| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155521 | A. Building<br>B. Wing | 04/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Alexandria Care Center | 1912 S Park Ave<br>Alexandria, IN 46001 |

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) |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to provide supervision to mitigate the risk of repeated falls and failed to ensure individualized fall interventions were developed, added to the plan of care, and implemented to prevent repeated falls for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in the resident suffering a left hip fracture requiring surgical repair. Finding includes: Resident B' s clinical record was reviewed on 4/27/26 at 11:41 a.m. Diagnoses included Alzheimer's disease, displaced intertrochanteric fracture of the left femur, insomnia, trigeminal neuralgia, and anxiety. Current orders included memantine (treats dementia) 10 mg twice daily (11/14/25), carbamazepine (anticonvulsant) extended release 100 mg twice daily for trigeminal neuralgia (1/14/26), bed alarm to alert staff to unassisted transfers (9/12/25), and chair alarm on at all times for fall prevention (3/2/26). A 1/29/26, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. Resident B required partial assistance from staff for toileting, bathing, dressing, footwear donning and doffing, and personal hygiene. She required supervision from staff for chair/bed transfers, toilet transfer, and to move from sitting position to standing position. She required set-up assistance to walk 10 feet. The resident had two or more falls with no injury since admission or the prior assessment. She used a wheelchair for mobility. The resident was taking anticonvulsant medication. Resident B had a current, 6/25/25, care plan problem of falls related to a history of falls, unsteadiness, and poor safety awareness. Interventions included non-skid footwear at all times (8/19/25), non-skid strips at bedside (8/19/25), ensure pathways are clutter free (8/19/25), visual checks every hour (11/20/25), staff to assist resident to restroom at 4:00 a.m. (12/29/25), provide night light for adequate lighting (2/26/26), keep bed in low position while in bed (3/10/26), motion detector at bedside (3/27/26), ensure pathways are clear of unused walkers (4/14/26), staff to assist resident out of the dining room while adjusting to new glasses (4/15/26), and resident to remain in day room/dining room after meals until staff offers assistance to bed (4/27/26). The care plan was last reviewed on 4/27/26. The care plan lacked interventions for the bed alarm and chair alarm. An 11/3/25 care plan problem indicated the resident was dependent on others for all activities of daily living and required 24-hour supervision. Interventions included provision of one-to-one service as needed. The care plan was last reviewed on 2/13/26. An 11/3/25 care plan problem indicated the resident wandered and was at risk of getting into potentially dangerous places. Interventions included ensure all basic needs are met (11/3/25). The care plan was last reviewed on 2/13/26. Resident B's progress notes and assessments indicated the following fall history: On 11/20/25 at 7:00 p.m., the resident had an unwitnessed fall and was found by family on the floor at the end of her bed near the closet. She had a 3-centimeter (cm) abrasion to her left lower back. Cognitive factors included resident wandering without regard to fatigue or hunger. Neurological checks were completed. The immediate intervention implemented was resident education to go back to bed and to use her wheelchair. An 11/21/25, Interdisciplinary Team (IDT) progress note indicated the root cause of the fall on 11/20/25 included weakness and poor safety awareness. The new intervention was visual checks every hour. On 12/1/25 at 4:00 a.m., the resident had an unwitnessed fall in front of her restroom and was laying on<br>(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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | her back. No injuries were found. Cognitive factors included resident wandering without regard to fatigue or hunger. The immediate intervention implemented was that she was assisted to the toilet. A 12/2/25, IDT progress note indicated the root cause of the fall on 12/1/25 included resident fell. The new intervention was staff providing assistance to the bathroom at 4:00 a.m. On 12/11/25 at 12:00 p.m., the resident had a witnessed fall in the dining room when she tripped over another resident's foot and fell on her left side. No injuries were found. The immediate intervention was to assist the resident to meals/table while adjusting to her new glasses. A 12/12/25, IDT progress note indicated the root cause of the fall on 12/11/25 included the resident adjustment to new glasses. The new interventions included provision of resident assistance from the table while adjusting to new glasses. On 1/17/26 at 1:55 p.m., the resident had an unwitnessed fall in the dining room. No injuries were found. Cognitive factors included resident wandering without regard to fatigue or hunger. The immediate intervention was to ensure paths were clear. An undated IDT progress note indicated the root cause of the fall on 1/17/26 indicated the resident attempted to pick up a puzzle piece from the floor. The new intervention included clear pathways. On 1/20/26 at 2:20 p.m., the resident had an unwitnessed fall on the floor in front of her recliner on her left side. No injury was found. The immediate interventions were resident laid down for a nap and a family member sat with her. A 1/22/26, IDT progress note indicated the root cause of the fall on 1/20/26 included resident fell in front of recliner in the room. The new intervention was provider evaluation. The clinical record lacked an individualized intervention related to falls prevention. On 1/24/26 at 7:07 a.m., the resident had an unwitnessed fall, landing on her right knee. The roommate's walker was tipped over. No injuries were found. Non-skid footwear was not in place. A 2/5/26 fall risk assessment indicated Resident B was at high risk for falls. On 2/25/26 at 3:35 a.m., the resident had an unwitnessed fall on the floor at the doorway with bare feet and complained of left hip/leg pain. The resident was found to have a left hip fracture. Immediate interventions included neurological checks, and the resident was transferred to emergency care for evaluation and treatment. A 3/2/26 care plan indicated a problem of a recent left hip fracture. Interventions included monitoring for signs and symptoms of infection at the surgical site (3/2/26). A 3/6/26, significant change, MDS assessment indicated the resident was severely cognitively impaired. The resident was dependent on staff for toileting hygiene bathing, lower body dressing, and donning and doffing footwear. She required substantial assistance from staff for upper body dressing and transfers. Resident B was dependent on staff to walk 10 feet and used a wheelchair for mobility. She had major surgery to repair a fracture prior to this admission. On 3/9/26 at 11:45 p.m., the resident had an unwitnessed fall on the floor on the left side beside the bed. No injuries were found. Cognitive factors included resident wandering without regard to fatigue or hunger. Neurological checks were completed. Immediate interventions included the resident's assistance with getting dressed and assisted back to bed with the bed alarm. A 3/10/26, IDT progress note indicated the root cause of the fall on 3/9/26 included the resident was trying to get out of bed to get dressed. The new intervention was a low bed. On 3/21/26 at 2:30 p.m., the resident had an unwitnessed fall on the floor in front of a glider/rocker chair without injuries. Cognitive factors included resident wandering without regard to fatigue or hunger. The immediate intervention included increased supervision. A 3/23/26, IDT progress note indicated the root cause of the fall on 3/21/26 included resident incontinence and attempting to clean self. The new intervention was a motion detector at the bedside at night. On 4/24/26 at 7:00 p.m., the resident had an unwitnessed fall on the floor in the restroom, with her buttocks against the bathtub. The resident had an abrasion to the middle right side of her back. Cognitive factors included resident wandering without regard to fatigue or hunger. The immediate interventions included assisting her to the toilet and keeping her in the common areas until offered to lay down. A 4/27/26, IDT progress note indicated the root cause of the fall on 4/24/26 was wandering. The new intervention included the resident was to remain in the dining room after meals until staff offered to put her to bed. The clinical record lacked any hourly checks according to care plan interventions prior to the resident's left hip fracture on 3/25/26. During an observation, on<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 4/27/26 at 4:17 p.m., Resident B self-propelled in her wheelchair wandering down the hallway and into another resident's room. On 4/27/26 at 4:30 p.m., an observation of Resident B's room indicated a lack of non-skid strips beside her bed. During an interview, on 4/27/26 at 11:11 p.m., CNA 6 indicated she was the only staff member on the Memory Care Unit on night shift when Resident B had an unwitnessed fall resulting in a hip fracture. CNA 6 was washing wheelchairs in the shower room early that morning. When she came out of the memory care shower room, Resident 6 was sitting on the floor, wearing a shirt and brief, with her back against the door frame to her room. The Memory Care Unit was typically staffed with one or two aides for night shift. There were 14 residents on the Memory Care Unit when Resident B fractured her hip. The nurse was scheduled on the other units when the resident fell. Occasionally, Resident B wandered out of her room at night and wanted coffee. The resident was at high risk for falls because of multiple falls. Prior to her hip fracture on 2/25/26, the resident was rounded on every two hours per protocol. Resident B's fall interventions prior to her hip fracture included non-skid footwear, a bed alarm, toileting, and snacks for redirection. On 4/27/26 at 11:25 p.m., RN 7 indicated she was the only nurse in the building on night shift on 2/25/26 when Resident B fell. She was at the 100 Unit nurses' station when CNA 6 opened the Memory Care Unit doors and yelled out for RN 7's assistance. Upon arrival to the Memory Care Unit, the resident was sitting in the doorway of her room, bare buttocks against the floor, pants around her ankles, and the bed alarm was activated. The resident expressed pain and was unable to tolerate weight bearing activity on her left leg during the assessment. Resident B was sent out of the facility for further evaluation. Resident B was known to wander at night and attempted to use the bathroom unassisted prior to her hip fracture on 2/25/26. On 4/28/26 at 10:51 a.m., CNA 8 indicated Resident B and three other residents on the Memory Care Unit were known to wander. She was not aware of any interventions for Resident B on her shift that required frequent monitoring. The CNA had an assignment sheet they followed for interventions. The 300 Hall CNA Assignment Sheet indicated Resident B's interventions included hourly visual checks, non-skid footwear at all times, and non-skid strips at bedside. On 4/28/26 at 11:02 a.m., CNA 9 indicated she was familiar with the Memory Care Unit residents on various shifts. Prior to Resident B's hip fracture on 2/25/26, the resident required some standby assistance with donning footwear and toileting hygiene. The resident walked without staff assistance and was able to get her pants and shirt on by herself. She was known to get up during night shift hours. CNA 9 was not aware of any frequent monitoring requirements for Resident B prior to the hip fracture. Since the resident's hip fracture, the resident wandered about in a wheelchair and required one person assistance for transfers to the wheelchair. The resident was more incontinent and required assistance with all dressing since the hip fracture.On 4/28/26 at 11:28 a.m., the Corporate Nurse Consultant reviewed Resident 6's room and indicated the room lacked non-skid strips on either side of the resident's bed for fall prevention. She reviewed the CNA Assignment sheet for the 300 Hall (Memory Care Unit) and indicated non-skid strips should have been in place on the floor beside the resident's bed. On 4/28/26 at 11:35 a.m., LPN 10 indicated fall interventions should have been implemented immediately when they were placed on the care plan. Non-skid strips should have been implemented for Resident B on 3/23/25. Failure to implement fall interventions placed the residents at risk for further falls. On 4/28/26 at 12:00 p.m., the Administrator indicated unit managers were supposed to complete rounding to ensure non-skid strips were in place and not peeling up. Over time, the non-skid strips would peel up from the floor. During an interview, on 4/28/26 at 12:08 p.m., the Administrator indicated Resident B's family had a timeframe, prior to the resident's hip fracture, when someone sat with the resident for one-on-one supervision. The resident did not have any falls during the time the family had someone with Resident B. Resident B was impulsive and would get up without assistance. The Administrator did not know what else the facility could do to prevent falls for Resident B. The resident's representative had voiced concerns after the resident's hip fracture regarding a need for more staff on the Memory Care Unit at night. There were times the Memory Care Unit was staffed at night with only one aide. She was uncertain how many staff were on the Memory<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Care Unit when Resident B fell on 2/25/26 and fractured her hip. On 4/28/26 at 2:10 p.m., the Regional [NAME] President of Operations indicated the facility did not have a fall preventions policy related to the provision of adequate supervision to prevent falls. On 4/28/26 at 2:23 p.m., the DON indicated the facility should have been able to identify a lack of supervision related to falls during root cause analysis of resident falls. On 4/28/26 at 2:49 p.m., the Administrator indicated the facility had an obligation to provide services to meet the residents' needs. The facility did not provide one-on-one care services, and the family signed acknowledgement of that information. The facility followed CMS guidelines regarding provision of safe care for the residents. A current facility policy, dated 10/2014, titled FALL PREVENTION PROGRAM, provided by the Administrator on 4/27/26 10:49 a.m., indicated the following: PURPOSE: To identify residents who are at risk for falls and subsequently implement appropriate, individualized fall prevention interventions. POLICY: It is the policy of this facility to identify any resident who is at increased risk for falls. Identified resident shall be monitored by the Interdisciplinary Team (IDT) in an effort to implement fall prevention interventions that minimize occurrence of falls thereby minimizing resident risk of injury. This deficiency relates to Intake 2977460. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a) |