

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/08/2025
NAME OF PROVIDER OR SUPPLIER Harrison Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 1924 Wellesley Blvd Indianapolis, IN 46219	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure staff were utilizing infection control practices with hand hygiene during a dining observation in Mapleton Dining Room. This had potential to affect 16 of 16 residents observed in the dining room. (Resident 43 and Resident 68) Findings include: An observation was conducted of the Mapleton Unit dining room during a lunch meal service on 9/2/25 at 12:06 p.m. Activities Director (AD) was observed passing out silverware at each table for the residents in the dining room. During that time, AD was reaching inside container pulling out silverware and placing it on napkins. Then touching his face and eyeglasses. There was no observation of AD utilizing hand hygiene after touching his face and eyeglasses. After, AD was observed passing out meal trays and assisting residents with beverages. During that time, he was observed pulling up his pants. There was no observation of hand hygiene after he touched and pulled up his pants. During an observation of the Mapleton Unit dining room on 9/2/25 at 12:07 p.m., the following was observed: Certified Nurse Aide (CNA) 7 touched her hair braids with her hands then touched Resident 68's shirt and her cloth napkin, CNA 7 touched her hair with her hands then served a meal tray to Resident 43, placing her dishes on the table, removing the coverings from the dishes, returned the tray to the meal cart, then used hand sanitizer, and CNA 7 sat down with Resident 68, placed her cloth napkin, that the CNA had touched earlier, on her chest like a bib, and proceeded to assist the resident with their meal. There were 16 residents in the dining room. An interview was conducted with the Regional Director of Operations on 9/4/25 at 8:20 a.m. They indicated the staff should be utilizing hand hygiene if he or she touches their hair and/or body prior to continuing the meal service. The current Hand Hygiene Policy, with a revised date of 12/2021, was provided by the Director of Nursing Services on 9/4/25 at 11:58 a.m. The policy indicated, .To provide a standardized approach to Hand hygiene to reduce or minimize the transmission of infection from potential microorganisms on the hands of all employees.personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:.After touching a resident or the resident's immediate environment.After touching self or clothing during meal service. 3.1-18(l)		

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the facility was free of odor, clean and in good repair with linens and walls for 4 of 4 residents reviewed for physical environment. (Residents' D, F, G, and H) Findings include: A. During the initial tour of the facility on 9/2/25 at 9:55 a.m., the main entry smelled strongly of urine. Upon entering the Meridian Hills Unit, the floor in the hallway was sticky, especially around rooms [ROOM NUMBERS]. The floor between the entrance door and the nurse's station had an approximate six-inch black spot. There was a wet floor sign in the dining room beside the spot. During an observation on 9/2/25 at 2:28 p.m., the floor on the Meridian Hills Unit, between the entrance door and the nurse's station, had an approximate six-inch black spot. During a Confidential Interview 20, they indicated the Meridian Unit does have a urine odor. B. Upon entering the Mapleton Unit on 9/2/25 at 9:57 a.m., a strong urine odor was noted. An observation was conducted of the Mapleton Unit on 9/2/25 at 10:59 a.m. The unit smelled strong of urine odor. Upon entering the Mapleton Unit on 9/4/25 at 2:26 p.m., a strong urine odor was noted. C. An observation was conducted of Resident G's room on 9/5/25 at 1:11 p.m. The door frame to the bathroom was observed with chips and scratches. The bed linen had a small hole in the top right corner. During a Confidential Interview 21, they indicated the Meridian Unit recently had a urine odor when you walk in the unit. The floors were dirty, linens were worn with holes, the rooms are not kept tidy with throwing of used gloves, dirty briefs and clothing on the floor. An environmental tour was conducted, on 9/8/25 at 11:00 a.m., with the Maintenance Supervisor (MS) and the Administrator. An observation was made of Resident G's room. The bathroom door frame was observed with chips and scratches on it. A used glove was lying on the floor below the bathroom sink. During that time, the resident's linen on his bed was observed. A small hole was in the linen on the top right corner. The MS reported the top of the door frame was chipped by the door closing and the bottom half was from wheelchairs hitting it. The dirty glove on the floor at that time was removed and discarded. Next, Resident D's room was observed. The chair rail along the wall had scrapes and chips and missing a piece of the chair rail by the bed. After, Resident H's room was observed. The walls were observed with two scrapes and paint missing. An interview was conducted with the Administrator and the MS on 9/8/25 at 11:15 a.m. The Administrator indicated she had been working with the housekeeping department to replace the older linen. She recently had the floors cleaned. An interview was conducted with the MS on 9/8/25 at 11:59 a.m. He indicated the repairs were completed in the resident's room on an as needed basis. The residents' families and the staff fill out work orders that were located at the nurse's station if they observe rooms that need to be repaired. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility does not have a policy for homelike environment. This citation relates to Intake 1576791. 3.1-19(f)(5)		

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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 a resident had his face washed and shaved for 1 of 3 residents reviewed for activities of daily living (ADL) care. (Resident K) Findings include: The clinical record for Resident K was reviewed on 9/2/25 at 10:55 a.m. The diagnoses included, but were not limited to, dementia and acute osteomyelitis. A care plan, last reviewed/revised on 8/21/25 and obtained from the electronic health record on 9/4/25 at 9:19 a.m., indicated Resident K needed assistance with ADL care. The goal was for him to maintain his current functional status. The interventions included, but were not limited to, assisting with bathing as needed, assisting with dressing, grooming and hygiene as needed, and encouraging him to do as much for himself as possible. A care plan, last reviewed/revised on 8/21/25 and obtained from the electronic health record on 9/4/25 at 9:19 a.m., indicated Resident has a DX [Diagnosis] of Vascular Dementia. Resident has impaired daily decision-making skills and poor insight into care. Resident will refuse medications or allow staff to get him out of bed at times. Resident will not allow staff to turn or reposition. Per the family resident has always been very cautious of taking medications and believed that taking vitamins was the way to maintain good health. Resident will also refuse showers at times. resident is continuously putting on his call light stating that his TV is messed up despite staff turning TV back to preferred channel each time. Resident will not have any negative side effects due to medication refusals. On 9/2/25 at 10:55 a.m., Resident K was observed lying in bed. He had a heavy growth of beard on his face with dry flakey skin in his beard. On 9/3/25 at 10:01 a.m., Resident K was observed lying in his bed. He was unshaved and had dry, flakey skin in his beard and food on his face. During an interview on 9/4/25 at 11:28 a.m., Certified Nurse Aide (CNA) 16 indicated she sometimes provided care for Resident K. He required extensive assistance with ADL care. He would sometimes refuse care, but she had not known him to refuse to wash his face or shave. He would refuse to use deodorant. Residents were usually shaved on their shower days. On 9/4/25 at 3:00 p.m., Resident K was observed lying in bed. He was unshaved and had dry skin and food stuck in his beard and on the corners of his mouth. He indicated he used to get shaved. During an interview on 9/4/25 at 3:06 p.m., Registered Nurse 18 indicated Resident K's shower days were on Wednesday and Saturday on evening shift. On 9/5/25 at 11:20 a.m., Resident K was observed sitting in his wheelchair wearing a black t-shirt. He was unshaved and had dry skin in his beard. There were dried skin flakes present by the collar of his shirt, under his chin. The corners of his mouth were red. During an interview on 9/5/25 at 11:26 a.m., Licensed Practical Nurse (LPN) 14 indicated there was dried skin in Resident K's beard and probably flakes of potato chips that he liked to eat. Resident K was picky about things. He had previously lived off the grid. During an observation on 9/5/25 at 2:24 p.m., the Director of Nursing Services (DNS) obtained a warm washcloth and gently washed Resident K's face. This citation relates to Intake 1576791.3.1-38(a)(3)(A)3.1-38(a)(3)(D)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to administer an antibiotic as ordered by the physician, obtain blood sugars and administer insulin as ordered by the physician, and to administer insulin per the manufacturer's guidelines for 2 of 5 residents reviewed for unnecessary medications and 2 of 20 residents reviewed for quality of care. (Resident K, Resident F, Resident 20, and Resident 59) Findings include: 1. The clinical record for Resident F was reviewed on 9/2/25 at 10:55 a.m. The diagnoses included, but were not limited to, dementia and acute osteomyelitis (infection of the bone) of the right ankle and foot. A Significant Change of Status Minimum Data Set (MDS) assessment, completed 8/15/25, indicated he was severely cognitively impaired. A care plan, initiated 7/31/25, indicated Resident F had impaired skin integrity with a pressure injury to the sacrum and right heel. The goal was for his wounds to heal without complications. The interventions included, but were not limited to, obtain labs as ordered, provide treatment as ordered by the physician, and notify the physician of changes in wound such as worsening or signs of infection. A wound care progress note, dated 8/27/25 at 11:30 a.m., indicated Resident F's heel was painful and with suspected osteomyelitis (infection of bone). Resident F was to begin Cipro (antibiotic) 500 milligram (mg) every 12 hours for 14 days for osteomyelitis of the right heel starting 8/27/25. The August 2025 Medication Administration Record (MAR) indicated Resident F had received a dose of Cipro on 8/27/25 at 8:00 p.m., and 8/28/25 at 8:00 a.m. The MAR indicated the 8/28/25 8:00 p.m. dose of Cipro was unavailable from the pharmacy. The 8/29/25 and 8/30/25 doses were administered as ordered. The Cipro dose was not signed as being given on 8/31/25 at 8:00 a.m., and the 8/31/25 8:00 p.m. dose was documented as not given due to unavailable from the pharmacy. During an interview on 9/5/25 at 1:43 p.m., the Director of Nursing Services (DNS) indicated the first two doses administered were removed from the emergency drug cabinet. Resident F's supply of Cipro arrived at the facility on 8/29/25 at 5:03 a.m. She was unsure of why the supply of Cipro did not arrive from the pharmacy sooner and was unsure why the 8/31/25 8:00 p.m. dose was not administered because the Cipro was in the building. 2. The clinical record for Resident K was reviewed on 9/2/25 at 12:13 p.m. The diagnoses included, but were not limited to, dementia and diabetes. A physician's order, dated 4/8/25, indicated he was to have blood sugar checks with meals and at bedtime. The physician was to be notified if the blood sugar was below 70 or greater than 350. A physician's order, dated 7/28/25, indicated he was to receive lispro (short-acting) insulin five units subcutaneously (injection in the fat layer below the skin) three times a day. The dose was to be held if blood sugar was below 70. The administration times were listed as 7:00 a.m., 11:00 p.m., and 5:00 p.m. A Quarterly MDS assessment, completed 8/8/25, indicated he had severely impaired cognition and received insulin daily. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The August 2025 MAR did not contain documentation that Resident K had received blood sugar checks on the following day(s) and time(s): 8/9/25 at 8:00 p.m., 8/25/25 at 7:00 a.m., and 8/26/25 at 7:00 a.m. The August 2025 MAR did not contain documentation that he had received lispro insulin on the following day(s) and time(s): 8/1/25 at 11:00 p.m., 8/9/25 at 11:00 p.m., 8/15/25 at 11:00 p.m., 8/20/25 at 11:00 p.m., 8/25/25 at 7:00 a.m., 8/26/25 at 7:00 a.m., and 8/27/25 at 11:00 p.m. During an interview on 9/8/25 at 1:05 p.m., the Regional Nurse Consultant (RNC) indicated the staff should have documented the blood sugar results on the MAR. The insulin administration should have been documented when completed. She was unsure why there was a dose of lispro insulin due at 11:00 p.m., instead of 11:00 a.m., and would clarify the lispro order. The Nurses should follow the physician's orders. 3. During an observation on 9/2/25 at 12:06 p.m., Licensed Practical Nurse (LPN) 5 was preparing to administer Humalog insulin to Resident 20. The LPN removed the Humalog insulin pen from the medication drawer, applied a needle, turned the dose knob to 9 units, then pushed the end of the pen indicating he was priming the pen by wasting a unit of insulin. The pen was held sideways, and the cap was still covering the needle, so no insulin was visible coming out of the needle. He then administered 8 units of insulin to Resident 20. 4. During an observation on 9/2/25 at 12:12 p.m., LPN 5 was preparing to administer Humalog insulin to Resident 59. The LPN removed the Humalog pen from the medication drawer, applied a needle, turned the dose knob to 5 units, then pushed the end of the pen indicating he was priming the pen by wasting a unit of insulin. The pen was held sideways, and the cap was still covering the needle, so no insulin was visible coming out of the needle. He then administered 4 units of insulin to Resident 59. During an interview on 9/4/25 at 10:15 a.m., Registered Nurse 2 indicated when administering insulin using a pen, staff should clean the top of the pen before applying the needle. The pen should be primed by holding it up right with the cap off to ensure the insulin came out of the needle tip. On 9/4/25 at 11:49 a.m., the DNS indicated the facility would follow the manufacturer's guidelines related to insulin administration. The Humalog Manufacturer's Instructions were provided by the DNS on 9/4/25 at 11:49 a.m. The instructions indicated, .Wipe the rubber seal with an alcohol swab .Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly .If you do not prime before each injection, you may get too much or too little insulin .To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming .no more than 4 times . 3.1-37(a)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure care planned fall interventions were implemented appropriately for 1 of 3 residents reviewed for accidents. (Resident 22) Findings include: On 9/3/25 at 9:45 A.M., Resident 22 was observed in her room in her bed. The resident's wheelchair was several feet away from the resident near the other bed in the room but was still visible to the resident from where she was lying. A black recliner with a remote control was in the room a few feet away from the resident to the right of her bed. On 9/3/25 at 12:57 P.M., the resident was observed in her room in her bed. The resident's wheelchair was several feet away from the resident near the foot of the other bed in the room but was still visible to the resident from where she was lying. A black recliner with a remote control was in the room a few feet away from the resident to the right of her bed. On 9/4/25 at 10:01 A.M., the resident was observed in her room in her bed. The resident's wheelchair was a few feet away from the resident in between the two beds in the room but was still visible to the resident from where she was lying. A black recliner with a remote control was in the room a few feet away from the resident to the right of her bed. The resident's clinical record was reviewed at 9/3/25 at 10:04 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 8/8/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, non-Alzheimer's dementia, repeated falls, and depression. The resident used a wheelchair and required staff supervision or touch assistance when walking. The resident had experienced two or more falls without injury, and one fall with an injury that was not a major injury since the last assessment. An Interdisciplinary Team (IDT) Progress Note, dated 6/26/25 at 10:44 A.M., indicated the resident experienced a fall on 6/26/25 at 5:30 A.M. Staff witnessed the resident attempting to self-transfer from her bed to her wheelchair when the resident fell to the floor. The resident was not injured. The immediate/short-term intervention was for nursing staff to assess the resident and then assist her up and into her chair as she requested. The IDT review determined the root cause of the fall was that the resident attempted to self-transfer from her bed to the wheelchair. The resident required hands-on staff assistance for transfers. The resident was impulsive and had poor safety awareness. The intervention put in place to address the root cause of the fall was to keep the resident's wheelchair out of sight while it was not in use. The resident's care plan was updated with the new intervention. An IDT Progress Note, dated 8/11/25 at 4:01 P.M., indicated the resident experienced a witnessed fall on 8/9/25 at 2:33 P.M. The resident had been sitting in her recliner in her room and put the recliner in the upright position so she could adjust her fan. Staff were unable to get to the resident in time and the resident slid to the floor. The resident was not injured. The immediate/short term intervention was for nursing staff to assist the resident back to her chair, place it in a reclining position, and adjust the fan to her liking. The resident's call light was placed within her reach. The IDT review determined the root cause of the fall. The resident stated she was trying to adjust her fan. The intervention put in place to address the root cause of the fall was to ask the resident's family to bring in a recliner that could not be adjusted to the point that the resident could slide out. The resident's care plan was updated with the new intervention. During an interview on 9/4/25 at 10:06 A.M., Registered Nurse (RN) 4 indicated the resident understood her physical decline but had poor safety awareness. Currently, the resident was in her room in bed. RN 4 observed the resident's room and indicated the recliner in her room was the same one she had before she fell, and it had not been moved out of the room. A different recliner had not been brought in by the family at this time. The resident's wheelchair was observed and was not out of the resident's line of sight. RN 4 indicated the resident's wheelchair was usually moved out of her room and placed in the hallway at night. RN 4 moved the wheelchair out of the resident's room and placed it in the hallway. The current facility policy, titled Fall Management Policy, with a most recent revision date of 6/25, was provided by the Director of Nursing Services on 9/4/25 at 11:58 A.M. The policy indicated, .ensure (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents residing within the community have adequate assistance to prevent injury related to falls.falls will be discussed by the interdisciplinary team.to determine root cause and other interventions to prevent future falls.3.1-45(a)(2)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to accurately document the urinary output for a resident with an indwelling urinary catheter for 1 of 1 resident reviewed for urinary catheter. (Resident 49) Findings include: The clinical record for Resident 49 was reviewed on 9/5/25 9:32 a.m. The diagnoses included, but were not limited to, dementia and retention of urine. A Quarterly Minimum Data Set (MDS) assessment, completed 8/7/25, indicated he was severely cognitively impaired. A physician's order, dated 8/28/25, indicated he should receive catheter care, and the nurse was to record the urinary output every shift. The August and September 2025 Medication Administration Record (MAR) did not include documentation of Resident 49's urinary output each shift. The urinary output documented in the electronic health record (EHR), under vital signs, were as follows: 8/29/25- night shift large, day shift large, evening shift medium, 8/30/25- day shift large, evening shift 500 milliliters (ml), night shift large, 8/31/25- night shift medium, day shift large, 9/1/25- night shift large, day shift 300 ml, evening shift 400 ml, 9/2/25- night shift 500 ml, day shift 400 ml, evening shift large, 9/3/25- day shift large, evening shift large, night shift large, 9/4/25- day shift large, evening shift large, night shift large, 9/5/25- day shift 600 ml, evening shift large, 9/6/25- night, day, and evening shift large, 9/7/25- night and day shift large, evening shift medium, and 9/8/25- night shift large, day shift 800 ml. During an interview on 9/8/25 at 10:50 a.m., Licensed Practical Nurse (LPN) 12 indicated the nurses should document urinary output from an indwelling urinary catheter in milliliters. The Electronic MAR prompts the nurse to enter the output. She was unsure why the urinary output was not showing on the MAR. On 9/8/25 at 1:10 p.m., the Regional Nurse Consultant provided the Bowel and Bladder Program Policy, last revised May 2019, that indicated .Urinary output from indwelling urinary catheters will be documented .3.1-41(a)(2)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely develop and implement an individualized plan of care for a resident with dementia who displayed a new behavior of making physical contact with peers for 2 of 3 residents reviewed for abuse (Resident B and Resident C). Findings include: 1a. The clinical record for Resident C was reviewed on 9/2/25 at 11:37 a.m. The diagnoses included, but were not limited to, dementia, anxiety, and insomnia. He was admitted to the facility on [DATE]. 1b. The clinical record for Resident B was reviewed on 9/3/25 at 8:55 a.m. The diagnoses included, but were not limited to, dementia with psychotic disturbances and psychotic disorder with delusions. The resident was admitted to the facility on [DATE]. Resident C had room changes on the following dates: 5/27/25, 7/1/25, 7/16/25, 7/24/25, and 7/25/25. A Social Service Progress Note, dated 7/24/25 at 12:11 p.m., indicated Resident C's daughter gave approval for him to move rooms. A Social Service Progress Note, dated 7/25/25 at 2:57 p.m., indicated Resident C was moved to room [ROOM NUMBER] due to him not being compatible with his peer. A New/Worsening/High Risk Behavior Event, dated 7/28/25 at 3:15 p.m., indicated Resident C was in the dining area. Another resident was banging a toy on the table. Resident C grabbed the other resident by the wrists to get the toy out of their hands. The residents were separated, and Resident C was able to go to his room, away from stimulation. The intervention put into place to prevent another behavior was for Resident C to have his medications evaluated. An Interdisciplinary Team (IDT) note, dated 7/29/25 at 9:46 a.m., indicated Resident C was in the dining area when another resident grabbed an item and banged the item on the table. In an effort to stop the other resident from banging, Resident C made contact with the other resident's wrist. Both residents were immediately separated and placed in their rooms in a less stimulating environment. The assessment of potential correlation to the root cause was overstimulation in the common area. Resident C was to have labs completed and to be seen by the physician and the psychiatric provider. Resident C has had multiple room moves due to incompatible roommate. The root cause of behavioral expression was Resident C has diagnoses of dementia, cognitive impairment, and insomnia. Resident C was still adjusting to community, peers and new environment. Resident C may have been experiencing overstimulation in the dining room. Resident space invaded and peer banging on table. The preventative intervention relating to above root cause was Resident C being redirected to room to decrease overstimulation. Resident C will undergo a medication review and labs. He was added to the physician and psychiatric provider list. Resident C will have increased supervision when the other resident was present. A New/ Worsening/ High Risk Behavior Event, dated 7/29/25 at 6:46 p.m., indicated Resident C was in the dining area when another resident entered Resident C's personal space. The environment was quiet and calm. The event occurred in the common area. Resident C asked the other resident to get out of his personal space. The other resident did not respond and got closer. Resident C then grabbed the other resident in an attempt to move the other resident out of his way. The two residents were separated. The physician and family of Resident C were notified. The intervention put into place to prevent another behavior was for Resident C to be evaluated by the Psychiatric Nurse Practitioner. The clinical record did not contain a care plan addressing Resident C's new behavior of grabbing another resident. A Quarterly Minimum Data Set (MDS) assessment, completed 7/31/25, indicated he was severely cognitively impaired. He had displayed physical behaviors, such as hitting, kicking, pushing, or grabbing others, one to three days during the seven day look back period. He was able to independently perform a sit to stand transfer and independently able to walk 150 feet in the corridor. A Psychiatric Provider Progress Note, dated 7/31/25 at 7:07 a.m., indicated the visit was a New Patient Visit. Nursing staff reported ongoing anxiety and aggression since admission, including incidents of grabbing peers. Resident C has required six room changes due to behavioral disruptions and was currently awaiting a (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room move into a private room. Staff report no signs of depression, sleep disturbances, appetite changes, or hallucinations. Resident C will be started on lorazepam (anti-anxiety medication) 0.5 milligrams (mg) twice daily to target anxiety and reduce agitation. The clinical record did not contain a care plan addressing Resident C receiving lorazepam. The clinical record did not contain a care plan addressing anxiety and agitation. On 7/31/25, Resident C was moved to a different room without a roommate. A Physician's Progress Note, dated 8/1/25 at 9:35 a.m., indicated the reason for the visit was for medication review, increased agitation, and anxiety. The facility requested Resident C to be seen for medicine review. Resident C had labs received 7/30/25. He was noted with increased agitation and anxiety by facility staff. He was moved to a private room and was started on lorazepam 0.5 mg twice daily, thus resolving his agitation. A care plan, last reviewed 8/4/25, indicated Resident C had cognitive loss/ dementia and was moderately to severely impaired. The goal was for him to continue to participate in daily decisions as able and to remain alert and oriented at current status. The interventions included to encourage participation in daily activities particularly regarding orientation, socialization and stimulation. Give him choices throughout the day regarding decisions. Provide him with prompts and cues as needed. Provide him with simple instructions and repeat them as needed. A Psychiatric Provider Progress Note, dated 8/7/25 at 7:04 a.m., indicated lorazepam was initiated at the last visit to target anxiety and reduce agitation. Nursing staff reported no ongoing anxiety or aggression since lorazepam initiation and no observed side effects. Staff reported no signs of depression, sleep disturbances, appetite changes, or hallucinations. On 8/13/25, Resident B was admitted to the facility and placed with Resident C as his roommate. A Nursing Progress Note, dated 8/14/25 at 1:52 a.m., indicated on 8/14/25 at 1:47 a.m., Resident C was seen pulling Resident B by his shirt to the doorway of the room. Resident B claimed that Resident C had made contact with him. The residents were immediately separated. One-on-one attention was given to each resident. Both residents were assessed and placed on increased supervision. Resident C never appeared upset or angry, just confused. Suggested intervention was a room move. A care plan, dated 8/15/25, indicated Resident C had behavioral symptoms. Resident C had diagnoses of dementia, anxiety, and insomnia. He was at risk for peer incidents due to perceived invasion of personal space and overstimulation in busy environments. Resident C was also at risk for increased confusion or sundowning (confusion in the evening) and may attempt to make contact with peers in an attempt to redirect them. The goal was for staff to prevent triggering situations that provoke or encourage him to attempt to redirect peers through physical contact. The interventions included to build coping skills and non-physical communication methods with resident when he attempts to make contact with peers, give medications as ordered, promote respectful environment and reduce any potential triggers. The clinical record did not contain a care plan addressing Resident C's incompatibility, agitation, or aggression with roommates. A reportable incident to the Indiana Department of Health, dated 8/14/25, indicated [Resident B] claimed to staff that roommate, [Resident C] made contact with him. Immediate Action Taken: Staff immediately separated residents. Staff moved [Resident C] to room [number]. Follow up: 8/19/25 Based on investigation, it is unsubstantiated that contact was made by [Resident C] to [Resident B] as described by [Resident B]. Based on investigation, [Resident C] assisted [Resident B] out of the room by resident's shirt. During this assistance, neither resident showed any signs of symptoms of psychosocial distress. According to [Resident B's Representatives] resident has a hx [history] of delusions, as referenced by [Resident B's Representatives] in other settings. In interviews with [Resident B] he has had conversations that are conflicting due to his dx [diagnoses] of dementia with psychotic disturbances, UTI [Urinary Tract Infection] and psychotic disorder with delusions . The reportable incident investigation was provided by the Administrator on 9/3/25 at 9:00 a.m. It included, but was not limited to, the following documents: A statement by Licensed Practical Nurse (LPN) 10, dated 8/17/25, indicated, On the evening of 8/13/25 this writer heard commotion down the hallway of the Meridian unit, noticed resident [C] pulling another resident [B] through the doorway of their shared room, the resident (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being pulled was on the floor on his back with his shirt up over his head while the other resident has both hands on his shirt pulling him. I got up and yelled for the nurse on the other unit while running to the area where the resident was now on the floor on his back leaning slightly against the wall by this time the other resident had let go of the resident's shirt. The scene was this - small/moderate amount of blood under the resident who had been pulled to the doorway, foley catheter on the floor inside room hooked to bed with the bulb inflated with small amount of urine in the catheter bag. Residents bed was in the lowest position, light in room was on. Resident that was on the floor had a polo type shirt on and a disposable brief along with non-slip socks. When asked resident that was on the floor what happened he said 'I was shot in the back I think,' nurse from other unit suggested this writer contact Administrator and DNS [Director of Nursing Services] immediately. Called facility Administrator explained what happened and she said, 'I am getting clothes on, It will take me about 30 minutes to drive in.' CNA [Certified Nurse Aide] and nurse from other unit assisted patient that was on the floor to his bed his v/s [vital signs] were taken and we assessed his body for any open areas or bruising, two small purple bruises noted on bruise of nose and the sclera [the white outer layer of the eyeball] was red. Went back and talked to the resident after he was in bed and when asked what happened he stated, 'some man got me.' Administrator came in and advised we put him in another room for the night, his bed was moved, staff was sitting in doorway of his room for the shift. An interview was conducted with LPN 10 on 9/3/25 at 10:36 a.m. She indicated, on the night of 8/13/25, she had been sitting at the nurse's station when she had heard a commotion meaning a rustling noise down the hallway. She looked up and saw Resident B was on the floor being pulled out of his room by his roommate, Resident C, by his shirt. She yelled out for LPN 9 to assist her and ran down to Resident B and Resident C's room. The residents were not observed yelling or aggressive toward one another. During that time, she had observed blood on the floor and Resident B's Foley catheter was out and the bulb still inflated. Resident B's nose was bruised, and his eye was red. Resident B had pointed to his roommate and stated, he shot me in the back. Resident C did not respond when he was asked what happened. She had not observed Resident C being aggressive to other residents before. Resident B had fallen a couple hours prior due to getting himself up without assistance to use the bathroom. After she had assessed, he did not have any injuries from the fall. Resident C was moved to another room after the incident. Later, Resident B was sent out to the hospital for an evaluation, because his blood pressure was elevated. During an interview on 9/3/25 at 2:48 p.m., CNA 11 indicated she worked with Resident C previously. She had not been informed that Resident C had a history of putting his hands on other residents. During an interview on 9/3/25 at 2:50 p.m., CNA 13 indicated she worked with Resident C previously. She was not aware that he had a history of putting his hands on other residents. During an interview on 9/3/25 at 2:14 p.m., the Dementia Care Director (DCD) indicated Resident C had several room moves due to not being compatible with roommates. The rooms at the facility were small spaces and it could be challenging to find compatible roommates. Resident C displayed sundowning in the evening with increased confusion. Resident C's behaviors seemed to be a side effect of the confusion. Resident C had worked with troubled youth in his past and was prone to trying to help others. The lorazepam had been started due to increased anxiety. During an interview on 9/4/25 at 10:28 a.m., the Social Services Director (SSD) indicated a care plan had not been initiated when the new behaviors of grabbing other residents were observed on 7/28/25 and 7/29/25. The IDT team had met and reviewed the behaviors. During an interview on 9/4/25 at 11:53 a.m., Nurse Practitioner (NP) 8 indicated she had seen Resident C, on 7/31/25, and had started lorazepam for his anxiety and agitation. NP 8 was aware that Resident C had several room changes since his admission and understood at the time of her, 7/31/25, visit with Resident C, that he was to get a private room as an intervention for his anxiety and agitation. Resident C's behavior toward Resident B, on 8/14/25, was not normal behavior for Resident C. On 9/4/25 at 8:28 a.m., the Administrator provided the Behavior Management Policy, revised August 2022, which indicated .It is the policy of American Senior Communities to provide behavior (continued on next page)		

Department of Health & Human Services
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expression.1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other residents or caregivers. Care plan interventions should be individualized and non pharmacological interventions which address both proactive and responsive interventions. 2. Care plans should be initiated when a resident is receiving a psychotropic medication used to treat either mood or behavior. The care plan should clearly identify the specific mood, thought process or behavioral expression which the prescriber has identified as the indication for use of the psychotropic medication.7. Direct care staff will be educated as to the interventions for residents reviewed by the IDT.This citation relates to Intake 2591193 and Intake 2589663.3.1-37(a)		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observation, interview, and record review, the facility failed to provide privacy curtains that extended completely around the bed in a room shared by two residents for 2 of 2 residents randomly observed for privacy. (Resident 16 and Resident 49) Findings include: 1 a. The clinical record for Resident 49 was reviewed on 9/5/25 9:32 a.m. The diagnoses included, but were not limited to, dementia and retention of urine. 1 b. The clinical record for Resident 16 was reviewed on 9/8/25 at 10:20 a.m. The diagnoses included, but were not limited to, dementia. On 9/8/25 at 9:50 a.m., Licensed Practical Nurse (LPN) 12 and the Assistant Director of Nursing (ADON) were observed providing urinary catheter care for Resident 49. Resident 49's privacy curtain was drawn between Resident 49 and Resident 16. The privacy curtain for Resident 49's bed did not go around the entirety of the ceiling track and did not obscure view from the room walkway leading to the bathroom. Resident 16's privacy curtain did not extend the entirety of the track and did provide total visual privacy for his bed. During an interview on 9/8/25 at 10:05 a.m., LPN 12 indicated the wrong size privacy curtains may have been hung in the room. During an interview on 9/8/25 at 10:06 a.m., the ADON indicated the privacy curtains should go all the way around the bed. On 9/8/25 at 10:12 a.m., the Administrator provided the Privacy Curtains Policy, last revised in December 2021, which indicated .Routine daily, weekly and/or monthly visual inspections should be completed to ensure curtains are hung properly .The curtain shall provide adequate privacy to the resident . 3.1-19(l)(7)		