| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155522 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Elwood Health and Living | 2300 Parkview LN<br>Elwood, IN 46036 |

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| (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 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>Based on observation, interview, and record review the facility failed to protect the residents' right to be free from misappropriation of property for 3 of 5 residents reviewed for drug diversion. (Residents B, C, and D) Findings include:During an interview, on 3/10/26 at 10:00 a.m., the DON and Administrator indicated they had been called early in the morning about an unusual occurrence with a shift-to-shift narcotic count. The count had been off by one pill from when the original count was done. LPN 13 indicated she thought she left a pill in a cup in the medication room. She went into the medication room and brought out a pill in a cup. The Administrator and DON had reviewed the camera footage and saw LPN 13 take a pill out of her bag that was in the medication room, place the pill in a med cup, then leave the medication room. During review of camera footage, on 3/10/26 at 12:22 p.m., the DON showed a clip of LPN 13 entering the medication room, getting into her personal backpack, and pulling out a plastic bag of pills. She removed a pill from the bag. She then opened a new sleeve of medication cups. As she went to a shelf unit in the medication room, one pill in a plastic medication cup was visible in her hand. She exited the medication room. Another video clip showed LPN 13 placing a sheet of paper on Medication Cart 1, along with several medication cups. She placed three medication cups on the top of the medication cart. She popped out a pill from a medication card into her hand then placed it into the medication cup. Another clip showed LPN 13 at the 300 hall medication carts. She placed six medication cups on Medication Cart 2. She opened the first drawer, then closed it. She opened the second drawer of the medication cart. She looked though the cards, then took the first medication cup and moved in the direction of Medication Cart 1's trash. She opened the third drawer of the medication cart and looked through the medication cards. Then, back to the second drawer. Next, she opened the narcotic drawer. She popped out a narcotic pill into her left hand and closed her fingers. Then, she looked in the second drawer, pulled a card out, and popped a pill into her right hand. She put the pill from her right hand into a medication cup. She continued to keep three fingers of her left hand closed with the pill contained in the hand. She pulled another card out and popped a pill into her left hand with her left hand. With her right hand, she removed one pill from the left hand and placed it in a medication cup on the cart. She moved her hands to her right pocket as if dropping something into her pocket and swung her body like she was stretching. She continued to look through the medication cards in the drawers, then leaned down and put her left hand on a card in the cart and pushed on the card. Her hand was closed when she withdrew her hand from the cart. She opened the narcotic drawer, while keeping her left hand closed, she pulled up a narcotic card and popped a pill into her left hand. She then placed one pill into the medication cup. She retrieved the narcotic log book, while keeping three fingers of her left hand closed. She passed the narcotic log book to her right hand. Then, she placed her left hand in her left pocket and pulled her hand out of her pocket. She passed the narcotic book back to her left hand. She opened the second drawer with her right hand and passed the narcotic log book back to her right hand. She put her left hand in her left pocket, then her right pocket, looking into her pockets. She placed the narcotic log book on the opened second drawer. Next, she flipped through the narcotic log book and looked at the medications in the narcotic drawer. She placed her right hand deeply into the narcotic drawer. Then she placed her left hand deeply into the drawer, moving the drawer with the exertion. Next, she pulled up a narcotic<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 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | card and popped it into her left hand and placed a pill into a medication cup. Three fingers of her right hand remained closed as she held a pen while going through the medications. She popped another narcotic pill into her left hand and kept three fingers of her left hand closed. She did not put any medications in any cups after popping the most recent narcotic pill she had popped out. She closed the narcotic drawer, took something from her left hand and placed it into her right hand. Her right hand moved in the direction of her right pocket. Her hands were no longer partially closed. During an interview, on 3/12/26 at 10:23 a.m., LPN 5 indicated when she came in, on dayshift on 3/10/26, LPN 7 was waiting to get report. LPN 13 finished giving report to LPN 6, then went into the medication room. LPN 7 indicated the narcotic count was off. LPN 13 indicated Resident B's hydrocodone-acetaminophen (opioid pain medication) 10-325 mg narcotic card contained 50 tablets, but the log book indicated 51 tablets should have been left. LPN 13 went into the medication room to get the medication. She was in the medication room for longer than it would take to grab something off the counter. LPN 13 indicated she had double popped the medication. She had popped out the medication, then went to get the Resident B's roommate's intravenous (IV) medication supplies. She had left the medication in the medication room and had popped it out again. LPN 5 indicated she looked through the as needed (PRN) narcotics that were signed off for the shift LPN 13 worked. LPN 13 had given multiple PRN medications to residents who did not typically take PRN medication during the night. During an interview, on 3/12/26 at 11:14 a.m., the Administrator indicated she had completed the reportable to the State agency and had concluded LPN 13 had taken residents' medications and multiple activity supplies from the facility. The police were currently investigating the incident. A narcotic sign out sheet for Resident D, provided by the Administrator on 3/12/25 at 11:43 a.m., indicated that LPN 13 signed out an oxycodone-acetaminophen (opioid pain medication) for Resident B on 3/10/26 at 4:30 a.m. Resident routinely received the medication daily at 8:00 a.m. The facility's investigation of the incident, reviewed on 3/12/26 at 11:43 a.m., included, but was not limited to the following items:The report to the state agency indicated: On 3/10/26 during a shift-to-shift count, a discrepancy was noted. LPN 13 reported she forgot she had pulled a narcotic medication and went to the medication storage room. She returned with medication, and the narcotic count was correct. The staff were concerned with the medication coming from the medication room. An investigation was initiated. Camera footage was reviewed and appeared to show LPN 13 pull a pill from her personal backpack. The staffing agency from where LPN 13 was contracted was notified. LPN 13 will not be permitted to return to the facility. A follow-up on 3/12/26 indicated LPN 13 had taken multiple medications through her shift. Per the security camera footage, LPN 13 would pop out a medication and hold it in her hand and then drop the medication in her pocket. In addition to medication, she was observed on video in the activities room putting items such as lotion, jewelry, and games in a filing cabinet and later putting them in her backpack and exiting the building. Pain assessments and interviews were conducted by the facility with residents, on 3/10/26, which included Resident C and Resident D. Resident D denied experiencing any pain. She denied requesting or receiving any pain medication during the previous night. Resident C indicated LPN 13 entered his room to administer his 12:00 a.m. medication. He immediately recognized it did not look like his regular medication. LPN 13 argued for several minutes and said the medication was likely from a different manufacturer. He declined to take the medication. LPN 13 returned a few minutes later with the medication he recognized as his own, and he took the medication. At 4:00 a.m., he was woken up for his routine oxycodone and given a medication cup. He did not look at the medication prior to putting it in his mouth. The medicine began to immediately dissolve, so he spit it out and did not recognize it as his pain medication. He reported this to the oncoming nurse at 6:00 a.m. on 3/10/26. The day shift nurse was given a medication cup with a bright pink colored, disintegrating pill which was given to Unit Manager 4, then given to the DON. Statements were received from employees and included, but were not limited to the following:LPN 5's statement indicated she was at the desk when LPN 13 and LPN 7 counted the narcotics. LPN 13 went into the medication room, and LPN 7 indicated<br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the count was off. Resident B's narcotic count record indicated she had 51 pills, but she had 50 pills. LPN 13 came out of the medication room and indicated she had double popped her narcotic. She said she had popped it out, and took the pill into the medication room while she was getting Resident B's roommate's IV supplies. Then, she popped it out again and gave it to Resident B. LPN 5 told LPN 13 she would have to fill out a medication error because at first, she thought LPN 13 gave Resident B two pills. Then, LPN 5 understood what LPN 13 meant. LPN 5 and LPN 7 verified the pill was the correct one. LPN 7 notified the DON. A Narcotic Shift to Shift Count Record for the 300 Hall, contained two lines of documentation. On 3/9 at 10:00 p.m., indicated LPN 25 signed as off going nurse and LPN 13 signed as oncoming nurse. On 3/10/26 at 6:00 a.m., the off going nurse box was not signed and LPN 7 signed to oncoming nurse box. During a phone interview, on 3/12/26 at 11:57 a.m., LPN 7 indicated LPN 13 gave report on 3/10/26 from night shift to day shift and did not indicate any PRN medications were given. When she counted the narcotics with LPN 13, Resident B was missing a hydrocodone-acetaminophen 10-325 mg pill. LPN 13 indicated she might have popped out an extra one for Resident B. The narcotic count was finished, then LPN 13 went into the medication room. While she was in the medication room, LPN 7 called LPN 5 over and told her that something was not right and a hydrocodone was missing. LPN 13 came out of the medication room with a hydrocodone in a medication cup. LPN 13 said she left it on the counter when she was gathering Resident B's roommate's IV medication supplies. LPN 13 took about two minutes to return from the medication room to get a medication cup that was supposedly on the counter. After LPN 13 brought the pill, LPN 5 and LPN 7 verified with LPN 13 the pill was a hydrocodone by its markings and appearance. The medication was destroyed. During a phone interview, on 3/12/26 at 12:07 p.m., LPN 24 indicated she counted narcotics with LPN 13 on 3/9/26 for evening to night shift. The narcotic count was correct at that time. During a phone interview, on 3/12/26 at 2:56 p.m., CNA 25 indicated she worked with LPN 13 on 3/9/26 from 6:00 p.m. to 10:00 p.m. LPN 13 turned off all the lights at the nurses' station and in the hallway at 9:30 p.m. The lights at the nurses' station were not normally turned off. Some sconces on the wall provided some light, but the area was quite dark. During a phone interview, on 3/12/26 at 3:00 p.m., CNA 26 indicated she worked with LPN 13 from 10 p.m. on 3/9/26 to 6:00 a.m. on 3/10/26. LPN 13 asked CNA 26 when CNA 26 first arrived for her shift about the activity room exit that led to the parking lot. LPN 13 had turned off all the lights but one and was sitting in the corner of the activity room. She repeatedly went in and out of the activity room, swearing the whole time. She was swearing because she had to do a medication pass and count narcotics on the Assisted Living area. In the morning, LPN 13 went to the locked medication room, down the hall, and then to the activity room. CNA 26 had seen LPN 13 sitting in her car in the front parking lot when she arrived for her shift at 10:00 p.m. Later that shift, she saw LPN 13's car sitting in the back parking lot when she emptied the trash. Resident B's clinical record was reviewed on 3/12/26 at 11:20 a.m. Diagnoses included hereditary and idiopathic neuropathy (damage to nerves outside the brain and spinal cord which often causes pain), spondylosis (age related degenerative condition of the spine which frequently causes neck and back pain), and other intervertebral disc displacement, lumbar region (slipped disc which often causes lower back pain). Resident B's orders included hydrocodone-acetaminophen every 6 hours for pain (10/3/2025). A quarterly Minimum Data Set (MDS) assessment, dated 2/5/26, indicated Resident B was cognitively intact. During an interview, on 3/12/26 at 3:44 p.m., Resident D indicated she had not received any pain medications in the past several nights, as she did not need any. Resident D's clinical record was reviewed on 3/12/26 at 11:32 a.m. Diagnoses included chronic pain and polyneuropathy (disorder affecting multiple nerves, causing numbness, tingling ( pin and needles), burning sensations, and intense sensitivity to touch). Resident D's orders included oxycodone-acetaminophen 5-325 mg PRN 2 times a day for pain (2/19/26) and oxycodone-acetaminophen 5-325 mg daily (2/19/26). A quarterly MDS assessment, dated 12/10/25, indicated the resident was severely cognitively impaired. A medication administration sheet for 3/2026 lacked documentation that a PRN oxycodone had been given on 3/10/26 at 4:30 a.m. During a<br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | phone interview, on 3/12/26 at 4:21 p.m., Resident C indicated LPN 13 brought in his medications on 3/9/26 evening. He had two pills due at that time. He looked at the medications and told LPN 13 they were not his medications. She told him they were from a different manufacturer. He told her they were not his medications, and he was not going to take them. She returned about five minutes later with the correct medications. Later, through the night, she gave him his scheduled medication. The light was off, and the room was dark. He turned on the light and looked at the medication. The pill was pink and resembled his medication, but it was more like a wafer than a rounded pill. He put the pill in his mouth then spit it into a container as it did not taste like his medication, and he gave it to the day shift nurse later that morning. When LPN 13 came in again, later, she told Resident C that the medication would not have hurt him, it was just a vitamin. Resident C's clinical record was reviewed on 3/12/26 at 11:26 a.m. Diagnoses included low back pain, lower back pain, and wedge compression fracture of the first lumbar vertebra. Resident C's orders included oxycodone 10 mg every 4 hours for pain (2/23/26) and pregabalin (anticonvulsant) 100 mg 3 times a day (2/12/26). An admission MDS assessment, dated 2/18/26, indicated the resident was cognitively intact. LPN 13 was not available for interview during the survey dates. A current facility policy, revised 4/2017 and titled Abuse, Neglect, and Exploitation, provided by the Administrator on 3/5/26 with the entrance conference paperwork, indicated the following: .The resident has the right to be free from mistreatment, neglect, and misappropriation of property. ?Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's personal belongings or money without the resident's consent. This citation relates to Intake 2799652. 410 Indiana Administrative Code (IAC) 16.2-3.1-28(a) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, interview, and record review, the facility failed to provide accommodations to support a resident's ability to reposition in bed for comfort and safety and to have access to physician ordered respiratory supplies according to their plan of care 1 of 5 residents reviewed for accommodation of needs. (Resident 62) Findings include:During an observation, on 3/5/26 at 11:50 a.m., a sign hung on Resident 62's wall. The sign indicated Resident 62 was to only receive nectar thickened liquids when she was in an upright position, no straws, small sips were to be taken, the head of the bed was to be elevated to 90 degrees, and the resident was to be kept up for 30 minutes after meals. Resident 62 was lying on her back in her bed. The head of the bed was not elevated. A white foam cup, dated 3/5/26, with a lid and straw, sat on a bedside table that was positioned across the mid-section of Resident 62. A continuous pressure airway machine (CPAP, a machine to help breathing) sat on a nightstand at the head of the bed. No CPAP mask was present. Resident 62 indicated she preferred to wear the CPAP at times, per her discretion, but was unable to do so due to no mask being available. She was unable to recall the last time a mask was present in her room. Resident 62 was unable to elevate the head of her bed due to not having a handheld bed control remote. The bed was controlled by staff by the controls that were located on the footboard of the bed. She drank her fluids while lying flat.During an observation, on 3/6/26 at 10:40 a.m., the head of Resident 62's bed was elevated less than 30 degrees in the bed with controls at the footboard. A CPAP mask was not present.During an observation, on 3/9/26 at 11:02 a.m., a nurse entered Resident 62's room and elevated the residents head of the bed with the controls at the footboard, administered the resident's medication, and then lowered the head of the bed prior to her departing the room. During an observation, on 3/9/26 at 4:13 p.m., a CPAP mask was not present in Resident 62's room.During an observation, 3/10/26 at 9:43 p.m., a CPAP mask was not present in Resident 62's room.Resident 62's clinical record was reviewed on 3/11/26 at 11:16 a.m. Diagnoses included dysphagia at the oropharyngeal stage (difficulty initiating to swallow), chronic obstructive pulmonary disease (COPD, incurable lung disease), gastro-esophageal reflux (GERD, backflow of stomach acid into the esophagus), obstructive sleep apnea (sleep disorder), and hemiplegia and hemiparesis following a cerebral infarctions (paralysis and weakness after a stroke).Current physician orders included BIPAP (Bilevel Positive Airway Pressure, a machine to help breathing) on while sleeping, head of bed elevated per resident preference to prevent shortness of breath while lying flat related to COPD, and reduced carbohydrate diet, mechanically soft with ground meat texture, and nectar thick liquid consistency.A quarterly Minimum Data Set (MDS) assessment, dated 2/5/26, indicated Resident 62's cognitive status was intact. Resident 62 had no impairment to functional range of motion in her upper and lower extremities. She required set up or clean up assistance for eating and was dependent on staff for rolling left and right. She received a mechanically altered diet which required a change in the texture of food or liquids. She received oxygen therapy.A current care plan, dated 8/12/24, indicated Resident 62 had COPD, received oxygen and nebulizer treatments, and the residents head of bed was to be elevated to alleviate shortness of breath while lying flat. Interventions included the following: BIPAP as ordered (2/17/25) and head of bed to be elevated or out of bed upright in a chair during episodes of difficulty breathing (8/12/24).A current care plan, revised 2/6/26, indicated Residents 62 had an activity of daily living performance deficit related to a stroke, seizures, and impaired mobility. Interventions included the following: Resident 62 was dependent for bed mobility and required the assistance of two staff members (2/6/26) and the resident was able to feed self (8/12/24).A current care plan, dated 8/12/24, indicated Resident 62 was at risk for a potential alteration of nutrition and/or weight status related to her having a diagnosis of diabetes, COPD, anemia, anxiety, GERD, and schizophrenia. She needed a therapeutic diet. Interventions included the following: encourage the resident to consume fluids (8/12/24), monitor for signs and symptoms of dysphasia and swallowing/chewing problems (8/12/24), serve diet as ordered, mech soft ground meat and nectar<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | thickened liquids (3/26/25).During an observation, on 2/11/26 at 1:42 p.m., no CPAP mask was present in Resident 62's room.During an interview, on 3/11/26 at 1:43 p.m., CNA 15 indicated Resident 62 was alert and voiced her wants and needs. She had a bed remote in her room and used it to control the bed. The resident attached it to the call light so she could reach both at the same time. The resident received thickened liquids. The resident laid on her back most of the time per her request and preference.During an interview, on 3/11/26 at 1:47 p.m., Resident 62 indicated she was unsure why she never had a handheld bed remote. She was aware she was to sit up with liquids but was unable to do so without a bed remote and she often took drinks of her fluids while lying flat. She wanted a bed remote so she could use it accordingly. During an interview, on 3/11/26 at 1:51 p.m., LPN 6 indicated Resident 62 was alert and oriented and able to voice needs and wants. Resident 62 used to wear her CPAP and had a mask in her room previously, but she began to refuse to wear it, so the electronic treatment administration record was marked as refused. Resident 62's bed was controlled by the buttons on the foot board. The resident would be able to use bed remote if one was available to her. If Resident 62 wanted the head of the bed elevated to drink her liquids, the resident used the call light and staff elevated the head of the bed for her.During an interview, on 3/11/26 at 1:53 p.m., Unit Manager 4 indicated Resident 62 did not want to use her CPAP most of the time. She was unsure when a CPAP mask was last in the resident's room. She was not sure about the bed not having a handheld bed remote. A lack of having a bed remote prevented and restricted Resident 62 from independent movement and position changes. Resident 62 was on thickened liquids due to a failed swallow study (an exam to evaluate safety of swallowing). The resident would often take a drink and lay right back down.During an interview, on 3/11/26 at 1:55 p.m., CNA 16 indicated she always used the buttons on the footboard to control Resident 62's bed. She had never observed a handheld bed remote on Resident 62's bed.During an interview, on 3/11/26 at 2:17 p.m., Unit Manager 4 confirmed Resident 62 did not have a bed remote in her room. She had not been aware previously that the bed did not contain a handheld remote.During an interview, on 3/11/26 at 2:40 p.m., the DON indicated there was not a known reason why Resident 62 did not have a handheld bed remote. Resident 62's positioning was restricted due to not having a bed remote. She did not know the facility had any beds without a handheld bed remote.During an interview, on 3/11/26 at 2:40 p.m., the Nurse Consultant indicated Resident 62 was to have a handheld bed remote and not having one could put the resident at risk for complications. She was unaware the facility had any beds without a handheld bed remote.<br>The facility did not have a policy pertaining to bed remotes or accommodation of needs.A facility policy, dated 10/17, titled COMPREHENSIVE CARE PLANS, provided by the Administrator, on 3/12/26 at 4:44 p.m., included the following: Policy: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights and that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.The facility must establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. 410 IAC (Indiana Administrative Code) 16.2 - 3.1-3(v)(1) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview and record review, the facility failed to ensure an allegation of physical abuse was reported to the State Agency for 1 of 1 residents reviewed for abuse. (Resident 5)Resident 5's clinical record was reviewed on 3/10/26 at 8:59 a.m. Diagnoses included hemiplegia and hemiparesis (paralysis) following a cerebral infarction affecting the right dominant side.A progress note, dated 2/15/26 at 3:11 p.m., indicated Resident 5 called for the nurse to come to her room. The resident stated someone was really rough when changing her and her wrist got slammed on the wall. The nurse asked the resident what time it happened and Resident 5 stated it happened overnight. The aides were not paying attention and were in a rush. The resident's wrist was assessed and no redness or swelling were noted. The resident continued to complain of pain in the right wrist.A progress note, dated 2/15/26 at 3:14 p.m., indicated a new order for a right wrist x-ray.An acute care note, dated 2/16/26 at 3:55 p.m., indicated Resident 5 was seen for an acute visit for wrist pain. The resident reported the previous day that when nursing staff was providing care, they were really rough when changing her and her wrist got slammed against the wall. During the visit, the resident described how when she was turned, her arm fell off the bed and was bent backward. An x-ray of the wrist was ordered and results were pending.A follow-up note, dated 2/18/26 at 4:49 p.m., indicated Resident 5 was seen for a follow-up visit after a traumatic incident a few days prior. The right wrist x-ray, performed on 2/18/26, indicated a complete compression fracture of the lunate bone and partial compression fracture of the scaphoid bone (both bones found in the wrist). A previous x-ray of the right wrist from 11/2022 had a similar abnormal appearance of the lunate bone which suggested a lunate fracture. A CT scan of the wrist would be helpful for further characterization. The findings of the 2/18/26 x-ray of the right wrist were not acute fracture findings. Resident 5 reported diminishing pain in her wrist, describing it as sore. Recommendations were made for rest, ice, and elevation.During an observation and interview on 3/10/26 at 4:36 p.m., Resident 5 indicated she was doing just fine. When asked about her right wrist, she said it was fine. She did not remember her wrist getting hurt.A written and unsigned statement, provided by the DON on 3/11/26 at 3:20 p.m., indicated the following: CNA 23 and I (CNA 22) went into Resident 5's room at about (not legible) on 2/15/26 to get her dressed. We moved the bed away from the wall and I stood on one side. CNA 23 was on the other side, and we continued to get her dressed. She complained of right wrist pain and had CNA 23 put her brace on before CNA 23 went to get her a cup of coffee.A written statement by CNA 23, provided by the DON on 3/11/26 at 3:20 p.m., indicated the following: Aides (CNA 23 and CNA 22) entered resident's room between 4:00 and 4:30 a.m. to get resident dressed for the day. (We) gathered clothes and supplies and got started. CNA 22 pulled the bed away from the wall to stand on each side. I was on the side closest to the door. We got Resident 5 dressed and she asked for (her) brace to be put on. I ever so gently put brace on for resident, then went and made her a cup of coffee. Resident 5 complained of right wrist pain at the beginning of the shift. Stated someone was too rough. Signed and dated by CNA 23 on 2/15/26.During an interview with the DON and Regional Nurse Consultant (RNC) on 3/11/26 at 10:21 a.m., the DON remembered the incident was on a weekend but did not remember the details. When she interviewed Resident 5, the resident said nobody hurt her. The DON did not report the incident to the State Agency. The RNC indicated Resident 5 was not a reliable witness. During an interview with CNA 22 on 3/11/26 at 10:30 a.m., she indicated she knew nothing about the wrist until a nurse contacted her. The nurse asked CNA 22 to write out a statement about care provided to Resident 5 on the night of the incident. The nurse told CNA 22 about the resident's wrist hurting the day after CNA 22 and CNA 23 provided care. CNA 22 described how they moved the bed away from the wall and did not see anything unusual. Resident 5 said her wrist was hurting and CNA 23 put the brace onto Resident 5's right wrist. CNA 22 did not notice any redness or swelling of the right wrist.An interview with CNA 23 was attempted on 3/11/26 at 10:30. The voice mailbox was<br>(continued on next page) |

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| | 155522 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Elwood Health and Living | 2300 Parkview LN<br>Elwood, IN 46036 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | full, and no message could be left. Two more calls were attempted at 10:40 a.m. and 10:50 a.m. CNA 23 was not available for an interview.A current facility policy titled Reporting of Reasonable Suspicion of a Crime, Reporting, Investigate/Prevent/Correct Alleged Violations, provided by the RNC on 3/11/26 at 10:15 a.m., indicated the following: .It is the policy of this facility .to report any reasonable suspicion of crimes committed against a resident of this facility.The purpose of this policy is to ensure reporting of crimes occurring in federally funded long term care facilities is in accordance with the Social Security Act.11) Final report of the results of all investigations to the administrator or his/her designated representative and to other officials in accordance with State law, including to the State Survey Agency within five working days of the incident and if the alleged violation is verified appropriate corrective action must be taken.12) Facility has conducted a thorough investigation, have prevented further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress and all results of thorough investigation has been reported within five working days.410 IAC (Indiana Administrative Code) 16.2 - 3.1-28(c) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supervision and develop and implement interventions to prevent recurrent falls for 2 of 4 residents reviewed for accidents (Resident 7 and Resident 6). Findings include: 1.During an observation, on 3/5/26 at 3:03 p.m., Resident 7 walked up and down the unit's hallway. Resident 7's clinical record was reviewed on 3/9/26 at 9:36 a.m. Diagnoses included difficulty walking, low back pain, unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain, restless leg syndrome (RLS), and hypertension. Current orders included donepezil (for dementia) 10 mg daily at bedtime (8/9/23), memantine extended release (for dementia) 28 mg daily (7/5/23), acetaminophen 1000 mg daily for pain (2/6/26), activity level: up ad lib (6/8/21), apply gripper socks at bedtime to prevent falls at bedtime for fall prevention (12/19/23), fall mat at bedside at night - put out of walk way during waking hours every shift (2/4/25), mattress on the floor with another mattress beside the mattress while in bed, stack mattress while resident out of bed every shift to help prevent falls (2/9/26), and may use weighted blanket while in bed every shift (2/7/26). A quarterly Minimum Data Set (MDS) assessment, dated 12/23/25, indicated the resident was severely cognitively impaired. He had no functional range of motion impairments to his extremities and utilized no mobility devices. He required supervision/touching staff assistance with rolling in bed, dressing his lower body, donning and doffing footwear, and moving from sitting to lying position. He required partial/moderate assistance with moving from lying to sitting, moving from sitting to standing, chair to bed and bed to chair transfers, toilet transfers, and tub/shower transfers. He walked 150 feet independently. A care plan, initiated 6/7/21, indicated the resident was at risk for falls due to abnormalities of gait, dementia, potential side effects from medications, and syncope. He was currently up ad lib. Interventions included the following: gripper socks as ordered (9/6/24), keep call light within reach (6/8/21), and keep walkways free of clutter (6/8/21). A care plan, initiated 6/8/21 and last revised 2/24/26, indicated the resident had falls with multiple dates listed including, but not limited to 1/5/26, 1/7/26, 1/9/26, 1/11/26, 1/15/26, 2/1/26, 2/4/26, 2/5/26, 2/8/26, 2/10/26, and 2/23/26. Interventions included the following: increase rounding when resident not in line of staff view (1/6/26), request medication review, possible restless leg syndrome and change in brexpiprazole times from morning to bedtime (1/6/26), medication review requested by physician (1/12/26), medications reviewed per pharmacy, restless leg syndrome (1/13/26), staff to assist resident to lay down when found ambulating with eyes closed (1/19/26), monitor resident more closely and assist to chair with attempts to sit down (1/27/26), frequent and routine rounds to prevent resident from physical discomfort which may increase restlessness or need to wander (2/1/26), pool noodle bolster under sheet to right side of bed (2/1/26), have physician review meds and ask for acetaminophen at bedtime (2/5/26), weighted blanket in bed to help with RLS, mattress on floor (2/8/26), keep wheelchairs in room or if in hallway have wheels locked (2/11/26), and refer to physical and occupational therapy (2/24/26). A progress note, dated 1/3/26 at 1:14 p.m., indicated the resident was walking around with his eyes closed and bumped his head on the wall and frames hanging by the doors. The staff attempted to lay the resident down. The resident was restless and attempted to get up. The staff assisted the resident up, and he continued to pace. The resident's representative sat with the resident. A progress note, dated 1/5/26 at 3:40 a.m., indicated the resident was found on the floor. He had an unwitnessed fall. He was on the floor sitting up leaning against his bed when staff arrived in the room. The bed was lowered all the way to the floor. His fall mat and bed alarm were in place. He wore his nonskid footwear. The immediate intervention was to meet the resident's needs and continue to monitor. A progress note, dated 1/5/26 at 2:00 p.m., (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated the resident ambulated in the hallway, dining room, and lounge with his eyes closed. He ran into things. He was unable to sit still. He was toileted then assisted to the lounge to listen to music. The resident's representative sat with him and indicated she had to push a chair under him several times to prevent him from falling. The resident was assisted to bed but only lay in bed for several minutes before he crawled out. A progress note, dated 1/5/25 at 6:02 p.m., indicated the resident had an unwitnessed fall. He was found in the music room by the outside door with his bottom on the floor and his head and back against the wall. The immediate intervention was to increase rounding while resident was not in sight. A progress note, dated 1/6/26 at 8:38 a.m., indicated the IDT (interdisciplinary team) met to review the fall that occurred on 1/5/26 at 3:40 a.m. The resident was found sitting upright on the floor mat beside the bed. The unit manager indicated the resident continued to often be restless when he was in bed. He moved his legs frequently and caused the bedsheets to tangle which caused him to end up on the floor mat bedside the bed. The immediate intervention was to meet the resident's needs and assist him back to bed. IDT recommended his medications be reviewed and to consider a medication for his RLS as well to change his brexpiprazole from morning to bedtime. A progress note, dated 1/6/26 at 12:46 p.m., indicated the IDT met to review the fall that occurred on 1/5/26 at approximately 4:30 p.m. when resident was sitting in the music room and was found sitting on the floor in front of the outside door. It was thought the resident got up as he usually did and tried to sit back down, missed the chair, and landed on the floor. No injuries were noted. He was assisted by two staff members to his feet. The resident was progressively declining and having increased falls. He walked with his eyes closed, and his gait had become less stable. He walked into walls and furniture and continued to keep going. Immediate and future intervention was to increase rounding on resident when he was not in the line of vision of the staff. A progress note, dated 1/9/26 at 11:01 a.m., indicated the resident grabbed the side railing and squatted up and down. He was unable to stand all the way up, and the staff member lowered the resident to the floor. The resident smelled of bowel movement. He was assisted to the restroom and had a bowel movement. It appeared the resident tried to have a bowel movement and experienced a vasovagal response. He was cleaned up, taken to his room, and assisted to bed. The physician and the resident's representative were notified. A progress note, dated 1/12/26 at 12:54 a.m., indicated the resident had an unwitnessed fall and was found on the floor. He was found sitting up with his back against the bed. The resident was given a drink and checked for incontinence. A light was left on in the room. A progress note, dated 1/12/26 at 12:53 p.m., indicated the IDT met to review the fall that occurred on 1/9/26 at approximately 11:00 a.m. The staff witnessed the resident holding on to the sideral of his bed and squatting up and down. The resident could not get to a standing position, so the resident was lowered to the floor. The nurse found the resident cool and clammy. He was taken to the bathroom as he smelled like bowel movement. He was incontinent of a large bowel movement. The immediate intervention was to provide incontinence care and assist him to bed. IDT believed the resident had a vasovagal response. A progress note, dated 1/13/26 at 1:12 p.m., indicated the IDT met to review the fall that occurred on 1/12/26 at approximately 12:33 a.m. When staff heard the bed alarm sounding, they went into the room. The resident sat on his bottom on the bedside mat. No injuries were noted. He was assisted back to bed after he was toileted. He recently started medication to treat his RLS. The order was clarified per pharmacy recommendation. The IDT believed once the RLS medication became effective, the need to move constantly would improve. A progress note, dated 1/15/26 at 7:06 p.m., indicated the resident was found on the floor with a chair on top of him. The resident was assisted to bed and given incontinence care. No injuries were noted. A progress note, dated 1/19/26 at 10:18 a.m., indicated the IDT met to review the fall that occurred on 1/15/26 at approximately 6:00 p.m. The resident had ambulated with his eyes closed and went into a room where he attempted to sit in a chair and missed the chair which caused him to fall. A new intervention was for the staff to assist the resident to bed when he ambulated with his eyes closed. No injuries were noted. A progress note, dated 2/1/26 at 4:30 a.m., indicated the resident was found<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | kneeling on both knees on the fall mat beside his bed. He wore non-slip socks. No injuries were noted. He was repositioned to a more comfortable position. A progress note, dated 2/2/26 at 12:08 p.m., indicated the IDT met to review the fall on 2/1/26. The resident was found with his knees resting on the foam mat beside his bed. The resident had a history of throwing his legs off the side of the bed while he was asleep. The IDT recommended a pool noodle bolster under the sheet on the right side of the bed to prevent the resident from kicking his legs off the bed. A progress note, dated 2/4/26 at 10:55 p.m., indicated the resident had an unwitnessed fall. His knees were slightly reddened. A progress note, dated 2/5/26 at 11:41 p.m., indicated the resident had an unwitnessed fall. He was found with his knees on the fall mat, and his top half of his body was on the bed in a kneeling position. A progress note, dated 2/6/26 at 8:45 a.m., indicated the IDT reviewed the fall on 2/5/26 at 11:41 p.m. He was found with his knees on the fall mat and upper body in bed. The resident had RLS and liked to dangle his legs off the bed. IDT recommended a weighted blanket to see if it would help with the RLS. A progress note, dated 2/9/26 at 10:20 a.m., indicated the IDT reviewed the resident's change of plane on 2/8/26. The resident was found on his knees beside the bed on his mat. No injuries were noted. The physician recommended a mattress on the floor and to have acetaminophen at bedtime. A progress note, dated 2/10/26 at 5:18 p.m., indicated the resident was on the floor in the hallway on his right side with a wheelchair on top of him. No injuries were noted. Wheelchairs were removed from the hallway. A progress note, dated 2/11/26 at 4:35 p.m., indicated the IDT reviewed the fall on 2/10/26. Resident ambulated in the hallway with his shoes on. He attempted to move the wheelchair and sit down. The wheelchair moved, and he fell onto his right side. The wheelchair was found on top of him. He did not exhibit any injuries. A new intervention was to keep all wheelchairs in rooms or locked if they were in the hallway. A progress note, dated 2/23/26 at 5:30 p.m., indicated the resident fell. He was found on his back with his head by another resident's wheelchair. A progress note, dated 2/24/26 at 10:41 a.m., indicated the IDT reviewed the resident's fall on 2/23/26. He was observed sitting with his legs crossed. He attempted to stand up with his legs crossed which caused him to fall. He hit his head on a nearby wheelchair. The resident had been leaning forward more when walking. The IDT recommended getting an order for a physical and occupational therapy evaluation. During an observation, on 3/9/26 at 10:35 a.m., the resident lay on his low bed facing the wall. A mattress was beside his bed. The bed did not have a pool noodle on it or under the sheets. During an observation, on 3/9/26 at 11:40 a.m., the resident walked down the hall with his head bent down and his hands in his pockets. During an observation, on 3/10/26 at 8:38 a.m., the resident lay in his bed with his eyes closed. He was propped on his right side with the use of two pillows. A pool noodle was not utilized on the bed for a bolster. A mattress was beside the low bed. During an observation, on 3/10/26 at 11:02 a.m., the resident sat in a chair in the dining room with his eyes tracking the movement of staff and other residents. During an observation, on 3/10/26 at 11:03 a.m., the floor mattress in the resident's room was propped up against the resident's bed at an angle. During an observation, on 3/10/26 at 11:06 a.m., two wheelchairs were in the hallway. One was located along the wall near the doorway of the resident's room and was not locked. Another one was located against the wall across from the dining room and was not locked. During an interview, on 3/10/26 at 11:57 a.m., CNA 10 indicated the resident's mattress was usually put up against the wall and then put the mattress behind the headboard of the bed against the wall. She did not understand the order for stacking the mattress. She indicated the wheelchairs were to be locked in the hallway as she locked the wheelchair near the resident's doorway to his room. The resident used to have a pool noodle, but she did not think they used it anymore. She found the pool noodle on the chest of drawers behind pictures. He did not use the pool noodle during the day, but she thought he did during the evening. To keep the resident from falling, she toileted him frequently, walked with him, gave him interactive books, and played music (as he loved music). During an observation, on 3/10/26 at 3:52 p.m., the resident walked out of the lounge area and mumbled something incoherently. He walked up to a two wheeled walker located against the wall in the hallway and lifted it sideways. During an interview, on (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3/10/26 at 4:26 p.m., RN 9 indicated she did not know what the mattress order meant, but she did make sure the bed was lowered to the floor, and the floor mattress was placed behind the bed up against the wall to prevent a resident from tripping over the mattress. She did not know about the pool noodle. She had not used it. CNAs could access the interventions on the electronic medical record. Most of the resident's falls were at night. She rounded more frequently than every two hours. During the day, he was toileted often. He sometimes fell asleep while walking, so she tried to assist him to sit down or lie down. Wheelchairs in the hallways should be on one side and locked. During an interview, on 3/10/26 at 4:35 p.m., CNA 12 indicated she checked the Kardex on the electronic medical record for any updates and interventions. To prevent falls for the resident, she made sure he had on gripper socks, his bed was lowered to the floor, had his bed alarm on, put the mattress beside his bed when he was in bed in case he rolled out of bed, put the mattress behind the bed when the resident was up so no one would trip on it, and put shoes on him when he was up. She did not use the pool noodle. During an interview, on 3/12/26 at 11:09 a.m., the DON indicated the resident previously had a different bed and was rolling out of it at night. He liked to lay on the bed with his knees on the floor. He was marked for falls because of the change of plane. A couple of his falls were because he needed to have a bowel movement. He squatted down and then fell. The staff should be following the care planned interventions. She did not know why the nurse had put in an order to stack mattress, as it should have been mattress on the floor. 2.During an observation on 3/6/26 at 11:54 a.m., Resident 6 was propelling himself to the dining room.During an observation on 3/9/26 at 10:46 a.m., Resident 6 was sitting in a wheelchair across from the nurse's station, eating a snack.During an observation on 3/9/26 at 3:27 p.m., Resident 6 was asleep in his wheelchair in the dining room.Resident 6's clinical record was reviewed on 3/9/26 at 10:44 a.m. Diagnoses included hemiplegia (paralysis) following cerebral infarction (stroke) affecting left non-dominant side, dysphasia, displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, fracture of superior rim of right pubis, subsequent encounter of fracture with routine healing, muscle weakness, difficulty in walking, unsteadiness on feet, other lack of coordination, and need for assistance with personal care. A comprehensive Minimum Data Set (MDS) assessment, dated 9/3/25, indicated the resident was cognitively intact, impaired on the left side of both his upper and lower extremities, used a wheelchair to ambulate, required substantial to maximal assistance for bed mobility (rolling left to right and sit to stand),bed to chair transfers, and shower and toilet transfers. He was able to ambulate independently. A current care plan, initiated on 7/9/25 and revised on 10/15/25, indicated Resident 6 had an Activity of Daily Living (ADL) self-care performance deficit and required supervision for toileting, bed mobility, transfers, and set-up and clean-up assistance for eating/drinking related to weakness from a stroke. Interventions included assisting the resident during bathing, one to two staff to reposition and turn the resident in bed, one staff to assist with dressing, encourage the resident to use call light for assistance, one staff to assist with toileting, and one staff to assist with all transfers. A current care plan, initiated on 7/10/25 and revised on 1/15/26, indicated Resident 6 was at risk for falls related to weakness, impaired balance, and hemiparesis. Interventions included anticipating and meeting the resident's needs (7/9/25), ensure the call light was within reach and encourage the resident to use if for assistance as needed, offering the resident activities to promote exercise, physical activity for strengthening and improved mobility, PT (physical therapy) to evaluate and treat as ordered as needed, re-educate the resident on the importance of using the call light (7/24/25), review information on past falls and attempt to determine cause of falls, record possible root causes, alter or remove any potential causes if possible, and weight bearing as tolerated (8/31/25). A current care plan, initiated 7/14/25, indicated Resident 6 had hemiparesis related to a stroke. Interventions included giving medications as ordered, monitoring for side-effects and effectiveness of medications, obtaining and monitoring labs and diagnostics, providing alternative comfort measures as needed, and physical therapy, occupational therapy, and speech therapy to evaluate and treat as ordered. A progress note, dated 7/18/25 at 11:40 p.m., indicated Resident 6<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | turned on his call light and was found on the floor. He got up to use the restroom without assistance. He was not wearing non-skid socks and said he got tripped up on a blanket on the floor. The immediate intervention was to advise him to ask for help before transferring. Non-skid socks were placed on his feet, and the clutter was removed from the floor. An occurrence note, dated 8/5/25 at 11:20 p.m., indicated Resident 6 was found on the floor beside his bed, knees drawn up and resting against his recliner. Resident 6 did not complain of pain or discomfort and was not injured. Resident 6 stated he was sitting on the edge of the bed and just slid off onto the floor. He was not trying to self-transfer. He was assisted back to bed, and the call light was left within his reach. The root cause(s) of the occurrence was determined to be the resident was sitting on the edge of the bed, self-transferring, gait imbalance, ambulating without assistance, and poor lighting. A progress note, dated 8/6/25 at 11:57 a.m., indicated the interdisciplinary team (IDT) met to review falls that occurred on 8/3/25 and 8/5/25. In both incidents, the resident was in bed prior to the falls. Staff found Resident 6 sitting on the floor next to his bed. Resident 6 said he slid off the edge of the bed. He was not injured in either incident. The care plan was reviewed and updated as needed. An occurrence note, dated 8/9/25 at 6:55 p.m., indicated staff heard a loud crash and went to Resident 6's room to investigate. He was found lying on the floor on his right side, legs bent, and head towards the recliner. Resident 6 stated he was ambulating with his walker, lost his balance, and fell. He had been ambulating around his room and up and down the hallway all day. Staff returned Resident 6 to his bed and gave him the call light. He was re-educated about using the call light to get help when ambulating. The fall care plan indicated the resident was provided education after the fall on 8/9/25. A Fall Follow-Up note, dated 8/19/25 at 12:25 p.m., indicated the IDT met to review a fall from 8/16/25 where the resident stated he slid out of bed. He was found wearing a pressure-relieving boot on his right foot and he was alert and oriented. The resident was known to be non-compliant with safety. He complained of right hip pain and had a scratch on his right temple. He was assisted back to bed, a mobile x-ray was ordered, and the x-ray results indicated multiple fractures of the pelvis.The clinical record lacked indication of updated interventions to mitigate the risk of subsequent falls following the resident's pelvic fracture on 8/16/26. An IDT progress note, dated 8/21/25 at 7:55 a.m., indicated the team met to discuss Resident 6's recent decline in condition. The resident sustained a fall which resulted in pelvic fractures, causing an overall decline in the resident's condition. A Fall Follow-Up note, dated 9/3/25 at 8:16 a.m., indicated the IDT met to review a fall occurring on 8/27/25 at approximately 12:35 p.m. Resident 6 was found sitting on the foot pedals of his wheelchair in his room. The call light had been pulled out of the wall. The resident stated he was trying to put the call light back in the wall. The resident tended to be impulsive and had no safety awareness. The immediate intervention was to place a pressure alarm in the seat of the wheelchair to alert staff when Resident 6 attempted to self-transfer. The pressure alarm was not added to the care plan until 9/4/26.An occurrence note, dated 9/1/25 at 10:30 p.m., indicated Resident 6 was found sitting on his buttocks on the floor in front of his bed with his back against the bed frame and his legs crossed in front of him. There were no visible signs of injury or pain. The note had a pre-populated area regarding the use of a personal alarm, which was marked not applicable. The resident stated he was trying to get up to get his walker, realized he would not be able to get to the walker, and sat down on the floor. To prevent the recurrence of the fall, the call light and walker were left within reach of the resident. He was assisted back to bed and re-educated on safety and fall precautions. The root cause(s) of the occurrence were listed as ambulating without assistance, gait imbalance, needs unmet, and refusal to allow staff to assist with care.A care plan intervention was added for the resident's bed to be placed in the lowest position when the resident was in bed (9/4/25).A progress note, dated 9/8/25 at 7:32 a.m., indicated the IDT met to review a fall that occurred on 9/7/25 at approximately 1:19 a.m. A CNA entered the resident's room and found him lying on the floor next to his bed. He was assessed for injury with no findings. Resident 6 indicated he was reaching for something on his bedside table. The bed was not in the lowest position. Re-education was provided to staff regarding following care plan<br>(continued on next page) |

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| | 155522 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Elwood Health and Living | 2300 Parkview LN<br>Elwood, IN 46036 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interventions. The fall care plan was updated to say staff were re-educated to follow fall prevention interventions (9/8/25). An occurrence note, dated 9/16/25 at 2:50 a.m., indicated Resident 6 was found sitting on the floor of his room with his legs bent in front of him, leaning against his bed. No injuries were identified. The personal alarm was in place but did not sound when the resident slid out of bed. Resident 6 stated he was sitting on the side of the bed and fell when the bed rolled out from under him. The immediate interventions were to move the bed, reset the bed alarm, and check the call light. The resident was given a drink and a snack. The root cause(s) of the fall were determined to be the brakes on the bed were not locked, the personal alarm was not sounding, and the resident was sitting on the side of the bed.A current care plan, initiated on 9/22/25 and revised 10/15/25, indicated Resident 6 had a history of self-transferring and lack of safety awareness. Interventions included making sure the call light was within reach and reminding the resident to use the call light to ask for assistance. An occurrence note, dated 10/9/26 (with a correction date of 10/10/25) at 6:36 a.m., indicated Resident 6 fell out of his wheelchair and hit his head while falling. He sustained a small bump on the head. No other injuries were noted. He was sent to the ER for a CT (radiology study) scan of his head. Immediate interventions were to help Resident 6 to his bed. He was encouraged to use the call light. The personal alarm was moved from the wheelchair to the bed and placed under the resident. Root cause(s) of the fall were determined to be the resident was drowsy, refused assistance, and was unsteady. The clinical record lacked an individualized fall prevention intervention following 10/10/25.An IDT fall follow-up note, dated 11/3/25 at 11:35 a.m., indicated the team met to review a fall that occurred on 11/1/25 at 4:50 p.m. Resident 6 was found lying on the floor with his knees next to the bed. No injuries were notes. Resident 6 stated he was not trying to get up. He was just sitting and probably slid off the bed. The nurse noted that the resident had only one non-skid sock in place. The nurse had failed to re-apply the resident's non-skid sock after completing a skin treatment. The IDT determined the nurse required re-education to ensure non-skid socks were in place prior to leaving the room.A quarterly MDS assessment, dated 11/18/25, indicated the resident was severely cognitively impaired, impaired on the left side of both his upper and lower extremities, used a walker and a wheelchair to ambulate, required substantial to maximal assistance for bed mobility, and was dependent for all transfers. An IDT fall follow-up note, dated 11/25/25 at 12:38 p.m., indicated Resident 6 fell on [DATE] at approximately 11:15 a.m. The resident was found sitting on the floor in front of his wheelchair near the entrance to the bathroom. He was assessed for injury and a scrape to his back was noted. The personal alarm did not sound. The CNA reported the alarm was malfunctioning. Resident 6 was assisted up to his wheelchair, then taken to the restroom.A quarterly MDS assessment, dated 12/30/25, indicated the resident was severely cognitively impaired, was impaired on the left side of both his upper and lower extremities, used a walker and wheelchair for ambulation, required substantial/maximal assistance for bed mobility (rolling left to right and sit to stand), and substantial/maximal assistance for tub/shower and toilet transfers. An occurrence note, dated 1/3/26 at 1:40 a.m., indicated a CNA found Resident 6 on the floor of his room, lying on his right side with his feet towards the bed and his head resting on his arm. The bed alarm was in place and working properly. Resident 6 stated he wanted to get up and walk over there. The bed was placed in low position, and the resident was reminded to use the call light for assistance. During an interview with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) on 3/11/26 at 1:58 p.m., the DON indicated it was her responsibility to update care plans. Some of the fall interventions for Resident 6 were resolved and were no longer applicable. Resident 6's cognition fluctuated and some days he was more capable of following fall interventions. Personal alarms were supposed to be checked every shift. When the battery was low, the alarm would start to beep. Sometimes, when staff replaced the batteries, they forgot to turn the alarm back on. The RNC indicated Resident 6 was often non-compliant with many things. The wheels on all beds should be locked in place. It was possible someone may have moved the bed and forgot to engage the locks. The bed controller, which raises and lowers the height of the bed and the head of the bed, was needed for staff when providing care.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | She thought Resident 6 might be responsible for raising the bed above the lowest position. She felt it was the resident's right to move the position of the bed if he wanted. A current facility policy, titled Fall Policy and Procedure, provided by the Administrator on 3/12/26 at 4:47 p.m., indicated the following: .7) All falls, regardless of injury, will be reviewed the following morning, during normal business hours, by the Interdisciplinary Team to determine if fall process was followed and an appropriate intervention was put in place. The care plan will be updated, and the CNA Care Guide will be reviewed to ensure new interventions are in place 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(2) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview and record review, the facility failed to ensure the narcotic shift to shift count was completed for 4 of 5 medication carts reviewed. Findings include::During a medication cart observation, on 3/5/26 at 11:07 a.m., the 200-hall back medication cart Narcotic Shift to Shift Count Record was missing signatures on 3/2/26 at 6 p.m. for the oncoming nurse, on 3/3/26 at 6 a.m. for the off going nurse, on 3/3/26 at 10 p.m. for the oncoming nurse, on 3/4/26 at 6 a.m. for the off going nurse, and on 3/5/26 at 9 a.m. for the oncoming nurse. The 200-hall front medication cart was missing signatures on 2/15/26 at 6 a.m. for the oncoming nurse, on 2/15/26 at 2 p.m. for the oncoming nurse, on 2/15/26 at 6 p.m. for the off going nurse, 2/15/26 at 6 p.m., for the oncoming nurse, 2/15/26 at 10 p.m. for the off going nurse, on 2/26/26 at 6 a.m. for the oncoming nurse, on 3/3/26 at 6 a.m. for the off going nurse, 3/3/26 at 10 p.m. for the oncoming nurse, and on 3/3/26 at no time listed for the off going nurse. During the observation, RN 14 indicated the Narcotic Shift to Shift Count Record was missing signatures and should be signed with each oncoming and off going nurse. During a medication cart observation, on 3/5/25 at 12:19 p.m., the 300-hall back medication cart Narcotic Shift to Shift Count Record was missing signatures on 2/20/26 at 6 a.m. for the oncoming nurse, on 2/20/26 at 6 p.m. for the off going nurse, on 2/20/26 at 10 p.m. for the off going nurse and the oncoming nurse, on 2/21/26 at 6 a.m. for the off going nurse, on 2/24/26 at 6 a.m. for the off going nurse, on 2/27/26 at 6 a.m. for the off going nurse, on 2/27/26 at 6 p.m. for the oncoming nurse, and on 2/28/26 at 6 a.m. for the oncoming nurse. During the observation, LPN 5 indicated the Narcotic Shift to Shift Count Record was missing signatures and should be signed every shift. During a medication cart observation, on 3/5/26 at 1:03 p.m., the 100-hall medication cart Narcotic Shift to Shift Count Record was missing signatures on 1/28/26 at 6 a.m. for the oncoming nurse, on 1/28/26 at 6 p.m. for the off going nurse., on 3/1/26 at 6 a.m. for the oncoming nurse, on 3/1/26 at 2 p.m. for the off going nurse, on 3/2/26 at 10 p.m. for the off going nurse, and on 3/5/26 at 6 a.m. for the off going nurse. During the observation, RN 9 indicated the Narcotic Shift to Shift Count Record was missing signatures and should be signed every shift upon arriving and leaving with the other nurse. During an interview, on 3/12/26 at 10:48 a.m., the DON indicated the narcotics should be counted and the shift-to-shift count should be signed every shift. Sometimes the nurses and QMAs will sign on but then do not sign off. Since the QMAs worked eight-hour shifts and the nurses worked 12-hour shifts, it can be confusing. But they should still be signing the Narcotic Shift to Shift Count Record. A current facility policy, reviewed 2/1/23, titled Medication Administration General Guidelines, provided by the Administrator on 3/11/26 at 3:10 p.m., indicated the following: Policy: Preparation or administration of medication(s) or biologicals completed in accordance with physician's orders; manufacturer's specifications (not recommendations); accepted professional standards and principles that apply to professionals providing service. The accepted professional standards and principals include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards and councils. Do Not report off shift without ensuring documentation is complete. 410 IAC (Indiana Administrative Code) 16.2-3.1-25(e)(3) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 2 of 5 residents (Residents 22 and 27) observed during the medication pass. There were 29 opportunities for error observed with 2 medication errors, resulting in a medication error rate of 6.9 percent. Findings include: 1. During a medication administration observation, on 3/10/26 at 8:42 a.m., LPN 6 prepared Resident 27's medications. She knocked on the door and took the prepared pills into the resident's room along with an 8 ounce of cup of water mixed with 17 grams of polyethylene glycol 3350 (laxative). The resident drank about four ounces of the medicated water mix. LPN 6 left the remainder of the medicated water mix on the resident's table. During an interview, on 3/10/26 at 8:57 a.m., LPN 6 indicated she left the of polyethylene glycol 3350 water mix with the resident to sip on. She would go back and check on the resident later. Resident 27's clinical record was reviewed on 3/11/26 at 9:37 a.m. Diagnoses included constipation, unspecified. Current orders included polyethylene glycol 3350 give 17 grams daily for constipation (7/21/24). The orders lacked an order for self-administration of medications. A quarterly Minimum Data Set (MDS) assessment, dated 2/3/26, indicated the resident was severely cognitively impaired. 2. During a medication administration observation, on 3/10/26 at 8:57 a.m., LPN 6 prepared Resident 22's medications. She knocked on the door and took the prepared pills into the resident's room along with an 8 ounce of cup of water mixed with 17 grams of polyethylene glycol 3350 (laxative). The resident drank approximately 2 ounces of the medication water mix. LPN 6 left the remainder of the medicated water mix on the resident's table. During an interview, on 3/10/26 at 9:08 a.m., LPN 6 indicated she would check back with the resident later. Resident 22's clinical record was reviewed on 3/11/26 at 10:17 a.m. Diagnoses included constipation. Current orders included polyethylene glycol 3350 give 17 grams daily for constipation (9/20/23). The orders lacked an order for self-administration of medications. A quarterly MDS assessment, dated 12/11/25, indicated the resident was moderately cognitively impaired. A care plan, initiated 6/1/21, indicated the resident had a potential for constipation related to impaired mobility. Interventions included administer medications as ordered (revised 11/30/23). During an interview, on 3/10/26 at 3:55 p.m., LPN 8 indicated polyethylene glycol 3350 mixed with water was not to be left with the residents as it was considered a medication. The residents were to be observed taking their medications. During an interview, on 3/11/26 at 10:47 a.m., RN 9 indicated medications including the polyethylene glycol 3350 mixed in water could not be left unattended with residents. The nurse must observe the residents take their medications. During an interview, on 3/11/26 at 2:19 p.m., the DON indicated medications including polyethylene glycol 3350 mixed with water were not to be left in the residents' rooms to be taken without being observed. A current facility policy, reviewed 2/1/23, titled Medication Administration General Guidelines, provided by the Administrator on 3/11/26 at 3:10 p.m., indicated the following: . Licensed nurse/authorized personnel MUST stay with the resident to ensure medication(s) are completely ingested. 410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(1) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation and staff interview, the facility failed to ensure medications were stored in a manner to prevent loose pills in the medication cart drawers for 2 of 3 medication carts reviewed out of 5 facility medication storage carts. (200 hall and 300 hall)Findings include: During a medication cart observation on 3/5/26 at 11:07 a.m., accompanied by RN 14, a blue oblong pill inscribed with A-17 was found loose in the second drawer on the left side of the 200-hallway medication cart. RN 14 indicated that the pill should be destroyed in a drug buster (a drug disposal system). The medication carts were cleaned out weekly. During a medication cart observation on 3/5/26 at 12:19 p.m., accompanied by LPN 5, the following loose pills/capsules were observed in the third drawer from the top of the 300 hallway medication cart: one peach colored capsule inscribed with 215, a pink round pill inscribed with 262, a white round pill inscribed with HP 23, a green oblong pill inscribed with E 45, a pink and orange pill inscribed with EP 102, a white round pill inscribed with L 150, and a pink oblong pill inscribed with 894. During an interview with the Director of Nursing (DON) on 3/12/26 at 10:50 a.m., she indicated the facility performed medication cart audits and it was unusual to have loose pills in the carts. Unit managers cleaned out the carts once a week. A current facility policy, titled Medication Cart Supplier and Maintenance, provided by the Administrator on 3/12/26 at 4:47 p.m., indicated the following: .To ensure that medication carts are maintained in the proper manner .21) Disposal of medications should be completed for medications that are without secure closure, outdated, contaminated and/or deteriorated. a) Disposal needs to be timely. b) Remove medications immediately from stock. c) Dispose of medications per medication disposal procedure .e) Document medication disposal 3.1-25(o)(s) |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>Based on observation, interview, and record review, the facility failed to provide adaptive tableware for 1 of 2 residents reviewed for assistive devices used during dining. (Resident 16) Finding includes:During a dining observation, on 3/6/26 at 12:43 p.m., Resident 16's meal was provided in the dining room on a white plate.During a dining observation, on 3/10/26 at 12:57 p.m., Resident 16's meal was provided in the dining room on a white plate. During an interview, on 3/10/26 at 1:30 p.m., LPN 5 indicated Resident 16 often fed himself but needed increased cuing and staff assistance during the lunch and supper meals. Resident 16 did not use specialty cups, plates, or utensils during meals.Resident 16's clinical record was reviewed on 3/10/26 at 3:45 p.m. Diagnoses included need for assistance for personal care, dysphagia at the oropharyngeal stage (difficulty initiating to swallow), lack of coordination, and dry eye syndrome.Current orders included regular diet with regular texture, thin liquids, and a red plate at meals (2/26/26).An annual Minimum Data Set (MDS) assessment, dated 2/6/26, indicated Resident 16 had severe cognitive impairment. He required supervision or touching assistance with eating. He had adequate vision and did not have corrective lenses.A current care plan, dated 12/16/24, indicated Resident 16 was at risk for a potential alteration of nutrition and/or weight status. Interventions included the following: serve diet as ordered (12/16/24) and red plate for meals related to vision issues (2/27/26).A nurses note, dated 2/26/26 at 11:04 a.m., indicated a discussion occurred regarding Resident 16's vision and decreased meal intakes. A red plate at meals was to be attempted to see if intakes improved.During an interview on 3/11/26 at 11:25 a.m., [NAME] 17 indicated specialty items for dining were relayed to the dietary staff verbally from the nursing staff and a form was completed by nursing and turned into dietary. A few residents received their meals on a red plate. She was unsure which residents received red plates on the 300 hall. The Dietary Manager arrived during the interview and indicated Resident 37, who resided on the 300 hall, received a red plate for meals. Neither [NAME] 17 nor the Dietary Manager indicated Resident 16 used a red plate.During an interview, on 3/11/26 at 11:37 a.m., the Dietary Manager indicated Resident 16 was to get a red plate for meals and not Resident 37. During an interview, on 3/11/26 at 1:42 p.m., CNA 19 indicated Resident 16's lunch meal was not served on a red plate today. She recalled she had picked up a standard white plate when she picked up Resident 16's lunch items from the dining room. She opened the food cart she was pushing and confirmed there were no red plates in the cart.During an interview, on 3/11/26 at 2:17 p.m., Unit Manager 4 indicated she was unaware that Resident 16 had not received his meals on a red plate. CNAs were not typically aware of who needed red plates. It was not on the assignment sheets. She had made the dietary department aware of Resident 16 needing a red plate on the day she entered the order. She had also given the dietary department a copy of the updated dietary order that listed the red plate.During an interview, on 3/11/26 at 2:20 p.m., Speech Therapist 20 indicated Resident 16's red plate was utilized due to the resident having visual problems. The red plate was less effective if staff fed him. The facility used dark tablecloths, and red plates were more effective with lighter backgrounds.During an interview, 3/11/26 at 2:36 p.m., the DON indicated Resident 16's dining and visual problems were identified by the occupational therapist and during a nutrition at-risk meeting. A verbal report of Resident 16's need for the red plate intervention occurred during an IDT type meeting. There was no documentation of this discussion. An order was in place for Resident 16 to have a red plate. The red plate intervention was care planned and was identified on Resident 16's meal ticket. Dietary staff did not have to serve Resident 16's meals on a red plate but it did help the resident. Resident 16's dietary order and care plan implied the resident may have a red plate and not that he had to actually have one. It relied on the preference of the dietary staff. The dietary staff was aware the nursing staff was assisting Resident 16 more often and they could determine if he needed the red plate or not.During an interview, on 3/11/26 at 2:42 p.m., the Nurse Consultant indicated a red plate was to be used for<br>(continued on next page) |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 16, especially if the meal consisted of pale foods.A facility policy, revised 4/17, titled Assistive Devices, provided by the Administrator, on 3/12/26 at 9:40 a.m., included the following: .Assistive devices will be provided to residents who need them. Purpose: To encourage residents to feed themselves. To maintain quality of life at highest level possible.D. Adaptive equipment is made available at mealtime by Dining Services . 410 IAC (Indiana Administrative Code) 16.2-3.1-21(h) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>A.Based on observation, interview, and record review, the facility failed to utilize infection prevention and control strategies related to handling of a urinary drainage bag for 1 of 2 residents reviewed for indwelling catheters. (Resident 65)B. Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions (EBP) were implemented during perineal care and wound care for a resident with a feeding tube for 1 of 3 residents reviewed for wound care. (Resident 56) Finding includes:A.During an observation, on 3/6/26 at 10:45 a.m., Resident 65's indwelling urinary catheter drainage bag hung under his wheelchair. The bag touched the floor. The bag drug on the floor as Resident 65 self-propelled his wheelchair in the hallway.<br><br>During an observation, on 3/6/26 at 12:13 p.m., Resident 65's urinary catheter drainage bag drug on the floor as Resident 65 self-propelled his wheelchair in the hallway.<br><br>During an observation, on 3/9/26 at 10:45 a.m., Resident 65's urinary catheter drainage bag drug on the floor as Resident 65 self-propelled his wheelchair in the hallway.<br><br>During an observation, 3/9/26 at 4:16 p.m., Resident 65 sat in his wheelchair in room. The urinary catheter drainage bag hung under his wheelchair. The bag was dated 3/1 and rested on the floor.<br><br>Resident 65's clinical record was reviewed on 3/9/26 at 9:46 a.m. Diagnoses included obstructive and reflux uropathy (urine flow is blocked or flows backward into the kidneys) and dementia.<br><br>Current physician orders included urinary drainage bag changed weekly on Wednesdays (10/22/25).<br><br>A Minimum Data Set (MDS) assessment, dated 1/23/26, indicated Resident 65 had moderate cognitive impairment. He used a wheelchair for mobility. He was dependent on staff assistance for toileting and personal hygiene and for chair/bed to chair transfers. He had an indwelling catheter.<br><br>A current care plan, revised on 1/27/26, indicated Resident 65 had a catheter due to urinary retention. Interventions included the following: catheter care as ordered (10/20/25), change urinary catheter as ordered by medical doctor (10/20/25), keep catheter tubing and bag below level of bladder (10/20/2025) and notify medical doctor if problems occur with catheter (10/20/2025).<br><br>The electronic treatment administration record (ETAR) indicated Resident 65's urinary drainage bag was changed on 3/4/26.<br><br>During an observation, on 3/10/26 at 4:33 p.m., Resident 65 sat in his wheelchair in his room. The urinary catheter drainage bag hung under his wheelchair. The bag was dated 3/1 and rested on the floor.<br><br>During an interview, on 3/10/26 at 4:46 p.m., CNA 21 confirmed Resident 65's catheter drainage bag was resting on the floor under his wheelchair. CNA 21indicated a catheter bag should never touch the floor because of infection control issues. She put on a pair of gloves, lifted the privacy cover on the front of the bag and did a visual inspection of the urine. The bag contained approximately 200 milliliters of urine. She did not empty the urine from the drainage bag. She unhooked the bag from under the wheelchair and hung the bag on the right arm rest of the wheelchair.<br><br>During an interview, on 3/10/26 at 4:53 p.m., LPN 5 indicated a urinary catheter drainage bag was not<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155522 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Elwood Health and Living | 2300 Parkview LN<br>Elwood, IN 46036 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to touch the floor and it was an infection control issue. The urinary drainage bag was to be secured so it would not slide down and touch the floor. Facility staff were aware the catheter bag was not to touch the floor. Urinary drainage bags were changed by night shift nurse, weekly, on Wednesdays. The ETAR indicated the bag was changed on 3/4/26. LPN 5 confirmed the urinary drainage bag was dated 3/1/26.<br><br>During an interview, on 3/10/26 at 5:10 p.m., the DON indicated a catheter drainage bag was not to touch the floor, ever, and touching the floor was an infection control issue.<br><br>During a catheter care observation, on 3/11/26 at 2:47 p.m., CNA 19 confirmed Resident 65's urinary catheter drainage bag was resting on the floor under Resident 65's wheelchair. CNA 19 indicated the catheter bag was not to touch the floor. The bag may get snagged and leak and it was an infection control issue.<br><br>A facility policy, revised 7/27/21, titled Foley Catheter Policy, found on conference table on 3/11/26 at 8:45 a.m., included the following: . 4. The use of an indwelling urinary catheter will be in accordance with physician orders. 8. Indwelling catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible. Possible complications include but are not limited to urinary tract infection. 9. The plan of care will address the use of an indwelling urinary catheter, including strategies to prevent complications.<br><br>B. Resident 56's clinical record was reviewed on 3/9/26 at 3:10 p.m. Diagnoses included dysphagia, oropharyngeal phase, central cord syndrome at C3 level of cervical spinal cord and C4 level of cervical spinal cord, and personal assistance with personal care.<br><br>Current orders included enhanced barrier precautions – don appropriate PPE (personal protective equipment) when caring for feeding tube every shift.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 2/4/26, indicated the resident was dependent on staff for all activities of daily living.<br><br>A current care plan, revised 4/18/25, indicated the resident required enhanced barrier precautions related to his feeding tube. Interventions included the following: Continue to provide education to staff as needed (4/18/25) and EBP signage on the door to assist staff in identifying need for PPE (4/18/25).<br><br>During a wound care and perineal care observation, on 3/10/26 at 1:11 p.m., LPN 8 and CNA 11 sanitized their hands and applied gloves upon entering the resident's room to perform perineal and wound care. They removed the resident's brief and performed incontinence care. They rolled the resident back and forth on the bed with his body touching their arms. After the incontinence care was performed, LPN 8 performed wound care after washing her hands and applying new gloves. LPN 8 and CNA 11 did not wear gowns during these activities.<br><br>During an interview, on 3/10/26 at 1:34 p.m., LPN 8 indicated she did not need to wear a gown during the wound or incontinence care for EBP because the EBP was specific to feeding tube care.<br><br>During an observation, on 3/10/26 at 1:36 p.m., a sign on the resident's door indicated he was on EBP which indicated the following: EVERYONE MUST: Clean their hands, including before entering and<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy Wound Care: any skin opening requiring a dressing.<br><br>During an interview, on 3/11/26 at 10:51 p.m., CNA 11 indicated she had not worn a gown during Resident 56's perineal care yesterday, but she found out yesterday she was supposed to wear gowns with all residents on EBP when providing high contact care.<br><br>During an interview, on 3/11/26 at 2:19 p.m., the DON indicated she would expect the staff to apply PPE to perform high contact care on residents on EBP.<br><br>A current facility policy, dated 4/2/24, titled Enhanced Barrier Precautions, provided by the Administrator on 3/11/26 at 3:10 p.m., indicated the following: . Enhanced Barrier Precautions (EBP) will be in place during high contact care activities for resident with the following conditions: . All Resident's with indwelling medical devices which includes but is not limited to catheter, central lines, feeding tubes, tracheostomy tubes.Residents for whom EBP are indicated, EBP is employed when performing the following high contact resident care activities; Dressing, Bathing/Showering, Transferring, providing hygiene, changing linens, changing briefs/incontinent care/toileting, Device care or use: Central line, urinary catheter, feeding tube, tracheostomy, ventilator, Wound care other than skin tears or simple breaks in the skin.<br><br>410 IAC (Indiana Administrative Code) 16.1-3.1-18(a) |