STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexandria Care Center	1912 S Park Ave 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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure residents prescribed antipsychotic medications received appropriate Gradual Dose Reductions (GDR) attempts and had indication for continued use when GDRs were attempted and were deemed unsuccessful without clinical justification for 2 of 5 residents reviewed for unnecessary medications (Residents 8 and 12).Findings include:1. During an observation, on 8/11/25 at 11:21 a.m., Resident 8 ambulated up behind another resident and spoke with the other resident. During an observation, on 8/11/25 at 3:04 p.m., Resident 8 sat in a chair in the dining/activity area and participated in an activity. During an observation, on 8/12/25 at 10:06 a.m., Resident 8 ambulated around the tables in the dining area and observed the Activity Director setting up a bucket activity. During an observation, on 8/12/25 at 3:49 p.m., Resident 8 stood at the dining table and worked on a puzzle. During an observation, on 8/13/25 at 8:22 a.m., Resident 8 ambulated down the hall to the dining room. During an observation, on 8/14/25 at 10:09 a.m., Resident 8 smiled and tapped a balloon during a balloon activity. During an observation, on 8/14/25 at 3:53 p.m., Resident 8 stood at a table in the dining area and put together puzzle pieces. Resident 8's clinical record was reviewed on 8/13/25 at 8:49 a.m. Diagnoses included Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, major depressive disorder, and unspecified psychosis not due to a substance or known physiological condition. Current orders included quetiapine (antipsychotic) 12.5 milligrams (mg) at bedtime (1/29/25) and mirtazapine (antidepressant) 7.5 mg at bedtime. A 7/29/25, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. She had no mood indicators or behaviors marked for the assessment period. She required supervision/cueing with eating, upper body and lower body dressing, and putting on/taking off footwear. She required supervision/ touching staff assistance with personal hygiene. She required partial/moderate staff assistance with oral hygiene, toileting hygiene, and showering/bathing. For mobility, she required supervision/touch assistance of staff for rolling left to right in bed, moving from sitting to lying on bed, and ambulating 10 feet. She required partial/moderate staff assistance with lying to sitting on edge of bed, coming from sitting to standing position, chair to bed/ bed to chair transfers, tub/shower transfers, and walking 50 with two turns and 150 feet down a corridor. She received an antipsychotic with a gradual dose reduction attempted on 1/22/25. A current care plan for behavior symptoms indicated the resident presented with primary diagnoses of psychosis, other dissociative and conversion disorders and may exhibit mood and behavior challenges. The long-term goal indicated the episodes of mood and behaviors will be redirected and/or diffused daily through the next review. Approaches included the following: psychiatric care as ordered, ensure all needs are met, assess for pain/discomfort as needed, encourage the resident to vent their feelings and provide reassurance, be a good listener, encourage activities of interest and pleasure, redirect any inappropriate behavior and comments, and assist the resident in problem solving any issues. The care plan was last reviewed/revised 6/24/25. A current care plan for behavior symptoms indicated the resident presented with a diagnosis of anxiety disorder and may exhibit mood and behavior challenges. The long-term goal indicated episodes of mood and (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors will be redirected and/or diffused daily through next review. Approaches included the following: psychiatric care as ordered, ensure all needs are met, assess for pain/discomfort as needed, encourage the resident to vent their feelings and provide reassurance, be a good listener, encourage activities of interest and pleasure, redirect any inappropriate behavior and comments, and assist the resident in problem solving any issues. The care plan was last reviewed/revised 6/24/25. A current care plan for major depressive disorder had a long-term goal of episodes of depressed moods will be redirected and diffused daily through the next review as evident by documented efficacy of interventions on the Behavior Memos. Interventions will be effective as evidenced by fewer episodes through next review as evident by review of documented Behavior Memos denoting number of episodes exhibited. Resident may exhibit signs and symptoms of tearfulness, negative statements, decreased appetite, and sad expressions. Approaches included the following: Observe for depressive symptoms such as crying, change in sleeping and eating patterns, restlessness and negative statements, assess for pain/discomfort as needed, medications as ordered, if applicable, complete depression assessment as needed, provide mental health services as needed, encourage activities of choice and interest, notify physician and resident representative of any significant change in condition, provide Social Services One to One programming as needed. Provided reassurance and comfort as needed, validate the resident's feelings and emotions as needed, ensure all basic needs are met, and quetiapine as ordered. The care plan was last reviewed/revised on 6/24/25. A current care plan for medications indicated the resident required the use of an antipsychotic medication and was at risk for adverse side effects. Approaches included the following: administer the medication as ordered, monitor for adverse side effects such as : drowsiness, sedation, agitation, somnolence, insomnia, headache, nervousness, and hostility, observe for change in mood or behavior, notify the nurse of noted problems for further evaluation and possible physician and resident representative notification, refer for psychological evaluation, attempt gradual dose reduction per policy, monitor for extrapyramidal symptoms per policy, refer to consultant pharmacist as needed, and medication is quetiapine. A facility pharmacy recommendation, dated 1/22/25, indicated a gradual dose reduction of quetiapine was recommended. The recommendation to discontinue quetiapine 12.5 mg daily was accepted by the provider. A Mood and Behavior Communication Memo, dated 1/23/25 at 1:00 p.m. and provided by the Administrator on 8/15/25 at 2:48 p.m., indicated the resident approached the nurse's station and said she was looking for her children. The staff member told the resident her son had been in earlier. The resident said that was not true and became verbally aggressive. She raised her voice and asked why the staff member lied to her. The resident was assisted to call her son and calmed down. A Mood and Behavior Communication Memo, dated 1/23/25 at 2:00 p.m. and provided by the Administrator on 8/15/25 at 2:48 p.m., indicated the resident was tearful, anxious and wanted to see her family. The resident was provided one on one attention, allowed to vent feelings, and provided conversation of interest. The behavior remained unchanged. A Mood and Behavior Communication Memo, dated 1/26/25 at 10:00 a.m. and provided by the Administrator on 8/15/25 at 2:48 p.m., indicated the resident was restless and kept asking to leave. She said her parents were coming to get her soon. The resident was provided with a snack, one on one, time to calm and reapproached, and redirection. The staff member attempted to calm resident and was pushed away. The behavior remained unchanged. A Mood and Behavior Communication Memo, dated 1/27/25 at 6:30 p.m. and provided by the Administrator on 8/15/25 at 2:48 p.m., indicated the resident repeatedly asked where her parents were and why she could not leave and go home. The staff walked with the resident. The resident was provided with fluids, allowed to vent feelings, and family was called for assistance. The behavior was unchanged. A Mood and Behavior Communication Memo, dated 1/29/25 at 4:40 p.m. and provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident demonstrated confusion. The son requested a behavior memo be completed. The resident was provided with a snack, conversation of interest, and reassurance and comfort. The resident's increased confusion remained unchanged. A (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing progress note, dated 1/29/25 at 4:42 p.m., indicated the resident's representative came to facility to visit and was upset about the recent medication changes and wanted the staff to document the resident's confusion. The resident was pleasant and cooperative. She came down to the dining room for meals with a decrease noted in her appetite. She had no falls. She had no distress and denied pain/discomfort A nursing progress note, dated 1/29/25 at 4:56 p.m., indicated the nurse contacted the Psychiatric Nurse Practitioner (NP) about the family's concern of a failed GDR. The NP gave orders to restart quetiapine 12.5 mg daily. A Mood and Behavior Communication Memo, dated 1/31/25 at 9:00 p.m. and provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident repeatedly called her son saying her granddaughter had run away with the kids. The resident was provided with fluids, a quiet environment, redirection, reassurance and comfort, and pleasant pictures or photo album. The staff walked with her and used humor. The behavior remained unchanged. A nursing progress note, dated 2/2/25 at 3:25 p.m., indicated the resident had needed increased assistance performing activities of daily living. She had a decline in memory and needed redirection and reassurance more frequently. Family reported a change in the resident and said she was tearful at times. The psychiatric NP was notified. A nursing progress note, dated 2/8/25 at 8:46 p.m., indicated the resident's representative came in and demanded the resident's urine be collected and sent out to assess due to her having hallucinations and increased confusion. Urine was checked. The urine showed positive for leukocytes (white blood cells) and hemoglobin (blood cells). The physician was notified and received new orders to send urine to lab for urinalysis and culture and sensitivity. A Mood and Behavior Communication, dated 2/14/25 at 2:50 p.m., provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident thought her son was her husband. She repeatedly referred to him as her husband during the conversation. The resident was allowed to vent feelings and provided a conversation of interest. The behavior improved, and she recognized her son as her son. A Mood and Behavior Communication, dated 2/26/25 at 3:30 p.m., provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident requested the staff to let her out to get her kids from school. Later, at supper time, she repeatedly asked where her food was, and it was in front of her. She called her son. The behavior improved. A nursing progress note, dated 3/2/25 at 4:30 p.m., indicated the resident repeatedly asked where her grandchildren were and needed the nurse to find them. The resident was easily redirected for a short time. A Mood and Behavior Communication, dated 3/21/25 at 4:00 p.m., provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident was very confused and thought her parents and sons were coming in to pick her up. Son attempted to redirect the resident. The resident was provided with fluids, a quiet environment, and one on one. The behavior remained unchanged. A Mood and Behavior Communication, dated 3/30/25 at 12:00 p.m., provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident repeatedly asked where the kids were and if they were safe. She went out with her son and was confused. She asked where the kids were and did not believe the answers he gave her. The resident was provided with relaxation techniques, a quiet environment, fluids, a snack, one on one, and time to calm. She was allowed to vent her feelings. The behavior improved. A Mood and Behavior Communication, dated 4/15/25 at 9:00 p.m., provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident was more confused and restless according to family. The resident was provided with fluids and toilet. The behavior remained unchanged. The nurse indicated she was going to request labs and check the resident's urine. A nursing progress note, dated 4/25/25 at 9:54 a.m., indicated urinalysis results were normal and negative for an infection. During an interview, on 8/14/25 at 3:54 p.m., CNA 8 indicated she had not seen the resident have behaviors. She sometimes would pace around the doors and look for her kids. She told the resident her kids had been picked up from school. During an interview, on 8/15/25 at 11:52 p.m., CNA 9 indicated the resident became a lot more confused when she had a urinary tract infection, and when she had to have help with walking after she fell. During an interview, on 8/15/25 at 12:14 p.m., RN 7 indicated the resident became very confused. She called the nurse her daughter and did not recognize her son. She seemed to be getting better lately. When she had a urinary tract (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection and fell, she became very hateful. During an interview, on 8/15/25 at 2:06 p.m., the DON and Administrator indicated the resident's representative became very upset when a GDR was done. During an interview, on 8/15/25 at 3:34 p.m., the DON indicated the behaviors documented could be related to dementia. However, she wondered if the resident hallucinated. The resident often would influence her roommate when she was upset, and the roommate would also become upset. The resident's representative insisted the resident needed antipsychotic medication. The black box warning for quetiapine, accessed from the FDA website on 8/15/25 at https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/020639s069lbl.pdf, indicated the following: .WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS; and SUICIDAL THOUGHTS AND BEHAVIORS. The indications for usage were schizophrenia, bipolar I disorder manic episodes, and bipolar disorder, depressive episodes. 2. During an observation, on 8/11/25 at 12:27 p.m., Resident 12 sat in a wheelchair and conversed nonsensically with other residents. During an observation, on 8/11/25 at 3:12 p.m., Resident 12 sat in her wheelchair and talked to another resident. During an observation, on 8/12/25 at 10:04 a.m., Resident 12 in her wheelchair at a table and colored a picture as she talked to other residents. During an observation, on 8/13/25 at 9:13 a.m., Resident 12 sat in her wheelchair in the TV lounge and participated in a current events activity. During an observation, on 8/13/25 at 10:54 a.m., Resident 12 was tearful. The Activity Director sat down beside resident at a table and talked with her. The Activity Director read the resident a book. The resident was no longer tearful. During an observation, on 8/14/25 at 10:12 a.m., Resident 12 sat in her wheelchair and actively watched a balloon activity. Her eyes followed the balloon. During an observation, on 8/14/25 at 3:51 p.m., Resident 12 sat in her wheelchair in the hall watching other doing activities. Resident 12's clinical record was reviewed on 8/13/25 at 12:01 p.m. Diagnoses included dementia in other diseases classified elsewhere, mild, with other behavioral disturbance, major depressive disorder, single episode, mild, Alzheimer's disease with late onset, unspecified psychosis not due to a substance or known physiological condition, and depression. Current orders included divalproex (anticonvulsant for mood disorder) 250 mg twice a day, risperidone (antipsychotic) 0.125 mg twice a day, and sertraline (antidepressant) 100 mg daily. A 7/15/25, quarterly, MDS indicated the resident sometimes understood others and was sometimes understood. The resident was unable to complete the interview for mental status. The staff assessment of the resident's mental status indicated the resident's cognitive skills for daily decision making were moderately impaired, and decisions were poor. She had disorganized thinking and inattention which fluctuated. No mood indicators or behaviors were marked. She required supervision/touching assistance with eating. She required partial/moderate staff assistance with oral hygiene. She required substantial/maximal staff assistance with upper body dressing. She was dependent on staff for toileting, showering/bathing, lower body dressing, putting on/taking off footwear, and personal hygiene. She was dependent on staff for rolling left to right, moving from sitting to lying, moving from lying to sitting, chair to bed and bed to chair transfers, toilet transfers, tub/shower transfers. She required partial/moderate staff assistance with walking 10 feet and 50 feet with two turns. She required partial/moderate staff assistance in wheelchair for 50 feet and was dependent on staff for 150 feet. A current care plan for delirium indicated the resident was at risk for delirium or acute confused episodes related to diagnoses of Alzheimer's dementia and psychosis as evidenced by disorganized thinking and inattention. The long-term goal was that the resident will have no complication associated with signs or symptoms of delirium through next review. Approaches included the following: administer medications, as ordered: divalproex and risperidone, ensure resident's safety, give reassurance to resident, manipulate resident's environment as needed, monitor for change in resident's mood and behaviors, monitor for signs or symptoms of delirium such as inattention, disorganized thinking, altered level consciousness, psychomotor retardation, and acute confusion, monitor for underlying signs or symptoms of medical condition that could cause delirium such as : UTI or other type of infection, hypoxia or signs or symptoms of dehydration, monitor lab (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results as ordered, monitor resident for ADL (activities of daily living) needs, oxygen saturation levels as needed and oxygen as needed, refer to psych services, speak calmly, slowly, and call resident by name, update physician as needed of resident's condition, and vital signs as needed. A current care plan for medications indicated the resident required the use of an antipsychotic medication and was at risk for adverse side effects. The long-term goal was that the resident will have no signs or symptoms of adverse reaction associated with the use of anti-psychotic medication through the next review. Approaches included the following: administer medication as ordered, monitor for adverse side effects such as drowsiness, sedation, agitation, somnolence, insomnia, headache, nervousness, hostility, observe for change in mood or behavior, notify the nurse of noted problems for further evaluation and possible physician and resident representative notification, refer for psychological evaluation as indicated, attempt gradual dose reduction per policy, monitor for extrapyramidal symptoms per policy, refer to consultant pharmacist as needed, and medications used is risperidone to treat dementia with agitation. A current care plan for the diagnosis of anxiety indicated symptoms may include fatigue, restlessness, sweating, irritability, racing thought, excessive worry, fear, poor concentration, sensation of abnormal heartbeat, or trembling. The long-term goal was that the episodes of increased anxiety will be successfully addressed, and resident will be calmed as evident by documented efficacy of interventions listed in the Behavior Memo. Interventions will be effective as evidenced by fewer episodes of anxiety as evident by review of documented Behavior Memos denoting number of episodes of anxiety exhibited. Approaches included: ensure calm environment, ensure all basic needs have been met, encourage activities of preference, provide mental health services as ordered, encourage resident to express thoughts and feelings, provide reassurance and comfort as needed, provide relaxation techniques as needed such as visualization, relaxing music, and massage, administer medication as ordered, and medication hydroxyzine as ordered. A current care plan for behavioral symptoms indicated the resident presented with primary diagnosis of psychosis and may exhibit mood and behavior challenges. The long-term goal was that episodes of mood and behaviors will be redirected and/or diffused daily through the next review. Approaches included the following: psychiatric care as ordered, ensure all needs are met, assess for pain/discomfort, encourage the resident to vent their feelings and provide reassurance, be a good listener, encourage activities of interest and pleasure, redirect any inappropriate behavior and comments, assist the resident in problem solving, and monitor for changes, notify the physician if warranted. The care plan lacked indication of how the resident's psychosis presented, nor how the resident expressed behaviors. A current care plan for cognitive loss/dementia indicated the resident has the progressive cognitive and communicative deficits associated with Alzheimer's disease. Approaches included the following: administer medications as ordered, approach the resident from the front, change the topic if the resident becomes upset/agitated, divalproex as ordered, encourage family and friends to visit and bring familiar objects from home, ensure you have been seen before initiating therapeutic touch, explain the purpose for your visit in terms the resident can understand, monitor for changes in status and notify the physician and responsible party as indicated, risperidone as ordered, speak in a clear, low calm tone of voice at a volume that is easily heard by the resident, and use nonverbal gestures to supplement verbal communication where appropriate. A current care plan for medication indicated the resident required the use of divalproex and risperidone to treat dementia and is at risk for experiencing adverse side effects. The long-term goal indicated that the resident would have no signs or symptoms of an adverse reaction associated with the medications used to treat dementia through the next review. Approaches included the following: administer medications as ordered, give no more than two choices to avoid confusion and over stimulation, monitor for changes in mood or behavior, monitor for signs and symptoms of adverse reaction such as diarrhea, insomnia, headache, nausea, dizziness, monitor labs as ordered, notify nurse of change for further evaluation and possible physician and resident representative notification, and try to use short simple sentences and ask questions that require a yes or no type answer. A Mood and Behavior Communication Memo, dated (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/31/25 at 7:00 p.m. and provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident became upset when the staff member was unable to get to her right away to be toileted. The behavior improved when the resident was toileted. A Mood and Behavior Communication Memo, dated 2/3/25 at 8:15 p.m. and provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident was assisted out of her wheelchair to go to the bathroom, and she began crying. She cursed at the staff member and then sat in her chair. The resident was provided toileting, position was changed, and time to calm/reapproach. The behavior worsened. The resident became more agitated. A nursing progress note, dated 2/25/25 at 1:52 p.m., indicated the resident had a couple of tearful episodes. A Mood and Behavior Communication Memo, dated 2/26/25 all day 2:00 p.m. to 10:00 p.m., provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident was emotional after she had been toileted. She became tearful and scooted around in her wheelchair for a few hours. The resident was provided toileting, a quiet environment, and reassurance and comfort. The behavior improved after she ate dinner. A facility pharmacy recommendation, dated 2/26/25, indicated a gradual dose reduction of risperidone was recommended. The recommendation to decrease the risperidone 0.25 mg daily to 0.125 mg daily was ordered 2/28/25 by the provider. A nursing progress note, dated 2/27/25 at 11:04 a.m., indicated the resident was cooperative until the water was turned on for her shower. The resident called the CNA names during the shower. She took the shower hose and sprayed the CNA. She hit the CNA in the arm during the shower. A Mood and Behavior Communication Memo, dated 2/28/25 for 2:00 - 10:00 p.m., provided by the Administrator on 8/15/25 at 2:48 p.m., indicated the resident was rolling her wheelchair too close to other residents. She saw her mom and dad. She told the staff they were not listening to her and cried over not getting attention all the time. The resident was provided toileting, a snack, one on one, and time to calm. The behavior remained unchanged. A nursing progress note, dated 3/5/25 at 9:15 a.m., indicated the resident was anxious and tearful for an unknown reason. She was reassured numerous times, but the reassurance was not helpful. She was given a snack, and a male peer sat next to her. She ate her breakfast, patted the male sitting next to her on the head and shoulder and smiled. She had no further tearfulness. A Mood and Behavior Communication Memo, dated 3/7/25 at 4:30 p.m., provided by the Administrator on 8/15/25 at 2:48 p.m., indicated the resident was hallucinating repeatedly that another resident was her husband. The resident was provided toileting, venting of feelings, and redirection. The behavior was unchanged. A Mood and Behavior Communication Memo, dated 4/15/25 at 6:10 a.m., provided by the Administrator on 8/15/25 at 1:30 p.m., indicated the resident was crying. She was upset and paced in her wheelchair. The resident ran over the staff member's feet with wheelchair twice while going back and forth on the unit. The resident was provided with a drink, toileting, and one on one. The behavior was unchanged. During an interview, on 8/14/25 at 3:54 p.m., CNA 8 indicated she had seen Resident 12 have behaviors only a few times. She cried and sometimes she kicked when the behaviors were bad. During an interview, on 8/15/25 at 11:52 p.m., CNA 9 indicated the resident would sometimes become very tearful. She did not have many problems with her. During an interview, on 8/15/25 at 12:16 p.m., RN 6, RN 7, and CNA 9 indicated behavior sheets were supposed to be filled out for things like agitation and aggression, but not for regular confusion. During an interview, on 8/15/25 at 2:06 p.m., the Administrator and DON indicated they would look for additional behavior sheets completed on the resident. During an interview, on 8/15/25 at 3:36 p.m., the DON indicated the behaviors exhibited by the resident could be dementia associated behaviors, or they could be hallucinations. She was uncertain that she was qualified to determine if the resident's behaviors were hallucinations or dementia associated behaviors. A black box warning for risperidone, accessed from the FDA website https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/020272s056,020588s044,021346s033,021444s0 on 8/15/25 indicated the following: .WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS. The indications for use indicated treatment of schizophrenia, short-term treatment of acute manic or mixed episodes associated with bipolar I disorder in adults, and the treatment of irritability associated with autistic disorder in children and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adolescents aged 5-16 years. A current facility policy, dated 4/2025 and provided by the DON on 8/15/25 at 3:02 p.m., titled PSYCHOTROPIC MEDICATION CONSENT, USE AND GRADUAL DOSE REDUCTION, indicated the following .Antipsychotic medications are generally used only for the following diagnoses as documented in the resident's record, consistent with the definitions(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions) . The use of these diagnoses only to support the use of anti-psychotic medication is strictly prohibited. Use of these diagnoses must be verifiable according to accepted standards of practice. A. Schizophrenia b. Schizo-affective Disorder c. Schizophreniform Disorder d. Delusional disorder e. Mood Disorders (e.g. bipolar disorder, depression with psychotic features, and treatment refractory major depression) f. Psychosis g. Medical illness with psychotic symptoms and/or treatment-related psychosis or mania h. Tourette's Syndrome i. Huntington's Disease.The facility will, in consultation with the facility's consulting pharmacist and the prescribing provider, consider gradual dose reduction.in order to find the lowest effective dose of psychotropic medications. Observation will be performed in order to identify symptoms of failed dose reduction, and the same shall be documented if observed. 3.1-48(a)(4)3.1-48(b)(2)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident's representative was notified in writing of transfer/discharge appeal rights and the facility bed hold policy for 4 of 7 residents reviewed for hospitalizations (Resident 6, 7, 22, and 57) and failed to provide communication to the receiving health care facility for 1 of 7 residents reviewed for hospitalizations. (Resident 22)Findings include: 1.Resident 7's clinical record was reviewed on 8/14/25 at 9:04 a.m. Diagnoses included Alzheimer's disease, vascular dementia, unspecified severity, with agitation, dementia, moderate, with agitation, unspecified dementia, unspecified severity, with other behavior disturbance, and major depressive disorder, recurrent, severe with psychotic symptoms. A nursing progress note, dated 6/3/25 at 7:22 p.m., indicated the resident became physically aggressive and threw clothing items, hangers, and a television out of the resident's room. She tried to slam her walker into the staff members. A referral was sent to a psychiatric facility. The resident's emergency contact and power of attorney were notified of the occurrence. A nursing progress note, dated 6/3/25 at 11:30 p.m., indicated the resident was awakened to transfer to the psychiatric facility. The emergency medical technicians (EMT) were given all transfer paperwork and clothing for three days. The resident left the building at 11:30 p.m. The clinical record lacked indication the resident's representative was notified of the notice of transfer/discharge appeal rights and bed hold policy in writing for the resident's transfer to the hospital A Nursing Home to Hospital Transfer Form, left on the conference table on 8/15/25 at 1:30 p.m., indicated the resident transferred to the psychiatric facility on 6/3/25. In the Additional Relevant Information section was written Family aware. During an interview, on 8/15/25 at 12:03 p.m., RN 6 indicated when a resident was transferred the following paperwork is sent: SBAR (form which included situation, background, assessment, and recommendation, the CCD (continuity of care document which included diagnoses, medications, next of kin contact information, vaccinations, and resident goals), and a face sheet. The packet also included a bed hold in it. The paperwork was sent with the EMTs. During an interview, on 8/15/25 at 12:09 p.m., RN 7 indicated when a resident was transferred, she printed off the CCD, the resident face sheet, and some additional paperwork which included a transfer/discharge notice, and a bed hold for resident transfers. The notice of transfer was given to the DON, the bed hold was given to the EMTs. During an interview, on 8/15/25 at 3:16 p.m., the Social Services Director (SSD) indicated she filled out transfer paperwork including the bed hold and transfer/discharge appeal rights for planned discharges. She did not manage any of the paperwork for the emergent transfers except for the ombudsman notification of the resident's transfer/discharge. During an interview, on 8/15/25 at 3:40 p.m., the DON indicated the nursing units had packets to fill out for emergent transfers, which included a bed hold. The nurse would hand the documents to the family if they came to the facility, otherwise the nurse gave the papers to the EMTs. If the resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	08/15/2025

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Alexandria Care Center	1912 S Park Ave Alexandria, IN 46001

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was out of the facility for an extended period, the transfer/discharge forms and bed hold policy would be mailed to them. The facility did not keep a log of transfer/discharge and bed hold notifications that were sent to the resident representatives. 2.Resident 6's clinical record was reviewed on 8/14/25 at 10:21 a.m. Diagnoses included chronic respiratory failure with hypoxia (low oxygen level), congestive heart failure, and disorientation. A progress note, dated 1/28/25 at 6:09 p.m., indicated Resident 6 had a high heart rate, high blood pressure, confusion, and incontinence. The on-call provider was notified, and staff were instructed to send Resident 6 to the emergency department. Bed hold paperwork was filled out and faxed to the hospital emergency department. Resident 6's emergency contact and ADON were made aware of the transfer. Resident 6's clinical record included an incomplete Nursing Home to Hospital Transfer Form dated 1/28/25. The first page of the form did not include the resident's date of birth , admission date, contact person information or transfer notification, who to call at nursing home, primary care physician name and telephone number, resident risk alerts, and personal belongings that were sent with the resident at the time of the transfer. The second page of the form was blank other than the resident's name, date of birth , and the hospital transfer date. The form completed by section was signed by the nurse with a time entered of 6:20 p.m. A Notice of Transfer or Discharge form dated 1/28/25, and a copy of the bed hold policy was present. The Notice of Transfer or Discharge Request for Hearing form in the record was blank and lacked any information on the form. A progress note, dated 3/01/25 at 6:30 p.m., indicated Resident 6 requested to go to the emergency room. The facility provider was made aware and transfer order received. A progress note, dated 3/01/25 at 7:40 p.m., indicated report was given to a staff member at the hospital. Emergency services provided Resident 6 transportation to the hospital emergency department. Resident 6's clinical record included a Nursing Home to Hospital Transfer Form, Notice of Transfer or Discharge form, a copy of the bed hold policy, and a Notice of Transfer or Discharge Request for Hearing. All the forms were dated 3/1/25. The second page of the Nursing Home to Hospital Transfer Form was not located in the resident's clinical record. A progress note, dated 6/8/25 at 3:39 p.m., indicated Resident 6 had shortness of breath, wheezing, an elevated heart rate, and whistling sounds noted on respiration. The facility provider was notified and gave an order to send Resident 6 to the emergency room. The resident's daughter was notified and the [NAME] Fire Department transported Resident 6 to the emergency room. The facility CCD report and the bed hold policy were sent with the [NAME] Fire Department at the time of the transfer. Resident 6's clinical record included an incomplete Nursing Home to Hospital Transfer Form. The form did not include the name of the hospital the resident was transferred to, the date of the transfer, physician's name and telephone number, or the primary care clinician at the nursing facility. The second page was left blank. The Notice of Transfer or Discharge form, a copy of the bed hold policy, and a Notice of Transfer or Discharge Request for Hearing were in the record and dated 6/8/25. Resident 6's clinical record lacked documentation indicating her representative was notified in writing of the transfer/discharge appeal rights and the bed hold policy at the time of all three (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	08/15/2025

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Alexandria Care Center	1912 S Park Ave Alexandria, IN 46001

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospitalizations. 3.Resident 57's clinical record was reviewed on 8/13/25 at 11:45 a.m. Diagnoses included displaced intertrochanteric fracture of right femur (a break in the upper thigh bone), chronic kidney disease, and hypertension (high blood pressure). A progress note, dated 6/28/25 at 9:01 p.m., indicated that Resident 57's family was notified of Resident 57's medical status and it was determined to send her to the emergency room (ER). The DON and ED were notified, and report was called to the hospital ER. Resident 57's clinical record included a Nursing Home to Hospital Transfer Form, Notice of Transfer or Discharge form, a copy of the bed hold policy, and a Notice of Transfer or Discharge Request for Hearing. All the forms were dated 6/28/25. The Notice of Transfer or Discharge Request for Hearing form did not indicate Resident 57's name, telephone number, or address. Resident 57's clinical record lacked documentation indicating her representative was notified in writing of the transfer/discharge appeal rights and the bed hold policy. During an interview, on 8/14/2025 at 2:05 p.m., the Social Services Director (SSD) indicated she did not have anything to do with the bed hold policies and notifications, other than making sure the completed forms were in resident's discharge files. Due to the nursing staff being responsible for completing paperwork at the time of a resident's facility transfer, she was unsure if the nursing staff provided families with copies of the bed hold paperwork. During an interview, on 8/14/2025 at 2:21 p.m., the Administrator indicated there was a packet, located at the nurse's station, that consisted of the paperwork that was to be filled out by the nurses at the time of resident transfers or discharges. Bed hold policy was given to residents who were alert and oriented, as long as they are awake. If not given to the resident, and a family member was at the bedside they would be provided with paperwork, and if no one is present, copies were mailed. She was unsure if there was a log indicating if paperwork was mailed to families. During an interview, on 8/15/2025 at 3:12 p.m., the SSD indicated she was responsible for making sure residents who had planned facility discharges had their discharge instructions and paperwork. In emergent situations the nursing department were responsible for completing the necessary paperwork. She had never mailed a bed hold policy or a copy of the Notice of Transfer or Discharge paperwork to a family member. During an interview, on 8/15/2025 at 3:39 p.m., the DON indicated nurses were to fill out transfer paperwork at the time of a resident's facility transfer. The paperwork was located in a prepared emergent packet at the nurse's station. The completed paperwork was sent with the EMT's to be taken to the receiving provider. If the paperwork was not able to be completed prior to EMT arrival, paperwork was faxed to receiving provider. The packet was able to be given to an oriented resident or a family member if present, and they were able to give the packet to the receiving provider. Staff verbally informed families when a bed hold policy had been sent to a facility. Facility staff may possibly mail transfer paperwork if a resident is out for an extended leave. She was unsure if any had been mailed out, as there is not a log indicating this. 4.Resident 22's clinical record was reviewed on 8/15/25 at 10:28 a.m. Diagnoses included unspecified dementia, type 2 diabetes mellitus, stage 4 chronic kidney disease, and gastro-esophageal reflux (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	08/15/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease (GERD). The facility census report indicated Resident 22 was hospitalized on the following dates: 1/17/25, 3/1/25, 3/3/25, 4/11/25, and 7/22/25. The clinical record lacked progress notes for hospitalizations on 3/3/25, 4/11/25, and 7/22/25. A Notice of Transfer or Discharge, dated 1/17/25, provided by the DON on 8/15/25 at 1:30 p.m., was completed and signed by the DON. The clinical record lacked indication of the resident and/or their representative being notified of transfer/discharge rights. The clinical record lacked documentation of a report of Resident 22's condition being given to the receiving facility. A Notice of Transfer or Discharge, dated 3/1/25, provided by the DON on 8/15/25 at 1:30 p.m., was completed and signed by the DON. The clinical record lacked indication of the resident and/or their representative being notified of transfer/discharge rights. A Notice of Transfer or Discharge, dated 3/3/25, provided by the DON on 8/15/25 at 1:30 p.m., was completed and signed by the DON. The clinical record lacked indication of the resident and/or their representative being notified of transfer/discharge rights. The clinical record lacked documentation of a report of Resident 22's condition given to the receiving facility. A Notice of Transfer or Discharge, dated 4/11/25, provided by the DON on 8/15/25 at 1:30 p.m., was completed and signed by the DON. The clinical record lacked indication of the resident and/or their representative being notified of transfer/discharge rights. A Notice of Transfer or Discharge, dated 7/22/25, provided by the DON on 8/15/25 at 1:30 p.m., was completed and signed by the Administrator. The clinical record lacked indication of the resident and/or their representative being notified of transfer/discharge rights. During an interview with the DON, on 8/15/25 at 11:55 a.m., she indicated family was usually notified by phone to let them know when their family was transferred (to the hospital). All paperwork would be printed and given to the emergency medical technicians (EMTs) who picked up the residents to transfer them to the hospital. EMTs got report from the nurse and would then pass the information on to the receiving facility. (continued on next page)

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	155521	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility document, titled Transfer Discharge and Discharge Planning, provided by the Administrator on 8/14/25 at 2:50 p.m., indicated the following: .The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless.A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs A through F, the facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.Documentation in the resident's medical record must include: A) The basis for the transfer, B) In the case of 'the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility', facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).The documentation required must be made by the resident's physician when transfer or discharge is necessary under paragraph A). A current facility document, titled Bed Hold, provided by the Regional Nurse Consultant (RNC) on 8/15/25 at 1:47 p.m., indicated the following: .Before a resident is transferred to a hospital or goes on a therapeutic leave, facility personnel will provide written information to the resident or resident representative that specifies the facility bed hold policy. In case of emergency transfer, every effort will be made to notify the resident or resident representative at the time of transfer as to the bed hold policy. Should this not occur, effort will be made to provide written notice to the resident or resident representative within 24 hours of transfer. 3.1-12(3) 3.1-12(5) 3.1-12(6)(A)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	08/15/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to administer a PRN (as needed) medication per physician orders for 2 of 16 residents reviewed for physician orders. (Resident 35 and Resident 5)1.Resident 35's clinical record was reviewed on 8/13/25 at 1:56 p.m. Diagnoses included Alzheimer's disease, essential hypertension (high blood pressure), and atrial fibrillation (irregular heartbeat).Current orders included hydralazine 10 milligrams four times a day as needed for high blood pressure [to lower blood pressure]. Special instructions included: administer the medication when Resident 35's blood pressure was above 165 [systolic (top number)].The clinical record indicated the following:On 7/1/25 the resident's blood pressure was 170/83. Hydralazine was not administered.On 7/6/25 the resident's blood pressure was 198/87. Hydralazine was not administered.On 7/14/25 the resident's blood pressure was 181/77. Hydralazine was not administered.On 7/15/25 the resident's blood pressure was 169/73. Hydralazine was not administered.On 7/17/25 the resident's blood pressure was 170/72. Hydralazine was not administered.On 7/24/25 the resident's blood pressure was 183/77. Hydralazine was not administered.On 7/25/25 the resident's blood pressure was 170/88. Hydralazine was not administered.On 7/29/25 the resident's blood pressure was 182/92. Hydralazine was not administered.On 7/30/25 the resident's blood pressure was 175/83. Hydralazine was not administered.On 8/14/25 the resident's blood pressure was 181/86. Hydralazine was not administered.A quarterly Minimum Data Set (MDS) assessment, dated 7/30/25, indicated Resident 35's cognitive status was severely impaired.A current care plan, dated 5/15/25, indicated Resident 35 had a diagnosis of hypertension and was at risk for associated complications. Interventions included administer medications as ordered, hydralazine as ordered, amlodipine as ordered, metoprolol as ordered, monitor blood pressure routinely and notify physician and resident representative per call order parameters, and monitor for signs of hypertension. 2.Resident 5's clinical record was reviewed on 8/15/25 at 1:36 p.m. Diagnoses included dementia, essential hypertension, and anxiety.Current orders included hydralazine 25 milligrams every 6 hours as needed for high blood pressure. Special instructions included: administer the medication when Resident 5's blood pressure was above 165 [systolic].The clinical record indicated the following:On 7/3/25 the resident's blood pressure was 170/78. Hydralazine was not administered.On 7/19/25 the resident's blood pressure was 172/84. Hydralazine was not administered.On 7/28/25 the resident's blood pressure was 169/85. Hydralazine was not administered.On 7/29/25 the resident's blood pressure was 168/93. Hydralazine was not administered.On 7/31/25 the resident's blood pressure was 168/67. Hydralazine was not administered.On 8/3/25 the resident's blood pressure was 181/86. Hydralazine was not administered.A quarterly Minimum Data Set (MDS) assessment, dated 5/6/25, indicated Resident 5's cognitive status was severely impaired.A current care plan, dated 5/21/25, indicated Resident 5 had a diagnosis of hypertension and was at risk for associated complications. Interventions included administer medications as ordered, hydralazine as ordered, clonidine as ordered, lisinopril as ordered, monitor blood pressure routinely and notify physician and resident representative per call order parameters, and monitor for signs of hypertension. During an interview, on 8/15/25 at 3:39 p.m., the DON indicated the facility's nurse practitioner had given parameters to recheck blood pressures an hour after medication administration and prior to hydralazine administration. Blood pressure rechecks should be documented by the nurses in the residents' progress notes. She was unsure if parameter instructions were being followed or documented. She confirmed Resident 5 and 35's hydralazine was not administered per orders. If administered as ordered, it should have helped in managing their blood pressure.A current policy, revised April 2017, titled MEDICATION ADMINISTRATION, provided by the DON on 8/15/25 at 3:02 p.m., indicated the following: PURPOSE: To safely administer medications as per physicians' orders.A current facility policy, revised September 2017, titled PRN MEDICATIONS, provided by the Regional Consultant on 8/15/25 at 4:15 p.m., indicated the following: .POLICY: It is the policy of this facility to monitor the administration of all PRN medications.PROCEDURE: 1. Each (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	08/15/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident should have a PRN Flow Sheet housed with the applicable resident Medication Administration Record.4. Should a PRN be necessary to treat another symptom (e.g. constipation, fever, etc.) the same should be listed on the flow sheet.6. The nurse/QMA must re-visit the resident follow PRN medication administration to evaluate medication efficacy.the nurse must further assess and determine the need to contact the physician relative to the resident's unresolved complaint/concern/symptom.3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	08/15/2025

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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 follow the dietitian's recommendations and follow a physician's order for a resident with significant weight loss for 1 of 3 residents reviewed for nutrition. (Resident 8) Finding includes:During an observation, on 8/13/25 at 7:48 a.m., Resident 8 was eating her biscuits and gravy. She had white milk on her tray. Resident 8's clinical record was reviewed on 8/13/25 at 8:49 a.m. Diagnoses included Alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, recurrent, mild, anxiety disorder, unspecified psychosis not due to a substance or known physiological condition, Vitamin D deficiency, vomiting, and underweight. Current orders included the following: regular diet, chocolate milk with meals, cottage cheese with meals, vanilla ice cream with lunch and dinner, yogurt with breakfast, Boost (supplement) high protein - give 350 ml (milliliters) three times a day, Boost breeze daily, Boost plus high protein - twice a day, quetiapine(antipsychotic) 12.5 milligrams (mg) at bedtime (1/29/25), and mirtazapine (antidepressant) 7.5 mg at bedtime. A 7/29/25 quarterly Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. She had no mood indicators or behaviors marked. She required supervision/cueing with eating. She had significant weight loss and was on a therapeutic diet. A current care plan indicated the resident had incurred significant weight loss. Approaches included the following: mirtazapine as ordered, determine potential causal factor of decreased consumption/weight loss and involve appropriate disciplines to provide intervention - food preferences - depression/isolation - need for increased assistance - dining seating/atmosphere. Review of the resident's weights indicated on 2/2/25 the resident weighed 94.8 pounds and on 8/1/25 the resident weighed 82.8 pounds, which was a 12.66 % weight loss over six months. The resident was seen on 6/24/25 for weight loss by the nurse practitioner (NP). She requested a dietitian consultation. A dietitian consult note, dated 7/11/25 indicated the resident had greater than 10% weight loss in six months. The dietitian indicated the resident had triggered a significant weight loss and had trending weight loss. She received a regular diet with yogurt at breakfast, chocolate milk with meals, Boost with meals, and Boost three times a day. The resident's acceptance of the supplements varied. Mirtazapine was started on 7/9/25. The dietitian recommended discontinue the Boost at meals to promote oral intake at meals., change Boost plus high protein to twice a day and add Boost breeze daily. During an observation, on 8/14/25 at 12:03 p.m., the resident received white milk on her tray. During an observation, on 8/14/25 at 12:11 p.m., LPN 13 brought a Boost high protein supplement to the resident while the resident was eating her meal. During an interview, on 8/14/25 at 12:19 p.m., LPN 13 indicated chocolate milk was not on the dietary slip. The resident should have chocolate milk. The chocolate milk was signed off for each meal on the medication administration record (MAR). She indicated she gave the resident chocolate Boost at meals and wondered if that counted as chocolate milk. A review of the resident's lunch ticket for 8/14/25, provided by LPN 13 on 8/14/25 at 12:19 p.m., indicated chocolate milk was not listed. During an interview, on 8/15/25 at 1:53 p.m., RN 10 indicated the DON reviewed the dietitian's recommendations and notified the NP for new orders. During an interview, on 8/15/25 at 1:57 p.m., the DON indicated the when the dietitian made recommendations, the DON discussed them with the NP. The DON indicated the resident's representative had indicated the resident seemed to do better drinking than eating. The DON was unable to provide documentation of the reasoning for not following the dietitian's recommendation to not give the Boost at meals. A current facility policy, dated 10/2014, provided by the DON on 8/15/25 at 3:02 p.m., titled DIETITIAN RECOMMENDATION, indicated the following: .Administrative nursing staff shall be responsible to ensure said recommendations are communicated to the resident's physician as soon as possible, but no later than three (3) days from receiving said recommendation. Physician response shall be documented and implemented accordingly. 3.1-46(a)(2)

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	155521	A. Building B. Wing	08/15/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were stored in a secure manner when one medication cart was left unlocked and unattended. This deficiency had the potential to allow access to medications belonging to 19 residents. Findings include:During an observation on 8/12/25 at 11:03 a.m., the 100-hallway medication cart was unattended and unlocked. The hallway was empty until 11:10 a.m. when two (unidentified) Certified Nursing Assistants (CNAs) approached and entered a nearby resident room. At approximately 11:15 a.m., LPN 5 approached and locked the medication cart. She indicated she was the nurse responsible for the medication cart. She had inadvertently left the cart unlocked. Keys to the cart were in her pocket. The cart contained medications for 19 residents.During an interview with the Director of Nursing (DON) on 8/15/25 at 3:53 p.m., she indicated all medication carts should be locked when not in use.A current facility document, titled Storing Drugs, provided by the DON on 8/15/25 at 3:02 p.m., indicated the following: .Drugs and biologicals will be stored in a safe, secure, and orderly manner at appropriate temperatures and accessible only to licensed nursing and pharmacy personnel or staff members lawfully authorized to administer medications .2) When a permitted person is not in a drug storage area, the drug storage areas and devices must be kept locked 3.1-25(m)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155521	A. Building B. Wing	08/15/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure hygienic food handling practices were followed during dining services for 1 of 19 residents observed in the main dining room. (Resident 35)Findings include:During an observation, on 8/11/2025 at 12:06 p.m., CNA 4 offered to cut Resident 35's hamburger sandwich. Using her left hand, CNA 4 placed all five of her fingertips on the top bun and pushed the top bun in a downward motion to secure the bun in place as she used a knife, in her right hand, to cut the sandwich in half. During an interview, on 8/11/2025 at 12:43 p.m., CNA 4 indicated she should not have touched Resident 35's food with her bare hands. Food was not to be touched barehanded and a fork and knife was to be used to cut a sandwich. During an interview, on 8/15/25 at 3:39 p.m., the DON indicated staff were not to touch resident's food with bare hands. All staff were previously educated on hand hygiene, food handling, and other specifics of food service(s). A facility policy, dated August 2024, provided by the DON on 8/15/25 at 3:02 p.m., titled Glove Use & Meal Service, indicated the following: Policy: In an effort to protect food products from contamination, all products should be used serving utensils. Procedure: 4. Employees may not touch ready-to-eat food with bare hands; gloves must be worn. 3.1-18(a)