching the television. The resident indicated she would like the facility to offer arts and crafts, play cards, have music and go outside when the weather was nice. Review of the clinical record of Resident B on 1/22/26 at 10:51 a.m., indicated the resident's diagnoses included, but were not limited to, end stage renal disease (irreversible phase of kidney failure), heart failure (chronic, progressive condition where the hear muscle was too weak) and weakness. The annual Minimum Data Set (MDS) for Resident B, dated 11/4/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. It was somewhat important to the resident to read the newspaper, books, magazines, be around animals, listen to music and keep up with the news. The care plan for Resident B, dated 11/13/25, indicated the resident enjoyed group programs such as bingo, cards, outings, resident council, going outdoors and attending church. The preference evaluation for Resident B, dated 1/21/26, indicated the resident enjoyed spending time with her family member, jigsaw puzzles, watching television, going to church and socializing with other residents. The resident indicated it was (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	very important to have books, magazines, newspapers, keep up with the news, listen to music, do activities in groups, go outside when the weather was good and participate in religious services. During an interview with the Activity Director, on 1/23/26 at 1:34 p.m., she indicated she started working at the facility in November 2025. The facility had not had an activity assistant for the long term care part of the facility, but had one start work yesterday. The facility did have an activity assistant that worked on the two memory care units and when she had time she attempted to help the Activity Director on the long term care side of the facility. The Activity Director indicated she was required to attend meetings daily, from 9:00 a.m. to 10:00 a.m., and then had care plan meetings every Wednesday, from 10:00 a.m. to 1:00 p.m., it depended on how many care plan meetings were scheduled that day. The Activity Director indicated Resident B enjoyed going to bingo and had not reported to her that she would like to do other activities. The activity policy provided by the Director Of Nursing (DON) on 1/23/26 at 2:00 p.m., indicated the facility would provide an ongoing activity program to support residents in their choices. Activities were to promote self-esteem, pleasure, comfort, education, creativity, success, and independence. This citation relates to Intake 2713078. 3.1-33(a)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to administer medications as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident 11) Findings include: 1.The clinical record for Resident 11 was reviewed on 1/21/26 at 11:30 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus (chronic metabolic disorder characterized by high blood sugar). A care plan, dated 1/10/25, indicated Resident 11 had diabetes mellitus. The interventions included, but were not limited to, the staff were to administer the diabetic medications as ordered. A physician's order, dated 9/11/25, indicated Resident 11 was to receive 5 units of aspart insulin before meals. The insulin was not to be given if the resident's blood sugar was less than 100. The order was discontinued on 1/21/26. The January 2026 Medication Administration Record indicated on the following dates and shifts Resident 11 had received 5 units of aspart insulin when her blood sugar reading was less than 100: -On 1/8/26 in the morning, the resident's blood sugar reading was 94. The resident was administered 5 units of insulin. -On 1/13/26 in the morning, the resident's blood sugar reading was 92. The resident was administered 5 units of insulin. -On 1/17/26 in the morning, the resident's blood sugar reading was 89. The resident was administered 5 units of insulin. A physician's order, dated 11/19/25, indicated the staff were to administer 20 units of glargine insulin to Resident 11 in the mornings. The insulin was to be held if the resident's blood sugar was less than 110. The January 2026 Medication Administration Record indicated on the following dates and shifts Resident 11had received 20 units of glargine insulin when her blood sugar reading was less than 110: -On 1/8/26, the resident's blood sugar reading was 94. The resident was administered 20 units of glargine insulin. -On 1/9/26, the resident's blood sugar reading was 80. The resident was administered 20 units of glargine insulin. -On 1/13/26, the resident's blood sugar reading was 92. The resident was administered 20 units of glargine insulin. -On 1/16/26, the resident's blood sugar reading was 83. The resident was administered 20 units of glargine insulin. -On 1/17/26, the resident's blood sugar reading was 89. The resident was administered 20 units of glargine insulin. -On 1/20/26, the resident's blood sugar reading was 91. The resident was administered 20 units of glargine insulin. -On 1/21/26, the resident's blood sugar reading was 106. The resident was administered 20 units of glargine insulin. -On 1/22/26, the resident's blood sugar reading was 90. The resident was administered 20 units of glargine insulin. -On 1/25/26, the resident's blood sugar reading was 71. The resident was administered 20 units of glargine insulin. -On 1/26/26, the resident's blood sugar reading was 93. The resident was administered 20 units of glargine insulin.-On 1/27/26, the resident's blood sugar reading was 102. The resident was administered 20 units of glargine insulin. A physician's order, dated 1/21/26, indicated the staff was to administer 3 units of aspart insulin to Resident 11 before meals. If the resident's blood sugar was less than 110, the insulin was not to be given. The January 2026 Medication Administration Record indicated on the following dates and shifts Resident 11had received 3 units of aspart insulin before meals when the resident's blood sugar reading was less than 110: -On 1/25/26 in the morning, the resident's blood sugar reading was 71 and in the afternoon, the resident's blood sugar reading was 84. The resident was administered 3 units of insulin in the morning and in the afternoon. -On 1/26/26 in the morning, the resident's blood sugar reading was 93. The resident was administered 3 units of insulin. -On 1/27/26 in the morning, the resident's blood sugar reading was 102. The resident was administered 3 units of insulin. An interview was conducted with the Director of Nursing on 1/27/26 at 3:22 p.m. She indicated the staff had administered the resident's insulins when they should have been held, per the prescribed parameters as ordered by the physician. 2.The clinical record for Resident 11 was reviewed on 1/21/26 at 11:30 a.m. The resident's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis included, but was not limited to, congested heart failure (chronic condition where the heart muscle weakens and can't pump enough oxygen-rich blood to meet the body's needs). A care plan, dated 1/22/25, indicated Resident 11 had swelling in her legs due to heart valve replacement, hypertension (high blood pressure), congestive heart failure and chronic kidney disease. The interventions included, but were not limited to, the staff were to monitor vital signs and notify medical provider of abnormalities and give medications as ordered. A physician's order, dated 9/23/25, indicated the staff were to administer 2 tablets of 20 milligrams of torsemide (water pill, used to treat excess fluid retention) daily to Resident 11. The medication was not to be given if the resident's systolic blood pressure (the top number in a blood pressure reading) was less than 100. The January 2026 MAR indicated Resident 11 had received 40 milligrams of torsemide every morning from 1/1/26 through 1/27/26. There were no blood pressures obtained prior to the administrations as ordered. An interview was conducted with the Director of Nursing on 1/27/26 at 3:22 p.m. She indicated she was unable to find blood pressure readings that had been obtained prior to the administration of the resident's 40 milligrams of torsemide medication. The order was not set up correctly in the electronic medication system in error. A medication administration policy was provided by the Executive Director on 1/23/26 at 2:54 p.m. It indicated, Policy.Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 3.1-37(a)

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F 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure each resident must receive and the facility must provide necessary behavioral health care and services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, and record review, the facility failed to timely develop and update behavior plans of care and to document behaviors on behavior tracking logs for 3 of 3 residents reviewed for behaviors (Resident 12, Resident 50, and Resident 1). Findings include:

1. The clinical record for Resident 50 was reviewed on 1/23/26 at 10:20 a.m. The resident's diagnosis included, but were not limited to, schizophrenia (a chronic and severe mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and bipolar disorder (a mental health condition causing extreme shifts in mood, energy, and activity levels, ranging from manic highs to depressive lows).

A Quarterly Minimum Data Set (MDS) Assessment, completed 8/11/25, indicated the resident was able to make herself understood and understand others. She had severely impaired decision making and was independent with transfers and ambulation.

A Change of Condition Situation progress note, dated 9/1/25 at 3:12 p.m., indicated Resident 50 had told staff that a male resident (Resident 1) went inside her room, touched her breast and private parts, and slapped her face. However, the male resident (Resident 1) was on his bed when staff checked his room. Resident 50 had repeated the same story to the writer (of the progress note). The male resident was on his bed asleep. A head-to-toe assessment was done and no redness or swelling noted on the resident's face. Resident 50 had no reports of discomfort or pain.

A physician's progress note, dated 9/2/25, indicated Resident 50 was seen due to reports/allegations of inappropriate contact by another resident on 9/1/25. Resident 50 had alleged male resident came to her room, touched her inappropriately and slapped her face. Staff reports that male resident was resident in his bed in his own room at the time of the report/allegation. Resident 50 had no apparent evidence of acute injury noted at the time. The assessment and plans indicated Resident 50 had paranoid schizophrenia chronic fluctuating psychosis with labile mood as well as delusions and apparent hallucinations, acutely anxious and paranoid with recent allegations against another resident. No physical evidence of assault as resident reported to staff over weekend.

A Behavior Charting note, dated 9/25/2025 at 1:39 p.m., indicated Resident 50 reported a false interaction with another resident. Resident 50 with noted delusional thinking. Prior to behavior, Resident 50 was walking in the hallway and up in communal space. The intervention attempted by staff was to return the resident to her room. Effectiveness of intervention indicated Resident 50 was able to be redirected at that time.

A Physician's Progress note, dated 11/6/25, indicated Resident 50 had poor judgement and poor insight in her medical condition due to her diagnosis of paranoid schizophrenia. She had delusional symptoms and was unable to make firm and consistent decisions for herself.

A General Note created by Registered Nurse (RN) 20 on 12/15/25 at 11:44 a.m. as a late entry for 12/13/25 at 10:45 a.m., indicated Resident 50 approached RN 20 with a video of another resident (Resident 1) exposing himself to Resident 50. When Resident 50 was asked why Resident 1 was in her room and Resident 50 indicated she invited him but did not state why. RN 20 educated Resident 50 about recording someone without permission and nursing staff would monitor both parties for 72 hours following

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	event. Resident 50's clinical record contained a Capacity to Consent assessment, dated 12/13/25, that indicated Resident 50 could tell you what it means to engage in sexual activity. She had the ability to avoid exploitation, the ability to say yes or no to sexual activities at any time, understood that they could change their mind about engaging in sexual activity at any time. Resident 50 had the ability to identify who they are having a relationship with. Resident 50's sexual behaviors were consistent with her formally held beliefs and understood that sexual activity can have physician, emotional, and health consequences. Resident 50's clinical record did not include a physician's assessment of her cognitive ability and insight to engage in a sexual relationship. Resident 50's clinical record contained a General Note, dated 12/29/2025 at 10:30 a.m., that indicated the nurse was alerted to Resident 50's room. When the room was entered, Resident 50 was sitting on the floor on her knees, with her feet behind her and was undressed from the waist down. Male resident (Resident 1) was noted to be on the floor, fully dressed. Resident 50 then became agitated and started yelling at staff to leave her room. A General Note, dated 12/29/2025 at 10:30 a.m., indicated Resident 50 was in the hallway partially dressed in her bra but had removed her shirt. Resident 50 was gesturing to a male resident (Resident 1) who was also in the hallway. Resident 50's clinical record contained a Physician Note written by NP 21, dated 12/29/2025 5:13p.m., that indicated when provider walked into room, Resident 50 was sitting on the floor with bra on and unknown if undergarments were present. NP 21 and Licensed Practical Nurse (LPN) 22 attempted to educate Resident 50 on sexual behavior, STDs, and possible pregnancy. Offered Resident 50 birth control, however Resident 50 became verbally abusive to NP 21 and repeatedly stated to get the F*** out of her room. To prevent Resident 50 further distress, NP 21 left room. Staff reported that Resident 50's guardian had returned call and agreed to placing Resident 50 on Depo Provera birth control shots. The physician has ordered labs and Depo Provera would not be started until lab results are obtained. Resident 50 had a previous episode of sexual behavior noted by staff on 12/13/2025 and per staff note resident had recorded another resident (Resident 1) exposing himself to her. Resident 50's clinical record contained a Progress Note from the physician, dated 1/1/26 at 8:00 a.m., indicated Resident 50 was being evaluated due to her request she and a male resident at the facility wish to participate in intimate sexual activities. Resident 50 was not cooperative during interaction and was rather very agitated and yelling and grabbing the physician's document and apparatus and threw them away. This was after we had been communicating by writing for approximately 45 minutes. Some of the things Resident 50 had said were that she did not initiate this and that it was the male resident who had approached her about the relationship. Resident 50 eventually told the physician that she would like to engage in intimate sexual relationship with a male, but she does not want any birth control. Resident 50 indicated she does not want to have any birth control treatments. Resident 50 was educated in writing that a serum pregnancy test, hepatitis b and c test, and HIV test were ordered. She was informed at this time that birth control was a must have if she wanted to have any intimate sexual relationship with a male. The impression the physician got was that she had an acute flareup of her manic episode with her bipolar disorder. Resident 50 does not have any decision-making capability to engage in sexual activity with a male as requested. The physician's conclusion was that Resident 50 did not have the decision-making capability to have any sexual relationship with (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a male resident at this facility because she had no insight in her decision. Resident 50's clinical record did not contain a care plan that indicated she was unable to consent to sexual activity. During an interview on 1/23/26 at 2:06 p.m., Certified Nursing Assistant (CNA) 23 and CNA 24 indicated they worked with Resident 1 and Resident 50 often. The nurse had informed them, sometime around New Years, to try to keep them out of each other's rooms. During an interview on 1/23/26 at 2:29 p.m., Social Worker (SW) 1 indicated she had not been made aware that Resident 50 had video tapped Resident 1 exposing himself. SW 1 should have been made aware of these incidents. During an interview on 1/23/2026 at 2:50 p.m., the Staff Development Coordinator (SDC) indicated on 12/13/25 she had been made aware that Resident 50 had videotaped Resident 1 with his hands down his pants. The ED had been made aware. SDC had not seen the video. The SDC could not recall if any specific interventions were set up for either resident after the incident. The staff did look in on them often to ensure they were not together. During an interview on 1/27/25 at 10:03 a.m., the DON indicated that she had updated Resident 50's history of behaviors care plan on 1/5/26. During an interview on 1/27/26 at 11:10 a.m., Qualified Medication Aide (QMA) 25 indicated he had not been informed to try to keep Resident 1 out of Resident 50's room. Resident 1 often went to Resident 50's room and Resident 50 would come to Resident 1's room. During an interview on 1/23/26 at 3:22 p.m., RN 20 indicated the staff were told to keep Resident 1 and Resident 50 separated and to keep an eye on them. Resident 50 often went to Resident 1's room and asked Resident 1 to come with her. The facility had done an Inservice about respecting the resident's right to be sexual and to provide privacy for resident's who were being sexual. During an interview on 1/27/26 at 12:27 p.m., SW 1 indicated Resident 50 did not have a care plan about redirecting others from her room or what to do if a resident may want to visit with her privately. Resident 50's clinical record did not include a care plan related to Resident 50 identifying herself as different people. 2.The clinical record for Resident 1 was reviewed on 1/21/26 at 12:05 p.m. The resident's diagnoses included, but were not limited to, vascular dementia (losing touch with reality, characterized by hallucinations and delusions caused by brain damage) with behavior disturbance, schizophrenia (a chronic and severe mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and chronic hepatitis C (a long-term, contagious liver infection caused by the hepatitis C virus). A care plan, initiated 5/20/25, indicated Resident 1 had impaired cognition function/dementia and communications deficits related to dementia and a history of stroke (blood flow to the brain was interrupted or blood vessels burst causing brain cells to die). The goal was for him to maintain current level of cognitive function. The interventions was for staff to reorient and supervise as needed; (continued on next page)

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F 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

keep his routine consistent and try to provide consistent care givers as much as possible to decrease confusion; use task segmentation to support short term memory deficits; break tasks into one step at a time as needed to promote understanding.

A care plan, initiated 6/24/25, indicated Resident 1 had a behavior problem of intrusive wandering or exit seeking related to his vascular dementia with behavior disturbance. He was known to propel his wheelchair backwards with potential to bump into objects or people. The goal was for him to have no evidence of behavior problems, and he would have no injury to self or others. The intervention was for staff to redirect Resident 1 from others resident's rooms as needed, initiated 6/24/25.

A Quarterly MDS Assessment, completed 9/27/25, indicated Resident 1 was able to make himself understood and to understand others. He was severely cognitively impaired. The resident required set-up assistance and supervision for transfers from his bed to his wheelchair.

A Psychiatric Subsequent Assessment, dated 10/15/25, indicated Resident 1 was seen to manage a chronic condition. Resident reported that his mood was okay. Resident 1 believed the year was 2002 and the month was March.

A General Note, created by RN 20 on 12/15/25 at 11:45 a.m. as a late entry for 12/13/2025 at 10:45 a.m., indicated Resident 1 was in another resident's [Resident 50] room exposing himself when asked what he was doing in the other resident's room Resident 1 indicated she told me to come in there. Resident 1 was removed from Resident 50's room and will be monitored for 72 hours.

Resident 1's clinical record contained a Capacity to Consent assessment, dated 12/13/25, that indicated Resident 1 was able to tell you what it means to engage in sexual activity. He was able to avoid exploitation and had the ability to say yes or no to sexual activity at any time. He understood that they could change their mind about engaging in sexual activity at any time and had the ability to identify who they are having a relationship with. Resident 1's sexual behaviors were consistent with his formally held beliefs, and he understood that sexual activity can have physical, emotional, and health consequences.

The clinical record did not contain a physician's assessment of Resident 1's cognitive ability to consent to a sexual relationship

Resident 1's clinical record contained a General Note, dated 12/28/2025 at 6:30 p.m., that indicated Resident 1 was found in another resident's room. Both residents appeared calm. Resident 1 had his clothes and shoes on and was sitting in his wheelchair. Resident 1 was redirected back to his own room and provided education about the importance of asking consent prior to going into another resident's room.

Resident 1's clinical record did not contain a care plan related to Resident 1's wishes to be in a sexual relationship with another resident at the facility.

Resident 1's clinical record contained a Progress note from the physician, dated 1/1/2026 at 8:00 a.m., that indicated the provider was asked to evaluate Resident 1, who wishes to engage in intimate sexual relationship with a female resident (Resident 50) at the same facility. Resident 1 was unable to provide detailed treatments that he had for hepatitis C. He was informed he was at risk of passing this sexually to the female resident. The physician did not approve that Resident 1 engage in any sexual activities with this female because she did not have the mental capacity to consent to

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sexual relationship. Resident 1 was told that the female partner he was trying to engage in sexual activity with did not have decision-making capability to engage in sex. She does not have good insight and the consequences of what she was trying to get into, so it was up to him not to engage in any sexual activity with this female resident. Resident 1's mental capacity was also impaired as he could not tell the physician what he had in mind to prevent a pregnancy or STD. Resident 1's clinical record did not contain a care plan that indicated he was unable to consent to sexual activity. A General Progress Note, dated 1/4/2026 at 3:30 p.m., indicated Resident 1 continued to go into another resident's room after being redirected back to his own room. Management was made aware. Staff would continue to monitor. A General Progress Note, dated 1/5/25 at 6:00 p.m., indicated family and unit manager made aware that Resident 1 was transferred to another room. During an interview on 1/23/26 at 2:06 p.m., Certified Nursing Assistant (CNA) 23 and CNA 24 indicated they worked with Resident 1 and Resident 50 often. The nurse had informed them, sometime around New Years, to try to keep them out of each other's rooms. During an interview on 1/23/26 at 2:29 p.m., Social Worker (SW) 1 indicated she had not been made aware that Resident 1 had exposed himself to Resident 50. SW 1 should have been made aware of these incidents. During an interview on 1/23/2026 at 2:50 p.m., the Staff Development Coordinator (SDC) indicated on 12/13/25 she had been made aware that Resident 50 had videotaped Resident 1 with his hands down his pants. The ED had been made aware. SDC had not seen the video. The SDC could not recall if any specific interventions were set up for either resident after the incident. The staff did look in on them often to ensure they were not together. Resident 1 had impaired cognitive ability and did not make rational decisions. During an interview on 1/27/26 at 11:47 a.m., SW 1 indicated Resident behaviors are tracked by behavior notes and charting by the CNAs in Point Click Care (PCC). The Behavior Note Report and the behavior notes were reviewed in morning meeting. The behavior notes were used more for new behaviors. The PCC behavior charting was more for behaviors that had already been identified. Behavior care plans were made by social services and with an IDT team. On 1/27/26 at 10:03 a.m., the DON provided the current Behavioral Health Services Policy that read .It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being.3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.5. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being.7. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person0centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will.b. Obtain history from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health. c. Monitor the residents (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	closely for expressions or indications of distress. d. Evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable.f. Assess and develop a person-centered care plan for concerns, identified in the resident's assessment. g. Share concerns with the interdisciplinary [IDT] to determine underlying causes of mood and behavior changes, including differential diagnosis. h. Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record. i. Ensure appropriate follow-up assessment, if needed. j. Discuss potential modifications to the care plan. k. Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the residents.8. The resident, and as appropriate the resident's family, are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall: a. Have interventions that are person-centered, evidenced-based, culturally competent, trauma-informed, and in accordance with professional standards of practice.c. Reflects the resident's goals for care.e. maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety.h. Be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition.12. The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside r=sources such as physician psychiatrists, or neurologists On 1/27/26 at 9:13 a.m., the ED provided the Sexual Expression of Residents policy, that read .1. The staff will document observations of residents engaging in intimacy and/ or sexual activity and notify social services and the Director of Nursing. 2. The social services staff will notify the interdisciplinary team. 3. The social services staff will educate the residents about any disease processes and the residents' rights. a. Residents with decisional capacity have the right to seek out and engage in consensual intimacy and/ or sexual expression. b. Resident with decisional capacity have a right to privacy, including private space for sexual expression. c. Resident with decisional capacity have a right to confidentiality. 4. The physician will be notified regarding all residents participating in se for a clinical and cognitive evaluation to determine intact cognitive decision-making-capacity and capacity to give consent.6. Care plan meeting with the interdisciplinary team shall be scheduled as soon as possible from the initial notification of the social services staff. a. The interdisciplinary team shall conduct a review of situations and accounts of sexual expression among or between residents or with visitors to determine a solution that best meets the needs of and protects those involved. B. Outcomes of the interdisciplinary team review will be shared with the residents involved and documented in the plan of care. On 1/30/26 at 2:30 p.m., the Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists ©American Bar Association Commission on Law and Aging - American Psychological Association from the American Psychological Association web site which read .There are no generally accepted approaches or criteria for the assessment of consent to sexual activity. [NAME] et al., [1999] suggest that the following be considered by the examining clinician, with the understanding that some individuals with capacity to consent would not meet all of these criteria: Is an adult, as defined by state law; demonstrates an awareness of person, time, place, and event; possesses a basic knowledge of sexual activities; possesses the skills to participate safely in sexual activities; i.e., whether the person understands how and why to effectively use an appropriate method of birth control, and whether the person chooses to do so; understands the physical and legal responsibilities of pregnancy; is aware of sexually transmittable diseases and how to avoid them; demonstrates an awareness of legal implications concerning wrongful sexual behaviors [e.g., sexual assault, inappropriateness of sex with minors, exploitation, etc.]; can identify when others' rights are infringed; (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, revision date of 1/9/26, indicated Resident 12 had a diagnosis of cognitive communication deficit evidence by becoming forgetful and needed reminders or verbal cues for daily decision-making. The following interventions, with an initiated date 4/14/25, indicated, but were not limited to: staff were to Cue, reorient and supervise as needed, encourage resident to go to dialysis as scheduled, and report suspected worsening of cognition or memory to the Medical Doctor. A intervention with a revision date of 12/15/25, indicated to discuss concerns about confusion, disease process, nursing home placement with resident/family/caregivers. An elopement assessment, dated 12/9/25, indicated Resident 12 was not an elopement risk. A nursing note, dated 12/27/25 at 4:24 p.m., indicated Resident 12 attempted to leave the building. The resident appeared to be agitated and verbalized I am leaving. The resident was redirected back in the building by another staff member. A behavior note for Resident 12, dated 12/27/26, indicated around 2:45 p.m., the resident was taling and happy then at 4:30 p.m., the resident was found to be attempting to leave the facility unaccompanied. The physician assistant (PA) on call was notified and ordered alprazolam (used for short-term relief of anxiety and panic disorders by slowing down the central nervous system) 0.5 mg (milligrams) every 8 hours for anxiety and agitation x 3 days. A medical provider note, dated 12/27/25, indicated Resident 12 had exhibited exit-seeking behavior this afternoon. He was redirected without incident. Will continue to monitor. A medical provider visit note, dated 12/29/25, indicated Resident 12 was being seen that day for making attempts to get out of the facility by himself over the weekend. The resident had reported to the medical provider he would like to leave and go back to (another State). The resident was unable to provide who he would be staying with, other than friends nor how he would continue with his dialysis treatments in the other State. The resident did not have family that resided in the other State. The resident had poor judgment, and poor insight in his medical condition. He suffered from some cognitive challenges which was likely related to his previous polysubstance use disorder causing encephalopathy (a diagnosable mental health condition where a person compulsively uses three or more different classes of substances, leading to significant impairment in their life). A physician's order, dated 12/30/25, indicated Resident 12 was to receive 0.5 milligrams of Xanax every 8 hours as needed (PRN) for agitation and anxiety. A care plan for elopement was not developed with interventions for Resident 12. A behavior note, dated 12/30/25, indicated, the resident was found near the employee log-in area. The resident was .pressing [a keyless digital lock] keypad near the employee log-in area. Staff had attempted to redirect the resident and the resident started cursing and refusing to be redirected. The unit manager was able to intervien. A behavior note, dated 12/31/25, indicated, the resident was agitated, yelling in the dining room, calling staff names and was screaming loudly in the dining room. The staff tried to redirect the resident and the resident screamed louder calling staff more names and threw self on the floor out of wheelchair in the dining room. Resident 12's behavior care plans were not updated with new interventions to address behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An elopement evaluation, dated 1/4/26, indicated Resident 12 did not have a history of elopement and wandering. He was not an elopement risk. A social services note, dated 1/7/26, indicated the resident reported that he did not plan to be in this State. He stated he was traveling when he experienced a medical emergency, was taken to a hospital in this State. An elopement evaluation, dated 1/9/26, indicated Resident 12 did have a history of elopement and wandering. The resident scored a five on the assessment indicating he was an elopement risk. A nursing note, dated 1/9/26, indicated the resident called 911 (emergency services) without informing the nurse at 2:45 p.m. The emergency service team (911) arrived at the facility since the resident indicated he wanted to kill himself to the 911 caller. Hospital discharge report, dated 1/9/26, indicated, the resident arrived at the emergency department related to suicidal ideation. The resident was trying to leave his facility and had threatened to kill himself if he was not able to leave. A nursing note, dated 1/10/26, indicated the resident returned from hospital with no new orders. The hospital noted indicated they had conversations with him about different coping mechanisms while feeling angry about things. The resident indicated he was just mad and was not really going to do anything. The resident was to be checked on every 30 minutes for 72 hours

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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, interview and record review, the facility failed to ensure staff maintained infection control by touching pill medications with their bare hands for 1 of 1 random observations of a medication administration. (Resident 53) Findings include:An observation was made of Qualified Medication Aide (QMA) 5 at a medication cart on 1/23/26 at 9:44 a.m. QMA 5 was observed to touching the medication drawers and multiple medication cards. The QMA pulled a medication card out of her medication cart and popped the resident's medication tablet into her bare hand. She placed the tablet into a medication cup full of other medications. The QMA indicated, at that time, the medication was for Resident 53. No hand washing or hand sanitizer was used by QMA 5, prior to popping the resident's medication into her hand or during the observation. An interview was conducted with the Nurse Consultant and the Director of Nursing (DON) on 1/23/26 at 2:00 p.m. The DON indicated staff should not touch medication tablets with their bare hands. The clinical record for Resident 53 was reviewed on 1/22/26 at 1:30 p.m. The residents diagnoses included, but were not limited to type II diabetes mellitus. A medication administration policy was provided by the Executive Director on 1/23/26 at 2:54 p.m. It indicated, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines:.14. Remove medication from source, taking care not to touch medication with bare hand. 3.1-18(l)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure residents' rooms were homelike and in good repair for 2 of 4 resident rooms observed during an environmental tour. (Resident 10 and Resident 24) Findings include: 1.An observation was made of Resident 10's room on 1/21/26 at 11:22 a.m. The resident's closet door was observed to be broken. During an environmental tour, with Housekeeping Staff 1, Housekeeping Staff 2, and the Senior District Operations Manager on 1/28/26 at 11:51 a.m., Resident 10's room was observed. The sliding closet door was observed not attached inside the medal track causing the closet door to freely move out instead of glide back-n-forth in the track. Housekeeper Staff 1 indicated the closet door had been broken for a while. The Senior District Operations Manager indicated the medal track was bent and needed replaced. 2. An observation was made of Resident 24's room on 1/21/26 at 11:39 a.m. The bottom brown baseboard was observed pulled away from the wall under the heat and air unit. An interview was conducted with Resident 24 on 1/21/26 at 11:40 a.m. The resident indicated the baseboard had been like that for a long time. During an environmental tour, with Housekeeping Staff 1, Housekeeping Staff 2, and the Senior District Operations Manager on 1/28/26 at 11:51 a.m., Resident 24's room was observed. The bottom brown baseboard was observed pulled away from the wall under the heat and air unit. They indicated the maintenance department would address repairs that were needed in the resident rooms. The Facility Maintenance Guidelines and Procedure was provided by the Executive Director on 1/28/26 at 12:17 p.m. It indicated, It is our intent to provide a clean, comfortable environment. The maintenance of the facility will be conducted as follows:.Staff should place items they find in the normal course of their day in the TELS Work Order System when found as well as placing items in the system when residents make requests. 3.1-19(f)(5)