STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
American Village	2026 East 54th St Indianapolis, IN 46220

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the resident's right to be free from physical and mental abuse by another resident using the reasonable person concept, it is likely when a resident voice he wanted to kill another resident and grabbed the resident's neck this would lead to fear and distress for 1 of 2 residents reviewed for abuse. (Resident 127) Findings include: The clinical record for Resident 127 was reviewed on 3/17/26 at 3:07 p.m. The resident's diagnosis included, but was not limited to, Alzheimer's disease (progressive irreversible neurodegenerative disorder that causes the brain cells to die, the brain to shrink, and significant impairment of memory, thinking, and behavior). A Quarterly Minimum Data Set (MDS) Assessment, completed 2/26/26, indicated Resident 127 had severely impaired cognition. A Nursing Progress Note, dated 3/12/26 at 3:46 p.m., indicated Resident 127 was involved in an altercation with another resident (Resident 97). Resident 127 had no injuries noted and no signs and symptoms of distress. Resident 127 continued to participate in day-to-day activities. The clinical record for Resident 97 was reviewed on 3/17/26 at 3:07 p.m. The resident's diagnoses included, but were not limited to, dementia (a decline in mental ability including memory, thinking, reasoning, and behavior) and psychosis (loss of contact with reality, where an individual struggles to distinguish what was real from what was not). An Annual MDS Assessment, completed 2/5/26, indicated Resident 97 had severely impaired cognition. A care plan, created 8/23/24 and last reviewed on 3/13/26, indicated Resident 97 could become verbally/ physically aggressive, make threatening remarks to staff and other residents at times, knock over items in room, slam doors, throw things in the hallway, rip decorations off the walls, curse, charge at nurse and residents, hit walls, and not flip over tables in dining room. The goal was for the resident to not cause distress to others, and he would not cause harm to self or others. The interventions, created 8/28/24 and last reviewed on 3/13/25, were to address any immediate needs. Administer medications as ordered by the physician. Ensure safety, allow him time to cool off. Provide calm, unhurried and supportive approach. The physician and responsible party notified of behaviors. Remove from immediate area to further evaluate needs. A care plan, created 10/25/25 and last reviewed on 3/11/26, indicated Resident 97 had refused to have a Stop sign on his door, will accept stop sign on his door to detour other residents from coming inside his room without permission. The goal was that residents would not enter Resident 97's room without permission. The intervention, initiated 10/25/25, was to redirect other residents to activities and/or their rooms. A nursing progress note, dated 3/6/26 at 4:58 p.m., indicated Resident 97 became upset when another resident (Resident 127) went to his room. Resident 97 came to the dining room area yelling and made threats to hit other residents and staff. Resident 97 proceeded to flip over the dining table and chairs. Staff members attempted to calm Resident 97; however, he stated he would not listen to anyone. The Nurse Practitioner (NP) arrived and spoke with Resident 97 and he eventually calmed down. A physician's order for a one-time dose of clonazepam (a medication used to treat anxiety and panic disorder) was received and administered to Resident 97. The Director of Nursing (DON) was notified of situation. Resident 97 had calmed down and was lying in bed. A Nursing Progress Note, dated 3/12/26 at 2:50 p.m., indicated Resident 97 had displayed violent behaviors. 911 had been called and Resident 97's (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

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	guardian had been notified. Resident 97 was calm and sitting in the hallway being monitored directly by staff until the emergency medical service arrived. The incident report, dated 3/12/26 at 2:39 p.m., indicated Resident 97 and Resident 127 had a disagreement resulting in Resident 97 being verbally aggressive and Resident 97 putting his hands toward the neck of Resident 127. As Resident 97 made contact with Resident 127 the staff immediately separated the residents. Resident 97 was placed on one-on-one care (one staff member to one resident direct observation) until the emergency medical services arrived and Resident 127 had no recollection of the event. No injuries were noted to either resident. An Acute Care Progress Note from Nurse Practitioner (NP) 20, dated 3/12/26, indicated Resident 97 was evaluated for an acute visit due to explosive and violent behaviors. The resident had become violent and extremely upset due to his family being out of the facility for the last few days. The staff were aware and were attempting to remedy the situation. The resident (Resident 97) in the meantime had choked another resident, told the social worker he was going to kill her and shoved another resident that approached his room. The patient was impossible to redirect. 911 was called due to no other options available acutely. The patient was put on 1 to 1 care as the facility waited for emergency services. During an interview on 3/20/2026 at 1:13 p.m., Certified Nursing Assistant (CNA) 21 indicated she had witnessed the incident between Resident 97 and 127 on 3/12/26. Resident 97 had been sitting in a chair in the hallway across from the nursing station. Resident 127 was in her wheelchair, talking out loud and propelling herself up the hallway, past Resident 97. Resident 97 had told Resident 127 to shut up. Resident 127 kept moving and talking to herself and then Resident 97 jumped out of his chair and put his hands around Resident 127's neck. CNA 21 had been sitting behind the nursing station and immediately went to Resident 127 and got Resident 97's hands from around Resident 127's neck. CNA 21 then removed Resident 127 from the area and told the nurse what had happened. During an interview on 3/23/26 at 2:58 p.m., Family Member (FM) 22 indicated that prior to Resident 127 having impaired cognition, Resident 127 would have been scared, upset, and distressed if another person had put their hands around her neck and attempted to choke her. On 3/20/26 at 2:24 p.m., the ED provided the Abuse Prohibition, Reporting, and Investigation policy, last revised June 2018, indicated . It is the policy.to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to verbal abuse, sexual abuse, physical abuse, mental abuse, corporal punishment, and involuntary seclusion. Definitions/ Examples of Abuse: Willful used in the definition of abuse means the individual must have acted deliberately, not that the individual intended to inflict injury or harm.Physical abuse- a willful act against a resident by another resident, staff member, or other individual [s]. Examples may include but not limited to hitting, beating, slapping, punching, shoving, striking with an object, pulling, twisting, squeezing, pinching, scratching, tripping, biting, burning, and use of improper restraints. 410 IAC (Indiana Administrative Code) 16.3.1-27(a)(1)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to assist residents with fingernail care and facial hair removal for 2 of 6 residents reviewed for Activities of Daily Living (Resident J and Resident K). Finding include:1.The clinical record for Resident K was reviewed on 3/18/25 at 9:00 a.m. The diagnoses for Resident K included, but were not limited to, stroke (blood flow to the brain was blocked or a vessel burst killing brain cells) and dementia (decline in mental function). An Activities of Daily Living (ADL) care plan, dated 10/25/25, indicated the staff was to assist hygiene and provide showers twice a week and partial bed baths all other days. A quarterly Minimum Data Set (MDS) Assessment, dated 2/4/26, indicated Resident K was moderately cognitively impaired. She was dependent on staff to provide hygiene care. An observation was made of Resident K with Resident K's Representative on 3/18/26 at 11:10 a.m. The resident's fingernails were observed long in length. Resident K had indicated she would like her nails to be trimmed, shaped and painted. The staff had never offered to trim her fingernails, only trimmed her toenails. Resident K's Representative indicated the resident's fingernails were very long and unkept. They needed to be trimmed. An observation was made of Resident K in bed on 3/23/26 at 11:18 a.m. The resident's fingernails were observed to be long in length. An observation was made of Resident K on 3/24/26 at 11:03 a.m. The resident's fingernails were long in length. The resident indicated she did want her fingernails trimmed and filed. The staff had not offered to trim them. She wanted to have her nails look groomed and nice. An interview was conducted with Certified Nursing Assistant (CNA) 7 on 3/24/26 at 11:05 a.m. She indicated nail care was provided when it was observed that the resident's nails are dirty and long in length she will ask if they would like nail care. The March 2026 shower reports for Resident K were provided by the DNS on 3/24/26 at 2:20 p.m. The resident had received a bed bath on 3/17/26. The shower report did not include documentation of nail care provided. An interview was conducted with the Director of Nursing Services (DNS) on 3/24/26 at 2:20 p.m. She indicated Resident K had been refusing her showers at times. The shower sheets did not include a place for staff to document nail care services that had been provided. 2. During an observation and interview with Resident J on 3/18/2026 12:21 p.m., Resident J indicated the facility they just wash me up. The resident had moderately long fingernails on both hands with a black substance underneath them. The resident had facial hair of a full mustache. The resident indicated she always shaved her facial hair with a razor at home and no staff had offered to shave her face. The resident indicated she would be willing to use the cream that takes off facial hair if that was what the facility used. During an observation on 3/19/26 at 2:35 p.m., Resident J was lying in bed dressed. The resident had moderately long fingernails on both hands with a black substance underneath them and had a full (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mustache. During an observation and interview with Resident J on 3/20/2026 at 1:11 p.m., Resident J had a full mustache and her fingernails on both hands were moderately long with black substance underneath them. The resident was eating a turkey sandwich with her bare hands. Resident J indicted the facility staff had not offered to clean her nails yet. Review of the clinical record of Resident J on 3/19/26 at 2:50 p.m., indicated the resident's diagnoses included, but were not limited to, weakness and repeated falls. The plan of care for Resident J, dated 12/17/26, indicated the resident required assistance with Activities of Daily Living (ADL). The interventions included, but were not limited to, offer a shower two times a week and assist with grooming as needed. The admission Minimum Data Set (MDS) for Resident J, dated 12/22/25, indicated the resident was moderately impaired for daily decision making. The resident had no behaviors of refusal of care. The resident required substantial from staff for showers and partial to moderate assistance from staff with personal hygiene. During an interview with Unit Manager 1 on 3/20/26 at 1:40 p.m., indicated it was the responsibility of the CNA's to clean and trim Resident J's fingernails and shave her facial hair. The Unit Manager indicated Resident J was scheduled to have showers on Wednesday and Saturday. The A.M. care policy provided by the Executive Director on 3/23/26 at 11:32 a.m., indicated the staff were to assist residents with washing their hands and shaving during morning care. This citation relates to Intake 2646777. 410 IAC (Indiana Administrative Code) 3.1-38(a)(3)(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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure residents' pain were assessed, monitored and addressed for 2 of 3 residents for pain management. (Resident C and Resident D) Findings include: 1.The clinical record for Resident C was reviewed on 3/17/25 at 10:00 a.m. The diagnoses for Resident C included, but were not limited to, pain, osteoarthritis (loss of cartilage causing rubbing of bone to bone at the joints), kidney disease (kidneys not filtering blood properly), and type 2 diabetes mellitus (pancreas does not make enough insulin) with diabetic neuropathy (damage of the nerves). A quarterly Minimum Data Set (MDS) Assessment, dated 3/19/26, indicated Resident C was moderately cognitively impaired. A pain care plan, dated 12/27/23, indicated the staff were to administer pain medications as ordered, assess and document the effectiveness of PRN medications, notify the medical provider if the pain was the relieved or had worsened and provided non pharmacological interventions for pain relief. A controlled substance record indicated 5-325 milligrams of hydrocodone (pain medication) was administered to Resident C on 3/17/26 at 12:00 p.m. An interview was conducted with Resident C on 3/17/26 at 11:28 a.m., the resident indicated the staff did not ask her the location of her pain or how bad her pain was. The pain medication she received did not work at times. A random observation was made of License Practical Nurse (LPN) 6 on 3/17/26 at 11:48 a.m. Resident C was observed sitting in her room and had requested a pain medication from LPN 6. LPN 6 indicated it would be just a minute. He then went to the medication cart and pulled a medication out of the narcotic box. After, he returned to Resident C's room, handed her the medication and then left the room. There was no observation of LPN 6 assessing Resident C's pain location or level of her pain before or after the pain medication was administered. An interview was conducted with LPN 6 on 3/19/26 at 12:26 p.m. He indicated he was supposed to assess and document the location and level of the resident's pain when giving a PRN pain medication. 2. The clinical record for Resident D was reviewed on 3/17/25 at 3:00 p.m. The diagnoses for Resident D included, but were not limited to, pain. A quarterly MDS assessment, dated 9/15/26, indicated Resident D was severely cognitively impaired. A pain care plan, revised 2/18/26, indicated on a start date of 8/28/18, the staff was to notify the medical provider if the resident's pain was not relieved or had worsened and staff were to assess for signs of pain the resident displayed related to being nonverbal. A physician's order, dated 11/27/24, indicated Resident D was to receive 1,000 milligrams of Acetaminophen three times a day. A progress note, dated 10/1/25 at 1:37 p.m., indicated Resident D had complaints of right leg pain. The medical provider had been notified. A physician's order, dated 10/1/25, indicated Resident D was to receive 50 milligrams of tramadol every 8 hours PRN for pain. A progress note, dated 10/7/25, indicated Resident D had bruising on right leg behind the knee and swollen foot. The resident had complaints of pain when she touched her foot. A progress note, dated 10/8/25, indicated, Resident D had a bruise to the right leg. The resident had faded scattered bruising from knee to ankle on the right lower leg and the foot was swollen. Upon the resident's foot being touched the resident yelled in pain. New orders were received by the Nurse Practitioner (NP) for an x-ray of the resident's right knee, right ankle, lower leg bones at that time. The October 2025 Medication Administration Record for Resident D indicated the resident had received the 50 milligrams of PRN tramadol on 10/9/25 at 12:31 p.m., and the pain medication was effective. A controlled substance record, dated 10/2/25, for 50 milligrams of tramadol indicated Resident D had received the 50 milligrams of tramadol on 10/2/25 at 1:00 p.m. and 10/9/25 at 12:00 p.m. The resident's clinical record lacked documentation Resident D's pain was assessed with location of pain, level of pain, or effectiveness after pain medications were administered. There was no documentation the resident's pain was monitored or addressed on 10/7/25 and 10/8/25. An interview was conducted with the Director of Nursing Services (DNS) on 3/24/26 at 12:00 p.m. She indicated pain assessments should be conducted with residents that receive scheduled pain medications. Resident D had received 1,000 milligrams of Acetaminophen three times a day. The staff (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have conducted pain assessments every shift, and they were not. She was unable to provide information that the resident's pain was addressed on 10/7/25 and 10/8/25 other than the scheduled 1,000 milligrams of Acetaminophen had been administered three times those days. A pain policy was provided on 3/19/26 at 10:00 a.m. It indicated, .policy: It is the policy of American Senior Communities to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management. Procedure: 1. Residents are assessed for pain upon admission, weekly, and during medication administration.7. Residents receiving routine pain medication should be assessed each shift by the charge nurse during rounds and/or medication pass.Documentation of administration of ordered PRN pain medication will be documented on the Electronic Medication Administration Record (EMAR). 9. Additional information including, but not limited to reasons for administration, and effectiveness of pain medication will be documented of the Electronic Medication Administration Record (EMAR). This citation is related to Intake 2733447. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely updated the individualized plan of care for residents who displayed behaviors, document non-pharmacological interventions attempted prior to the administration of an as needed anti-anxiety medications, and to document effectiveness of interventions attempted to alleviate behaviors for 2 of 3 residents reviewed for dementia care (Resident 6 and Resident 97).Findings include: 1 The clinical record for Resident 97 was reviewed on 3/17/26 at 3:07 p.m. The resident's diagnoses included, but were not limited to, dementia (a decline in mental ability including memory, thinking, reasoning, and behavior) and psychosis (loss of contact with reality, where an individual struggles to distinguish what was real from what was not). A care plan, created 10/25/25 and last reviewed on 3/11/26, indicated Resident 97 had refused to have a Stop sign on his door, will accept stop sign on his door to detour other residents from coming inside his room without permission. The goal was that residents would not enter Resident 97's room without permission. The intervention, initiated 10/25/25, was to redirect other residents to activities and/or their rooms. A care plan, created 8/23/24 and last reviewed on 3/13/26, indicated Resident 97 could become verbally/ physically aggressive, make threatening remarks to staff and other residents at times, knock over items in room, slam doors, throw things in the hallway, rip decorations off the walls, curse, charge at nurse and residents, hit walls, flip over tables in dining room, etc. The goals were that Resident 97 would not experience lasting distress. He would not cause distress to others, and he would not cause harm to self or others. The interventions, created 8/28/24 and last reviewed on 3/13/25, were to address any immediate needs. Administer medications as ordered by the physician. Encourage preferred activities such as bingo, watching television, and games. Ensure safety, allow him time to cool off. Provide calm, unhurried and supportive approach. The physician and responsible party notified of behaviors. Remove from immediate area to further evaluate needs. An Annual MDS Assessment, completed 2/5/26, indicated Resident 97 had severely impaired cognition. A Behavioral Health Monthly Review, dated 2/4/26, indicated Resident 97 had a new/worsening behavior exhibited on 1/9/26. He was agitated with staff and threw a chair up against the wall. The Interdisiplinary Team (IDT) had reviewed the event. Care plans updated with effective interventions was marked as not applicable (N/A). Resident 97 was taking psychotropic (drugs that alter the brain chemistry to treat mental health conditions) medications. The targeted behavior for each medication was depression and agitation. A Behavioral Health Monthly Review, dated 2/13/26, indicated Resident 97 had a new/ worsening behavior of yelling and charging at a nurse on 1/9/26. The IDT team had reviewed the event. Care plan updated with effective interventions was marked as not applicable (N/A). Resident 97 was taking psychotropic medications. The targeted behavior for each medication was anxiety. A nursing progress note dated 3/6/26 at 4:58 p.m., indicated Resident 97 became upset when another resident went to his room. Resident 97 came to the dining room area yelling and made threats to hit other residents and staff. Resident 97 proceeded to flip over the dining table and chairs. Staff members attempted to calm Resident 97; however, he stated he would not listen to anyone. The Nurse Practitioner (NP) arrived and spoke with Resident 97 and he eventually calmed down. A physician's order for a one-time dose of clonazepam (a medication used to treat anxiety and panic disorder) was received and administered to Resident 97. The Director of Nursing (DON) was notified of situation. Resident 97 had calmed down and was lying in bed. A NP Acute Care Progress Note, dated 3/6/26, the residents interval history indicated the resident was evaluated that day for an acute visit due to anxiety and anger outburst. The resident had chronic anxiety and was on clonazepam daily. Another resident entered his room and he had become quite angry and was yelling out loudly. The resident was hard for staff to redirect. An additional dose of clonazepam was ordered that afternoon. An IDT Behavior Review Note, dated (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/11/26, indicated a resident had come into Resident 97's room and he became very upset, made threats, and flipping over a table and a chair. The immediate intervention was that the NP spoke with Resident 97 and staff gave resident space and time to calm down. The assessment of potential correlation to root cause was a dementia diagnosis and a resident came into Resident 97's room. The root cause of behavioral expression was that a resident came into Resident 97's room.There were no new interventions added to Resident 97's behavioral care plans. Resident 97's clinical record contained a nursing progress note, dated 3/12/26 at 2:50 p.m., that indicated he had displayed violent behaviors. 911 had been called and Resident 97's guardian had been notified. Resident 97 was calm and sitting in the hallway being monitored directly by staff until the emergency medical service arrived. An Acute Care Progress Note from Nurse Practitioner (NP) 20, dated 3/12/26, indicated the resident had an acute visit due to explosive and violent behaviors. The resident had become violent and extremely upset related to his family member being out of the facility for the last few days. The staff were aware and were attempting to remedy the situation. The resident had choked another resident, told the social worker he was going to kill her and shoved another resident that approached his room. The resident was impossible to redirect. 911 was called due to no other options available acutely. The resident was placed on one to one observation (one staff to one resident) until emergency services arrived. During an interview on 3/20/2026 at 1:13 p.m., Certified Nursing Assistant (CNA) 21 indicated she had witnessed the incident between Resident 97 and another resident on 3/12/26. Resident 97 had been sitting in a chair in the hallway across from the nursing station. The other resident was in her wheelchair, talking out loud and propelling herself in the hallway, past Resident 97. Resident 97 had told the other resident to shut up. The other resident had kept moving and talking to herself. Resident 97 jumped out of his chair and put his hands around the other resident's neck. CNA 21 had been sitting behind the nursing station and immediately went to the other resident and removed Resident 97's hands from around the other resident's neck. CNA 21 then removed the other resident from the area and told the nurse what had happened. During an interview on 3/20/26 at 1:18 p.m., Licensed Practical Nurse (LPN) 23 indicated she had been the nurse for Resident 97 on 3/12/26. Resident 97 had been calm and had come out of his room to sit in the hallway prior to the incident with the other resident. During an interview on 3/23/26 at 11:32 a.m., Social Services (SS) 24 indicated Resident 97 was calm most of the time. The staff used Soda, candy, chips, and tea to help calm him when he got upset. Those specific interventions had not been captured on the care plan. The behavioral incident, dated 1/9/26, had been related to Resident 97 believing his wallet was missing. Resident 97's wallet was found and he immediately calmed down. SS 24 had provided one-on-one (one staff to one resident) care for Resident 97 after the behavioral incident on 3/12/26. SS 24 had given Resident 97 some snacks and drinks and he had been calm while he was receiving one-on-one care. During an interview on 3/23/26 at 11:32 a.m., SS 25 indicated Resident 97's behavioral outbursts on 3/6/26 and 3/12/26 had both involved the same female resident on the unit. Resident 97 did not normally flip over tables or throw chairs. Resident 97 was normally easily redirected. During an interview on 3/23/26 at 11:32 a.m., the Director of Nursing Services (DNS) indicated Resident 97 was a creature of habit, using the example that Resident 97 received pancakes every morning for breakfast. If he received 2 pancakes instead of 3 pancakes, he would become upset. Resident 97 was usually very redirectable. Resident 97 did not know what to do when he was out of his normal routine. During the behavior incident on 3/6/26 the NP had ordered a one-time dose of clonazepam. During the behavioral incident on 3/12/26 the NP had been on the unit and Resident 97 was placed on one-on-one care until the emergency medical services had arrived. 2. The clinical record for Resident 6 was reviewed on 3/17/26 at 4:08 p.m. The resident's diagnosis included, but were not limited to, dementia with anxiety and depression. She was admitted to the facility on [DATE]. An admission MDS Assessment, completed 2/21/26, indicated Resident 6 had severely impaired cognition. She displayed the behavior of rejection of care four to six days during the seven day look back period. She had displayed the behavior of wandering daily during the seven day look (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back period. Her wandering had significantly intruded on the privacy or activities of others. A care plan, initiated on 2/27/26 and last reviewed on 3/11/26, indicated Resident 6 experienced the following behavior expressions and intrusive wandering. Refusal of care at times and wander into other residents' rooms at times. She had a diagnoses of dementia and major depression disorder with a treatment of psychoactive medications. The goals were for her not to experience lasting distress, not to cause others distress, and not to cause harm to herself or others. The interventions, initiated on 2/27/26 and last reviewed on 3/11/26, were to address any immediate needs, offer diet coke, Resident 6's favorite drink. Ensue safety. Allow Resident 6 time to cool off. Provide calm, unhurried, and supportive approach. Remove from the immediate area/ resident rooms to further evaluate needs. A Psychiatry Progress Note, dated 3/3/36, indicated Resident 6 had transitioned to the memory care unit. Staff reported Resident 6 remained anxious and restless. She had delusions involving needing to leave the facility to get care and take care of her cat. Resident 6 was unable to participate in activities due to her restlessness and inattentiveness. Resident 6 was receiving sertraline (anti-depressant medication) 50 milligrams (MG) daily. The dose had been adjusted on 2/24/26 to assist with her anxiety. The clinical record did not contain behavior progress notes or behavioral events from 3/3/26 to 3/6/26. A Nurse Practitioner (NP) Acute Care Progress Note, dated 3/6/26, indicated the chief complaint for the visit was aggressive behavior and insomnia. The interval history indicated Resident 6 was being seen due to aggressive behaviors and insomnia. Resident 6 had been aggressive with staff. The NP has discussed Resident 6 with the psychiatry provider who recommended lorazepam (anti-anxiety medication) as needed for seven days. The psychiatry provider would follow up with Resident 6 next week. A physician's order, dated 3/6/26, indicated Resident 6 was to receive lorazepam 0.25 mg every 12 hours as needed. The March 2026 Medication Administration Record (MAR) indicated Resident 6 had received lorazepam on 3/7/26 at 9:52 a.m. for anxiety which was effective. The Controlled Substances Record for Resident 6's lorazepam 0.25 mg indicated she had received a dose of lorazepam 0.25 mg on the following days and times: 3/7/26 at 8:00 a.m. and 8:00 p.m., 3/8/26 at 8:00 p.m. The clinical record did not indicate what non-pharmacological interventions had been attempted prior to administering the as needed lorazepam. A Behavioral Health Monthly Review, dated 3/7/26, indicated no new or worsening behaviors had been noted. An IDT review for the events and care plan updated with effective interventions were not applicable (N/A). A Nursing Progress Note, dated 3/08/2026 at 8:56 p.m., indicated Resident 6 was riding in wheelchair, going in and out of other resident rooms. She was being re-directed and she then attempted to get up from her wheelchair and ended up falling to the floor. Staff would continue with ongoing observation. A Nursing Progress Note, dated 3/10/2026 at 12:26 p.m., indicated a new physician's order had been received to increase sertraline to 100 mg daily, discontinue lorazepam 0.25 mg twice daily, and start lorazepam 0.5 mg twice daily as needed for 14 days. The March MAR indicated Resident 6 had received lorazepam 0.5 mg on the following days and times: 3/10/26 at 1:39 p.m. for behavioral issues which was effective, 3/10/26 at 7:23 p.m. for behavioral issues with was not effective, and 3/11/26 at 8:46 a.m. for agitation which was effective. The clinical record did not indicate what non-pharmacological interventions had been attempted prior to administration of the as needed lorazepam. An NP Follow-Up Progress Note, dated 3/11/26, indicated Resident 6 was being seen for frequent falls. She had fallen 3 times in 12 hours. She has had no apparent injuries. Nursing reported that Resident 6 was significantly anxious and frequently trying to get up from her wheelchair which was when the falls occurred. She had lorazepam available as needed, but nursing did not feel it had been effective. Resident 6 had labs drawn on 3/9/26 which were reviewed. The plan was to change lorazepam to 0.5 mg twice daily and to continue the 0.5 mg twice a day as needed. An IDT Psychotropic Medications New/ Change Order Review, dated 3/12/26, indicated Resident 6 had received a new or changed as needed lorazepam order. The clinical indication for medication use was anxiety. The list of non-pharmacological interventions attempted prior were to encourage activities of choice, encourage family involvement, encourage independence, (continued on next page)

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	155292	A. Building B. Wing	03/25/2026

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encourage resident to verbalize fears and anxiety. The expected benefits from medication use was to decrease anxiety. A nursing progress note, dated 3/16/26 at 5:53 a.m., indicated Resident 6 appeared restless throughout the night. Staff attempted multiple times to redirect resident and assist her to her bed and wheelchair; however, redirections were difficult and largely unsuccessful. She became combative during care and resistive to assistance. Resident 6 remained in wheelchair at nursing station to ensure safety. On 3/18/26 at 9:30 a.m., Resident 6 was observed sitting in her wheelchair in the hallway on the dementia care unit with staff standing around her. She was holding a stuffed cat that meowed and purred. She was petting the cat and talking about the cat's name and how much she loved the cat and smiling when it meowed. A Behavior Communication Note, dated 3/18/26 at 12:33 p.m., indicated that at 12:00 p.m., Resident 6 was in the dining room and had punched a staff member in the cheek. The interventions attempted was to move her away from all other residents and she was put on one-on-one for monitoring and safety. The interventions were effective. A NP Acute Care Progress Note, dated 3/18/26, indicated Resident 6 was seen due to violent behavior. She had punched a staff member and another resident in the common area. She had been moved to a separate area and appeared to calm down. An additional dose of as needed lorazepam was given. During an interview on 3/19/2026 at 3:39 p.m., Activity Aide (AA) 26 indicated if residents displayed behaviors, she would tell the nurse so that the behavior could be documented. During an interview on 3/19/26 at 3:42 p.m., CNA 27 indicated when Resident 6 was agitated, CNA 27 would offer to rub her back, talk with her, and offer reassurance. CNA 27 informed the nurse of any behaviors so that they could be documented. During an interview on 3/20/2026 at 1:19 p.m., LPN 23 indicated Resident 6 had ups and downs. Resident 6 could be sweet and the next minute she doesn't want to be bothered. Resident 6 loved cats. The staff would use her stuffed cat to redirect her, and it helped. At times Resident 6 became overstimulated and when she was taken to a quiet place she would calm down. If Resident 6 was wandering, LPN 23 would ask her if she needed to go to the bathroom. Normally, after being taken to the bathroom, Resident 6 would calm down. The behavioral care plan had not been updated with the interventions of using Resident 6's stuffed cat to distract and/ or redirect her or to offer to take Resident 6 to the bathroom when she was wandering. During an interview on 3/23/25 at 2:34 p.m., LPN 23 indicated Resident 6 had not made physical contact with another resident since being on the dementia care unit. On 3/20/26 at 2:24 p.m., the Executive Director provided the Behavior Management Policy, last revised August 2022, that read .It is the policy of American Senior Communities to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expressions.Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other resident or caregivers. Care plan interventions should include individualized and non pharmacological interventions which address both proactive and responsive interventions.If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/Worsening Behavior Event. New or worsening behaviors are reviewed by the IDT for assessment and preventative actions.The IDT review is a discussion with the team as to the behavioral expression, an evaluation of interventions, presentation of new interventions if applicable and an assessment of any underlying causes of the behavior [ie pain, environmental stressor, medical illnesses, etc]. The root cause and preventative interventions will be included in the resident's plan of care.If the behavioral expression is not new, worsening or high risk; the nurse will record the behavior in the progress notes using the Behavior Communication Note. The IDT will review progress notes the next business day to determine if immediate follow up action is required for the Behavior Communication. If the behavior requires an interdisciplinary response as described above, the IDT will complete the IDT Behavior Review. If not, the plan of care will be reviewed and updated if needed to include a description of the behavior and effective intervention. 410 IAC (Indiana Administrative Code) 16.3.1-37

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure a resident received the correct medications for 1 of 6 residents reviewed for unnecessary medications. (Resident 51)Findings include:The clinical record for Resident 51 was reviewed on 3/17/25 at 12:00 p.m. The diagnosis for Resident C included, but was not limited to, heart failure (heart cannot pump enough blood throughout the body). An interview was conducted with Resident 51 on 3/17/26 at 12:21 p.m. He indicated he had to monitor the staff with administration of his medications. The nurse had given him in error his roommates evening medications a couple of months ago. He was monitored by staff afterward, and there were no adverse effects from the error. A nursing progress note dated 1/11/26 at 8:25 p.m. indicated the nurse administered metoprolol 100 milligrams (mg) and metformin 500 mg scheduled for another resident (Resident D) to Resident C. New orders were received to monitor Resident C's Blood pressure and pulse every 4 hours overnight to watch for hypotension (low blood pressure). The resident continued sitting on the side of the bed conversating with roommate, no concerns or comments noted at that time and the nurse would continue to monitor. An interview was conducted with the DNS on 3/24/26 at 3:00 p.m. She indicated License Practical Nurse (LPN) 8 had received education after she administered the wrong medication to Resident 51.A medication administration procedure guide was provided by the Executive Director on 3/24/26 at 12:02 p.m. It indicated, .Procedures for all medications.2nd step. The 5 rights of medication performed: Right Resident, Right Medication, Right Dose, Right Route, Right Time. 410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(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 ensure gloves were doffed and hand hygiene was performed timely during incontinent care and that a resident's urinary catheter tubing was not dragging on the floor for 2 of 3 residents reviewed for activities of daily living (Resident 54 and Resident 102).Findings include:1 The clinical record for Resident 102 was reviewed on 3/24/26 at 2:10 p.m. The resident's diagnosis included, but was not limited to, dementia (mental decline). On 3/24/26 at 2:10 p.m., Certified Nursing Assistant (CNA) 29 was observed performing incontinent care for Resident 102. CNA 29 performed hand hygiene (HH), donned gloves, and removed Resident 102's pants and opened his brief. Resident 102 had been incontinent of stool. CNA 29 assisted Resident 102 to turn to his side and performed incontinent care. CNA 29 did not doff soiled gloves or perform hand hygiene. CNA 29 then put a clean incontinent brief on Resident 102, assisted Resident 102 out of his shirt and to put a gown on him. CNA 29 then doffed his gloves and performed hand hygiene. During an interview on 3/24/26 at 2:28 p.m., CNA 29 indicated he normally changed his gloves and performed hand hygiene after doing incontinent care and prior to assisting a resident to dress in clean items. 2. The clinical record for Resident 54 was reviewed on 3/18/26 at 2:10 p.m. The resident's diagnosis included, but was not limited to, obstructive and reflux uropathy (a condition where urine flow was blocked or flows backward). A current care plan, last reviewed on 3/19/26, indicated Resident 54 required an indwelling urinary catheter related obstructive uropathy. The goal was for her to have her catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infections or urethral trauma (damage to the tube that carries urine from the bladder). The interventions included, but was not limited to, staff were to not allow the catheter tubing or any part of the drainage system to touch the floor. On 3/24/26 at 2:30 p.m., Resident 54 was observed in the common area around nurses station. Two nursing staff were standing by her. Resident 54 was wheeling back and forth, talking out loud and her catheter tubing was dragging on the floor. Resident 54 ran over her catheter tubing with her wheelchair. Resident 54 then wheeled herself behind the nurses station. Nursing staff were present in the nursing station. Resident 54's catheter tubing continued to drag on the floor. On 3/24/26 at 3:10 p.m., Resident 54 was observed in her wheelchair, rolling herself in the hallway with her catheter tubing dragging on the floor. Two nursing staff were at the medication cart in the hallway. Resident 54 requested for someone to help her up the hallway. The nursing staff came to talk with Resident 54 and attempted to assist her up the hallway. Resident 54's catheter tubing continued to be on the floor. During an interview on 3/24/26 at 3:15 p.m., the Assistant Director of Nursing indicated that Resident 54's catheter tubing should not be on the floor. 410 IAC (Indiana Administrative Code) 16.3.1-18(l)