STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Retirement Village	8616 W 10th St Indianapolis, IN 46234

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observations, interviews, and record review, the facility failed to ensure staff responsible for food service and kitchen sanitation demonstrated competency in monitoring food service equipment and maintaining required temperature documentation for safe food preparation and storage. This deficient practice had the potential to affect 86 of 86 residents served from the kitchen.Findings include:On 3/2/26 at 10:06 a.m., during the initial tour of the kitchen, the dish machine and refrigeration monitoring records were reviewed. The following was observed: Dishwasher temperature logs for February 2026 were missing. January dishwasher logs contained gaps, with multiple entries missing and several recorded temperatures that did not reach the required 180 F sanitizing temperature for high-temperature dish machines. Wash temperatures were documented as only getting to 160 F, and rinse temps only as high as 122 F. Posted instructions indicated staff were to notify the manager if water temperatures were below 120 degrees Fahrenheit (F) or greater than 150 F. The logs showed wash temperatures of 160 F and rinse temperatures of less than 120 F, with no documentation that management had been notified or corrective actions implemented. Walk-in refrigerator temperature logs for February 2026 were missing, preventing verification that food was consistently maintained at safe storage temperatures. During an interview on 3/2/26 at 10:06 a.m. the Kitchen Manager indicated February refrigerator temperature logs were missing and that all staff were responsible for completing daily logs but the records were not present for review. During testing of the dish machine, several dishwasher cycles were observed with the Kitchen Manager, but the machine failed to reach the required 180 degrees Fahrenheit and the Kitchen Manager indicated she did not know why. The kitchen staff attempted to verify sanitation levels using test strips. The test strip reading registered 10 parts per million (ppm, a unit of concentration of the solution) after three attempts to obtain a reading, and staff demonstrated difficulty properly performing the test procedure. On 3/3/26 at 9:31 a.m., the Kitchen Manager indicated the facility had contacted the contract company technician, who discovered fuses on the booster heater had blown, preventing the dish machine from reaching appropriate sanitizing temperatures and staff had been unaware. On a return visit to the kitchen on 3/3/26 at 12:16 p.m., a mechanical technician from the contract company indicated the heat boosters for the dishwasher were broken, so until they could be repaired, he adjusted the temperature and sanitation requirements so that the machine could run and sanitize dishes via chemical rinse. The technician instructed kitchen staff that 50 to 100 ppm chlorine sanitizer was an appropriate sanitizing range when operating under a chemical sanitation process and demonstrated how to test the machine's ppm. On 3/5/26 at 11:03 a.m., during an observation of the pureed food process was scheduled, the following was observed: [NAME] 13 failed to perform hand hygiene before, during or after a puree demonstration. Failed to follow a standardized recipe. Once the puree chicken was completed, [NAME] 13 proceeded to the dish room and ran the equipment through the dishwasher. When asked if she would check the parts per million (PPM), she indicated she did not know how, so the Kitchen Manager came to read the PPM. The Kitchen Manager ran a small plate through the machines and placed a test strip on a puddle of water once the wash was complete. The strip did not change colors. It was brought to the Kitchen Manager's attention that the sanitizer (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

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	container, located under the machine was empty.The Kitchen Manager replaced the chemical sanitizer with a new bucket and indicated if the machine was being run on a lower temperature with chemical sanitizer, staff should ensure the sanitizer bottle was full and/or functional. During an interview on 3/5/26 at 11:43 a.m., the Kitchen Manager indicated she contacted the contract company and received clarifying instructions on how to test the machine's ppm, she had been doing it incorrectly. Instead of dropping the test strip into standing water that came out on the washed plate, she needed to drain the water from the plate, and place the strip directly on the porcelain. Upon a final observation, at that time, the test strip changed to the appropriate color. Cross reference F812. On 3/6/26 at 12:20 p.m., the Director of Nursing (DON) indicated there was no specific policy which spoke to Kitchen Staff Competency, but it was expected that they would meet and execute the required competencies related to their job-specific descriptions and training. The DON, provided copies of those requirements for the Kitchen Manager at that time which indicated, .position summary. plans organizes, develops and directs the overall operations of food services to ensure daily provisions of quality nutritional services in accordance with all applicable laws, regulations and Life Care standards. must be knowledgeable of food service practices and procedures as well as laws, regulations and guidelines governing food service functions in the post-acute care facility. must perform proficiently in all competency area including but not limited to: general food service responsibilities, planning, supervisory responsibilities, patient rights and safety and sanitation. 410 Indiana Administrative Code (IAC) 16.2-3.1-20(h).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to ensure general cleanliness, proper sanitation and infection control practices during food preparation and dishwashing activities. This deficient practice had the potential to affect 86 of 86 residents who received food from the kitchen.Findings include:1. During an initial tour of the kitchen on 3/2/26 at 10:06 a.m., the following was observed: Sticky floors in and around the dishwashing area. Food crumbs and debris scattered across the floor throughout the kitchen areas. Several dented cans which had not been removed from the service rack. The dishwashing table where clean dishes were stacked to air dry was observed to have standing water with soggy food crumbs throughout. There were no readily accessible temperature logs for the walk-in refrigerator. Several dishwasher cycles were observed with the Kitchen Manager, but the machine failed to reach the required 180 degrees Fahrenheit and the Kitchen Manager indicated she did not know why. There were no readily accessible dishwasher temperature logs for the month of February, and the January had several missing temperatures with wash temperatures only getting to 160, and rinse temps only as high as 122. The Kitchen Manager could not account for the discrepancies and would call the contract company to come out and look at the dishwasher. On a return visit to the kitchen on 3/3/26 at 12:16 p.m., a mechanical technician from the contract company indicated the heat boosters for the dishwasher were broken, so until they could be repaired, he adjusted the temperature and sanitation requirements so that the machine could run and sanitize dishes via chemical rinse. 2. On 3/5/26 at 11:03 a.m., an observation of the pureed food process was scheduled, however upon entry into the kitchen, the Kitchen Manager indicated the lunch pureed foods had already been prepared. She called [NAME] 13 over and indicated, Just puree something to get it over with. Upon entry into the kitchen for this observation, the floor were observed with various food crumbs, and sticky in several locations that caused the bottom of shoes to stick. There was standing water which splashed when stepped in throughout the entire dish area, including where the clean dishes were stacked. [NAME] 13 was wearing a pair of blue rubber gloves and did not wash hands prior to beginning food preparation and continued wearing a previously used pair of blue gloves. She selected a previously cooked chicken breast to add to the blender. Without following a standardized recipe, [NAME] 13 first added an unmeasured amount of water, and when the mixture became too thin, she added an unmeasured amount of thickener. During the blending process, [NAME] 13 wiped her face after puree splash back and touched other surfaces without performing hand hygiene before continuing food preparation. Once the puree chicken was completed, [NAME] 13 proceeded to the dish room and ran the equipment through the dishwasher. When asked if she would check the parts per million (PPM), she indicated she did not know how, so the Kitchen Manager came to read the PPM. The Kitchen Manager ran a small plate through the machines and placed a test strip on a puddle of water once the wash was complete. The strip did not change colors. It was brought to the Kitchen Manager's attention that the sanitizer container, located under the machine was empty.The Kitchen manager replaced the chemical sanitizer with a new bucket and indicated, if the machine was being run on a lower temperature with chemical sanitizer, staff should ensure the sanitizer bottle was full and/or functional. During this observation, standing water was observed on the table for the clean dishes with soggy food crumbs. The Kitchen Manager indicated the table should be cleared after every wash to avoid splash back and potential contamination of the newly cleaned dishes. She did not know why water puddled and did not drain. On 3/3/26 at 9:16 a.m., the Director of Nursing provided a copy of current facility policy titled, Food Safety, dated 5/1/25. The policy indicated, Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. 410 Indiana Administrative Code (IAC) 16.2-3.1-21(i)(1).

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents and/or their family members were treated with respect and dignity by the Social Services Director (SSD) and the Kitchen Manager who spoke to and interacted with residents in a dismissive, argumentative, and disrespectful manner for 5 of 5 residents who participated in a resident council meeting (Residents 35, 43, 57, 75 and 85) and 1 of 2 randomly observed resident/staff interactions (Resident 12).Findings include:1. On 3/2/26 at 11:13 a.m., the SSD approached Resident 12, without invitation/request who was expressing concerns regarding the care of birds in a therapeutic bird habitat utilized in the facility. Rather than redirecting the conversation to a more private setting or responding empathetically, the SSD engaged the resident in a public argumentative exchange at the nurses' station. During the interaction, the SSD used dismissive and sarcastic language including stating Well I'll just have to take your word on that, and there's nothing we can do. The interaction resulted in the resident becoming increasingly distressed and stating the facility was a damn prison.On 3/3/26 at 11:59 a.m., Resident 12's record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, Alzheimer's with late onset, anxiety disorder, and a cognitive communication deficit.Her comprehensive care plans lacked implementation of person-centered dementia specific goals and/or interventions.She was also being seen on a regular basis by geriatric neuro-psych specialists to address and treat the progression of her Alzheimer's disease.On 3/6/26 at 9:43 a.m., the Director of Nursing provided a copy of current facility policy titled, Care of the Cognitively Impaired (Dementia Care) dated 9/2/25. The policy indicated, .ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety. 2. On 3/5/26 at 10:00 a.m., during a meeting with the Resident Council, with 5 residents present (Residents 35, 43, 57, 75 and 85), Resident 43 indicated residents frequently complained about the Kitchen Manager's poor attitude and concerns regarding the manner in which the Social Services Department and Kitchen Manager spoke with and interacted with the residents. Resident 43 stated the SSD was rude and often spoke to residents like they are children. On one occasion, the Resident 43 and two of her peers, Residents 75 and 35, expressed their concerns about a lunch meal, and the Kitchen Manager ran up on the table became defensive and argumentative with the resident which left them feeling embarrassed and afraid to make additional complaints. Resident 43 indicated, she filed a grievance related to the incident but it was not resolved and she was afraid to eat anything from the kitchen for fear the Kitchen Manager tampered with it.On 3/5/26 at 2:00 p.m., the DON provided a copy of a grievance form which was completed by Resident 43 on 2/19/26. Her grievance stated, [Kitchen Manager] just walked up on me. She is trying to intimidate people. She's so disrespectful. I'm not comfortable eating anything from that kitchen.Investigation steps indicated, Talked with Dietary Manager regarding concerns and appropriate approach. With follow up as needed.The grievance response lacked documentation of the concerned party's response to the action plan/outcome, but was signed as completed on 3/5/26.During an interview on 3/4/26 at 10:56 a.m., the DON indicated no staff should argue with a resident, and all residents should be treated with dignity and respect at all times. If conversations with residents or family members escalated, staff should offer a private place to discuss their concerns.410 Indiana Administrative Code (IAC) 16.2-3.1-3(a).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure discharge communication and documentation was completed for 4 of 5 residents reviewed for transfers and discharges (Residents 9, 87, 89, and 84). Findings include:1. Resident 9's record was reviewed on 3/3/26 at 1:26 p.m. Census information indicated the resident was hospitalized from [DATE] to 1/1/26. A quarterly Minimum Data Set (MDS) assessment, dated 1/28/26, indicated the resident received dialysis (treatment for kidney failure that filters waste, toxins, and excess fluid from the blood when the kidneys can no longer function properly). A progress note, dated 12/29/25, indicated the Certified Nurse Aide (CNA) answered the resident's call light and immediately notified the nurse. The nurse found blood saturated through the resident's long sleeves, side of the bed and on the floor. The source of the bleeding was determined to be the fistula (a surgical connection between an artery and a vein created to provide reliable, long-term vascular access for dialysis) to the resident's left upper extremity. Pressure was applied, and the nurse instructed the CNA to call 911. A second nurse assisted with applying pressure. The paramedics arrived and the resident was transferred to the hospital. The progress note lacked documentation the nurse communicated with the hospital where the resident was being transferred. A progress note, dated 1/2/26, indicated the resident was back at the facility and resting quietly. The resident's record lacked documentation the facility communicated with the hospital where the resident was being transferred, lacked documentation a notice of transfer or discharge and bed hold policy were provided to the resident or resident's representative, and lacked documentation the ombudsman was notified of the resident's hospital transfer. During an interview, on 3/5/26 at 9:24 a.m., the Director of Nursing (DON) indicated she reviewed the resident's record and was unable to find documentation of the notice of transfer or discharge and bed hold policy were provided to the resident or the resident's representative. If the resident was transferred in an emergency, and they were unable to provide the notice of transfer or discharge and the bed hold policy at the time of the transfer, it should have been provided as soon as possible. The DON indicated she was unable to find documentation the nurse communicated with the hospital where the resident was being transferred. The nurse should have called and talked to someone in the emergency room (ER). During an interview, on 3/5/36 at 9:26 a.m., the Social Services Director (SSD) indicated she was not sure who was responsible for notifying the ombudsman of the facility's transfers and discharges. During an interview, on 3/5/26 at 9:39 a.m., the Corporate Nurse indicated he was unable to find documentation the ombudsman was being notified of the residents' transfers and discharges. 2. On 3/3/26 at 12:32 p.m., a record review was completed for Resident 89. A Discharge summary, dated [DATE], indicated Resident 89 was being discharged to another skilled nursing facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	His record lacked a notice of transfer and discharge. The Ombudsman was not notified of his transfer to the hospital. During an interview on 3/6/26 at 10:40 a.m., the DON indicated there were a few progress notes but the discharge summary in the electronic medical record was incomplete and she could not locate ombudsman notification, a bed hold, or a discharge (DC) summary. The Social Services Director (SSD) was responsible for ensuring all that was completed and documented in the resident records. 3. On 3/3/26 at 11:21 a.m., a record review was completed for Resident 87. An Event Note, dated 12/5/25 at 5:01 a.m., indicated the Nurse Practitioner gave an order to send the resident out to the emergency room for evaluation and treatment, and report was given to the nurse at the hospital. Resident 87's record lacked a notice of transfer and discharge and the Ombudsman notification that he was discharged to the hospital. 4. On 3/3/26 at 1:35 p.m. Resident 84's medical record was reviewed. The record lacked documentation about Resident 84's discharge and the events leading up to his discharge. The record lacked documentation the facility communicated with the hospital where Resident 84 was being transferred to, a notice of transfer or discharge and bed hold policy were provided to Resident 84 or Resident 84's representative at the time of Resident 84's discharge. On 3/4/26 at 11:01 a.m. the Director of Nursing (DON) indicated Resident 84 was emergently transferred so they were unable to get the paperwork completed before sending the resident out. On 3/6/26 at 10:00 a.m. Licensed Practical Nurse (LPN) 12 indicated she was the nurse who sent Resident 84 out to the hospital on 3/2/26. LPN 12 indicated he had had trouble swallowing his morning medications and breakfast that morning, and his vitals at 12:00 p.m. showed his heart rate was in the 30's so she called the doctor and received an order to send Resident 84 to the hospital immediately for evaluation. On 3/2/26 at 1:08 p.m. Resident 84 was observed being wheeled out of his room on a gurney by ambulance staff with several family members at his side. That was approximately one hour after LPN 12 called the ambulance for Resident 84's transfer. On 3/5/26 at 10:29 a.m. a copy of a current facility policy titled, Notice of Transfers and Discharges, dated 2/17/2026 was provided. That policy indicated, .The facility will notify the resident and the resident representative(s), and Office of the State Long-Term Care (LTC) Ombudsman of the transfer or discharge and the reasons for the move in writing. On 3/5/26 at 10:29 a.m. a copy of a current facility policy titled, Notice of Transfers and Discharges, dated 2/17/2026, was provided. That policy indicated, .The bed hold policy should be given. upon transfer of a resident to the hospital (if an emergency within 24 hours). 410 Indiana Administrative 410 Indiana Administrative Code (IAC) 16.2-3.1-12(a)(25)(A). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	410 Indiana Administrative 410 Indiana Administrative Code (IAC) 16.2-3.1-12(a)(25)(B). 410 Indiana Administrative 410 Indiana Administrative Code (IAC) 16.2-3.1-12(a)(26).

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the resident was provided with adaptive equipment related to a visual impairment for 1 of 28 residents reviewed for accommodation of needs (Resident 15). Findings include: During an observation, on 3/2/26 at 12:09 p.m., Resident 15 was at the nurse's station yelling. The resident indicated he was tired of waiting and wanted his stuff. Two staff members approached the resident, and the resident told them he wanted his lunch, and that it was 2:00 p.m. One of the staff members told the resident it was actually around noon and offered to bring the resident's lunch to his room. The resident agreed and went to his room. During an observation, on 3/2/26 at 12:17 p.m., the resident was in his room. A clock next to his bed indicated the time was a little after 2:00 p.m. At the same time, the resident indicated he was legally blind, and the clock said the time out loud each hour so he could know what time it was. He was not aware the clock was set two hours fast. During an observation, on 3/2/26 at 1:00 p.m., Resident 15 was served lunch in the dining room. The resident's lunch was served in Styrofoam containers, and no adaptive equipment was provided. During an observation, on 3/3/26 at 11:25 p.m., the resident was observed in his room, and the clock remained approximately two hours fast at 1:21 p.m. During an observation, on 3/4/26 at 1:20 p.m., the resident was observed in his room, and the clock remained approximately two hours fast. Resident 15's record was reviewed on 3/4/26 at 1:40 p.m. Diagnoses on the resident's profile included, but were not limited to, legal blindness. A care plan, dated 1/31/24, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to impaired eyesight. Interventions included, but were not limited to, the resident required adaptive equipment including divided plate and Kennedy cup (a lightweight, spill-proof, and adaptive drinking cup designed to prevent mess, even when turned upside down) for all meals and a blue placemat. During an observation, on 3/5/26 at 12:20 p.m., Resident 15 was observed in the dining room eating lunch. The resident's lunch was served on a regular white plate. The resident's drinks were served in a small glass with no lid and a Styrofoam cup with a lid and straw. The table had a white tablecloth in place. There was no divided plate, blue placemat, or specialized cups provided. During an interview, on 3/5/26 at 12:23 p.m., Resident 15 indicated he used to receive a divided plate for meals, and it was helpful for him because it kept him from getting his food all mixed up. The resident indicated he used to get sippy cups which he liked, and they were helpful. He also used to get a blue placemat. The resident indicated, due to his visual impairment, he was unable to see a white plate on a white tablecloth. The blue placemat helped him see his plate. The resident indicated he had not received any of these items in a long time.During an interview, on 3/5/26 at 1:42 p.m., the Director of Nursing (DON) indicated residents should have received their adaptive equipment as indicated in their care plan. On 3/5/26 at 3:13 p.m., the DON provided a document titled, Assistive Devices-Special Eating Equipment, last reviewed on 5/1/25, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: The facility provides residents with special eating equipment and assistive devices as deemed necessary. 410 Indiana Administrative Code (IAC) 16.2-3.1-3(v)(1).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure behavior monitoring and documentation in the medical record to support rationales for denying gradual dose reductions (GDR) for antipsychotic and antidepressant medications for 2 of 5 residents reviewed for unnecessary medications (Resident 81 and 2). Findings include:1. On 3/3/26 at 10:37 a.m. Resident 81's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, dementia, major depressive disorder, and psychotic disorder. A pharmacy review was done on 7/14/25 indicating Resident 81 had Zyprexa (an atypical antipsychotic medication) 2.5 milligrams (mg) at bedtime ordered. The recommendation was to Gradual Dose Reduction (GDR) (a required process in nursing homes to taper psychotropic or antipsychotic medications to the lowest effective dose, thereby minimizing side effects.) the medication with the goal being to discontinue the medication. The recommendation was denied. The Nurse Practitioner (NP)'s reason for denying the recommendation was, Resident 81 was stable with the medication regimen she was currently on. The NP indicated the resident had also been in a recent resident to resident altercation and had had mixed delusional behaviors. A progress note, dated 7/13/25, indicated an unidentified male resident put his hand on Resident 81's shoulder. Resident 81 asked the male resident not to touch her again, but the male resident would not listen, and he put his hand back on Resident 81's shoulder. Resident 81 then hit the male resident. The record lacked documentation of delusional behaviors in the month leading up to the review.A pharmacy review was done on 8/11/25 indicating the resident had Lexapro (a prescription antidepressant) 10 mg at bedtime ordered. The recommendation was to GDR the medication to 5 mg. The recommendation was denied. The NP's reason for denying the recommendation was, Resident 81 had recent negative behaviors including intrusiveness. The record lacked documentation of increased behaviors, aside from the resident-to-resident altercation mentioned above, or intrusiveness in the month leading up to the review. A pharmacy review was done on 10/13/25 indicating Resident 81 had Zyprexa 2.5 mg at bedtime ordered. The recommendation was to GDR the medication by doing a trial discontinuation of the medication. The recommendation was denied. The providers' reason for denying the recommendation was, Resident 81 had a history of verbal aggression. A pharmacy review was done on 2/9/26 indicating Resident 81 had Lexapro 10 mg at bedtime ordered. The recommendation was to GDR the medication by doing a trial discontinuation of the medication. The recommendation was denied. The NP's reason for denying the recommendation was, Resident 81 had previously failed a GDR of this medication, and the resident had COVID at the time. The record showed a discontinued order for Lexapro 5 mg on 2/12/25 with a restart date of 2/20/25 at 10 mg. A progress note, dated 2/12/25, indicated Resident 81 had been transferred to a medical behavior center. The record lacked documentation of a failed GDR for this medication. 2. On 3/3/26 at 10:37 a.m. Resident 2's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to dementia and major depressive disorder with psychotic symptoms. A pharmacy review was done on 2/19/25 indicating Resident 2 had Quetiapine (an atypical antipsychotic medication) 200 mg at bedtime ordered for Schizophrenia. The recommendation was to attempt a GDR to 150 mg at bedtime. The recommendation was denied. The NP's reason for denying was, Resident 2 required that dose to maintain/control symptoms related to Schizophrenia. The record lacked documentation of Schizophrenia being a medical diagnosis for Resident 2.A pharmacy review was done on 11/25/25 indicating Resident 2 had fluoxetine (a prescription antidepressant) 40 mg daily ordered. The recommendation was to attempt a GDR to 30 mg daily. The NP declined the recommendation. The NP's reason for denying was, Resident 81 had recently had to increase the dose of Fluoxetine due to continued mood issues and depression.The record lacked documentation of an increase in Resident 2's fluoxetine dose. On 3/6/26 at 9:43 a.m., the Director of Nursing provided a copy of current facility (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy titled, Care of the Cognitively Impaired (Dementia Care) dated 9/2/25. The policy indicated, .A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Procedure 1. Identify, address, and/or obtain necessary services for the dementia care needs of residents; 2. Develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment; 3. Develop individualized interventions related to the resident's symptomology and rate of progression (e.g., providing verbal, behavioral, or environmental prompts to assist a resident with dementia in the completion of specific tasks); 4. Review and revise care plans that have not been effective and/or when the resident has a change in condition; 5. Modify the environment to accommodate resident care needs. 410 Indiana Administrative Code (IAC) 16.2-3.1-48(b)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded for 3 of 19 residents' MDS assessments reviewed (Residents 15, 12, and 3). Findings include:1. During an observation, on 3/2/26 at 12:17 p.m., Resident 15 was observed with no natural teeth (edentulous). Resident 15's record was reviewed on 3/4/26 at 1:40 p.m. An annual MDS assessment, dated 1/16/26, indicated the resident had no oral/dental issues, including being edentulous. During an interview, on 3/5/26 at 3:17 p.m., the Corporate Nurse indicated Resident 15 was edentulous, and the MDS assessment should have been coded accordingly. The facility used the Resident Assessment Instrument (RAI) manual and did not have a separate policy for MDS assessments. The Centers for Medicare and Medicaid Services (CMS) MDS RAI Manual, version 3.0, dated October 2025, indicated, .Section L: Oral/Dental Status. Intent: This item is intended to record any dental problems present in the 7-day look-back period. Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth. 2. Resident 12's record was reviewed on 3/6/26 at 10:01 a.m. A quarterly MDS assessment, dated 12/1/25, indicated the resident received one insulin injection during the assessment look-back period. Medication Administration Records (MARs), dated November and December 2025, lacked documentation the resident received any injections, including insulin. During an interview, on 3/6/26 at 10:53 a.m., the Director of Nursing (DON) indicated the resident had not received an insulin injection, and the MDS assessment should not have indicated they had. 3. Resident 3's record was reviewed on 3/6/26 at 9:28 a.m. A quarterly MDS assessment, dated 2/4/26, indicated the resident received one insulin injection during the assessment look-back period. Medication Administration Records (MARs), dated January and February 2026, lacked documentation the resident received insulin injections. The resident received an Ozempic injection one day of the assessment look-back period, 1/29/26.During an interview, the Director of Nursing (DON) indicated Ozempic should have been coded as an injection, but not insulin. Ozempic was not an insulin. The facility used the Resident Assessment Instrument (RAI) manual as their policy. The Centers for Medicare and Medicaid Services (CMS) MDS RAI Manual, version 3.0, dated October 2025, indicated, .Section N: Medications. Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident. 410 Indiana Administrative Code (IAC) 16.2-3.1-31(c)(9)410 Indiana Administrative Code (IAC) 16.2-3.1-31(c)(13).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interviews and record reviews, the facility failed to ensure a new Preadmission Screening and Resident Review (PASRR) level one was completed after a new major mental illness diagnoses was added to the diagnoses lists for 2 of 2 residents reviewed for PASRR compliance (Resident 81 and 2). Findings include:1. On 3/3/26 at 10:37 a.m. Resident 81's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, dementia, major depressive disorder, and psychotic disorder. On 5/12/25 Resident 81's medical chart was updated to add psychotic disorder as a new diagnosis. The record lacked documentation of the facility submitting a new level one PASRR to include the new diagnosis added to her medical record. On 3/4/26 at 12:13 p.m. the Executive Director (ED) indicated the most current PASRR level 1 was completed on 3/19/25, so the new psychotic disorder diagnosis added on 5/12/25 would not have been on that level one. 2. On 3/3/26 at 10:37 a.m. Resident 2's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to dementia and major depressive disorder with psychotic symptoms. On 2/10/26 Resident 2's medical chart was updated to add major depressive disorder with psychotic symptoms as a new diagnosis. The record lacked documentation of the facility submitting a new level one PASRR to include the new diagnosis added to her medical record. On 3/6/26 10:35 a.m. the Director of Nursing (DON) indicated the most current PASRR level 1 was completed on 11/20/25, so the new major depressive disorder with psychotic symptoms diagnosis added on 2/10/26 would not have been on that level one. On 3/5/26 at 11:23 a.m. a copy of a current facility policy titled, Pre-admission Screening and Resident Review (PASARR), dated 9/26/25. That policy indicated . A negative level 1 screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder.arises later. Procedure:.13. Any resident with newly evident or possible serious mental disorder. must be referred, by the facility to the appropriate state-designated mental health.authority for review. 410 Indiana Administrative Code (IAC) 16.2-3.1-16(d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADL) care was provided to residents who required assistance to maintain their personal hygiene for 2 of 28 residents reviewed for ADLs (Residents 6 and 15). Findings include:1. During an observation, on 3/2/26 at 10:45 a.m., Resident 6 was lying in bed. Resident 6 had untrimmed facial hair around her mouth, and the fingernails on her left hand were long and untrimmed with dark debris underneath them. During an observation, on 3/3/26 at 11:28 a.m., Resident 6 was lying in bed. The resident had untrimmed facial hair around her mouth. The resident's fingernails, on both hands, were long and untrimmed, with dark debris underneath them. During an observation, on 3/3/26 at 2:05 p.m., Resident 6 was lying in bed. The resident had untrimmed facial hair around her mouth. The resident's fingernails, on both hands, were long and untrimmed, with dark debris underneath them. During an observation, on 3/4/26 at 1:17 p.m., Resident 6 was lying in bed. The resident had untrimmed facial hair around her mouth. The resident's fingernails, on both hands, were long and untrimmed, with dark debris underneath them. During an observation, on 3/4/26 at 2:30 p.m., Registered Nurse (RN) 7 completed wound care for Resident 6. During the care, the resident continued with untrimmed facial hair around her mouth, and fingernails remained long and untrimmed, with dark debris underneath them. During an observation, on 3/5/26 at 10:02 a.m., Resident 6 was observed up in a chair, next to her bed. The resident had untrimmed facial hair around her mouth. The resident's fingernails, on both hands, were long and untrimmed, with dark debris underneath them. At the same time, the resident indicated she did not like having long fingernails. Resident 6's record was reviewed on 3/5/26 at 11:01 a.m. Diagnoses on the resident's profile included, but were not limited to, unspecified dementia (a decline in mental ability severe enough to interfere with daily life, characterized by loss of memory, reasoning, and language). A five day Minimum Data Set (MDS) assessment, dated 1/20/26, indicated the resident had a severe cognitive impairment and was dependent on staff for bathing. The assessment lacked documentation the resident exhibited any behaviors, including rejection of care. A care plan, initiated on 1/6/26, indicated the resident had an ADL self-care performance deficit. Interventions included, but were not limited to, the resident was totally dependent on one to two staff members for personal hygiene. Progress notes, dated February and March 2026, lacked documentation the resident was offered, provided, or refused shaving and fingernail care. A behavior task in the electronic record, dated 2/4/26 to 3/4/26, lacked documentation the resident refused hygiene care. Shower sheets, dated 2/3/26, 2/6/26, 2/10/26, 2/13/26, 2/17/26, 2/20/26, and 2/24/26, lacked documentation fingernail care or shaving was offered, provided, or refused. A shower sheet, dated 2/27/26, indicated the resident's fingernails were cleaned, but not trimmed or filed. The shower sheet lacked documentation shaving was offered, provided, or refused. During an interview, on 3/5/26 at 10:07 a.m., Certified Nurse Aide (CNA) 8 indicated Resident 6 did not refuse care, including fingernail care and shaving. Fingernail care and shaving should have been completed with showers. 2. During an observation, on 3/2/26 at 12:17 p.m., Resident 15's fingernails, on both hands, were long and untrimmed, with dark debris underneath them. At the same time, Resident 15 indicated he was legally blind was unable to safely take care of his own fingernails but would have allowed the staff to provide the care if offered. The resident indicated the staff had not offered to clean or trim his fingernails. During an observation, on 3/3/26 at 11:25 a.m., Resident 15 was observed with long and untrimmed fingernails with dark debris underneath them. During an observation, on 3/3/26 at 2:07 p.m., Resident 15 was observed with long and untrimmed fingernails with dark debris underneath them. During an observation, on 3/4/26 at 1:20 p.m., Resident 15 was observed with long and untrimmed fingernails with dark debris underneath them. Resident 15's record was reviewed on 3/4/26 at 1:40 p.m. Diagnoses on the resident's profile included, but were not limited to, legal blindness. An annual Minimum Data Set (MDS) assessment, dated 1/16/26, indicated the resident had a moderate cognitive impairment and required set-up or clean-up assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment lacked documentation the resident exhibited any behaviors, including rejection of care. A care plan, initiated 1/31/24, indicated the resident had an ADL self-care performance deficit. Interventions included, but were not limited to, the resident required the assistance of one staff member for personal hygiene. Shower sheets, dated 2/4/26, 2/11/26, 2/14/26, 2/18/26, 2/25/26, and 2/28/26, indicated the resident's fingernails were cleaned, but lacked documentation they were trimmed or filed. Shower sheets, dated 2/7/26 and 2/21/26, lacked documentation fingernail care was offered, provided, or refused. Progress notes, dated February and March 2026, lacked documentation fingernail care was offered, provided, or refused. The task section of the electronic record lacked documentation refusal of care was a behavior the resident was monitored for. During an interview, on 3/5/26 at 10:07 a.m., Certified Nurse Aide (CNA) 8 indicated Resident 15 did not refuse care, including fingernail care. Fingernail care should have been completed with showers. During an interview, on 3/5/26 at 10:13 a.m., the Director of Nursing (DON) indicated if a resident refused ADL care it should have been documented in the CNA's charting. The nurse should have re-attempted and documented refusals in the progress notes. On 3/5/26 at 3:13 p.m., the DON provided a document titled, Activities of Daily Living [ADLs], last revised 9/4/26, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy The resident will receive assistance as needed to complete activities of daily living.A resident who is unable to carry out activities of daily living receives the necessary services to maintain.grooming, and personal.hygiene. 410 Indiana Administrative Code (IAC) 16.2-3.1-38(a)(3)(D).410 Indiana Administrative Code (IAC) 16.2-3.1-38(a)(3)(E).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews, and record review, the facility failed to maintain a functional resident call system for 1 of 1 resident reviewed for call light concerns (Resident 7). Findings include:On at 3/2/26 at 10:11 a.m., Resident 7 called out repeatedly for help. Her call light was not illuminated. During an interview on 3/2/26 at 10:13 a.m., Resident 7 indicated her call light had not been working for months. Resident 7 pressed her call button, but the light did not illuminate outside of her room. On 3/2/26 10:32 a.m., the Maintenance Director began to work on repairing her call light. In the meantime, Resident 7 was provided a small hand-held bell. Additional observations throughout the survey period revealed missing hallway call light covers for multiple rooms which included, but were not limited to: 118, 117, 115, 114, 112, and 121, making call lights difficult to see if they were on or not. On 3/4/26 at 10:00 a.m., Resident 7's call light was illuminated and the alarm sounded. An unidentified passing nurse indicated, someone was in the room with Resident 7, but her call light was malfunctioning and wouldn't turn off. They were waiting for someone to come out and repair the light. During an interview on 3/4/26 at 10:12 a.m., the Maintenance Director indicated, he tried everything he could think of from replacing the chord, the room wall-box, the above the door box, and even attempted to replace a fuse, but the light was still not working consistently. He indicated they system was very old and constantly having problems. During an interview on 3/5/26 at 1:25 p.m., the Administrator indicated, the call light system for the building was very old and nearly obsolete. Repairs parts were hard to find and very expensive. Issues with the call light system were ongoing and as a back up, residents were provided with hand-held bells as needed. Resident 7 filed a grievance, dated 12/19/25, which indicated she pushed the call light several times but it wasn't answered in a timely manner. On 3/6/26 at 9:43 a.m., the Director of Nursing provided a copy of current facility policy titled, Resident Call System, dated 12/23/25. The policy indicated, The nurses' stations in the facility will be equipped to receive resident calls with a communication system through audible or visual signals from resident rooms, toilets, and bating facilities. All portions of the system will be maintained and function accordingly. 410 Indiana Administrative Code (IAC) 16.2-3.1-19(u).