STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grove Village	1021 E Central Ave Greensburg, IN 47240

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34232 Based on interview, observation, and record review, the facility failed to prevent pressure ulcers and implement Care Plan interventions for a resident who was at risk for pressure ulcers for 1 of 5 residents reviewed. (Resident 23) Findings include: During an interview and observation, on 04/22/25 at 12:41 P.M., Resident 23 indicated he had sores on both of his heels, and it felt like pins and needles were sticking into them. His heels were lying flat against the bed mattress. No soft boots or extra pillows were noted in the visible area. The resident indicated staff did not put a pillow behind his calves to keep the pressure off his heels or put soft boots on his feet. During an observation, on 04/23/25 at 3:45 P.M., the resident was lying in bed with his eyes closed, flat on his back with his heels flat against the bed mattress. No extra pillows or soft boots were noted on the floor or in the immediate area. During an observation, on 04/24/25 at 9:42 A.M., the resident was lying in bed with his eyes closed, flat on his back with his heels flat against the bed mattress. Staff members were exiting the room following the provision of care, carrying bags of soiled linens. The resident's wound treatments were observed, on 04/25/25 at 12:58 P.M., with Licensed Practical Nurse (LPN) 2. The nurse donned a gown and gloves, explained the procedure to the resident, and removed the soft boots and socks from the resident's feet. The left heel had a thick dime sized dried scab. The right heel had a silver dollar size dark area with a nickel size dried scab in the center. During an interview, on 04/25/25 at 2:51 P.M., Certified Nurse Aide (CNA) 5 and CNA 6 indicated Resident 23 required two staff members for assistance with transferring from his wheelchair to the bed. During an interview, on 04/25/25 at 3:37 P.M., the Director of Nursing (DON) indicated the resident's heels started looking purple on 03/07/25. (continued on next page)

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 04/28/25 at 1:45 P.M., the Assistant Director of Nursing (ADON) indicated the resident was admitted to the facility from the hospital on 02/25/25. He had no pressure ulcers at that time. He had calluses on both heels but no Deep Tissue Injuries (DTIs), just thick calluses. On 03/07/25, a CNA came and told her the resident had some discoloration on his heels. She went and measured them, and they were both 2.5 centimeters (cm) x (by) 1.5 cm, with no depth or drainage. She applied Skin Prep (a skin toughening agent), floated his heels using pillows, completed an Event in the computer, and opened a new Care Plan on 03/07/25. Preventative measures in place prior to the development of the pressure ulcers included a pressure reducing mattress, a pressure reducing cushion to his wheelchair, turning and repositioning every two hours and as needed, an incontinence care check every two hours and as needed, and house barrier cream as needed for incontinence care. That was the standard practice and in place prior to the development of the DTIs to his heels. They were not doing anything extra for the resident's feet prior to the development of the DTIs. He required staff help for positioning. Sometimes one person could roll him from side to side. For scooting up in bed, the resident needed the assistance of two staff members. The clinical record for Resident 23 was reviewed on 04/24/25 at 10:49 A.M. The resident's admitted was 02/25/25. A Significant Change Minimum Data Set (MDS) assessment, dated 04/21/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, obstructive uropathy, diabetes, and depression. The resident was at risk for pressure ulcers and had two unstageable Deep Tissue Injuries that were not present on admission. The resident had a pressure reducing device for the bed and his chair. The Admission MDS assessment, dated 03/04/25, indicated the resident was at risk for pressure ulcers but had no unhealed pressure ulcers. The New Skin Event records, dated 03/07/25, were provided by the DON on 04/25/25 at 3:31 P.M., and indicated the resident had the following: - A DTI to the right heel, measuring 2.5 cm x 0.5 cm, purple in color, with a new treatment order for Skin Prep, and - A DTI to the left heel, measuring 2.5 cm x 0.5 cm, purple in color, with new treatment orders for Skin Prep and to float the heels. The CNA Approaches on Profile pocket sheets describing individual resident needs and interventions was provided by CNA 6 on 04/24/25 at 2:10 P.M. The record indicated Resident 23 had DTIs to his left and right heels, his heels were to be floated while in bed, and he was to wear Heel Boots (soft pillow-like boots) while in bed. The Admission Braden Scale for Predicting Pressure Sore Risk assessment, dated 02/25/25, was provided by the Regional Director of Clinical Services on 04/28/25 at 2:05 P.M. The record indicated the resident was at Moderate Risk for pressure sores. The current SKIN MANAGEMENT PROGRAM policy, dated 05/2022, was provided by the DON on 04/25/25 at 3:31 P.M. The policy indicated, .It is the policy of American Senior Communities to ensure that each resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers .and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-40(a)(1) 3.1-40(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34232 Based on record review and interview, the facility failed to ensure the physician prescribed medications were available for 2 of 6 residents reviewed for pharmacy services. (Residents 23 and 35) Findings include: 1. The clinical record for Resident 23 was reviewed on 04/24/25 at 10:49 A.M. The resident's admitted d was 02/25/25. A Significant Change Minimum Data Set (MDS) assessment, dated 04/21/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, heart failure, obstructive uropathy, diabetes, and depression. The Electronic Medication Administration Record (EMAR) indicated the resident had a physician's order, with a start date of 02/25/25 and a discontinued date of 04/07/25, for Modafinil 100 milligrams (mg) once a day for a diagnosis of major depressive disorder. The medication was not administered on the following dates due to the medication not being available: - 02/26/25, - 02/27/25, - 02/28/25, - 03/01/25, - 03/02/25, - 03/03/25, - 03/04/25, - 03/05/25, and - 03/10/25. During an interview, on 04/25/25 at 2:07 P.M., the Director of Nursing (DON) indicated when a resident was admitted , the nurse on the floor admitting the resident would transcribe the resident's medication orders into the computer system and the medication orders were automatically sent to the pharmacy. The medications should arrive within 24 hours. If a medication was not available right away the facility could use a local pharmacy, or the family could bring in medications they had at home. 2. The clinical record for Resident 35 was reviewed on 04/28/25 at 9:32 A.M. An Admission MDS assessment, dated 03/24/25, indicated the resident was cognitively intact. The resident's diagnosis included, but were not limited to, hepatic encephalopathy, ascites (build-up of fluid in the abdomen), and Nonalcoholic Steatohepatitis (NASH). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMAR indicated the resident had a physician's order for Xifaxan 550 mg twice a day for a diagnosis of NASH, with a start date of 03/07/25 and a discontinued date of 03/13/25. The medication was not administered on the following dates and times due to the medication not being available: - 03/07/25 from 7:00 P.M. to 11:00 P.M., - 03/08/25 from 7:00 A.M. to 11:00 A.M., - 03/08/25 from 7:00 P.M. to 11:00 P.M., - 03/09/25 from 7:00 A.M. to 11:00 A.M., - 03/09/25 from 7:00 P.M. to 11:00 P.M., - 03/10/25 from 7:00 A.M. to 11:00 A.M., - 03/10/25 from 7:00 P.M. to 11:00 P.M., and - 03/11/25 from 7:00 A.M. to 11:00 A.M. During an interview, on 04/28/25 at 9:56 A.M., the Assistant Director of Nursing (ADON) indicated Resident 35 came to the facility following a hospital stay. He had formerly lived at a local Assisted Living (AL) facility. The resident received paracentesis treatments (needle drainage of fluid from a body cavity) due to his diagnosis of NASH. They had to get his supply of Xifaxan from the local AL he had resided at because it was high-cost medication and there was extra paperwork involved. The resident should not have gone five days without his medication. When the medication was ordered, the nurse on the floor would call the pharmacy about the medication and complete the required documents. The resident was discharged to the hospital on 03/11/25. When the resident came back from the hospital on 03/17/25, the facility had received the medication. The medication was for the resident's diagnosis of NASH. The medication is categorized as an antibiotic. The current Medication Shortages/Unavailable Medications policy, with an effective date of 12/01/07, was provided by the DON on 04/25/25 at 3:31 P.M. The policy indicated, .If a medication is unavailable during normal Pharmacy hours .If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery .If the next available delivery causes a delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose .If the medication is not available in the Emergency Mediation Supply, Facility staff should notify Pharmacy and arrange for a STAT (immediate) delivery, if medically necessary .If a medication is unavailable is [sic] discovered after normal Pharmacy hours .Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include .Emergency delivery .or .Use of an emergency (back-up) third-party Pharmacy . 3.1-25(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38239 Based on interview and record review, the facility failed to follow physician's orders related to a Gradual Dose Reduction (GDR) of a medication for 1 of 18 residents reviewed for quality of care. (Resident 47) Findings include: Resident 47's clinical record was reviewed on 04/23/35 at 2:00 P.M. A Quarterly Minimum Data Set assessment, dated 02/05/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, psychotic disorder, and depression. The resident experienced hallucinations. The resident's medication orders as of 01/15/25 included, but were not limited to, the following: - An open-ended order, with a start date of 07/12/24, for Risperdal (an antipsychotic medication). The resident received 1 milligram (mg) of the medication in the morning and 0.5 mg in the evening, and - An open-ended order, with a start date of 11/21/24, for sertraline (an antidepressant medication). The resident received 150 mg at bedtime. An Evaluation for Gradual Dose Reduction of Psychotropic Medication, dated 01/15/25, recommended a GDR of the Risperdal medication. The Psychiatric Nurse Practitioner (Psych NP) gave new physician's orders to increase the resident's sertraline to 200 mg every day and decrease the resident's Risperdal to 0.5 mg twice a day. A Progress Note documented by the Social Services Director, dated 01/15/25 at 1:17 P.M., indicated the Psych NP ordered a reduction of the resident's Risperdal to 1 mg in the morning and 0.5 mg in the evening, and an increased in the resident's sertraline to 200 mg in the evening. There was no indication in the resident's record that the medication orders were changed and the resident continued to receive the medications daily at the previously ordered doses. A Nursing Progress Note, dated 01/19/25 at 6:27 A.M., indicated the resident experienced no psychosocial distress related to the GDR of the Risperdal and the increase of the sertraline. A Nursing Progress Note, dated 01/21/25 at 9:39 A.M., indicated the resident experienced no psychosocial distress related to the GDR of the Risperdal and the increase of the sertraline. A Nursing Progress Note, dated 01/23/25 at 3:22 A.M., indicated the resident was hallucinating. He was seeing bugs on his feet. A Behavior Review Note, dated 01/24/25 at 12:40 P.M., indicated the resident urinated on the floor and exhibited increased confusion. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note, dated 01/24/25 at 3:43 P.M., indicated the resident's urine was checked and the results indicated the resident did not have a urinary tract infection. On 01/24/25, the resident's Risperdal medication order was changed to 0.5 mg twice a day. The resident's sertraline order remained the same, 150 mg at bedtime. The resident received the medications daily as ordered. A Pharmacy Consultation Report, dated 02/13/25, indicated the following: ***CLINICAL PRIORITY RECOMMENDATION: PROMP RESPONSE REQUESTED*** During the behavior management meeting in January, an order was given to increase the resident's sertraline to 200 mg a day. The order has not been processed. The resident continued on 150 mg daily. The resident's sertraline order was changed to 200 mg at bedtime on 02/14/25. During an interview, on 04/28/25 at 1:37 P.M., the Assistant Director of Nursing indicated the resident's orders weren't changed when the Psych NP decreased the Risperdal and increased the sertraline. The Psych NP came in a week later and realized the Risperdal hadn't been changed so she wrote a repeat order to decrease it again. Then, after the pharmacy recommendation they determined the sertraline hadn't been adjusted either. Nursing staff were noticing behaviors with the resident and thought the GDR was failing, but the medications hadn't actually been changed as ordered. During an interview, on 04/28/25 2:25 P.M., the Regional Director of Clinical Services indicated the facility did not have a policy related to following MD orders, it was just standard nursing practice. 3.1-25(i)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34232 Based on observation, interview, and record review, the facility failed to maintain resident snack refrigerators appropriately related to the storage of staff food items, incomplete labeling, and the storage of non-food items for 2 of 3 resident snack refrigerators observed. (100/200 Hall Resident Snack Refrigerator and the 400 Hall Resident Snack Refrigerator) Findings include: 1. The 100/200 Hall Resident Snack Refrigerator was observed on 04/28/25 at 12:38 P.M., with Licensed Practical Nurse (LPN) 7, and contained the following: - LPN 7's lunch bag, - One unopened carton of vanilla ice cream with no resident name, date, or room number, - One opened carton of vanilla ice cream dated 03/11/25 with no resident name or room number, - A tan plastic grocery bag with a paper note labeled with Qualified Medication Aide (QMA) 4's name and the numbers, 3-12 to 6-12, as identified by LPN 7, and - One long, over 12 inches, black ice pack with no resident name. The signage on the front of the refrigerator indicated the REFRIGERATOR RULES included, but were not limited to, For Residents & Visitors Only (Not For Staff Personal Items); Every open item must have a label with an open date and a use by date; NO STAFF FOOD! USE FRIDGE IN 400 HALL BREAK ROOM. The 100/200 Hall Resident Snack Refrigerator was observed on 04/28/25 at 12:51 P.M., with the Physical Therapist (PT). PT indicated the black ice pack belonged to the Therapy Department and had been used on a resident's neck. He did not know how the ice pack had gotten into the residents' snack refrigerator. 2. The 400 Hall Resident Snack Refrigerator was observed on 04/28/25 at 12:58 P.M., with Medical Records, and contained the following: - One open bottle of yellow soda, 3/4 full, dated 04/22/25, with the initials A.H., and - One unopened bottle of dark soda, dated 04/22/25, with the initials A.H. During an interview on 04/28/25 at 1:00 P.M., LPN 8 indicated there were no residents residing on the 400 Hall who had the initials A.H. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The current Food Brought in by Family and Visitors policy, with a revised date of 05/2023, was provided during the Entrance Conference. The policy indicated, .Food brought in by family and visitors will be easily distinguishable from facility food and stored to ensure food safety .If food must be stored, it will be labeled with the resident's name, the date the item was brought in, and the date it should be consumed or discarded . Staff will monitor for food in need of disposal . 3.1-21(i)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38239 Based on interview and record review, the facility failed to completely and accurately document the assessment and monitoring of a resident after a fall for 1 of 3 residents reviewed for Resident Records. (Resident 58) Findings include: During an interview, on 04/23/25 at 1:03 P.M., Resident 58 and the resident's family member indicated the resident had fallen three times in three weeks. The family member was present for one of the falls and indicated the resident was standing with her walker when she started to feel shaky and fell to the floor. The family member notified staff at the time of the fall. The resident's clinical record was reviewed on 04/25/25 at 2:20 P.M. An Annual Minimum Data Set assessment, dated 02/11/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, overactive bladder, and weakness. The resident used a walker and wheelchair. The resident required partial to moderate staff assistance to move from a sitting to a standing position and required staff supervision or touching assistance when walking. The resident experienced no falls since the last assessment. A Nursing Progress Note, dated 04/08/25 at 10:58 A.M., indicated the resident's family member requested help because the resident was on the floor next to her bed. The family member indicated the resident did not hit her head. The resident stood up to get into her wheelchair to go to lunch and said, I am going to fall. The resident lost her balance and fell to her right side. There were no injuries. A Nursing Progress Note, dated 04/08/25 at 11:06 A.M., indicated the Nurse Practitioner (NP), Director of Nursing (DON), and the resident's Power of Attorney (POA) were aware of the fall. The resident's record lacked further documentation related to the fall the resident experienced on 04/08/25. During an interview, on 04/25/25 at 2:20 P.M., Licensed Practical Nurse 9 indicated when a resident fell , nursing staff were to assess the resident and notify the NP, DON, Administrator, and POA. A progress note would be entered in the computer as well as a Fall Event. Specifics about the fall would be documented in the Fall Event so staff could determine what the issue might have been that caused the resident to fall, like if the resident wasn't wearing appropriate footwear or if they had to go to the bathroom so they got up without staff assistance. An immediate intervention would be put into place, and the Interdisciplinary Team (IDT) would review the fall to determine the root cause and if further interventions were warranted. The resident's care plan would be updated with any new interventions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 04/28/25 at 10:30 A.M., the Physical Therapist indicated he was familiar with the resident, and she was currently receiving physical therapy. She had experienced a few falls in the last month or so. He reviewed the facility's fall report every day. The report was generated from Fall Events documented in the residents' records. He was unaware the resident experienced a fall on 04/08/25 because there was not a Fall Event documented in the computer. During an interview, on 04/28/25 at 11:25 A.M., the Regional Director of Clinical Services (RDCS)indicated the resident did experience a fall on 04/08/25. There should have been a Fall Event created in the computer, an IDT review of the fall, and new fall intervention should have been implemented. The current facility policy, titled Fall Management Policy, dated 08/2022, was provided by the RDCS on 04/28/25 at 2:35 P.M. The policy indicated, .Any resident experiencing a fall will be assessed immediately .A fall event will be initiated as soon as the resident has been assessed and cared for .The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions .All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls .the fall event will be reviewed by the team .IDT note will be written .The care plan will be reviewed and updated as necessary .Hot Charting will be initiated post fall . 3.1-50(a)(2)