STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER Byron Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1661 Beacon Street Fort Wayne, IN 46805	

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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 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 proper labeling, storage, and sanitation were maintained in the kitchen. 103 of 103 residents who resided in the facility and received food from the kitchen.Findings include:During an initial observation of the kitchen on 3/25/2026 at 9:12 AM, the following items in the walk-in freezer were observed to be open to air, undated and did not contain an expiration date: one bag of frozen chips and one box of cinnamon rolls.In the refrigerator, a container of beef base was observed to be open, without a lid and did not contain an open date or expiration date.In dry storage, the following items were observed to be open, undated and did not contain an expiration date: elbow macaroni removed from its original packaging and placed in a plastic container, two bags of bread with approximately 10 slices each, one bag with 11 hamburger buns, two bags with one submarine bun each and one bag of whole wheat bread with three slices.On the countertop in the kitchen, the following items were observed to be open, tied in a knot and did not contain an open or expiration date: two bags of bread with six slices each, one bag of bread with 11 slices and one bag of bread with 20 slices.In the reach-in freezer, a box of frozen hamburgers was observed to be open to air and did not contain an open or expiration date.On the spice rack, a container of dill weed seasoning was observed to be open and did not contain a lid.On the back cabinets, Raisin Bran and Trix cereal were observed to be removed from their original packaging and placed in separate plastic containers that did not contain an open date.During an interview, on 3/25/2026 at 9:20 AM, the Dietary Manager (DM) indicated the facility labeled and dated all items when opened. The DM indicated the facility followed expiration dates if items remained in their original packaging. The DM confirmed the items identified did not contain an expiration date or open date. The DM further indicated all food should have been closed when stored and should not have been left open to air.A current facility policy, Food Receiving and Storage Policy, dated 12/2008, provided by the DM on 3/26/2026 at 11:19 AM, indicated Dry food that are stored in bins will be removed from original packaging, labeled, and dated. All foods stored in the refrigerator or freezer will be covered, labeled, and date.2. During an observation of the kitchen, on 3/25/2026 at 9:12 AM, a set of keys was observed sitting on the steam table serving area. The handwashing sink was observed to contain brown chunks and white debris. The grill was observed to have black buildup between the grill grates and black char buildup underneath the grill grates. The grill foil was observed to have a large accumulation of black buildup.A review of the weekly cleaning list provided by the Executive Director on 3/26/2026 indicated the grill foil, grill grates and shelving were cleaned by the AM [NAME] on Monday, 3/23/2026. The cleaning list indicated the grill and stovetop were cleaned by the PM [NAME] on Tuesday, 3/24/2026.During an interview, on 3/25/2026 at 9:25 AM, the DM indicated the black buildup was from cooking breakfast. The DM indicated staff may have had food on their hands when using the handwashing sink. The DM also indicated the keys should not have been left on the kitchen serving area.A current facility policy, Cleaning and Sanitizing of Kitchen Equipment, dated 4/26/2025, provided by the DM on 3/26/2026 at 11:19 AM, indicated all food service equipment and food-contact surfaces shall be cleaned and sanitized between tasks and at a frequency that prevents contamination.410 Indiana Administrative Code (IAC) 16.2-3.1-21(i)(2) and (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
	155364	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Byron Health Center	1661 Beacon Street Fort Wayne, IN 46805

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, record review, and interview the facility failed to have effective implementation of interventions to maintain kitchen sanitation for 103 of 103 residents residing in the facility ate food prepared in the kitchen.Findings include: A review of survey results, dated 5/19/25, indicated the facility was cited for F812. The citation included maintaining sanitation, open food items, labeling of food, and food open being dated.During an observation, on 03/25/2026 at 9:12 AM, in the kitchen there was a bag of frozen chips and cinnamon rolls in freezer open to air no open dates. Beef base without an open date, elbow macaroni in clear bin without a date, white bread, whole wheat bread, hamburger buns, and sub buns without dates. Dill weed seasoning without a lid, open to air. These were similar issues compared to the recertification survey dated 5/19/25 with F812 being cited 2 years in a row. In an interview, on 3/31/26 at 9:59am, the Executive Director (ED) indicated herself and the Assistant Executive Director did various observations of the kitchens and kitchenettes of the neighborhoods. The ED did not have any documentation of the observations. The ED indicated the committee had been working on food temperatures, labeling, dating, and cleanliness since last April. The facility had some change over in the dietary aids and felt this corrected the problem until annual survey results. No policy was given at time of exit.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure cervical collars were provided and maintained for 2 of 2 residents reviewed (Resident 2, and Resident 20). Findings include:1) In an observation, on 03/25/2026 at 10:04 AM, Resident 2 was observed lying in bed with no cervical collar in place around her neck. In an observation, on 03/27/2026 at 10:43 AM, Resident 2 was observed lying in bed with no cervical collar in place around her neck. In an observation, on 3/30/2026 at 11:15 AM, a soft cervical collar was observed on the bedside stand next to Resident 2's bed. Resident 2's record was reviewed on 03/25/2026 12:27 PM. Diagnoses included cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. A current significant change Minimum Data Set (MDS) assessment, dated 1/21/2026, indicated Resident 2 had a Basic Interview for Mental Status (BIMS) score of 9 (moderate cognitive impairment). A review of physician orders, dated 12/11/2025, indicated Resident 2 should wear a cervical collar while in bed and for all meals for contracture of the neck management. Nurse Practitioner's (NP) Progress notes, dated 12/12/2025 at 7:45 AM, indicated Occupational Therapy had suggested use of a soft cervical collar to maintain neck alignment when eating meals. The NP indicated Resident 2 liked wearing the collar and wanted to wear it more frequently than current order parameters. No additional progress notes pertaining to use or refusal of Resident 2's cervical collar were available for review. Resident 2's current care plan, dated 1/26/2026, did not address use or refusal of a soft cervical collar. A current CNA Kardex, provided by the Administrator on 3/30/2026 at 1:26 PM, did not include instructions for the use of a soft cervical collar for Resident 2. In an interview, on 03/30/2026 12:56 PM, Certified Nurse Aide (CNA) 11 indicated Resident 2 trialed a cervical collar for meals only a few weeks ago but was unsuccessful. CNA 11 indicated she understood the collar was discontinued due to non-use. In an interview, on 03/30/2026 1:08 PM, the Director of Nursing (DON) indicated the facility had been discussing with the family Resident 2's decline in eating. The DON indicated a soft collar was used when Resident 2 was eating meals consistently. The DON indicated Resident 2 was being offered food for pleasure only and would be receiving a feeding tube soon, so the soft cervical collar was not being used. In an interview, on 03/30/2026 at 2:10 PM, the DON indicated Resident 2's cervical collar was currently in the laundry because it was dirty. The DON indicated any refusal should have been (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented, and frequent refusals should have been cause for re-evaluation of the appropriateness of the device. The DON indicated the cervical collar was normally used for eating, but Resident 2 preferred to wear the device more often. She indicated the terms of the order were a compromise to accommodate Resident 2's preferences. The DON indicated the order should have been entered into the computer requiring a sign-off of acceptance or refusals each shift to track usage. In an interview, on 03/31/2026 at 8:42 AM, The Director of Therapy (DOT) indicated Resident 2 had a soft cervical collar implemented for a right-sided contracture of the neck. The DOT indicated Resident 2 had initially refused to take the cervical collar off, wishing to wear the collar while up in her chair and during meals. The DOT indicated she heard about Resident 2 refusing the collar about a month ago. The DOT indicated documentation of Resident 2 refusing the collar was the responsibility of the nursing department. A current policy, titled Braces and Assistive Devices- Assessment and Management, dated 10/23/2025, provided by the Administrator on 3/30/2026 at 12:47 PM, indicated refusals and follow up actions pertaining to an assistive device use should be documented and the care plan should be updated. The policy indicated the care plan should address the type of device, application instructions, monitoring guidelines, and any specific risks. 2. During an observation, on 3/25/2026 at 1:39 PM, Resident 20 was observed with her head leaning to the left side. Resident 20 was observed not to have her mechanical back splint in place. A food tray was in front of the resident, the plate was full and the chocolate milk was untouched. Resident 20 was not eating. During an observation, on 3/26/2026 at 1:34 PM, Resident 20 was observed with her head leaning to the left side and was not wearing her mechanical back splint. A food tray was in front of the resident with a food cover over the plate. During an observation, on 3/27/2026 at 12:37 PM, Resident 20 was observed with her head leaning to the left side and was not wearing her mechanical back splint. A full food tray was in front of the resident and she was not eating. Resident 20's record was reviewed on 3/25/2026. Diagnoses included unspecified intracranial injury with loss of consciousness of unspecified duration, hemiplegia affecting the left non-dominant side and traumatic subarachnoid hemorrhage without loss of consciousness. A review of the current care plan indicated Resident 20 had a problem of activities of daily living (ADL) self-performance deficit, with a goal to continue to feed herself meals with supervision through the next review. Interventions included application of a cervical/back splint during meals and removal after meals. A review of physician orders, dated 2/17/2025 at 5:30 PM, indicated the resident was to wear a cervical brace during all meals, angled approximately 30 degrees in extension, with a towel under the brace to reduce pressure. A review of the record indicated the last Minimum Data Set (MDS) assessment was completed on 1/6/2026. The MDS did not indicate Resident 20 utilized splints or braces. On 3/30/2026 at 10:19 AM, Resident Engagement (RE) provided a delivery receipt, dated 3/8/2026, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for a back splint strap cover for Resident 20. During an interview, on 3/27/2026 at 12:39 PM, Certified Nursing Assistant (CNA) 9 indicated Resident 20 should have had the brace on; however, she may have removed it. CNA 9 asked the resident if she wanted the brace applied and the resident indicated she did. CNA 9 assisted with applying the brace however, Resident 20's head slipped out. CNA 9 repositioned the resident and attempted to reapply the brace again, but the resident's head slipped out again. CNA 9 indicated Resident 20's head continued to fall out of the brace and stated she was unsure if anyone had notified the Nurse Practitioner or Therapy regarding the issue. CNA 9 indicated she would obtain additional staff assistance. During an interview, on 3/27/2026 at 12:47 PM, CNA 10 attempted to position Resident 20's head in the brace however, the Velcro released and the resident's head fell forward. CNA 10 indicated the facility had recently repaired the Velcro on the brace. CNA 10 indicated Resident 20 was sliding further into her seat and the Velcro was unable to support her head. CNA 10 indicated she had not been instructed to implement any alternative interventions if the brace was ineffective and was unaware if the Nurse Practitioner or therapy had been notified. CNA 10 attempted to reposition the resident again however, the resident's head continued to fall out of the brace. CNA 10 asked Resident 20 if she wanted her to assist her with eating, Resident 20 indicated she did. During an interview, on 3/30/2026 at 9:56 AM, the Director of Therapy (DOT) indicated therapy was initially responsible for the brace however, after discharge from therapy services, any issues were managed by restorative nursing. The DOT indicated therapy completed screenings every three months to ensure the assistive device remained appropriate. The DOT indicated she was aware that the Velcro had continued to come undone. The DOT did not indicate any other actions had been taken to ensure Resident 20's brace was safe and fit properly. During an interview, on 3/30/2026 at 10:10 AM, the DOT indicated the last assessment was completed on 10/26/2025 and indicated therapy completed quarterly screenings to ensure appropriateness of assistive devices. The DOT did not indicate any additional actions were taken when staff informed them a brace or splint was not fitting properly. During an interview, on 3/30/2026 at 10:10 AM, the RE indicated the Velcro for Resident 20's brace was replaced on 3/8/2026. RE indicated staff had not reported any ongoing issues and indicated she was not made aware of concerns with the brace prior to last week. During an interview, on 3/30/2026 at 1:48 PM, Qualified Medication Aide (QMA) 15 indicated nursing staff should notify restorative nursing through the facilities internal communication systems to report issues with assistive devices. QMA 15 indicated restorative nursing would notify therapy if needed. QMA 15 further indicated that a resident's head slipping out of an assistive device was a condition that should have been reported. During an interview, on 3/31/2026 at 8:41 AM, the DOT indicated therapy initially recommended the assistive device due to positioning concerns identified by social services and occupational therapy completed the assessment and trial. The DOT stated Resident 20 was missed for her scheduled reassessment, which should have occurred approximately three months after the last assessment. The DOT indicated the resident was on the list for reevaluation as therapy was waiting for an order. A current facility policy, dated 7/31/2024, provided by the Executive Director, indicated the facility (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will assess all residents for the need and proper use of braces and assistive devices upon admission, with changes in condition and periodically as part of the comprehensive care plan process. nursing staff would report changes in mobility or tolerance. and reassess quarterly with MDS review. 410 IAC (Indiana Administrative Code) 16.2-3.1-42(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview the facility failed to ensure neurological assessments were completed after falls for 3 of 8 residents reviewed. (Resident 6, Resident 13, and Resident 29)Findings include: Resident 6's record review began on 3/25/26 at 1:36pm. Diagnosis included epilepsy, dementia, and diabetes. In an interview, on 03/26/2026 at 1:46 PM, Licensed Practical Nurse 8 (LPN), explained the procedure for unwitnessed fall follow through. LPN 8 explained staff assess the resident for any injuries, attempt to figure out the cause of the fall, start neurological assessments, then did neuros every 15mins afterward x4, then neurological assessment (neuros) every hour x4, and then neuros every shift x 72 hours. The nurse would contact the provider and family. The nurse was to do a skin assessment, post fall assessment, dehydration assessment, and document findings in a progress note. In an interview, on 03/27/2026 at 11:12 AM, DIrector of Nursing (DON) indicated neuros were to be done after an unwitnessed fall every 15 minutes for the first hour, then hourly x4, and then every shift x3 days. Medical provider and family were to be notified. After each fall an intervention should be put into the care plan. A morse fall scale assessment should be done. On 3/30/26 at 10:15am, a review of Resident 6's neurological assessments indicated the following assessments were not completed for an unwitnessed fall:11/29/25 23:00 and 23:5811/30/25 1:03am and 2:00am 12/1/25 2nd shft12/2/25 3rd shift 2. Resident 13's record review began on 3/25/26 at 11:42am diagnosis included epilepsy, dementia, and diabetes.Resident 13's current care plan, dated 2/3/25, indicated he was at risk of falling. With a goal for fall to be minimized using care plan interventions to prevent injury through next review period. One intervention was to follow facility fall protocol. A review of neuro assessments indicated 9/16/25, 9/17/25 and 9/18/25 were missing 2nd shift neurological assessments.A review of neuro assessments, dated 12/20/25, was missing assessments at the following times; 10:20am, 10:35am, 10:50am, 11:05am, 12:05pm, 1:05pm, 2:05pm, and 3:05pm.A review of 12/21/25 neuro assessments indicated there were missing assessments for 1st and 2nd shift. A review of neuro assessments, dated 3/17/25, indicated no neuro assessment, were documented for the following times 4:15am, 4:30am, 5:30am. There were no neurological assessments every shift x72 hours for the dates of 3/18/25, 3/19/25, and 3/20/25.3. Resident 29's record review began on 3/25/26 at 12:41pm. Diagnosis included dementia, abnormal posture, and diabetes.In an interview, on 03/27/2026 at 2:04 PM, the DON indicated she was unable to locate neuros for the following falls: 4 on 11/10/25, 1 on 11/11/25, 1 on 11/12/25 and two on 11/13/25. The DON indicated the nurses began the 10/24/25 fall neurological assessments. She was unsure what happened the next three days. She was unable to find neuro assessments dated 10/25 through 27/2025 for Resident 29. A current policy, titled Falls Clinical Protocol, dated 11/16/17 was provided by the Executive Director on 3/26/26 at 11:29am indicated the following: In addition, the nurse shall assess and document/report the following:.Vital signsRecent injury, especially fracture or head injuryMusculoskeletal function, observing for change in normal range of motion, weight bearing, etc.Change in cognition or level of consciousnessNeurological statusPainFrequency and number of falls Precipitating factors, details on how fall occurredAll current medications, especially those associated with dizziness or lethargyAll active diagnosis. There were no specific directions of how often neurological assessments were to be done in the policy. 410 IAC (Indiana Administrative Code) 3.1-45(a)

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F 0742 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 mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a verbalization of suicidal ideation was investigated for 1 of 1 resident reviewed (Resident 77).Findings include:Resident 77's record was reviewed on 03/25/2026 at 11:25 AM. Diagnoses included Alzheimer's disease, anxiety, and depression.A current admission Minimum Data Set (MDS) assessment, dated 1/27/2026, indicated Resident 77 had a Basic Interview for Mental Status (BIMS) score of 4 (cognitively impaired).Resident 77's current care plan, dated 4/26/26, titled depression with history of suicidal ideation, indicated Resident 77 had a problem of depression. Interventions included redirecting Resident 77 when making comments related to suicidal ideation and notifying a supervisor immediately when suicidal comments were made.A progress note, dated 3/9/2026, at 4:24 PM, indicated Resident 77 told Volunteer 4 she had nothing to live for and wanted to kill herself. No additional progress notes regarding suicidal ideation were available for review. In an interview, on 03/27/2026 at 11:07 AM, the Director of Nursing (DON) indicated any resident verbalizing suicidal ideation should be asked if they had a plan to harm themselves. The DON indicated the resident's care plan for those types of issues should be reviewed and followed. The DON indicated a resident voicing suicidal ideation may be sent out for inpatient psychiatric care by the nurse practitioner if deemed appropriate. In an interview, on 03/27/2026 at 11:38 AM, Qualified Medicine Aide (QMA) 3 indicated upon a verbalization of suicidal ideation, staff should contact a supervisor and remain with the resident ensuring safety until given further instructions. QMA 3 indicated she was not aware of any recent statements by any residents. QMA 3 indicated she regularly worked on the unit Resident 77 resided on. QMA 3 indicated upon admission several months ago, Resident 77 was confused, and made suicidal remarks. QMA 3 indicated she was not aware of Resident 77's suicidal verbalization on the 9th of this month. In an interview, on 03/27/2026 at 11:45 AM, Life Enrichment Specialist (LCS) 2 indicated volunteers filled out a visit log describing 1 to 1 visits conducted with residents. LCS 2 indicated she collected 1 to 1 visit logs and entered visit notes into the computer on a weekly basis, LCS 2 indicated she read the statement of suicidal ideation on 3/18/2026 when she entered the log into the computer. LCS 2 indicated she should have reported the statement of suicidal ideation to the Resident Engagement Specialist as soon as she was aware. A document titled 1:1 log, provided by the Administrator on 03/27/2026 12:40 PM, indicated during a 3-minute visit with Volunteer 4 on 3/9/2026, Resident 77 indicated she had nothing to live for and wanted to kill herself . In an interview, on 03/27/2026 11:57 AM, Volunteer 4 indicated Resident 77 told him she had nothing to live for and wanted to kill herself on 3/9/2026. Volunteer 4 indicated he said kind words to Resident 77 and offered support. Volunteer 4 indicated he was unable to immediately find the unit nurse, so he went to the adjacent unit and reported the verbalization to the staff on that unit. In an interview, on 03/27/2026 1:13 PM, the Administrator indicated upon a report of suicidal verbalizations, staff should notify the nursing supervisor, initiate policy interventions such as performing a [NAME] suicide risk assessment and ensuring resident safety. The Administrator indicated results of the assessment should be reported to the provider and staff should follow any ensuing orders The Administrator indicated she had just become aware of the verbalization and was investigating where the communication lapse had occurred.A current policy, titled Suicide Threats, dated 2/28/2018, provided by the Administrator on 3/27/2026 at 12:51 PM, indicated staff should report any threats of suicide immediately to the Nurse Supervisor while maintaining supervision of the resident. The Nurse Supervisor or Resident Engagement Specialist should complete a Columbia Suicide Severity Rating Scale for the resident and report findings to the provider. Any applicable provider orders should be followed, and the details of the situation should be documented.410 IAC (Indiana Administrative Code) 16.2-3.1

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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 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 appropriate infection control practices related to the storage of resident care equipment for 1 of 2 residents reviewed (Resident 79).Findings include:During an observation on 3/25/2026 at 10:11 AM, the following was observed: Resident 79 was sitting in a recliner in his room and had a portable urinal bottle with yellow liquid inside hanging by the handle on the trash bin, dated 3/19/2026.During an observation on 3/26/2026 at 1:27 PM, the following was observed: Resident 79 was sitting in a recliner in his room and had a portable urinal bottle with yellow liquid inside hanging by the handle on the trash bin.During an observation on 3/27/2026 at 12:47 PM, the following was observed: Resident 79 was sitting in a recliner in his room and had a portable urinal bottle with yellow liquid inside hanging by the handle on the trash bin. A glove, plastic drinking cup, piece of folded paper and three paper towels were observed in the trash can.During an observation on 3/27/2026 at 1:15 PM, the following was observed: Resident 79 had a portable urinal sitting on top of his table. Also on the table were three remote controls and a piece of folded paper.Resident 79's record was reviewed on 3/25/2026. Diagnoses included altered mental status and diabetes mellitus.A review of Resident 79's current care plan did not indicate the resident required a urinal to be kept at the bedside or within immediate reach while seated in a recliner.In an interview on 3/27/2026 at 12:47 PM, Certified Nursing Assistant (CNA) 9 indicated the portable urinal hanging on the trash can was an infection control concern. CNA 9 indicated she was unsure where to place the urinal, as the resident's table had items on it. CNA 9 indicated Resident 79 went to the bathroom often and liked to have the urinal close by. Certified Nursing Assistant (CNA) 9 indicated she would dump the urinal and provide a fresh urinal.In an interview on 3/27/2026 at 12:47 PM, the Director of Nursing (DON) indicated that after a resident used a portable urinal, staff were expected to clean it and place it on the back of the toilet. The DON indicated clean portable urinals should be stored on the back of the toilet when not in use. The DON indicated this was the first time she had been made aware of Resident 79 storing the urinal on the trash can. The DON indicated the care plan should reflect if a resident preferred to have the urinal stored close by. The DON indicated Resident 79's care plan did not indicate such a preference.A current policy dated 10/2010, provided by the Executive Director, indicated: If the resident keeps his urinal at his bedside, check it frequently. Empty and clean it as necessary. Note on the resident's care plan his request to keep the urinal at his bedside. Remove urinal. Place it on a paper towel on the bedside stand. Cover the urinal immediately with a urinal cover or paper towel. Clean wash basin and return to designated storage area.410 IAC (Indiana Administrative Code) 16.2-3.1-18(a)