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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/09/2025 |
| NAME OF PROVIDER OR SUPPLIER Eagle Valley Meadows | | STREET ADDRESS, CITY, STATE, ZIP CODE 3017 Valley Farms Rd Indianapolis, IN 46214 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p> |

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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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to respond to call lights for 2 of 3 residents reviewed for dependent residents call light response times (Residents B and L). Findings include: 1. On 12/8/25 at 12:12 p.m., Resident B was observed sitting in a manual wheelchair (WC) in her room and indicated she had been waiting for 15 minutes for staff to come change her wet brief. The resident's call light was observed not to be activated, and she indicated staff had shut the light off and told her they would return. Certified Nursing Assistants (CNAs) 8 and 9 were observed in the hallway passing lunch trays, but they were not observed to enter the resident's room or speak to her. Resident B reactivated her call light. On 12/8/25 at 12:16 p.m., Licensed Practical Nurse (LPN) 13 was observed entering Resident B's room, she turned the call light off, left the room, and returned to the nurse's station. On 12/8/25 at 12:27 p.m., Resident B was observed sitting in the same position in her wheelchair eating her lunch. The resident indicated the nurse had shut the call light off and told her staff could not change her brief during lunch as it would cause contamination issues. LPN 6 was present during the conversation. On 12/8/25 at 12:49 p.m., Resident B remained in the same position in her wheelchair, her call light was activated and she indicated staff had not yet come to change her brief. CNAs 8, 9, and an unidentified CNA were observed walking up and down the hallway, they did not respond to the resident's call light. LPN 13 was observed standing at the nurse's station, and indicated she was responsible for resident care on the D Hallway to include Resident B. On 12/8/25 at 1:07 p.m., Resident B's call light remained activated and could be observed flashing in the hallway from the nurse's station. Resident B's clinical record was reviewed on 12/9/25 at 12:32 p.m. Diagnoses on Resident B's record included hemiplegia and hemiparesis (paralysis) affecting the left side, and Parkinson's disease. A quarterly MDS (Minimum Data Set) assessment, completed on 11/13/25, indicated Resident B was cognitively intact, had no behaviors and had no rejection of care. The resident required substantial/maximal assistance for toilet hygiene, transfers, standing, and used a wheelchair for mobility. The resident was frequently incontinent of bladder and bowel. A care plan for Resident B, dated 6/20/25, indicated the resident required assistance with toileting because she was incontinent, had impaired mobility, and she needed assistance with transfers. Approaches included assisting with elimination, assisting with incontinent care as needed, and checking every 2 hours for incontinence. A care plan for Resident B, dated 6/20/25, indicated the resident was at risk for falls due to hemiplegia/hemiparesis causing impaired mobility on the left non-dominant side and Parkinson's disease. The resident needed assistance with incontinence care, and she would attempt to self-transfer to and from bed into and out of her wheelchair. Approaches included environmental changes, and keeping her personal items and call light within reach. During an interview on 12/9/25 at 12:53 p.m., the Director of Nursing Services (DNS) indicated call light response times were not supposed to be over 5 minutes. All nursing staff and managers should answer call lights. 2. On 12/9/25 at 10:57 a.m., Resident L was observed lying on the bed watching the television, the sheet was partially covering his legs, and he was observed to be wearing an adult brief. The resident was alert, oriented, soft-spoken, and smiled during the conversation. The resident indicated he had a new below the knee amputation (BKA) and was in the facility for rehabilitation to learn to ambulate with a prosthesis. He could not transfer or ambulate on his own and used a bedpan versus getting up to the bathroom. Resident L indicated staff were often slow to respond to his call light which had caused him to have accidents and the need to wear an adult brief, all of which was embarrassing. Resident L's clinical record was reviewed on 12/9/25 at 12:32 p.m. Diagnoses on Resident L's record included acquired absence of left leg below the knee. An admission MDS, completed on 11/28/25, assessed Resident L as being cognitively intact, and having no rejection of care. The resident was dependent for toilet hygiene, transfers, personal hygiene, and was frequently incontinent of bladder and bowel. The resident used a wheelchair for mobility. A care plan for Resident L, dated 11/24/25, indicated the resident required assistance with toileting due to impaired mobility, incontinence, and needing assistance with transfers. Approaches included assisting with elimination, incontinent care as needed, and checking every 2 hours for incontinence. A care plan for Resident L, dated 11/24/25, indicated the resident was at risk for falls due to his age [AGE]-69, incontinence, needing assistance with transfers, activities of daily living, bed mobility, medications, unsteady gait, vision impairment, lack of understanding of one's physical and cognitive limitations, and a left BKA. Approaches included environmental changes, and keeping personal items and the call light in reach. During an interview</p> | | |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>(continued on next page)</p> |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a clean and sanitary environment on 3 of 4 hallways observed for cleanliness (Hallways A, B, and D). Findings include: 1. On 11/24/25 Resident CC's family member e-mailed the Executive Director (ED) requesting a deep cleaning of the resident's bathroom. The e-mail indicated during a visit the resident's room and bathroom floors were filthy, and she was requesting they be cleaned. During the initial tour of Hallway D the following was observed: a. On 12/8/25 at 10:58 a.m., Resident D was observed propped in a bed positioned against the wall, watching videos on her cellphone, and the television on but muted. There was a large area of dried dark substances on the wall near the resident's head. On 12/9/25 at 10:38 a.m. a second observation was made of Resident D's room. The large area of dried dark substances remained on the wall near the resident's head. b. On 12/8/25 at 11:05 a.m., Resident E was observed sitting on the side of the bed with handwritten notes in his hand, plastic labels from soda bottles taped to the wall behind his bed, personal items stacked haphazardly on the foot of the bed, two fast food bags hanging from the slats of the window blinds, the floor was dirty, and there were unidentified dark substances smeared on his sheets where he sat. On 12/9/25 at 10:41 a.m., a second observation was made of Resident E's room. The plastic labels from soda bottles taped to the wall behind his bed, personal items stacked on the foot of the bed, two fast food bags hanging from the slats of the window blinds, and dirty/ sticky floor remaining unchanged. There were chunks of food on the floor under the over-the-bed table, and the bed sheets remained soiled with a large area of smeared dark substances. c. On 12/8/25 at 11:11 a. m., the handrails and walls behind the handrails were observed to be soiled with dried substances. There was no housekeeper observed in the D Hallway. On 12/9/25 at 11:15 a.m., the Housekeeping Supervisor was observed to sweep and mop in Resident B's room, then she left the hallway. A second observation was made of the soiled handrails and walls around the handrails. d. On 12/8/25 at 12:12 p.m., Resident B was observed sitting in a manual wheelchair in her room. The resident's personal items were sitting among debris and sticky substances on an over-the-bed table, and the floors in her room were littered with dirt, debris, and trash. The toilet, floor in the bathroom, walls around the toilet, and sink were soiled in the bathroom that was shared between rooms for Residents B, Z, and BB. Resident B indicated her room had not been cleaned over the weekend. On 12/9/25 at 10:37 a.m., Resident B was observed to be out of her room. The Housekeeping Supervisor was observed sweeping up a pile of debris to include paper, an empty plastic soda bottle, straw papers, and dirt. The Housekeeping Supervisor indicated she and Housekeeper 12, who was permanently assigned to clean Hallway D, had to clean while the resident was out of the room as Resident B had accused both of them of stealing her belongings. e. On 12/8/25 at 12:20 p.m., Resident Z was observed in her room, sitting in a manual wheelchair, eating from a snack bag of potato chips. There was a long strip of toilet paper and a soiled vinyl glove on the floor near the resident's feet. The resident indicated she and her roommate, Resident BB, shared the bathroom with Resident B. She indicated it was not easy, especially in the middle of the night, as the other room's door was always left open, and anyone would walk in, and there were sometimes three wheelchairs in front of the sink preventing her from getting to it. Resident Z indicated housekeeping was supposed to clean her room every morning. 2. During the initial tour of Hallway A the following was observed: a. On 12/8/25 at 11:15 a.m., Resident F was observed being taken from her room in a manual wheelchair, she indicated she was headed to a church service. The resident's bathroom was observed to have small dark balls on the floor around her toilet. Licensed Practical Nurse (LPN) 6 indicated the resident required assistance with activities of daily living (ADL's) to include transfers and toileting. On 12/9/25 at 10:45 a.m., a second observation was made of Resident F's bathroom. The small dark balls remained on the floor around her toilet, and the toilet was smeared with bowel movement (BM). b. On 12/8/25 at 11:19 a.m., Resident G was observed to be out of his room. The toilet riser in his bathroom was heavily soiled with dried BM, and there were pieces of crackers and crumbs on the floor around the bed. On 12/9/25 at 10:47 a.m., Resident G was observed being assisted to the bathroom by an unidentified nurse. At 11:08 a.m., a second observation was made of the bathroom, and the toilet riser and toilet lid both remained heavily soiled with dried BM. c. On 12/8/25 at 11:21 a.m., Resident H was observed propped up in a bariatric bed, wearing oxygen per a nasal cannula (NC), eating a snack, and looking through a shipped box. The resident or his bedding had a pungent sour smell that permeated into the hallway. The resident indicated the window in the room was opened 3 inches at his request due to him being hot despite the</p> | | |