STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allison Pointe Healthcare Center	5226 E 82nd Street Indianapolis, IN 46250

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure meals were served with proper hand hygiene, coffee was covered when transported in hallways, food trays were air dried prior to storage, and the kitchen environment was clean related to ceiling vents potentially affecting 102 of 109 residents residing at the facility. Findings include: On 2/19/26 at 9:50 a.m., the facility kitchen was observed with the Head Chef (HC) and the Dietary Corporate Consultant (DCC). A dietary staff member was removing clean, wet food trays from a dishwashing rack and stacking them on a cart. The ceiling vents above the food preparation area and the food service area were noted to have dust built up. On 2/19/26 at 12:14 p.m., lunch service was observed on the Cambridge Unit. A coffee pitcher was on top of the food cart. The nursing staff were reaching up and taking the pitcher of coffee off the top of the food cart, pouring coffee for residents, and then placing the pitcher back on top of the food cart. The coffee pitcher did not have a lid and was open to air. The nursing staff indicated the coffee pitchers came down from the kitchen with a small plastic lid on them. The small plastic lids would fly off when the cart was moved and were not secured to the pitcher. The coffee pitchers usually came down from the kitchen that way without secured lids. During an interview on 2/19/26 at 12:50 p.m., Dietary Aide 22 indicated the coffee pitchers had little plastic lids that were not attached. During an interview on 2/19/26 at 2:01 p.m., the Head Chef (HC) indicated she had ordered lids for the coffee pitchers, but they had not come in yet. The kitchen put the plastic lids on the coffee pitchers prior to sending them to the hallways. During an interview on 2/19/26 at 2:02 p.m., the Dietary Corporate Consultant (DCC) indicated the coffee pitchers should be covered when in the hallway. On 2/23/26 at 12:10 p.m., the facility kitchen was observed. There was dust built up on the ceiling vents above the food preparation area and the food service area. The soiled dish area had splatters of dried food substances on the walls and a buildup of a black substance on the caulked area and black spatters on the tiled wall behind garbage disposal area. On 2/23/26 at 12:10 p.m., lunch service was observed in the facility kitchen. Dietary Aide (DA) 9 was observed placing food trays on the serving line. The food trays had drops of water on them. DA 9 had gloves on his hands. He adjusted his beard net strap on his head and pulled up his hood (clothing) over his head. DA 9 then used a cloth to dry the food trays on the food line. DA 9 did not perform hand hygiene or change his gloves after touching his clothing. On 2/23/26 at 3:10 p.m., the facility kitchen was observed with the DCC. The soiled dish area continued to have black substances on the caulk line and food substances splashed on the walls in the area. The air vents above the food preparation and distribution area continued to have dust built up on the ceiling vents. Dietary [NAME] 8 indicated the ceiling vents had built up dust on them. During an interview on 2/23/26 at 3:10 p.m., the DCC indicated the soiled dish area needed to be cleaned and wiped down. The DA 9 should have washed his hands and changed his gloves after touching his head, prior to wiping the food trays. The food trays should be air dried prior to being stored. On 2/19/26 at 2:49 p.m., the Executive Director (ED) provided the Meal Distribution policy, last revised 2/2023, that read . All food that is transported to dining areas that are not adjacent to the kitchen will be covered . On 2/23/26 at 3:57 p.m., the ED provided the Warewashing Policy, last revised 12/2024, that read .All dishware will be air dried and properly stored . 410 IAC (Indiana Administrative Code) 3.1-21(j)(3)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for 7 of 31 rooms, 1 of 2 exit doors, and 1 of 2 Nurse's Stations reviewed for environment. Doorknobs were loose, urine odor was present, designated smoking area exit door frame was pulled away from the wall, and a wall was in disrepair. (Cambridge Unit Rooms, 226, 228, 230, 231, 233, 210, Cambridge Bistro exit door, and [NAME] Nurse's Station). Findings include: On 2/19/26 at 12:27 p.m., the following was observed, the Cambridge Unit had an odor of urine and the [NAME] Unit had visible water damage (loosening paint, with a rippling effect, down the wall) to the wall behind the nurse's station. On 2/20/26 at 11:11 a.m., the following was observed, the doorknobs for the following resident rooms on Cambridge Unit were loose, room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]. On 2/24/26 at 1:17 p.m., the following was observed, an odor of urine was present at the Cambridge Unit's nurse's station and in the hall near room [ROOM NUMBER]. On 2/25/26 at 11:22 a.m., the following was observed, room [ROOM NUMBER] had an odor of urine odor detected from the hallway. On 2/25/26 at 1:39 p.m., the following was observed, the doorknobs for the following resident's rooms on Cambridge Unit were loose, room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]. On 2/25/26 at 1:42 p.m., during an interview with the Medical Records Coordinator, who was picking up room trays in room [ROOM NUMBER], indicated the urine odor was from the resident near the window. She believed he needed assistance with care. On 2/25/26 at 1:46 p.m., the following was observed, in the Cambridge Bistro, the designated smoking area's exit door was pulled away from the wall (the entire door frame was pulled away, allowed fingers to be placed behind the door frame and the wall) and the wall next to the door frame was marred (approximately 2 and one half feet) below the chair-rail with chunks of drywall missing (6 inches long). During an interview, on 2/25/26 at 2:13 p.m., the Maintenance Director indicated if something needed repaired, staff entered information into a building management electronic system. Routine rounds were done by the maintenance department to look for areas that needed repaired. There had been a water leak in the ceiling on the [NAME] Unit's nurse's station. The door frame in the Cambridge Bistro had been damaged from a resident using an electric scooter running into it. During an interview, on 2/25/26 at 2:20 p.m., the Administrator indicated the resident in room [ROOM NUMBER] refused care, care refusal was in his care plan, and his roommate had not complained of the odor. A current, undated, facility policy titled Resident Rights, was provided by the Executive Director on 2/24/26 at 1:15 p.m. The policy indicated .Dignity: a state worthy of honor or respect; includes but is (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not limited to speaking respectfully to resident, providing privacy for care and treatment, providing safe and secure housing 410 IAC (Indiana Administrative Code) 16.3.1-19(f)

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to assess and determine it was clinically appropriate for a resident to self-medicate for 1 of 1 resident randomly observed with medications at the bedside. (Resident 56) Findings include:The clinical record for Resident 56 was reviewed on 2/20/26 at 11:00 a.m. The diagnoses included, but were not limited to: end stage renal disease (below 15% [percent] functioning kidneys) An observation was made of Resident 56 on 2/23/26 at 12:00 p.m. The resident was observed lying in bed with a bedside table next to the bed. Two plastic cups were observed sitting on the bedside table. One cup had pill medications in it, and the second cup was sitting inside the cup with ice in it. Resident 56's clinical record did not include documentation she was able to safely self-medicate her medications. An interview was conducted with License Practical Nurse (LPN) 10 on 2/23/26 at 12:05 p.m. She indicated the pill medications were Resident 56's morning medications. The resident was scheduled to go to dialysis early that day. On dialysis days, the resident's morning medications are administered prior to going to dialysis by the night shift nurse. She was unsure why the resident's medications were sitting on the bedside table. An interview was conducted with Regional Nurse Consultant (RNC) 2 on 2/24/26 at 1:12 p.m. She indicated Resident 56 did not have a self-medication assessment that indicated she was able to self-medicate safely. The medications should not have been left on the resident's bedside table. A self-medication policy was provided by the RNC on 2/24/26 at 1:12 p.m. It indicated, .Procedures: 1. Determine if the resident desires to self-administer their own medication. a. Resident may not self-administer medication until the assessment is completed by the IDT team and determined to be safe to do so.c. Physician/Provider order is required for residents to self-administer medication.4. Assessments will include addressing the following and documenting in the care plan: a. Storage of the medication b. Responsible party for storage of medications (resident or nursing staff) c. Documenting the administration of drugs d. Location of where the drug will be administered. 410 IAC (Indiana Administrative Code) 3.1-11(a)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a call light was in reach for 2 of 2 residents reviewed for call lights. (Residents 41 and 116) Findings include:1. The clinical record for Resident 41 was reviewed on 2/20/2026 at 2:23 p.m. The diagnoses included, but were not limited to, hemiplegia (severe weakness or total paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral vascular disease affecting the left dominant side, generalized anxiety disorder, and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/25, indicated Resident 41 was moderately cognitively impaired, could usually make herself understood, and had the ability to usually understand others. The MDS indicated Resident 41 had impairment on one side to upper and lower extremity on one side, was dependent on toileting/hygiene, and required substantial/maximal assistance with rolling side to side, sitting up, and toileting transfers. During an observation and interview with Resident 41 on 2/19/26 at 2:33 p.m., no call light was visible in the resident's room. Resident 41 indicated she did not have a call light because they took it because she was calling out too much. She could not even get help to get something to drink. During an observation and interview on 2/20/26 at 1:34 p.m., Resident 41 was lying in bed with no call light in sight. Verified with Certified Nursing Assistant (CNA) 5 that Resident 41 did not have a call light in reach to use. CNA 5 then located two call lights placed inside of a bedside table with the drawer shut. The bedside table was located at the end of Resident 41's bed out of reach for the resident. One call light was not functioning and the other call light CNA then handed to Resident 41 to use. CNA 5 indicated she did not know why the call lights were placed into the drawers and out of reach for Resident 41. A plan of care, dated 2/10/22, indicated Resident 41 had Activities of Daily Living (ADL) self care performance deficit. The interventions included, but were not limited to, place call light within reach. 2.) The clinical record for Resident 116 was reviewed on 2/20/26 at 2:25 p.m. The diagnoses included, but were not limited to, seizures, depressive episodes, and anxiety disorder. The Annual Minimum Data Set (MDS) assessment, dated 2/8/26, indicated Resident 116 was severely cognitively impaired, had upper extremity impairment on one side, and was dependent with all activities of daily living (ADLS). During an observation on 2/19/26 at 2:43 p.m. and on 2/20/26 at 10:12 a.m., Resident 116 was lying in bed asleep with the call light on the floor behind the resident's bed. During an observation and interview on 2/20/26 at 1:44 p.m., Resident 116 was lying in bed asleep and the call light was out of reach for the resident, the call light cord was lying on a side chair underneath towels and blankets. Verified with the Social Service Director (SSD) that Resident 116's call light was out of reach lying on a chair. The SSD then placed the call light across Resident 116's lap. The SSD indicated he did not know why the resident did not have her call light in reach. An interview with the Executive Director (ED) was conducted on 2/24/26 at 1:20 pm. They indicated all staff were responsible to ensure residents had call lights readily available and in reach. The ED indicated the facility did not have a policy regarding call lights. 410 IAC (Indiana Administrative Code) 3.1-3(v)(1)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review, the facility failed to provide extra portions of oatmeal as preferred and ordered for 1 of 2 residents reviewed for choices. (Resident 51) Findings include:The clinical record for Resident 51 was reviewed on 2/20/26 at 2:19 p.m. The diagnoses included, but were not limited to, respiratory failure and cerebral infarction (death of brain tissue) affecting the left non-dominant side. A Quarterly Minimum Data Set (MDS) assessment, dated 1/28/26, indicated Resident 51 had moderate cognitive impairment. A physician's order, dated 10/14/25, indicated Resident 51 had a regular diet order and was to receive two servings of fortified oatmeal for breakfast. During an interview with Resident 51 on 2/19/26 at 12:42 p.m., they indicated they did not receive the daily double portions of oatmeal for breakfast. Resident 51 indicated he would have to always ask for another portion of oatmeal in the mornings. During an observation and interview on 2/23/2026 at 9:37 a.m., Resident 51 had his breakfast tray sitting in front of him. The food included two pieces of French toast, two pieces of bacon, syrup, one 6 oz (ounces) of fortified hot cereal (oatmeal), milk, coffee, and orange juice. The meal ticket on Resident 51's breakfast tray indicated there were two 6 oz. servings of fortified hot cereal on the tray but there was only one. Resident 51 indicated they only gave him one serving again today and he already had to ask for more. During an observation on 2/24/26 at 9:20 a.m., Resident 51's meal tray was delivered to his room. The meal ticket indicated 6 oz fortified hot cereal, 8 oz milk, 4 oz orange juice, and 4 oz of choice juice. Resident 51's tray contained one small, white bowl of oatmeal, biscuit, scoop of scrambled eggs, sausage patty, and a half of a cup of orange juice. A nutritional assessment, dated 1/27/26, indicated Resident 51 had a regular diet order with two portions of fortified oatmeal every morning. The nutritional assessment indicated Resident 51 reported a good appetite and especially enjoyed fortified oatmeal. A plan of care, dated 9/8/25, indicated Resident 51 was at risk for altered nutrition status. The interventions included, but were not limited to, identify resident food preferences and provide meals per diet order. During an interview with the Director of Nursing (DON) on 2/24/26 at 1:33 p.m., the DON indicated the kitchen staff was who was responsible to ensure diets were made and delivered as ordered. The dietary would sometimes serve larger portions of foods in one bowl for two servings, instead of one bowl for each serving. The small white fruit cup bowl holds 6 oz, and the large dark bowls hold 12 oz. During an interview with the Executive Director (ED) on 2/24/26 at 1:15 p.m., they indicated the facility did not have a policy regarding resident choices. 410 IAC (Indiana Administrative Code) 3.1-3(u)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to timely develop dental care plans for 2 of 2 resident's reviewed for dental care (Resident 51 and Resident 12).Findings include: 1. The clinical record for Resident 51 was reviewed on 2/19/25 at 12:43 p.m. The resident's diagnosis included, but was not limited to, hypertension. A dental consult noted, dated 12/19/25, indicated Resident 51 required a referral to an oral surgeon to have two teeth extracted. He was missing multiple teeth, and his oral tissue was red and irritated. A Quarterly Minimum Data Set (MDS) Assessment, completed 1/28/26, indicated he had moderately impaired cognition, was usually able to make himself understood and to understand others, and needed set up assistance with oral hygiene. The clinical record did not contain a care plan addressing Resident 51's dental care needs.2. The clinical record for Resident 12 was reviewed on 2/20/26 at 10:24 a.m. The resident's diagnosis included, but were not limited to, diabetes and hypertension.An oral assessment, dated 1/15/25, indicated Resident 12 had natural teeth on the upper and lower arch and several broken teeth. An Annual MDS Assessment, completed 9/14/25, indicated Resident 12 was cognitively intact and had no dental concerns. On 2/20/26 at 10:24 a.m., Resident 12 was observed lying in her bed. Her teeth were jagged and had visible decay. Resident 12 indicated she needed to see the dentist for her broken teeth. She had pain at times due to her teeth. The clinical record did not contain a care plan addressing Resident 12 broken teeth or dental status. During an interview on 2/25/26 at 11:17 a.m., the Minimum Data Set Coordinator (MDSC) indicated the MDS and the care plan could be modified to include Resident 12's broken teeth. On 2/25/26 at 11:48 a.m., Regional Nurse Consultant (RNC) 2 provided the current Dental Services Policy that read .Care Plan a. Provide care planning specific to the resident for dental and oral health concerns .410 IAC (Indiana Administrative Code) 3.1-35(a)

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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 observation, interview and record review, the facility failed to hold a resident's medication when vital signs were outside parameters for 1 of 2 residents reviewed for Hospitalization, ensure an insulin flex pen was primed with 2 units of insulin prior to the administration of the insulin dosage, and administer lidocaine cream as ordered for 2 of 38 residents observed for quality of care. (Resident 92, Resident 115 and Resident 119)Findings include:1.The clinical record for Resident 119 was reviewed on 2/20/26 at 1:28 p.m. The resident's diagnosis included, but was not limited to, hypertension. A physician's order, dated 12/11/25, indicated he was to receive Coreg oral tablet (medication used to treat high blood pressure) 12.5 milligram (mg) twice daily. The staff were to hold the resident's medication for systolic blood pressure (upper number of blood pressure reading) less than or equal to 120. The December 2025 Medication Administration Record (MAR) indicated Resident 119 received Coreg when his systolic blood pressure was less than or equal to 120 on the following days: -On 12/16/25 at 5 p.m., the resident's systolic blood pressure reading was 114, -On 12/17/25 at 9 a.m., the resident's systolic blood pressure reading was 102, -On 12/17/25 at 5 p.m., the resident's systolic blood pressure reading was 97, -On 12/19/25 at 9 a.m., the resident's systolic blood pressure reading was 110, and -On 12/19/25 at 5 p.m., the resident's systolic blood pressure reading was 118. During an interview on 2/20/26 at 3:03 p.m., Regional Nurse Consultant 1 indicated medications should be held if outside the parameters specified in the physician's orders. 2.The clinical record for Resident 92 was reviewed on 2/23/26 at 9:00 a.m. The resident's diagnosis included, but was not limited to, hepatitis C. A Quarterly Minimum Data Set (MDS) Assessment, dated 1/15/26, indicated Resident 92 was cognitively intact. A physician's order, dated 4/2/25, indicated staff were to apply the resident's 4% (percent) lidocaine cream onto her back, three times a day. An observation was made of a medication administration for Resident 92 with Registered Nurse (RN) 12 on 2/23/26 at 9:06 a.m. RN 12 was at the medication cart preparing Resident 92's medications. During that time, RN 12 had indicated she was unable to locate the resident's lidocaine medication. She was observed picking up boxes and reading labels of lidocaine patches that were labeled for other residents. Then, she looked in the medication supply room. After, she looked in a treatment cart for the lidocaine medication. RN 12 indicated she would have to reorder the lidocaine medication. She was unable to locate the medication. The resident has chronic back pain, and the lidocaine was applied on her back. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medication administration note, written by RN 12, dated 2/23/2026 at 9:42 a.m., indicated Resident 92's 4% lidocaine cream was not available. RN 12 reordered the 4% lidocaine cream. An interview was conducted with the Director of Nursing on 2/24/26 at 10:22 a.m. She indicated Resident 92's 4% lidocaine cream was found in the treatment cart. The resident was asked later that day, 2/23/26, if she wanted the lidocaine cream applied. The resident had refused. An interview was conducted with Resident 92 and the Director of Nursing on 2/24/26 at 10:22 a.m. Resident 92 indicated the lidocaine patches were applied to her left shoulder and lower back daily to help with pain relief. She had not received the lidocaine patches for a couple of days. The nursing staff had never discussed the change from patches to cream nor applied lidocaine cream on her back. An interview was conducted with the Director of Nursing on 2/24/26 at 11:07 a.m. She indicated she had clarified the lidocaine medication order, dated 4/2/25 for Resident 92 with the medical doctor. The resident was to receive 4% of lidocaine cream not lidocaine patches. 3. The clinical record for Resident 115 was reviewed on 2/23/26 at 11:30 a.m. The resident's diagnosis included, but was not limited to, type 2 diabetes mellitus. A physician's order, dated 8/15/25, indicated Resident 115 was to receive a sliding scale of Humalog (fast acting) insulin before meals. An observation was made of an insulin administration for Resident 115 with License Practical Nurse (LPN) 10 on 2/23/26 at 11:40 a.m. LPN 10 had obtained Resident 115's blood sugar reading. The reading was 333. She returned to her cart and reviewed the Humalog sliding scale in the resident's medical record. After pulling the supplies from the medication cart, she entered Resident 115's room. During that time, LPN 10 was observed setting up the resident's Humalog insulin flex pen to administer the insulin dosage. LPN 10 utilized an alcohol wipe to wipe down the top of the pen and inserted a needle. After, she dialed up 3 units of Humalog insulin and LPN 10 administered the insulin dosage in the resident's left arm. There was no observation of LPN 10 priming the flex pen with 2 units of insulin. An interview was conducted with the Regional Nurse Consultant (RNC) on 2/24/26 at 8:55 a.m. She indicated the nursing staff should be priming the insulin flex pens with 2 units of insulin (to remove air from flex pen cartridge and needle) prior to dialing up the insulin dosage. An injectable medication administration policy was provided by the Executive Director on 2/25/26 at 9:19 a.m. It indicated, Policy: Medications will be administered in a safe and effective manner. The guidelines in this policy detail how to administer injectable medications.Procedure:.Pen devices: dial the dose as instructed by the pen manufacturer. Instructions for use of Humalog flex pen at website https://pi.lilly.com dated 7/2023, was retrieved on 2/26/26. It indicated Prescribing information .Priming your pen: Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see (continued on next page)

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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	insulin at the tip of the needed. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. 410 IAC (Indiana Administrative Code) 3.1-37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. Building B. Wing	02/25/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to provide fluids at the bedside for 1 of 3 residents reviewed for hydration and a diet as ordered for 1 of 1 residents reviewed for nutrition/hydration. (Resident 56 and 116) Findings include: 1.The clinical record for Resident 116 was reviewed on 2/20/2026 at 2:25 p.m. The diagnoses included, but were not limited to, dysphagia (difficulty swallowing, causing pain or choking), profound intellectual disabilities, and contractures (permanent, painful tightening of the muscles, tendons, ligaments or skin) of the right wrist and left elbow and hand. The Annual Minimum Data Set (MDS) assessment, dated 2/8/26, indicated Resident 116 was severely cognitively impaired, had upper extremity impairment on one side, was dependent with all activities of daily living (ADLS), and was on a mechanically altered diet. During an observation on 2/19/26 at 2:15 p.m. and on 2/20/26 at 1:28 p.m., Resident 116 was in her bed and did not have any fluids at the bedside. During an observation on 2/23/26 at 9:40 a.m., Resident 116 was lying in bed watching t.v. and had a clear cup with a small amount of water in the bottom of it, with a straw inside the cup. An interview with Certified Nursing Assistant (CNA) 5 was conducted on 2/23/26 at 9:46 a.m. CNA 5 indicated Resident 116 did not have any fluids to drink at the bedside. Resident 116 received fluids with meals, medications, and the CNA would go in often throughout the day and give Resident 116 drinks of thickened liquids. She had to go to the kitchen to get the thickener for Resident 116's water, but she had not gotten around to it yet. A physician's order, dated 10/21/25, indicated Resident 116 was on a regular diet with puree texture and nectar thickened liquids consistency. Resident 116 was to have liquids by spoon and may use a nosey cup (an adaptive, u-shaped cutout cup designed for people with limited neck or upper extremity movement). A plan of care, revised 12/17/24, indicated Resident 116 had oral health problems related to poor oral hygiene and had a regular diet, puree texture, and nectar thickened liquids consistency. Resident 116 was to receive liquids by spoons. The interventions included, but were not limited to, provide nectar thickened liquids. During an interview with the Director of Nursing (DON) on 2/25/26 at 1:14 p.m., the DON indicated nursing was responsible to ensure residents had the proper fluids at the bedside and that fluids were offered throughout the day. Resident 116 had to be offered and given drinks of fluids by staff. 2. The clinical record for Resident 56 was reviewed on 2/20/26 at 11:00 a.m. The diagnoses included but were not limited to: end stage kidney disease (below 15% percent kidney function). A physician's order, dated 2/10/26, indicated the resident was to receive a regular diet. The resident was not to receive bananas, orange juice, or potato chips. An observation was made of Resident 56 on 2/23/26 at 12:00 p.m. The resident was observed lying in bed with a bedside table next to the bed. The resident's breakfast tray was sitting on the bedside (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	table. A cup of orange juice was observed on the tray. The meal ticket sitting on the tray indicated the resident was not to receive bananas, orange juice or potato chips. An interview was conducted with License Practical Nurse (LPN) 10 on 2/23/26 at 12:03 p.m. She indicated the resident was not to receive orange juice. She was unsure why the meal tray was delivered with orange juice. A therapeutic diet policy was provided by the RNC on 2/24/26 at 8:57 a.m. It indicated, Policy Statement. All residents have a diet order, including regular, therapeutic, and texture modification, that is prescribed by the attending physician, physician extender, or credentialed practitioner in accordance with applicable regulatory guidelines.Procedures.3. Diets are prepared in accordance with the guidelines in the approved Diet Manual and the individualized plan of care. A General Hydration Services policy was provided by the Executive Director (ED) on 2/24/26 at 1:15 p.m. It indicated .The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs.5. Provide fresh water at bedside in the proper consistency and drinking device. 410 IAC (Indiana Administrative Code) 3.1-46(a)(2)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely obtain outside dental services and to timely inform the physician of dental pain for 1 of 2 resident's reviewed for dental services (Resident 51). Findings include: The clinical record for Resident 51 was reviewed on 2/19/25 at 12:43 p.m. The resident's diagnosis included, but was not limited to, hypertension. A Quarterly Minimum Data Set (MDS) Assessment, completed 1/28/26, indicated he had moderately impaired cognition, was usually able to make himself understood and to understand others, and needed set up assistance with oral hygiene. A dental consult noted, dated 12/19/25, indicated Resident 51 required a referral to an oral surgeon to have two teeth extracted. A Social Services Note, dated 1/20/26, indicated an oral surgery office had been contacted for an appointment. Information had been faxed to the office, and the office would follow up with facility after the information was reviewed. A Social Services Note, dated 2/6/26, indicated the dental office had called and scheduled an appointment for July 30,2026. During an interview on 2/19/26 at 12:43 p.m., Resident 51 indicated he needed to see the dentist. His tooth was loose and had fallen out about a month ago. He had told someone but could not remember who he told. During an interview on 2/23/26 at 11:57 a.m., Resident 51 indicated when he bit down on something wrong he experienced pain like lightning' in his front tooth. During an interview on 2/23/26 at 11:59 a.m., the Social Services Designee (SSD) indicated he was aware of Resident 51's pain and that is why the dental appointment had been made. The July 2026 appointment was the first available and the facility had asked that Resident 51 be placed on the call list if a sooner appointment opened. On 2/23/26 at 3:00 p.m., Resident 51 was observed with Qualified Medication Aide (QMA) 7. Resident 51 wiggled his visibly loose front tooth. QMA 7 instructed Resident 51 not to move around too much. Resident 51 told QMA 7 that he had a shooting pain in his front tooth when he bit down on something wrong. During an interview on 2/25/26 at 10:39 a.m., Licensed Practical Nurse (LPN) 4 indicated tooth pain would be communicated to the physician. The facility had [NAME] health, or the Nurse Practitioner could be called. During an interview on 2/25/26 at 10:44 a.m., LPN 20 indicated she was Resident 51's nurse. She had been made aware that Resident 51 had tooth pain and that he had an upcoming dental appointment.During an interview on 2/25/26 at 10:45 a.m., SSD indicated Resident 51's upcoming dental appointment was the appointment scheduled on July 30, 2026. The clinical record did not include information that the physician or nurse practitioner had been informed of Resident 51's complaint of shooting dental pain on 2/23/26. During an interview on 2/25/26 at 11:03 a.m., Nurse Practitioner (NP) 21 indicated she would like to know if a resident has acute dental pain. She did not remember being informed of Resident 51's acute dental pain. On 2/25/26 at 11:48 a.m., Regional Nurse Consultant (RNC) 2 provided the current Dental Services Policy that read .It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. Dental and Oral health can impact the physical as well as the mental/ emotional and psychological health of a resident. Poor dentition and/or poor oral health may impact nutritional and weight loss status .The facility will assist the resident in: a. Obtaining routine Dental Services b. Obtaining 24-hour Emergency Dental Services c. Obtaining services to the resident to meet the needs of each resident D. Making appointments . 410 IAC (Indiana Administrative Code) 3.1-24(a)(1)410 IAC 3.1-24(a)(2)

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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 maintain infection control by not utilizing hand hygiene prior to donning gloves to administer eye medications for 2 of 38 residents observations for medication administrations and administered a pill medication that had dropped on the floor for 1 of 1 random observation related to infection control. (Residents 15, 92, and 113) Findings include:1.The clinical record for Resident 113 was reviewed on 2/20/26 at 10:45 a.m. The resident's diagnosis included, but were not limited to, heart failure(chronic progressive condition where the heart muscle becomes too weak or stiff to pump enough oxygen rich blood to meet the body's needs). An observation was made of a medication administration on 2/20/26 at 10:00 a.m. License Practical Nurse (LPN) 11 was administering pill medications to Resident 113. During that time, the resident dropped 1 pill medication from the medication cup onto the floor. LPN 11 was observed picking up the pill medication with her bare hands and handing it back to the resident. The resident placed the pill medication in her mouth after LPN 11 handed it to her. An interview was conducted with Resident 113 on 2/20/26 at 10:04 a.m. She indicated she did not want to take the pill medication that had fallen on the floor, but she had concerns if she requested to get a replacement; LPN 11 would not have returned with it.2. The clinical record for Resident 92 was reviewed on 2/23/26 at 9:00 a.m. The resident's diagnosis included, but was not limited to, hepatitis C (a contagious liver disease caused by the hepatitis C virus). A physician's order, dated 9/3/25, indicated Resident 92 was to receive 1 drop of refresh eye drops in each eye twice a day. An observation was made of a medication administration for Resident 92 with Registered Nurse (RN) 12 on 2/23/26 at 9:06 a.m. RN 12 was at the medication cart preparing Resident 92's medications. She had touched medication cart drawers, mouse to the computer lab top, medication packets, plastic cups, and water pitcher. Then, she knocked and entered the resident's room and administered pill medications. After, she donned gloves and administered eye drops to the resident. There was no observation of RN 12 utilizing hand hygiene prior to donning gloves. 3. The clinical record for Resident 15 was reviewed on 2/23/26 at 9:48 a.m. The resident's diagnosis included, but was not limited to, respiratory failure (a critical condition where the lungs cannot adequately supply oxygen to the blood). A physician's order, dated 1/19/26, indicated Resident 15 was to receive 0.2 % artificial tears twice a day. An observation was made of a medication administration for Resident 15 on 2/23/26 at 9:48 a.m. RN 12 was observed preparing the resident's medications at the medication cart. She had touched medication cart drawers, mouse to the computer, plastic cups, and water pitcher. Then, knocked on the resident's door and entered. After, RN 12 had donned gloves and administered eye drops to the resident. There was no hand hygiene observed prior to RN 12 donning gloves. An interview was conducted with Regional Nurse Consultant (RNC) 2 on 2/24/26 at 8:55 a.m. She indicated RN 12 should have utilized hand hygiene prior to donning gloves. Pill medications that fall on the floor should not be administered to the residents. A standard precautions policy as provided by the Executive Director on 2/25/26 at 9:19 a.m. It indicated, .Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Practicing hand hygiene is a simple but effective way to prevent the spread of infections by breaking the change of infection. Proper cleaning of hands can prevent the spread of germs, including those that are resistant to antibiotics and are becoming resistant to antibiotics.II. When to perform hand hygiene.G. after glove removal. A medication administration policy was provided by the Executive Director on 2/25/26 at 9:19 p.m. It indicated, .The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer. Procedure:.s. Do not touch the medication, either when opening a liquid or dose pack. i. Dropped medications will be discarded. 410 IAC (Indiana Administrative Code) 3.1-18(a)