STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155480	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Envive of Brookville	11049 State Road 101 Brookville, IN 47012

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer and provide education on the 2025-2026 Covid-19 vaccination and maintain documentation of such for 5 of 5 residents reviewed. (Residents 3, 7, 9, 10, and 12) Findings include: 1. The clinical record for Resident 3 was reviewed on 3/27/26 at 1:15 p.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease (a progressive, treatable lung disease, mainly caused by smoking or long-term irritant exposure, that restricts airflow and causes breathing difficulties) and hypertensive heart disease with heart failure (condition that occurs when chronic high blood pressure forces the heart to work harder, leading to thickened or weakened heart muscle that cannot pump effectively). She was admitted to the facility on [DATE]. There was no 2025-2026 Covid-19 vaccination information in the clinical record to indicate she accepted or refused the vaccination or was provided education regarding the vaccination. 2. The clinical record for Resident 7 was reviewed on 3/27/26 at 1:15 p.m. Her diagnoses included, but were not limited to, diabetes (a chronic condition characterized by high blood sugar levels caused by insufficient insulin production or ineffective insulin use) and hypertension (a chronic condition where blood force against artery walls is consistently too high, forcing the heart to work harder). She was admitted to the facility on [DATE]. There was no 2025-2026 Covid-19 vaccination information in the clinical record to indicate she accepted or refused the vaccination or was provided education regarding the vaccination. 3. The clinical record for Resident 12 was reviewed on 3/27/26 at 1:15 p.m. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (a progressive, treatable lung disease mainly caused by smoking or long-term irritant exposure that restricts airflow and causes breathing difficulties) and chronic kidney disease (the long-term, irreversible loss of kidney function, preventing the filtration of blood, waste buildup, and blood pressure regulation). He was admitted to the facility on [DATE]. There was no 2025-2026 Covid-19 vaccination information in the clinical record to indicate he accepted or refused the vaccination or was provided education regarding the vaccination. 4. The clinical record for Resident 10 was reviewed on 3/27/26 at 1:15 p.m. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease and hypertension. He was admitted to the facility on [DATE]. There was no 2025-2026 Covid-19 vaccination information in the clinical record to indicate he accepted or refused the vaccination or was provided education regarding the vaccination. 5. The clinical record for Resident 9 was reviewed on 3/27/26 at 1:15 p.m. Her diagnoses included, but were not limited to, emphysema (a chronic, progressive lung disease, typically caused by smoking or long-term exposure to air pollution, that destroys the alveoli, leading to severe shortness of breath,) and hypertension. She was admitted to the facility on [DATE]. There was no 2025-2026 Covid-19 vaccination information in the clinical record to indicate she accepted or refused the vaccination or was provided education regarding the vaccination. An interview was conducted with the Infection Preventionist on 3/27/26 at 11:34 a.m. She indicated they offered the Covid-19 vaccination to all residents on a yearly basis and provided the CDC (Centers for Disease Control) Fact Sheet on Covid-19 vaccination to residents at that time. An (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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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview was conducted with the Director of Nursing (DON) on 3/27/26 at 3:00 p.m. She indicated there was no documentation to indicate the residents were offered the 2025-2026 Covid-19 vaccination to the above five residents or staff provided the residents with education on the vaccination. The facility had offered vaccination consents in the past in the residents admission packet, but the facility no longer did that. The 2025-2026 COVID-19 Vaccination Guidance from the CDC (Centers for Disease Control,) effective 11/4/25, indicated, For Health Care Providers.The 2025-2026 COVID-19 vaccine is recommended for people ages 6 months and older based on individual-based decision-making (also known as shared clinical decision making). The recommended vaccine and number of doses are based on age and vaccination history. People can self-attest to factors that increase their risk for severe COVID-19 and receive COVID-19 vaccination.COVID-19 vaccination is recommended for all adults ages 65 years and older based on individual-based decision-making (also known as shared clinical decision-making). For people ages 6 months-64 years, vaccination is recommended based on individual-based decision-making (also known as shared clinical decision-making) with an emphasis that the risk-benefit of vaccination is most favorable for individuals who are at an increased risk for severe COVID-19 disease and lowest for individuals who are not at an increased risk, according to the CDC list of COVID-19 risk factors. In addition to the CDC list, the Moderna (Spikevax) package insert states that prematurity (birth at <37 weeks gestational age) has been associated with COVID-19-related hospitalizations in children ages 6-23 months. Additionally, some people may be at increased risk for SARS-CoV-2 infection including healthcare workers and residents and employees in long-term care facilities and other residential congregate settings.The Covid-19 Vaccination Education and Administration policy was provided by the Administrator on 3/25/26 at 11:34 a.m. It indicated, To protect LTC [long term care] residents from COVID-19, this facility shall adhere to the following procedures in effort to meet each resident's, resident representative, and staff member's information/educational needs and provide vaccines to all residents that elect them. Education.All residents and/or resident representatives and staff shall be educated on the COVID-19 vaccine they are offered, in a manner they can understand, including information on the benefits, risks, and common reactions (i.e., aches, fevers, and, in rare cases, anaphylaxis) consistent with CDC and/or FDA [Food and Drug Administration] information and shall be provided the FDA COVID-19 EUA [emergency use authorization] Fact Sheet before being offered the vaccine. If the vaccination recommends multiple doses of vaccine, the resident or resident representative and staff shall again be provided with education regarding the benefits and potential side effects of the vaccine and current information regarding those additional doses, including any change in the benefits or potential side effects, before requesting consent for administration of any additional doses. Offering Vaccinations.This facility shall offer residents and staff vaccination against COVID-19. Screening individuals prior to offering the vaccination for prior immunization, medical precautions and contraindications shall be conducted to determine whether they are appropriate candidates for vaccination at any given time. The vaccine may be offered and provided directly by this facility or indirectly, such as through an arrangement or referral to a local vaccination site or local health department.If a resident or staff requests vaccination against COVID-19 but missed earlier opportunities for any reason, this facility shall offer the vaccine to that individual as soon as possible. If the vaccine is unavailable in the facility, the facility shall provide information on obtaining vaccination opportunities (e.g., health department or local pharmacy) to the individual. This facility shall provide evidence, upon request, of efforts made to make the vaccine available to its residents and staff. Like influenza vaccines, if there is a manufacturing delay, the facility shall provide evidence of the delay, including efforts to acquire subsequent doses, as necessary. Indications and contraindications for COVID-19 vaccination are evolving, and this facility shall remain alert to any new or revised guidelines/recommendations issued by the CDC, FDA, vaccine manufacturers, or other expert stakeholders.Documentation of Resident Vaccination.The resident's medical record shall include documentation that indicates, at minimum, that the resident or resident representative was (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided education regarding the benefits and potential side effects of the COVID- 19 vaccine, and that the resident (or representative) either accepted and received the COVID-I9 vaccine or did not receive the vaccine due to medical contraindications, prior vaccination, or refusal.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure residents maintained dignity by answering call lights in a timely manner, resulting in incontinence leading to residents feeling uncomfortable and embarrassed for 2 of 4 residents reviewed for resident rights. (Resident F and Resident E) Findings include: 1. The record for Resident F was reviewed during the survey. The diagnoses included, but were not limited to, obstructive uropathy (a structural or functional blockage of urine flow anywhere along the urinary tract, from the kidneys to the urethra) and weakness. The most recent care plan for Resident F indicated they needed assistance with moderate assistance with toileting. The interventions for their bowel continence included, but were not limited to, assisting to sit on the toilet and providing toileting at the same time every day. The most current minimum data set assessment indicated Resident F was cognitively intact, did not exhibit behaviors, and was frequently incontinent of bowel. An interview completed during the survey with Resident F indicated they needed assistance with toileting needs. In the weekend prior to the survey, they had turned on their call light to use the bathroom and had to wait over an hour to get assistance. Because of the prolonged wait time, Resident F became incontinent of their bowels which made Resident F feel .uncomfortable and embarrassed . 2. The clinical record for Resident E was reviewed on 03/25/2026 at 12:57 p.m. The diagnoses included, but were not limited to Multiple Sclerosis (a chronic autoimmune disease of the central nervous system), generalized anxiety disorder, chronic pain syndrome, and neuromuscular dysfunction of the bladder (a condition where nerve damage disrupts brain-bladder communication, causing overactive or underactive bladder behavior). A Quarterly Minimum Data Set (MDS) assessment, dated 1/9/26, indicated Resident E was cognitively intact for daily decision making, had no behaviors exhibited for rejection of care, had impairments to bilateral upper extremities, and used a wheelchair for ambulation. Resident E was dependent lying to sitting and sitting to stand, depended on chair transfers, and was on a scheduled pain medication regimen. During an interview with Resident E on 3/24/26 at 10:07 a.m., they indicated a couple nights prior they started to get really uncomfortable lying in bed and the only thing that usually helped was repositioning or getting out of bed. Resident E indicated she turned her call light on and twenty minutes later a Certified Nursing Assistant (CNA) entered the room, her body was turned toward the door, so she did not know who it was. Resident E told the CNA she was hurting bad and needed to get up and reposition. The CNA then told Resident E that she did not have time for that right now because her partner was on break and walked out of the room. Resident E indicated it then took 40 more minutes to come back into the room to help her get up and reposition. Resident E indicated she timed it on her clock and it took a total of an hour before her needs were addressed. Resident E was very upset and worried about other residents who do not have the capability to speak up for themselves (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and thought that if they were ignoring her that much, then how much are they ignoring the residents who cannot speak up for themselves and were they getting the care they deserved either. A plan of care, dated 4/25/25, indicated Resident E had acute/chronic pain related to fibromyalgia. The interventions included, but were not limited to, anticipate the resident's need for pain relief and respond immediately to any complaint of pain and to attempt non-pharmacological interventions. A Resident's Rights policy was provided by the Administrator on 3/25/26 at 10:10 a.m. It indicated .The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident. This Citation relates to intake 2961693 and 2700913 410 IAC (Indiana Administrative Code) 3.1-3(a) 410 IAC 3.1-38(a)(2)(C)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to ensure a resident's right to be free from misappropriation of their narcotic medication for 1 of 1 resident reviewed for misappropriation. (Resident B) Findings include:A facility reported incident, dated 1/29/26, indicated a nurse noted a sleeve of 6 narcotic pills were missing from the narcotic box that belonged to Resident B. The clinical record for Resident B was reviewed on 3/25/2026 at 2:21 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, irritable bowel syndrome (chronic functional gastrointestinal disorder affecting the large intestine, characterized by abdominal pain, bloating, and diarrhea or constipation), and idiopathic chronic gout (a severe, long-term form of inflammatory arthritis). The Quarterly Minimum Data Set (MDS) assessment, dated 1/8/26, indicated Resident B was cognitively intact for decision making, used opioid medication, received scheduled and prn (as needed) pain medications, had pain frequently, and occasionally their pain would interfere with daily activities. A physician's order, dated 8/14/25, indicated Resident B had Percocet 5-325 mg (milligram) oral tablet, give one tablet by mouth every 8 hours as needed for neck pain. During an interview with the Administrator on 3/26/26 at 1:05 p.m., they indicated they were notified 1/29/26 in the afternoon by the Director of Nursing (DON) that a sleeve of 6 Percocet were missing from the narcotic lock box and the narcotic sheet was missing from the binder for Resident B. The Administrator indicated Registered Nurse (RN) 2 received the medication 1/28/26, signed off for them from the pharmacy, locked the 6 Percocet in the locked box, created a narcotic sheet, and placed it in the narcotic binder. On 1/29/26, Resident B had called out for pain medication. Licensed Practical Nurse (LPN) 4 went to the medication cart and there were no Percocet in the narcotic box nor a narcotic sheet in the narcotic binder. LPN 4 then informed the Administrator and DON about the missing medication. The Administrator indicated RN 3 was the last nurse to care for Resident B when the count was correct, then was incorrect. RN 3 told her that she knew the sleeve of medication had been in the locked box because she had given two pills throughout the night. RN 3 did not document giving the medication or assess Resident B's pain. Resident B indicated to the Administrator that she had not taken any pain medication the night of 1/28/26. The Administrator indicated through investigation and narcotic audits, they came to the conclusion that RN 3 was taking the medication, so she was ultimately terminated. RN 3 did not return to the facility after 1/29/26. During an interview with RN 2 on 3/26/26 at 1:25 p.m., they indicated they received a sleeve of 6 Percocet from the pharmacy for Resident B on 1/28/26. RN 2 indicated they put the 6 Percocet pills into the narcotic box on the medication cart and filled out a narcotic sheet and placed it in the narcotic binder. RN 2 indicated they did a narcotic count and handoff with RN 3 at the end of their shift and everything was correct. During an interview with LPN 4 on 3/26/26 at 5:23 p.m., they indicated they were going through the Electronic Health Record (EHR) to re-check who had pain medications due next for the day. LPN 4 noticed that Resident B did not have any pain medicine due and normally after lunch they would ask for a pain pill. LPN 4 indicated they thought maybe the resident was out of their Percocet and waited a little bit to see if pharmacy had a delivery when they came in that day. Pharmacy came in to the facility and informed LPN 4 that 6 Percocet were delivered the day before on 1/28/26 to RN 2 who signed off for them with a witness. LPN 4 indicated the pills along with the narcotic sheet were gone. LPN 4 indicated they did a narcotic report sheet sign off with RN 3 the morning of 1/29/26. LPN 4 indicated they counted all of the narcotic cards with RN 3 at shift change that morning and the hand off sheet did not look abnormal because it said there were 10 narcotic cards, which was what was counted and it should have been 11, but RN 3 had not added a card after a pharmacy delivery the night prior, she just removed the Percocet card from the drawer, so the sign off sheet said 10 and there were 10 cards, because throughout the night she did not add one to the hand off sheet, just placed the card in the drawer. RN 3 wrote 10 so it looked like nothing was added or subtracted. LPN 4 indicated they were supposed to sign out medication in pcc (point click care), but RN 3 would only sign the medication off (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the narcotic sheet and not pcc. LPN 4 indicated on the computer it showed RN 3 had not given any pain medication, but on the report hand off sheet, they documented they gave a pain pill, but there was no documentation because the narcotic sheet was missing, but on the report sheet they indicated they gave it. During an interview with the DON on 3/27/26 at 11:00 a.m., they indicated on 1/29/26 they were informed by LPN 4 that a card of Percocet 5mg with a quantity of 6 were missing from the narcotic drawer and the narcotic sheet from the binder was also missing. The DON immediately notified the Administrator and they initiated a search through all med carts, med rooms, and the nurse's station, but the search was unsuccessful. The DON indicated when she spoke with RN 3 who worked the prior night, she indicated she gave 3 Percocet that night. The DON indicated Resident B did not go without any pain medication and RN 3 was then placed on suspension. The DON indicated once a card was complete, the empty card and narcotic sheet was removed from the binder and it was given to the DON or Assistant DON. When pharmacy comes into the facility, we sign off on the medications that were delivered and get a copy for the facility. We then add the card count to the report sign off sheet so we know how many narcotic cards should be in that designated drawer. The January Medication Administration Record (MAR) indicated Resident B had not received any Percocet the night or early morning of 1/28/26 and 1/29/26. A plan of care, dated 3/17/25, indicated Resident B had acute/chronic pain. The interventions included, but were not limited to, administer analgesia per MD (physician) orders. The Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy was provided by the Administrator on 3/25/26 at 10:04 a.m. It indicated .Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.to protect residents from misappropriation by anyone including facility staff. This Citation relates to intake 2730371 410 IAC (Indiana Administrative Code) 3.1-28(a)

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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 assist a resident with feeding who had weight loss for 1 of 4 residents reviewed for nutrition. (Resident 8) Findings include:The clinical record for Resident 8 was reviewed on 03/25/2026 at 2:23 p.m. The diagnoses included, but were not limited to, dementia, epilepsy, dysphagia (difficulty swallowing), eating difficulties, and schizoaffective disorder (chronic mental health condition combining hallucinations, delusions, and disorganized speech with mania or depression). The Quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, indicated Resident 8 had severe cognitive impairment though usually understood others, had no behaviors for rejection of care, needed partial/moderate assistance to use suitable utensils to bring food and/or liquid to the mouth and swallow. Resident 8 had a loss of liquids/solids from mouth when eating or drinking, held food in mouth/cheeks or residual food in mouth after meals, and coughed or choked during meals or when swallowing medications. The Electronic Health Record (EHR) indicated Resident 8 had a 9.15% weight loss from 12/29/25 to 3/16/26. During an observation on 3/24/26 at 1:30 p.m., Resident 8 was sitting in the dining room being fed pureed food by the Social Service Director (SSD). The SSD was sitting to the right of the resident. A physician's order, dated 1/2/26, indicated Resident 8 was to be fed on left side for left head turn; feed in an upright position; small bites and sips at slow rate; 1:1 feed. During an observation on 3/26/26 at 12:30 p.m., Resident 8 was sitting at a table alone in the dining room. He had a pureed diet tray in front of him. Resident 8 was feeding himself. No staff observed assisted or observing Resident 8 while he ate. During an observation on 3/27/26 at 12:24 p.m., Resident 8 was sitting at a table alone in the dining area, feeding self. Observed Resident 8 having trouble putting his two handled cup up to his mouth. No staff assisting or observing resident while he ate. A Nutritional Risk Assessment, dated 3/10/26, indicated Resident 8 was at risk for malnutrition and received dietary supplements due to weight loss. An interview with the Director of Nursing on 3/27/2026 at 12:35 p.m., indicated Resident 8 was supposed to be a 1:1 (one staff member continuously observation of one resident) feed and was to be assisted on his left side with all meals. Nursing was who was responsible to ensure Resident 8 was assisted with feeding for every meal. An Assistance with Meals policy was provided by the Administrator on 3/27/26 at 2:08 p.m. It indicated .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident.Dining Room Residents: 2. Facility staff will help residents who require assistance with eating.3. Residents who cannot feed themselves will be fed with attention to safety.Residents who may benefit from adaptive devices: 2. Assistance will be provided to ensure that residents can use and benefit from special eating utensils. A Food and Nutritional Services policy was provided by the Administrator on 3/27/26 at 2:08 p.m. It indicated .5. The food and nutrition staff will be available and adequately staffed to assist residents with eating as needed. Nurse Aides and feeding assistants will provide support to enhance the resident experience. 410 IAC (Indiana Administrative Code) 3.1-46

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to store respiratory supplies correctly at the bedside for 1 of 1 resident reviewed for respiratory care. (Resident 21) Findings include:The clinical record for Resident 21 was reviewed on 3/25/2026 at 1:12 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD/a progressive, irreversible lung disease that restricts airflow and makes breathing difficult) hypothyroidism (underactive thyroid gland producing insufficient hormones), and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/24/26, indicated Resident 21 was cognitively intact. During an observation on 3/24/26 at 11:40 a.m., Resident 21 had an oxygen nebulizer with tubing and mask openly lying on an empty bed. The oxygen mask was not in a bag. During an observation and interview on 3/25/26 at 1:23 p.m., Resident 21 had the nebulizer and oxygen tubing and mask lying on an empty bed, covered with a blanket. Resident 21 indicated the nebulizer and mask usually always lay on the bed close to her and that she gets breathing treatments twice a day, once in the morning and again at bedtime. A physician's order, dated 8/14/25, indicated Budesonide Suspension 0.25 mg (milligrams)/2ml (milliliters), 2 ml inhale orally every 12 hours for copd. A plan of care, dated 8/29/25, indicated Resident 21 had copd. The interventions included, but were not limited to, give aerosol or bronchodilators as ordered. During an interview with the Director of Nursing (DON) on 3/27/26 at 11:10 a.m., indicated the nebulizer and supplies should all be in a bag at the bedside and the tubing gets changed weekly. A Respiratory Policy was provided by the Administrator on 3/27/26 at 11:38 a.m. It indicated .2. Oxygen administration. j. keep oxygen cannula and tubing used prn (as needed) in a plastic bag when not in use. 410 IAC (Indiana Administrative Code) 3.1-47(a)(6)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to schedule an oral surgeon appointment, as referred, and follow-up on a recommendation for a new toothbrush and water flosser for 1 of 1 resident reviewed for dental status and services. (Resident 12) Findings include: The clinical record for Resident 12 was reviewed on 3/26/26 at 2:26 p.m. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (a progressive, treatable lung disease mainly caused by smoking or long-term irritant exposure that restricts airflow and causes breathing difficulties) and nicotine dependence (a chronic brain disorder where tobacco use becomes compulsory, causing intense cravings, failed quit attempts, and severe withdrawal symptoms). An interview was conducted with Resident 12 on 3/24/26 at 2:20 p.m. He indicated he needed to see the dentist, because he had holes in his teeth. He thought he was supposed to have an appointment scheduled already. The dental consultation, dated 3/18/26, indicated a recommendation for a specific type of rechargeable toothbrush and water flosser. It included a referral to a specific oral surgeon for extraction of two teeth. There was no information in the clinical record to indicate follow-up to the recommendation for a rechargeable toothbrush and water flosser or that an appointment was scheduled for an oral surgeon for Resident 12. An observation and interview were conducted with Resident 12 on 3/27/26 at 12:03 p.m. He indicated no one had followed up with him on an appointment for teeth extractions or a new rechargeable toothbrush and water flosser. He wanted the extractions completed. Resident 12 pointed to the right side of his mouth and indicated his teeth hurt when he chewed on that side of his mouth, so he avoided chewing on that side. An interview was conducted with the SSD (Social Services Director) on 3/27/26 at 11:35 a.m. She indicated the nursing department was responsible for follow-up on the recommendation for a rechargeable toothbrush and water flosser as well scheduling an appointment for the oral surgeon. An agency nurse was working when Resident 12 returned from his dental appointment on 3/18/26, and they did not follow up on any of the recommendations. The Dental Services policy was provided by the Regional Clinical Consultant on 3/27/26 at 12:07 p.m. It indicated, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. 410 IAC (Indiana Administrative Code) 3.1-24(b)