| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155566 | A. Building<br>B. Wing | 09/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warsaw Meadows | 300 E Prairie St<br>Warsaw, IN 46580 |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review, the facility failed to store and serve food in a sanitary manner, related to undated foods, expired foods and thumbing of the plates for 1 of 1 kitchen and 2 of 2 nutritional pantries. This deficient practice had the potential to affect 63 of 63 residents who receive meals from the kitchen. Findings include: 1. During the initial tour of the kitchen, on 9/2/2025 at 9:48 A.M., with the Dietary Manager the following was observed: - in the stand up freezer 2 bags of frozen pancakes with no use by date During an interview, on 9/2/2025 at 9:53 A.M., the Dietary Manager Indicated there should have been a use by date on the pancakes. 2. During a follow up tour of the kitchen, on 9/03/2025 at 10:27 A.M., [NAME] 13 placed an opened container of pureed chicon on the counter top and placed a bucket of sanitizing liquid right next to the open container of chicken. During an interview, on 9/4/2025 at 11:20 A.M., the Dietary Manager indicated food items should not be near the sanitizing water bucket. 3. During an observation, on 9/04/2025 at 11:32 A.M., [NAME] 14 was observed placing her thumb on the eating surface of the plates as she plated food. During an interview, on 9/4/2025 at 11:34 A.M., [NAME] 14 indicted she should not have placed her thumb on the food surfaces of the plates.4. During observations, on 9/8/2025 at 11:16 A.M, of the heritage and freedom hall pantries with QMA 16 the following was observed:expired cranberry juice with a use by date of 9/7/2025, 5 peanut butter bars that had expired on 9/5/2025. -a container of med pass that had expired on 9/7/2025.During an interview, on 9/8/2025 at 11:18 A.M., QMA 16 indicated the expired items should have been removed from the pantries. On 9/8/2025 at 2:14 P.M., the Administrator provided the policy titled, Food Storage, dated 3/26/2020, and indicated the policy was the one currently used by the facility. The policy indicated . Food storage areas shall be maintained in a clean, safe and sanitary manner 3.1-21(i)(3) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on record review and interview, the facility failed to develop a person centered care plan for (Post Traumatic Stress Disorder) PTSD and failed to develop a care plan after a hospitalization with a new initiation of an anticoagulant medication and a diagnosis of severe anemia for 2 of 21 residents reviewed for care plans. (Resident 15 and 6)Findings include:<br><br>1. The record for Resident 15 was reviewed on 9/4/2025 at 9:53 A.M. Diagnoses included but were not limited to cancer, non-Alzheimer's dementia, anxiety, depression, psychotic disorder, bipolar, schizophrenia and PTSD (post-traumatic stress disorder).<br><br>An admission MDS (Minimum Data Set) assessment, dated 6/2/2025, indicated the resident had the ability to express ideas and wants, experienced delusions and received antipsychotic, antidepressant, anticonvulsant, and opioid medications.<br><br>Current Physician ordered medications included the following: Prazosin 2 mg capsule at bedtime for PTSD.<br><br>A current Care Plan, initiated on 5/28/2025, indicated Resident 15 had a psychosocial well-being problem related to a history of personal trauma or PTSD (post traumatic stress disorder). Interventions included: allow the resident time to answer questions and to verbalize feelings, perceptions, and fears. Consult with Pastoral care, Social Services, and Psych services. Encourage participation from resident who depend on others to make own decisions. There were no interventions specific to the resident's triggers and individual needs related to her trauma history. In addition, the care plan did not address the resident's delusional behavioral issues.<br><br>During an interview, on 9/8/2025 at 10:10 A.M., the Social Service unit Director indicated she was new and could not provide any information regarding the resident.<br><br>During an interview, on 9/8/2025 at 10:14 A.M., the MDS Coordinator indicated the social service director was responsible for completing the care plans for residents on the secured dementia unit.<br><br>2. During an interview, on 9/2/2025 at 2:12 P.M., Resident 6 indicated he had recently been prescribed an anticoagulant. He indicated had been hospitalized , in July 2025, due to a hemoglobin level of 2 g/dL (grams per deciliter, normal level 13.5-17.5 g/dL) and subsequently deep vein thromboses (blood clots) were discovered in his right upper and lower extremities.<br><br>A record review for Resident 6 was completed, on 9/5/2025 at 8:44 A.M. Diagnoses included, but were not limited to: cerebral palsy, iron deficiency anemia, spastic hemiplegia cerebral palsy and Parkinson's disease.<br><br>A Quarterly Minimum Data Set (MDS) assessment, dated 8/15/2025, indicated Resident 6 was cognitively intact and received an anticoagulant.<br><br>A Hospital History and Physical, dated 7/20/2025, indicated Resident 6's evaluation indicated he had presented with a hemoglobin level of 2 g/dL and had received four units of packed red blood cells which had raised his hemoglobin level to 7.1 g/dL Resident 6 was diagnosed with profound anemia and potential hemorrhagic shock. The record indicated Resident 6 had a history, o occasional bilateral<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | lower extremity edema and was noted to have worsening edema to the right lower extremity.<br><br>A Physician's Order, dated 7/29/2025, indicated the Apixaban 5 milligrams twice daily for a blood clot and ferrous sulfate 325 milligrams daily for anemia. was prescribed.<br><br>A Nurse Practitioner Note, dated 7/31/2025, indicated Resident 6 had been hospitalized and had been found to have a hemoglobin level of 2 g/dL, was diagnosed with deep vein thrombosis in the right upper and lower extremities and anemia. Resident 6 had an IVC filter placed for the treatment of the deep vein thromboses.<br><br>There were no current orders for observation of the side effects of the anticoagulant medication, nor a care plan to address the anticoagulant use or anemia diagnosis.<br><br>During an interview, on 9/8/2025 at 1:01 P.M., the MDS (Minimum Data Set) Coordinator indicated she had not written a care plan for the anticoagulant use or the anemia diagnoses. She indicated the care plan should have included the anticoagulant use and the anemia diagnoses.<br><br>A current policy was provided on, 9/8/2025 at 1:01 P.M., by the Director of Nursing (DON). The policy titled, Care Plans-Comprehensive, indicated, .An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS.4. Areas of concern that are triggered during the resident assessment are evaluated before interventions are added to the care plan.6. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician [or primary healthcare provider] is integral to this process.9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on interview, record review and interview, the facility failed to ensure residents were invited to care plan meetings and meetings were held timely for 5 of 21 residents reviewed for care plans. (Residents 15, 21, 17, 4 & 30)Findings include:<br><br>1.During an interview, on 9/2/2025 at 10:54 A.M., Resident 15 indicated she had never been to one (care plan meeting).<br><br>The record for Resident 15 was reviewed on 9/4/2025 at 9:48 A.M. Diagnoses included, but were not limited to bipolar, Schizophrenia, anxiety, PTSD, (post traumatic stress disorder), cancer, insomnia and delusions.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 9/4/2025, indicated Resident 15 had clear speech, make herself understood and understood others.<br><br>A Multidisciplinary Care Conference Note, dated 5/22/2025, indicated a care conference was held on 5/23/2025 at 9:00 A.M. Attendance at the meeting was documented as an LPN, a QMA and the resident's guardian via phone. The form lacked the documentation indicating the resident had been invited or was in attendance for the care meeting.<br><br>A Multidisciplinary Care Conference Note, dated 6/14/2025, indicated a care conference was held on 6/17//2025 at 2:00 P.M. Attendance at the meeting was documented as a QMA and the dietary manager. The form lacked the documentation of the resident having been invited or having been in attendance for the care meeting.<br><br>The Nursing Progress Notes dated 5/23/2025 and 6/17/2025 lacked the documentation to show the resident had been invited or had attended the care plan meetings.<br><br>During an interview, on 9/8/2025 at 10:14 A.M., the MDS (Minimum Data Set) nurse indicated the SSD (Social Service Director) was responsible for completing the care plan documentation and completing the invitations for the locked unit.<br><br>During an interview, on 9/8/2025 at 10:14 A.M., the Director of Nursing indicated the resident should have been invited to her care plan meetings.<br><br>2. During an interview on, 9/2/2025 at 2:59 P.M. Resident 21 indicated she couldn't remember any meetings.<br><br>The record for Resident 21 was reviewed on 9/5/2025. Diagnoses included, but were not limited to renal disease, Non Alzheimer's dementia, depression and hypertension.<br><br>A Quarterly MDS(Minimum Data Set) assessment, dated 7/16/2025,indicated Resident 21 had clear speech, make herself understood and understood others.<br><br>A Multidisciplinary Care Conference Note, dated 9/24/2024, indicated a care conference was held on 9/25/2024 at 12:00 P.M. Attendance at the meeting was documented as only an LPN. The form lacked the documentation indicating the resident had been invited or had attended the care meeting.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A Multidisciplinary Care Conference Note, dated 12/2/2024, indicated a care conference had been held on 12/3/2024 at 11:00 A.M. The form indicated the NP and the Social Service staff had attended the meeting. The record lacked documentation to show the resident had attended the care plan meeting.<br><br>A Multidisciplinary Care Conference Note, dated 3/9/2025, indicated a care conference had been held on 3/24/2025 at 10:15 A.M. The form indicated the NP, the dietary manager, the social service staff and the resident's guardian had attended the care plan meeting. The record lacked the documentation to show the resident had been invited or had attended the care plan meeting.<br><br>A Multidisciplinary Care Conference Note, dated 6/14/2025, indicated a care conference was held on 17/24/2025 at 12:00 P. M. Attendance at the meeting was documented as the NP, the dietary manager, the social service staff and the resident's guardian. The record lacked the documentation to show the resident had attended the care plan meeting.<br><br>During an interview, on 9/8/25 at 10:14 A.M., the MDS nurse indicated the SSD was responsible for completing the care plans and completing the invitations for the dementia unit.<br><br>3. A record review was completed for Resident 17 on 9/3/2025 at 1:19 P.M.<br><br>Resident 17's record indicated he had attended a care plan conference on the following dates:<br><br>-9/9/2024<br><br>-3/27/2025<br><br>-6/3/2025<br><br>Resident 17's record lacked documentation that a care plan conference had been completed in December 2025.<br><br>4. A record review was completed for Resident 30, on 9/4/2025 at 2:19 P.M., and indicated her diagnoses included: Post Traumatic Stress Disorder, chronic respiratory failure, Congestive Heart Failure, Type 2 Diabetes, Peripheral Vascular Disease, morbid obesity, Hypertension, poly-neuropathy, major depressive disorder, and Chronic Obstructive Pulmonary Disease,<br><br>The progress notes indicated a care plan meeting had been held on 4/16/24. The record lacked documentation of family or resident notification and listed only the Social Services Director and the dietary staff had attended and provided input.<br><br>A care plan meeting had been held on 10/4/24. The resident's daughter, a representative from the nursing department and the Social Services Director were listed as attending the meeting. The record lacked documentation that the resident had been invited or had attended the meeting. A care plan meeting had been documented as held on 4/1/25. The resident's representative, nursing staff and the Social Services Director were listed as having attended the meeting. There was no documentation to show the resident had been invited to the meeting. Finally, documentation indicated a care plan meeting had been held on 7/22/25. The resident was in attendance with social service director. There were no other staff listed as having attended the meeting.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. A record review was completed on Resident 4 on 9/8/2025 at 10:15 A.M. Diagnoses included but not limited to Bipolar disorder, colon cancer, vascular dementia and post-traumatic stress disorder.<br><br>A record review for care plan conferences conducted during past year indicated the meetings had not held quarterly. The care conferences were held on 9/24/2024, 3/27/2025, and 6/30/2025. The only individuals present at the conferences were the resident and the Social Services Director.<br><br>A record review of an Interdisciplinary Team (IDT) meeting, dated 9/25/24, revealed a meeting attended by pharmacy staff, the Geri-psych Nurse Practitioner, the attending Nurse Practitioner, the Social Services Director, the dementia program coordinator and the Director of Nursing had been held. The meeting did not include the resident and/or the resident's representative and there was no documentation the resident and/or the resident's representative had been invited to the IDT meeting. There were no further IDT meetings with multiple disciplines in attendance documented to have occurred over the past year.<br><br>During an interview, on 9/8/25 at 1:35 P.M. the Social Services Director indicated a care conference should have been held every 3 months and documentation should have included notification of the resident or the resident's representative. She indicated that all care conferences held were documented in the medical record.<br><br>On 9/5/2025 at 1:35 P.M., the Executive Director provided a policy called Care Planning - Interdisciplinary Team that indicated .an explanation will be included in the resident's medical record if the participation of the resident and his/her representative for developing the resident's care plan is determined to not be practicable. Furthermore, the policy stated .the Interdisciplinary Team must review and update the care plan: .at least quarterly.<br><br>3.1-35(c)(1) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on observation, record review and interview, the facility failed to follow a physician's order for a hypotensive medication, failed to administer bowel protocols for constipation, failed to follow physician's orders for insulin administration and failed to assess and document a skin issue for 4 of 18 residents reviewed for care needs. (Residents 5, 3, 7 & 18)Findings include:1.A record review for Resident 5 was completed, on 9/3/2025 at 2:01 P.M. Diagnoses included, but were not limited to: atrial fibrillation, hypotension and coronary artery disease.<br><br>An Annual Minimum Data Set (MDS) assessment, dated 7/2/2025, indicated Resident 5 was cognitively intact.<br><br>A Physician's Order, dated 4/3/2025, indicated the resident was to receive Midodrine 10 milligrams by mouth three times a day for hypotension. In addition there was an order to hold the Midodrine for a systolic blood pressure greater than 110 mmHg (millimeters of mercury).<br><br>The August 2025 Medication Administration Record indicated the following blood pressure readings with the administration of Midodrine:<br><br>-8/1/2025 8:00 P.M. 127/63 mmHg<br><br>-8/3/2025 8:00 P.M. 119/64 mmHg<br><br>-8/4/2025 8:00 P.M. 123/68 mmHg<br><br>-8/5/2025 8:00 P.M. 118/68 mmHg<br><br>-8/6/2025 8:00 P.M. 124/64 mmHg<br><br>-8/8/2025 8:00 A.M. 126/76 mmHg<br><br>-8/9/2025 8:00 P.M. 122/71 mmHg<br><br>-8/10/2025 8:00 A.M. 131/65 mmHg<br><br>-8/12/2025 8:00 P.M. 119/59 mmHg<br><br>-8/16/2025 8:00 P.M. 119/60 mmHg<br><br>-8/18/2025 8:00 P.M. 123/73 mmHg<br><br>-8/19/2025 8:00 P.M. 123/68 mmHg<br><br>-8/20/2025 4:00 P.M. 122/78 mmHg<br><br>-8/22/2025 8:00 P.M. 123/78 mmHg<br><br>-8/25/2025 8:00 P.M. 130/76 mmHg<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -8/29/2025 8:00 P.M. 122/69 mmHg<br><br>The July 2025 Medication Administration Record indicated the following blood pressure readings with administration of Midodrine:<br><br>-7/3/2025 8:00 P.M. 130/70 mmHg<br><br>-7/5/2025 8:00 P.M. 126/56 mmHg<br><br>-7/6/2025 8:00 P.M. 120/68 mmHg<br><br>-7/10/2025 8:00 P.M. 118/65 mmHg<br><br>-7/19/2025 8:00 P.M. 123/68 mmHg<br><br>-7/20/2025 8:00 P.M. 122/73 mmHg<br><br>-7/21/2025 8:00 P.M. 122/68 mmHg<br><br>-7/25/2025 8:00 P.M. 128/76 mmHg<br><br>The July 2025 Medication Administration Record indicated the following blood pressure readings with administration of Midodrine:<br><br>-6/1/2025 8:00 P.M. 116/73 mmHg<br><br>-6/2/2025 8:00 P.M. 123/67 mmHg<br><br>-6/7/2025 8:00 P.M. 117/68 mmHg<br><br>-6/8/2025 8:00 P.M. 135/78 mmHg<br><br>-6/9/2025 8:00 P.M. 115/60 mmHg<br><br>-6/11/2025 1:00 P.M. 122/70 mmHg<br><br>-6/11/2025 8:00 P.M. 131/74 mmHg<br><br>-6/14/2025 8:00 P.M. 117/65 mmHg<br><br>-6/15/2025 8:00 P.M. 123/69 mmHg<br><br>-6/17/2025 8:00 P.M. 122/70 mmHg<br><br>-6/19/2025 8:00 P.M. 122/63 mmHg<br><br>-6/25/2025 8:00 P.M. 123/73 mmHg<br><br>A Care Plan, initiated on 2/21/2025, indicated Resident 5 had altered cardiovascular status related to<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | congestive heart failure, hypotension, coronary artery disease, atrial fibrillation and hyperlipidemia. Interventions included, but were not limited to: administer medications as prescribed for hypotension and notify the physician of any abnormal readings.<br><br>During an interview, on 9/8/2025 at 10:04 A.M., RN 6 indicated Resident 5 should not have received the Midodrine medication if his systolic blood pressure was greater than 110 mmHg.<br><br>2. A record review for Resident 3 was completed, on 9/4/2025 at 9:14 A.M. Diagnoses included, but were not limited to: neuroleptic induced Parkinsonism, schizoaffective disorder, bipolar disorder and impulse control.<br><br>A Significant Change MDS assessment, dated 8/8/2025, indicated Resident 3 was cognitively intact and was always continent of their bowel movements.<br><br>A Point of Care Legend Report, dated July 16-25, 2025, of Resident 3's bowel movements indicated the resident had a medium bowel movement on 8/16/2025 at 5:49 A.M. There were no further bowel movements recorded, except for a small bowel movement, on 7/22/2025 at 1:48 A.M. and 7/24/2025 at 3:26 A.M., which were recorded as hard/constipated.<br><br>A Nursing Progress Note, on 7/21/2025 at 1:45 A.M., indicated Resident 3 had had a change in condition with decreased alertness and occasional coffee ground enemies. An order was obtained for a KUB (kidney, ureter, bladder) x-ray, laboratory tests of a complete blood count and a basic metabolic panel, urinalysis and intravenous fluids.<br><br>A KUB x-ray, completed on 7/21/2025 at 2:59 A.M., indicated there was abundant fecal material seen within the large bowel loops and a DDX (differential diagnosis) included constipation in the appropriate clinical setting.<br><br>A Nursing Progress Note, on 7/21/2025 at 8:13 P.M., indicated Resident 3 had complained of abdominal pain. The abdomen was soft and non-distended, but Resident 3 complained of pain when pressure was applied to the abdomen. A new order was obtained from the nurse practitioner for suppositories related to constipation.<br><br>The July 2025 Medication Administration Record indicated the following medications had been administered from 7/16-7/25/2025:<br><br>-Routine medications of Polyethylene Glycol Powder 17 grams daily for constipation and Senna Plus 8.6-50 milligrams one tablet daily for constipation.<br><br>-Dulcolax rectal suppository one suppository daily as needed for constipation on 7/21/2025 at 8:24 P.M. and 7/23/2025 at 11:49 P.M.<br><br>-Milk of Magnesia suspension 30 milliliters, on 7/22/2025 at 2:06 P.M.<br><br>-Fleets Enema one applicatorful on 7/22/2025 at 4:12 P.M.A Nursing Progress Note, on 7/22/2025 at 9:08 A.M., indicated Resident 3 had refused the new order for an enema.<br><br>A Nursing Progress Note, on 7/22/2025 at 1:59 P.M., indicated Resident 3 had been trying to have a bowel movement and appeared to experience a vasovagal episode (a fainting episode caused by a (continued on next page) |

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| | 155566 | A. Building<br>B. Wing | 09/08/2025 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | sudden decrease in blood pressure and pulse) and was lowered to the floor. Resident 3 was assisted back to the toilet and was asked by the nurse to all them to administer an enema to help pass the stool. However, Resident 3 had refused. A new order for Milk of Magnesium was obtained.<br><br>A Nursing Progress Note, on 7/22/205 at 2:05 P.M., indicated Resident 3 continued to refuse an enema after he was educated and he also refused to go to the hospital for an evaluation.<br><br>A Care Plan, initiated on 7/22/2025, indicated Resident 3 had constipation related to decreased mobility. The goal was for Resident 3 to have a normal bowel movement every three days. Interventions included, but were not limited to: record bowel movement pattern each day, describe amount, color and consistency and to encourage Resident 3 to sit on the toilet to evacuate bowels if possible.<br><br>During an interview, on 9/8/2025 at 11:28 A.M., RN 6 indicated the facility had a bowel movement protocol. She indicated if a resident did not have a bowel movement in three days an intervention of MiraLAX, prune juice, senna or docusate sodium would be administered. She indicated the nursing staff were provided with a no bowel movement list when a resident had not had a bowel movement documented for three days in a row. She indicated small bowel movements did not count for a documented bowel movement.<br><br>3. A record review was completed for Resident 7 on 9/3/2025 at 2:55 P.M. Diagnoses included, but were not limited to: type 2 diabetes mellitus.<br><br>A Physician's Order, dated 6/17/2025 indicated Resident 7 was to receive Lantus Subcutaneous Solution 100 UNIT/ML (milliliter) 38 units subcutaneously two times a day. Additional instructions indicated to hold the insulin if residents blood glucoses levels were less than 100 mg/dL and to call the Nurse Practitioner (NP) if the resident's blood glucose levels were above 450 mg/dL. A review of Resident 7's blood glucose levels indicated the resident had received Lantus 38 units subcutaneously when blood glucose levels were outside parameters on the following dates:<br><br>-On 6/22/2025, Resident 7's blood glucose level was 97 mg/dL.<br><br>-On 6/26/2025, Resident 7's blood glucose level was 97 mg/dL.<br><br>-On 6/27/2025, Resident 7's blood glucose level was 91 mg/dL.<br><br>-On 6/28/2025, Resident 7's blood glucose level was 99 mg/dL.<br><br>-On 7/4/2025, Resident 7's blood glucose level was 97 mg/dL.<br><br>-On 7/20/2025, Resident 7's blood glucose level was 90 mg/dL.<br><br>-On 7/30/2025, Resident 7's blood glucose level was 87 mg/dL.During an interview, on 9/8/2025 at 10:13 A.M., the DON indicated the resident's insulin should have been held on the days her blood glucose level was less than 100 mg/dL<br><br>4. During an interview, on 9/4/2025 at 1:55 P.M., CNA 8 indicated about two months ago, when she had arrived to work, CNA 17, the night shift aide had reported that Resident 18 had been up between 2 - 3:00 A.M. and she had had to redirect him back to his room. She indicated the night shift nurse had (continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | then shown CNA 8 a picture of Resident 18 with scratches all over his face. The night nurse indicated she had seen the resident and the night aide fighting with each other.<br><br>During an interview with the Director of Nursing, on 9/5/2025 at 1:39 P.M. and the Administrator, on 9/5/2025 AT 11:14 A.M, they both indicated there had been no further investigation into the incident and no documentation regarding the injuries in the clinical record.<br><br>During an interview, on 9/5/2025 at 10:59 A.M., the NP indicated she had been informed of the incident on 6/16/2025. She indicated she only knew there had been an altercation between the resident and another staff member. She indicated she had asked for documentation regarding the incident but was informed there was no documentation. She indicated although she had viewed the photograph and saw the scratches, she had not assessed the resident nor had she documented the injuries because the resident was not her resident.<br><br>The record for Resident 18 was reviewed on 9/08/2025 at 11:02 A.M. Diagnoses included: hypertension, diabetes, hip fracture, Alzheimer's disease, non- Alzheimer's dementia, and depression.<br><br>A Quarterly MDS (Minimum Data Set) assessment, dated 8/22/2025, indicated Resident 18 was able to make his needs known and had no behaviors, used a wheelchair for mobility, was independent sitting up on the side of the bed, wheeling in his wheelchair and required set up assistance for chair to bed and bed to chair transfers.<br><br>Physician's Orders, dated 4/7/2025, indicated the facility was to complete a weekly skin review every Monday for Resident 18.<br><br>A Weekly Skin Assessment, dated 6/16/2025, indicated Resident 18's skin was intact with no skin issues.<br><br>The clinical record lacked documentation to show the attending physician had been notified of the skin issues; lacked the documentation to show a treatment had been obtained for the scratched areas on the resident's face and lacked documentation to show the skin issue had been monitored until it had healed.<br><br>During an interview, on 9/8/2025 at 10:19 A.M., the Director of Nursing indicated the physician should have been notified and the area should have been monitored.<br><br>A current policy was provided, on 9/8/2025 at 1:01 P.M., by the Director of Nursing (DON). The policy titled, Medication and Treatment Orders, indicated, .Orders for medications and treatments will be consistent with principles of safe and effective order writing.<br><br>A current policy was provided, on 9/8/2025 at 1:01 P.M., by the Director of Nursing (DON). The policy titled, Bowel Protocol, indicated, .To provide effective interventions for signs and symptoms of constipation.Protocol.1. Nursing staff document the resident's bowel movements every shift. 2. The evening shift nurse assesses the bowel movement data daily and responds according to the protocol and/or physician orders. 3. If no bowel movement is recorded for three days, do the following on day four: assess for signs and symptoms of constipation, if the resident is alert and oriented, ask about unrecorded bowel movements and assess for constipation, if acute abdominal symptoms are present, contact the physician immediately. 4. If no bowel movement is recorded for four days, so the following on day five: administer routine or prn laxative, if acute abdominal symptoms are present, contact the<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | physician immediately.<br><br>On 9/8/2025 at 2:13 P.M., the Director of Nursing provided the policy titled, Change in a Resident's Condition or Status, dated 2/2021, and indicated the policy was the one used by the facility. The policy indicated . Our facility promptly notifies the resident, his or her attending physician. of changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's attending physician or physician on call when there has been a(an) a. accident or incident involving the resident. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition/status.<br><br>3.1-37 |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>Based on record review and interview, the facility failed to ensure a consent for psychotropic medication use was obtained timely for 1 of 5 residents reviewed for psychotropic medications. (Resident 15)Finding includes: The record for Resident 15 was reviewed on 9/4/2025 at 9:48 A.M. Diagnoses included but were not limited to: bipolar, Schizophrenia, anxiety, PTSD (post traumatic stress disorder), insomnia, non Alzheimer's dementia and delusions. The current Physician's Orders for medications included the following:-Trazadone 50 mg (milligram) at bed time ordered on 5/21/2025 for insomnia.-Lamotrigine 200 mg twice a day ordered on 5/21/2025 for Bipolar disease.-Lexapro 10 mg every day ordered on 5/22/2025 for depression.-Clonazepam 1 mg three times a day ordered on 6/4/2025 for anxiety.-Risperdal 0.5 mg at bed time ordered on 6/4/2025 for schizophrenia. A Psychoactive Medication therapy informed consent form, dated 6/17/2025, indicated the POA (power of attorney)/guardian had given a verbal consent on 6/17/2025 for the use of the above medications. The consent was obtained after the medication orders had been obtained and after the facility had commenced administering the medications. During an interview, on 9/8/2025 at 10:09 A.M., the Director of Nursing indicated the consent should have been obtained earlier and was not. On 9/8/2025 at 1:23 P.M., the Director of Nursing provided a policy titled, Psychotropic Medication Use, dated 2/2025, and indicated the policy was the one currently used by the facility. The policy indicated . 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal 3.1-3(w) |

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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, observation and record review, the facility failed to report an allegation of abuse for 1 of 2 residents reviewed for abuse. (Resident 18)Finding includes:During an interview, on 9/4/2025 at 1:55 P.M., CNA 8 indicated when she had came into work one morning about 2 months ago, the night aide, CNA 17, had given her report and said that Resident 18 had been up between 2-3:00 A.M., and she had had to redirect him back to his room. CNA 8 indicated then the night nurse had shown her a picture of Resident 18 with scratches all over his face. The night nurse indicated she had seen the resident and the night aide, CNA 17, fighting each other. CNA 8 indicated the previous Social Service/Unit Director (SSD) had came into work and had seen Resident 18 and asked, staff what had happened to him. CNA 8 indicated she told the former SSD that she was going to text the Administrator (regarding the scratches on Resident 18 and the night nurse's report about a fight between CNA 17 and Resident 18) but the SSD indicated she had already texted him. CNA 8 indicated when she came to work the next day, CNA 17 was not working on the dementia unit, but was working on another unit. CNA 8 indicated she had overheard the Social Service Director stating, they were going to do something about it. The record for Resident 18 was reviewed on 9/08/2025 at 11:02 A.M. Diagnoses included: hypertension, diabetes, hip fracture, Alzheimer's disease, non- Alzheimer's dementia, and depression.A Quarterly MDS (Minimum Data Set) assessment, dated 8/22/2025, indicated Resident 18 was able to make his needs known and had no behaviors, utilized a wheelchair for mobility, was independent with sitting on the side of the bed, wheeling his wheelchair and just required set up help for bed to chair and chair to bed transfers.During an interview, on 9/4/2025 at 2:13 P.M., with the previous Social Service/Unit Manager (SSD), she indicated she was not present when the staff to resident altercation happened. She indicated the night staff had reported the altercation between CNA 17 and Resident 18 and indicated it had occurred because the resident had been giving the staff member difficulty when she had attempted to provide incontinence care. The former SSD indicated when she had came into work, she questioned what had happened and CNA 8 indicated she had taken a picture of Resident 18's face and sent it to the Administrator. The Social Service staff indicated the picture looked worse than his face. When she was questioned if she would consider the incident a potential abuse allegation, the SSD replied, Yes. She indicated she had asked the Administrator about the incident investigation and he had informed the former SSD that it was being dealt with. The former SSD indicated the Administrator had informed her that the retribution was that person (CNA 17) would not work on the dementia unit. When asked if she had spoken to the Administrator any more about it, she replied she had spoken to the Nurse Practioner (NP) and had sent the photo of Resident 18 with scratches to his face.During an interview, on 9/5/2025 at 10:59 A.M., the NP indicated she had been informed of the incident on 6/16/2025. She indicated, all I know, it was an altercation between a resident and another staff member. She indicated she had asked if there was any documentation of the incident and the facility indicated there had been no documentation regarding what had happened. (to cause the scratches to Resident 18's face). She indicated from what she knew, it had occurred on the night shift. She indicated she had not documented the report or any assessment of the scratches/injuries in Resident 18's chart because this was not her resident. During an interview, on 9/5/2025 at 11:14 A.M., the Administrator indicated he had been made aware of an altercation with Resident 18 and another staff member. He indicated the staff had been transferring the resident and the resident was about to fall, so the staff member had tried to keep the resident from falling. He indicated the Social Service /unit director had notified him via a phone text. When asked if the incident had been reported, he indicated he had not reported the incident because he had not considered that there had been any potential abuse. When questioned whether there was any type of investigation, i.e., talk to other staff working with this aide that night, he had replied No, there had not been any investigation on his part. The Administrator was questioned<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | regarding the reason for the change in work assignment for CNA 17, who was involved with the incident , and he indicated the facility had no set staffing assignments on each unit and staff worked all over the building. Review of the nursing working schedules for March, April and May indicated CNA 17 had worked on the locked dementia unit frequently but the schedules for June, July and August indicated CNA 17 had not been scheduled to work on the dementia unit except for two 4-hour shifts.During an interview on 9/5/2025 at 11:58 A.M., the nursing scheduler indicated she had been instructed, by the DON and ADON, not to schedule CNA 17 on the secured dementia unit. She indicated the ADON had stated, It's best that we do not have her back there. The scheduler indicated she had been instructed CNA 17 could work on the secured dementia unit if someone else was also on the unit working with her.During an interview, on 9/5/2025 at 1:39 P.M., the Director of Nursing indicated she could not remember the incident very well. She indicated CNA 17 had been transferring Resident 18 but she did not recall the exact details. When asked if she had seen the scratches after it happened, she indicated she indicated she was unsure of when the resident had obtained the scratches, but there had just been scratches. The Director of Nursing indicated she had been made aware of the incident on maybe the next day after it had occurred, but she did not recall who had notified her even though the staff member had verbally told her face to face about the incident. When asked if anyone had investigated the incident/resident injury, she replied I am not sure. She indicated that they had asked CNA17 to give them a written statement about what had happened. The Director of Nursing indicated she did not have the aide's written statement in her papers for review but indicated the aide had written that she had been attempting to assist Resident 18 with a transfer, when he lost his balance and she had caught him. When asked if she had interviewed the other staff member working on the night shift when the incident had occurred, the DON indicated she did not recall. When the Director of Nursing was questioned regarding why CNA 17 was no longer scheduled to work on the locked unit, she had indicated the facility administrative nursing staff had decided that CNA 17 was not a fit for the locked unit. She confirmed the decision had been made after the incident between Resident 18 and CNA 17. She indicated, prior to the incident, CNA 17 had had one incident where she was sleeping during her work hours. The Administrative staff indicated it was decided to move CNA 17 to another unit so she would be busier and not fall asleep.During an interview, on 9/5/2025 at 3:16 P.M., QMA 18 indicated she had been in the break room and had heard a commotion so she had opened the break room door and walked out into the hall. She had heard Resident 18 yelling, get out- get out. The residents' room door was opened, and she walked in, she saw CNA 17 and the resident. She indicated she noticed a scratch on Resident 18's face. She indicated the scratch was bleeding and indicated she had asked CNA 17 what she had done to Resident 18. CNA 17 told her maybe she had scratched him with her nails. QMA18 indicated she had informed CNA 17 that she would have to report this, and the aide then told her that she was sorry. QMA 18 indicated she had reported the incident and scratches on Resident 18's face to the night shift nurse, who was working on another unit, but she was unable to recall the nurse's name. She indicated the nurse had instructed her to tell management and to take a picture of his face for proof. QMA 18 indicated she had called the Social Service Director of the unit ,and she had instructed her to send the picture of the resident's face to her. When questioned if she had talked to any management staff member, besides the unit SSD about the incident, or had been asked to provide a verbal or written statement, she indicated she had not spoken with anyone else nor had she provided a statement.On 9/5/2025 at 3:26 P.M., the Administrator provided a copy of text messages between himself and CNA 17. The first text, from the Administrator to CNA 17 was dated 6/16/2025 at 7:09 A.M. The text message indicated the Administrator was asking CNA 17 about the scratches to Resident 18's face. The messages from CNA 17 indicated around 2:00 A.M.,(on 6/16/2025) the resident was coming in the hallway and she had asked him to please go back to bed because he was going up and down the hall and other residents were sleeping. The text indicated the resident had started to kick CNA 17 and she had tried to stop him with her hands as he started going backwards in his wheelchair. CNA 17 indicated she had<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | grabbed Resident 19 because she was worried he was going to fall backwards in his chair. She indicated after she had spent a few minutes attempting to calm the resident down, the QMA had walked into the room. She indicated she had told the QMA what had happened and the QMA had pointed out the scratch on the resident's face. CNA 17 indicated she did not know how the resident had obtained the scratch because she was not even by his face, but she had reached for his chair to try and turn him to get him to stop kicking her.On 9/5/2025 at 1:37 P.M., the Administrator provided the policy titled, Abuse Policy, undated, and indicated the policy was the one currently used by the facility. The policy indicated . The resident has the right to be free from abuse. The facility must not use verbal, mental sexual or physical abuse. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff.Prevention-.identify, intervene, and correct situations of alleged, suspected, or substantiated abuse; supervision of staff.Investigating an reporting Allegations of Abuse Guidelines: All repots of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ( abuse) .shall be reported to local and federal agencies and thoroughly investigated by the administrator or designee. 1. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source, misappropriation of resident property) . will be reported immediately, but no later than: Two (2) hours if the alleged violation involves abuse . or Twenty-four (24) hours if the alleged violation does not involve abuse.3.1-28(c) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on interview, observation and record review, the facility failed to fully investigate an allegation of abuse for 1 of 2 residents reviewed for abuse. (Resident 18)Finding includes:During an interview, on 9/4/2025 at 1:55 P.M., CNA 8 indicated when she had came into work one morning about 2 months ago, the night aide, CNA 17, had given her report and said that Resident 18 had been up between 2-3:00 A.M., and she had had to redirect him back to his room. CNA 8 indicated then the night nurse had shown her a picture of Resident 18 with scratches all over his face. The night nurse indicated she had seen the resident and the night aide, CNA 17, fighting each other. CNA 8 indicated the previous Social Service/Unit Director (SSD) had came into work and had seen Resident 18 and asked, staff what had happened to him. CNA 8 indicated she told the former SSD that she was going to text the Administrator (regarding the scratches on Resident 18 and the night nurse's report about a fight between CNA 17 and Resident 18) but the SSD indicated she had already texted him. CNA 8 indicated when she came to work the next day, CNA 17 was not working on the dementia unit, but was working on another unit. CNA 8 indicated she had overheard the Social Service Director stating, they were going to do something about it. The record for Resident 18 was reviewed on 9/08/2025 at 11:02 A.M. Diagnoses included: hypertension, diabetes, hip fracture, Alzheimer's disease, non- Alzheimer's dementia, and depression.A Quarterly MDS (Minimum Data Set) assessment, dated 8/22/2025, indicated Resident 18 was able to make his needs known and had no behaviors, utilized a wheelchair for mobility, was independent with sitting on the side of the bed, wheeling his wheelchair and just required set up help for bed to chair and chair to bed transfers.During an interview, on 9/4/2025 at 2:13 P.M., with the previous Social Service/Unit Manager (SSD), she indicated she was not present when the staff to resident altercation happened. She indicated the night staff had reported the altercation between CNA 17 and Resident 18 and indicated it had occurred because the resident had been giving the staff member difficulty when she had attempted to provide incontinence care. The former SSD indicated when she had came into work, she questioned what had happened and CNA 8 indicated she had taken a picture of Resident 18's face and sent it to the Administrator. The Social Service staff indicated the picture looked worse than his face. When she was questioned if she would consider the incident a potential abuse allegation, the SSD replied, Yes. She indicated she had asked the Administrator about the incident investigation and he had informed the former SSD that it was being dealt with. The former SSD indicated the Administrator had informed her that the retribution was that person (CNA 17) would not work on the dementia unit. When asked if she had spoken to the Administrator any more about it, she replied she had spoken to the Nurse Practioner (NP) and had sent the photo of Resident 18 with scratches to his face.During an interview, on 9/5/2025 at 10:59 A.M., the NP indicated she had been informed of the incident on 6/16/2025. She indicated, all I know, it was an altercation between a resident and another staff member. She indicated she had asked if there was any documentation of the incident and the facility indicated there had been no documentation regarding what had happened. (to cause the scratches to Resident 18's face). She indicated from what she knew, it had occurred on the night shift. She indicated she had not documented the report or any assessment of the scratches/injuries in Resident 18's chart because this was not her resident. During an interview, on 9/5/2025 at 11:14 A.M., the Administrator indicated he had been made aware of an altercation with Resident 18 and another staff member. He indicated the staff had been transferring the resident and the resident was about to fall, so the staff member had tried to keep the resident from falling. He indicated the Social Service /unit director had notified him via a phone text. When asked if the incident had been reported, he indicated he had not reported the incident because he had not considered that there had been any potential abuse. When questioned whether there was any type of investigation, i.e., talk to other staff working with this aide that night, he had replied No, there had not been any investigation on his part. The Administrator was questioned regarding the reason for the change in work assignment for CNA 17, who was involved with the<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | incident , and he indicated the facility had no set staffing assignments on each unit and staff worked all over the building. Review of the nursing working schedules for March, April and May indicated CNA 17 had worked on the locked dementia unit frequently but the schedules for June, July and August indicated CNA 17 had not been scheduled to work on the dementia unit except for two 4-hour shifts.During an interview on 9/5/2025 at 11:58 A.M., the nursing scheduler indicated she had been instructed, by the DON and ADON, not to schedule CNA 17 on the secured dementia unit. She indicated the ADON had stated, It's best that we do not have her back there. The scheduler indicated she had been instructed CNA 17 could work on the secured dementia unit if someone else was also on the unit working with her.During an interview, on 9/5/2025 at 1:39 P.M., the Director of Nursing indicated she could not remember the incident very well. She indicated CNA 17 had been transferring Resident 18 but she did not recall the exact details. When asked if she had seen the scratches after it happened, she indicated she indicated she was unsure of when the resident had obtained the scratches, but there had just been scratches. The Director of Nursing indicated she had been made aware of the incident on maybe the next day after it had occurred, but she did not recall who had notified her even though the staff member had verbally told her face to face about the incident. When asked if anyone had investigated the incident/resident injury, she replied I am not sure. She indicated that they had asked CNA17 to give them a written statement about what had happened. The Director of Nursing indicated she did not have the aide's written statement in her papers for review but indicated the aide had written that she had been attempting to assist Resident 18 with a transfer, when he lost his balance and she had caught him. When asked if she had interviewed the other staff member working on the night shift when the incident had occurred, the DON indicated she did not recall. When the Director of Nursing was questioned regarding why CNA 17 was no longer scheduled to work on the locked unit, she had indicated the facility administrative nursing staff had decided that CNA 17 was not a fit for the locked unit. She confirmed the decision had been made after the incident between Resident 18 and CNA 17. She indicated, prior to the incident, CNA 17 had had one incident where she was sleeping during her work hours. The Administrative staff indicated it was decided to move CNA 17 to another unit so she would be busier and not fall asleep.During an interview, on 9/5/2025 at 3:16 P.M., QMA 18 indicated she had been in the break room and had heard a commotion so she had opened the break room door and walked out into the hall. She had heard Resident 18 yelling, get out- get out. The residents' room door was opened, and she walked in, she saw CNA 17 and the resident. She indicated she noticed a scratch on Resident 18's face. She indicated the scratch was bleeding and indicated she had asked CNA 17 what she had done to Resident 18. CNA 17 told her maybe she had scratched him with her nails. QMA18 indicated she had informed CNA 17 that she would have to report this, and the aide then told her that she was sorry. QMA 18 indicated she had reported the incident and scratches on Resident 18's face to the night shift nurse, who was working on another unit, but she was unable to recall the nurse's name. She indicated the nurse had instructed her to tell management and to take a picture of his face for proof. QMA 18 indicated she had called the Social Service Director of the unit ,and she had instructed her to send the picture of the resident's face to her. When questioned if she had talked to any management staff member, besides the unit SSD about the incident, or had been asked to provide a verbal or written statement, she indicated she had not spoken with anyone else nor had she provided a statement.On 9/5/2025 at 3:26 P.M., the Administrator provided a copy of text messages from CNA 17, dated ____to him. The messages indicated around 2:00 A.M.,(on 6/16/2025) the resident was coming in the hallway and she had asked him to please go back to bed because he was going up and down the hall and other residents were sleeping. The text indicated the resident had started to kick CNA 17 and she had tried to stop him with her hands as he started going backwards in his wheelchair. CNA 17 indicated she had grabbed Resident 19 because she was worried he was going to fall backwards in his chair. She indicated after she had spent a few minutes attempting to calm the resident down, the QMA had walked into the room. She indicated she had told the QMA what had happened and the QMA had pointed out the<br>(continued on next page) |

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| | 155566 | A. Building<br>B. Wing | 09/08/2025 |

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| Warsaw Meadows | 300 E Prairie St<br>Warsaw, IN 46580 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | scratch on the resident's face. CNA 17 indicated she did not know how the resident had obtained the scratch because she was not even by his face, but she had reached for his chair to try and turn him to get him to stop kicking her.On 9/5/2025 at 1:37 P.M., the Administrator provided the policy titled, Abuse Policy, undated, and indicated the policy was the one currently used by the facility. The policy indicated . The resident has the right to be free from abuse. The facility must not use verbal, mental sexual or physical abuse. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff.Prevention-.identify, intervene, and correct situations of alleged, suspected, or substantiated abuse; supervision of staff.Investigating an reporting Allegations of Abuse Guidelines: All repots of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ( abuse) .shall be reported to local and federal agencies and thoroughly investigated by the administrator or designee. 3.1-28(d) |

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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>Based on observation and record review, the facility failed to ensure physician orders for elopement risk were in place for 1 of 2 residents reviewed for elopement. (Resident 65)Finding includes:A record review for Resident 65 was completed, on 9/4/2025 at10:56 A.M. Diagnoses included, but were not limited to: altered mental status, visual hallucinations and disorientation.An admission Minimum Data Set (MDs) assessment, dated 7/3/2025, indicated Resident 65 had severe cognitive impairment.During an observation, on 9/3/2025 at 10:24 A.M., Resident 65 was observed seated in the common area parallel to the front exit door. A Wanderguard (electronic device that magnetically locks doors if a resident wearing the device comes in close proximity of the door) device was not observed on the resident. During an observation, on 9/4/2025 at 10:55 A.M., Resident 65 was observed seated in the common area parallel to the front exit door. A Wanderguard device was not observed on either wrist or ankle.During an observation, on 9/5/2025 at 11:46 A.M., Resident 65 was observed walking on a hallway and indicated, I'm on the wrong hallway.During an observation, on 9/8/2025 at 8:58 A.M., Resident 65 was observed seated in the common area parallel to the front exit. door. A Wanderguard device was not observed when Resident 65 exposed her wrists and ankles upon request. During an observation, on 9/8/2025 at 10:15 A.M., with RN 6 Resident 65's left wrist was viewed and there was no Wanderguard device on her write. Resident 65 indicated she had cut the Wanderguard off because it had been too tight and she had placed it in the drawers of her bedside nightstand. The Wanderguard was located by RN 6 in Resident 65's upper drawer of her bedside nightstand. The band had been cut. An Elopement/Wander Risk Evaluation, dated 6/27/2025 and 7/21/2025, indicated resident 65 was a moderate wander/elopement risk.A current Care Plan, initiated on 6/27/2025, indicated Resident 65 was an elopement risk/wanderer. Interventions included, but were not limited to: Wanderguard in place on the left wrist and staff to check for placement on every day shift. A Physician's Order, dated 8/18/2025, indicated a Wander-guard to the left wrist and every day shift staff were to check for proper functioning of the Wanderguard. During an interview, on 9/8/2025 at 9:59 A.M., RN 6 indicated the facility had an elopement binder with resident pictures for resident found at risk for wandering and elopement. She also indicated most residents wore a Wanderguard. She indicated Resident 65 should have had a Wanderguard on her left wrist. A current policy was provided, on 9/8/2025 at 1:01 P.M., by the Director of Nursing (DON). The policy titled, Elopement, indicated, .It is the policy of this facility to provide a safe and secure environment for our residents and to be proactive in preventing resident elopement. Residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the premises of the facility without the knowledge of facility staff.1. Upon admission, readmission, quarterly, and with a significant change of condition, residents will be assessed for elopement risk. 2. Residents that are identified at risk for elopement will have an intervention implemented for their safety.5. Electronic monitoring systems may be implemented as possible interventions as appropriate. If an electronic monitoring device is utilized as an intervention they shall be checked according to manufacturer's recommendations for function and placement.3.1-45(a)(2) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>Based on record review and interview, the facility failed to ensure a resident survivor of PTSD (Post Traumatic Stress Disorder) received culturally competent trauma informed care to reduce triggers for behaviors and reduce emotional distress for 1 of 1 residents reviewed for PTSD (Resident 15) The record for Resident 15 was reviewed on 9/4/2025 at 9:53 A.M. Diagnoses included but were not limited to cancer, non-Alzheimer's dementia, anxiety, depression, psychotic disorder, bipolar, schizophrenia and PTSD (post-traumatic stress disorder).An admission MDS (Minimum Data Set) assessment, dated 6/2/2025, indicated Resident 15 had delusions and received the following medications: antipsychotic, antidepressant, anticonvulsant, and opioids. A Nurse's Progress Note, dated 6/23/2025 at 5:40 P.M., indicated Resident 15 had received a call from her mother earlier in the afternoon and had been moody and tearful ever since she had received the call. Her behaviors were escalating towards dinner time. When her food tray arrived, the resident went into her room, got her walker and proceeded to walk down to the end of the hallway and began beating on the exit doors with closed fists. The resident was verbally directed to stop banging on the doors and replied, You can't make me! and continued to bang on the door. Staff then told her she needed to head to the dining room for dinner. The resident then began to loudly sob, verbalizing that she wanted to see her mom and dad. Staff then told her that beating on the doors was not acceptable behavior. Resident 15 replied she did not care and continued to sob loudly but had turned around with her walker and headed toward the dining room.During an interview on 9/4/2025 at 1:29 P.M., CNA 7 indicated when the resident was having behaviors or was anxious, she talked with her and tried to fix the problem. She indicated she also attempted to redirect the resident to an activity like coloring or writing notes. CNA 7 indicated Resident 15 would write notes about how she could fix whatever problem was upsetting her. When CNA 7 was questioned as to whether those interventions calmed the resident, she indicated sometimes it calmed her. CNA 7 indicated she had been told that Resident 15's dad was not allowed to visit her She indicated there was a written not note hung up at the nurse's desk with instructions not to allow male visitors.During an interview, on 9/4/2025 at 1:34 P.M. CNA 8 indicated when Resident 15 was upset, she went in and talked to her and encouraged her to read her Bible or listen to music. When questioned if these interventions helped calm the resident, CNA. 8 indicated it was usually not effective but the resident did enjoy coloring. CNA 8 indicated the resident's triggers were if staff told the resident they would be right back and did not return or if staff was to bring her something, like a soda, and did not return and bring the anticipated item. She indicated the note about no male visitors had been up at the nurse's station after the resident's father had first visited in June or July. She indicated the resident had behaviors after the visit. CNA 8 indicated she had been present when Resident 15's father had first visited and after greeting each other, Resident 15 and her father continued moving down the hall together talking. After Resident 15's father left, she had spent the rest of the day crying and sobbing, speaking about her Dad. CNA 8 indicated the resident's mother and father were had visited last Sunday. She indicated the resident's parents had brought her 2 shirts and the resident told them to take them back. Her parent were overheard telling her they were going to bring her back some lunch, however, they never returned.During an interview, on 9/4/2025 at 2:04 P.M., QMA 10 indicated Resident 15 got upset when she was in pain. QMA 10 indicated when the resident was upset, she asked her what was bothering her, tried to redirect her and tried to resolve the resident's problem. QMA 10 indicated Resident 15 had candy and sodas at the facility and she often asked for those items. She indicated she had just been informed that Resident 15's father was not allowed to visit the resident.A current Care Plan, initiated on 5/28/2025, indicated Resident 15 had a psychosocial well-being problem related to history of personal trauma or PTSD (post-traumatic stress disorder). Interventions included, but were not limited to: allow the resident time to answer questions and to verbalize feelings, perceptions, and fears, consult with Pastoral care, social services and psychological services and encourage participation from the resident who depend on<br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | others to make own decisions. There was no specific information regarding the resident's PTSD triggers, no personalized interventions and no consistent education to ensure staff were aware the resident's father was not allowed to visit.A policy regarding PTSD was requested on 9/8/2025, but one was not provided prior to the end of the survey. |

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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 record review and interview, the facility failed to ensure physician ordered medications were available for administration for 1 of 5 residents reviewed for medications. (Resident 15)Finding includes: The record for Resident 15 was reviewed on 9/4/2025 at 9:48 A.M. Diagnoses included but were not limited to: bipolar, Schizophrenia, anxiety, PTSD (post traumatic stress disorder), insomnia, cancer and delusions. Current Physician Orders included the following medications:-Lamotrigine (anticonvulsant) 50 mg (milligram) 1 tablet two times a day for Bipolar disease.-Trazadone (antidepressant) 50 mg 1 tablet at bedtime for insomnia.-Prazosin (antihypertensive) 2 mg 1 capsule at bedtime for PTSD. The May Medication Administration Record (MAR) indicated, on 5/30 and 5/31/2025, the Prazosin medication had not been administered because it was not available. The June MAR indicated, on 6/5, 6/6, 6/7, 6/8, 6/9. 6/10, 6/11, and 6/19/2025, the Prazosin medication had not been administered because it was not available. The July MAR indicated, on 7/1, 7/11, 7/12, and 7/17/2025, the Prazosin medication had not been administered because it was not available. The Trazadone medication had not been administered on 7/17/2025 because it was not available, and the Lamotrigine had not been administered, on 7/28/2025, because the facility was waiting on pharmacy. During an interview, on 9/4/2025 at 2:09 P.M., QMA 10 indicated if medications were not available and were not in the medication cart, she would have checked to see when it had been ordered or if it had been ordered. If the medication had not been ordered, she would have ordered it, documented it in the nurse's notes that the medication was out and had been reordered. In addition, she would have notified the nurse of the missing medication. During an interview, on 9/5/2025, QMA 16 indicated she if she could not find an ordered medication, she looked in the bottom of the medication cart for the medications, checked the EDK (emergency drug kit), called the pharmacy regarding the medications informed the Director of Nursing. During an interview, on 9/8/2025 at 10:11 A.M., the Director of Nursing indicated the nursing staff should have looked in the EKD for the meds and if they were not located there, they should have called the Pharmacy and the MD. On 9/8/2025 at 1:03 P.M., the Director of Nursing provided the policy titled, Emergency Pharmacy Service ad Emergency Kits, dated 5/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated . Emergency pharmacy service is available on a 24 -hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the pharmacy. An emergency supply of medications, including emergency drugs, antibiotics, controlled substances and products for infusion are supplied by the pharmacy in limited quantities, in portable, sealed containers 3.1-25(a)3.1-25(g)(3) |