STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155655	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a required Preadmission Screening and Record Review (PASRR) Level I screening assessment to determine if a Level II assessment was required when a resident received a new major mental illness diagnosis for 3 of 3 residents reviewed for PASRR (Resident 2, Resident 6, and Resident 160). Findings include: 1. Resident 160's clinical record was reviewed on 5/14/26 at 12:37 p.m. Diagnoses included psychotic disorder with delusions due to known physiological condition, depression, anxiety, and mood disorder due to known physiological condition with depressive features. Resident 160's clinical record indicated mood disorder was added as diagnosis 4/3/24 and the psychotic disorder diagnosis was added 4/1/25. A PASARR level I screening, dated 10/10/19, indicated Resident 160 had a diagnosis of depression/depressive disorder and took the medication escitalopram (antidepressant). The record lacked any additional Level I screenings. A physician's order, dated 4/2/25 and discontinued 4/17/25, indicated to administer lurasidone (an antipsychotic medication) 20 milligrams (mg), by mouth, one time a day related to psychotic disorder. A physician's order, dated 4/18/25 and discontinued 8/5/25, indicated to administer lurasidone (an antipsychotic medication) 20 mg, by mouth, one time a day related to psychotic disorder. Targeted behaviors for this antipsychotic use was mood disturbances, irritability, self-isolating, and noncompliance. A current physician's order, dated 4/15/26, indicated to administer divalproex (an anticonvulsant medication used as a mood stabilizer) 250 mg, by mouth, twice daily related to mood disorder. Targeted behaviors for this anticonvulsant use was mood disturbances, irritability, self-isolating, and noncompliance. The clinical record indicated Resident 160 had taken divalproex since 4/3/24 for a mood disorder. A current physician's order, dated 4/30/26, indicated to administer hydroxyzine (antihistamine medication used to treat anxiety) 25 mg, by mouth, once daily at bedtime, for anxiousness. Monitor for drowsiness, slurred speech, dizziness, nausea, aggression, and impulse behavior. An annual Minimum Data Set (MDS) assessment, dated 4/2/25, indicated Resident 160 was cognitively intact and had a psychotic disorder. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment, dated 7/3/25, indicated Resident 160 was cognitively intact, had a psychotic disorder, and received an antipsychotic on a routine basis. An annual MDS assessment, dated 3/31/26, indicated Resident 160 was cognitively intact, had a psychotic disorder, and received an anticonvulsant and antidepressant. A current careplan, dated 11/23/24, indicated Resident 160 received an anticonvulsant medication related to a mood disorder. Interventions included the following: administer anticonvulsant medications as ordered by physician and monitor for side effects and effectiveness (11/23/24), monitor for adverse effects and vital signs per order/policy, and report any changes to the prescriber (11/23/24), monitor for suicidal thoughts or actions and offer to talk to a doctor or counselor if needed (11/23/24), and monitor for targeted behaviors such mood disturbances, irritability, self-isolating, and noncompliance with effective interventions of validation, offer psych services, and provide reassurance (4/14/26). A current careplan, dated 4/17/26, indicated Resident 160 had a mood problem related to the resident may report not having interest in doing things, depression, difficulty sleeping, tired, appetite has started come back, and feeling bad about self. Interventions included the following: administer medications as ordered, monitor, and document any side effects and effectiveness (4/17/26), provide the resident with a program of activities that is meaningful and of interest, encourage and provide opportunities for exercise and physical activity (4/17/26), assist the resident, family, caregivers to identify strengths, positive coping skills and reinforce these (4/17/26), behavioral health consults as needed (psycho-geriatric team, psychiatrist)(4/17/26), monitor, record, and report to MD any risk for harming others, increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, and possession of weapons or objects that could be used as weapons (4/17/26). A provider's progress note, dated 8/5/25 at 9:39 a.m., indicated Resident 160 was prescribed Latuda 20mg daily for a psychotic disorder. The medication was ineffective for symptom management. Psychotropic medications taken was Viibryd (antidepressant) 20 mg daily, Depakote 250 mg twice a day, Latuda 20 mg daily, and hydroxyzine 25 mg every eight hours. A provider's progress note, dated 11/18/25 at 4:12 p.m., indicated Resident 160 was currently prescribed Viibryd and Depakote for a mood stabilizer. He was on adjunct therapy with an antipsychotic, which did not benefit his symptoms. He would benefit from ongoing cognitive-based psychotherapy from a psychologist. During an interview, on 5/15/26 at 11:42 a.m., SSD 5 indicated a follow up PASRR screening was to be done if a resident had a new mental health diagnosis. She confirmed Resident 160's clinical record indicated he had a psychotic and mood disorder diagnoses. The resident's insurance case manager was to be notified when he received the psychotic disorder diagnosis. She was unsure if the case manager was notified. A new PASRR screening would be completed if needed after the case manager reviewed the information. During an interview, on 5/15/26 at 1:50 p.m., the DON indicated she spoke with the psychiatric nurse practitioner and he gave Resident 160 a psychotic disorder diagnosis in error. She entered an order to remove the diagnosis on 5/15/26. The mood disorder diagnosis was to remain. During an interview, on 5/15/26 at 2:39 p.m., the DON indicated Resident 160 did not have a follow up PASSRR screening completed after a mental diagnosis was given and an antipsychotic medication (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was initiated due to the resident consistently displayed mood disorder symptoms rather than psychotic symptoms. The resident was not primarily being treated for a psychotic disorder. Latuda was initiated as an adjunctive medication when the medication Wellbutrin (an antidepressant) was not effective. Prior to the initiation of Latuda, the resident had an increase in his behavioral symptoms as a result of having had pneumonia. A psychotic disorder, as a result of a medical condition, did not indicate a PASRR screening was to be completed. The facility did not automatically send notifications for PASRR screenings to be completed. The interdisciplinary team determined if a notification of a level I screening was to be sent or not. If the screening was not going to change the outcome of the previous screening they did not have to send in the notification, even with a new psychiatric diagnosis. 2. Resident 2's clinical record was reviewed on 5/14/26 at 10:05 a.m. Diagnoses included senile degeneration of the brain (2/3/26), depression (9/8/23), unspecified dementia (unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety) (9/11/23), anxiety disorder (9/24/25), delusional disorder (9/2/25), and other sexual disorders (5/27/25). Current physician orders included lorazepam (anti-anxiety) 0.5 mg by mouth every four hours as needed for anxiety/restlessness. Targeted behaviors for anxiety included wandering into other residents' rooms, increased scratching, tiredness, decreased appetite, restlessness, yelling out for help continuously, unable to get adequate sleep due to yelling out throughout the night (3/24/26), and risperidone (antipsychotic) 0.5 mg by mouth two times a day related to delusional disorders. Targeted behaviors included increased agitation and anxiety, and excessive yelling out (11/18/25). A Significant Change Minimum Data Set (MDS) assessment, dated 2/6/26, indicated the following conditions/care areas were triggered: cognitive loss/dementia, urinary incontinence, psychotropic drug use, falls, nutritional status, pressure wound(s), dental care, pain, and anxiety, depression, and psychotic disorder (other than schizophrenia). A preadmission Level I PASRR Outcome document, completed on 9/7/23, indicated a Level II was not required. Rationale: .There is no evidence of a PASRR condition of an intellectual/developmental or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. During an interview with SSD 5, on 5/14/26 at 10:43 a.m., she indicated a new Level 1 PASRR screening should be performed when a resident was diagnosed with and new mental health disorder (e.g., major depressive disorder, schizophrenia). In Resident 2's case, because he already had a diagnosis of dementia, any new mental health diagnoses would be cancelled out and because of that, she had not submitted a new Level 1 screening. Technically, he should have had a new Level 1 screening. 3. Resident 6's clinical record was reviewed on 5/14/26 at 9:32 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included bipolar disorder, which was present upon admission to the facility. Current medications included risperidone 0.5 milligrams (mg) three times a day related to bipolar disorder (3/24/26). A 1/23/24, preadmission Level I PASRR Outcome document, submitted on 1/22/24 by the facility, (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated a Level II was not required. Rationale: .There is no evidence of a PASRR condition of an intellectual/developmental or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. During an interview, on 5/18/26 at 2:40 p.m., the Director of Nursing (DON) indicated the PASRR was completed prior to the resident's admission to the facility. The resident was admitted with a diagnosis of bipolar disorder. She was unable to locate a PASRR completed after the 1/23/24 PASRR. She notified the Social Services Designee (SSD) 5. During an interview, on 5/18/26 at 2:50 p.m., SSD 5 indicated she was continuing to look to see if a more recent PASRR Level I had been completed for the resident. She had access to the electronic site which contained PASRR submissions. During an interview, on 5/18/26 at 4:13 p.m., the DON indicated SSD 5 submitted a new PASARR Level I with the bipolar disorder for the resident today (5/18/26) as a PASARR had not been submitted since 1/22/24. She indicated the facility utilized the Maximus Provider Manual for the facility policy regarding PASRR assessments. The Maximus IN [Indiana] LCAR [Level of Care Assessment Representative] Provider Manual, provided by the Administrator on 5/18/26 at 12:35 p.m., indicated the following: .Submitting Level I for Mental Status Change If a nursing facility resident's behavioral or mental status significantly changes, the nursing facility must submit a new Level I to report the change through the PASRR process. This applies to people who have a known Level II condition and to people with a previous negative Level I. Nursing facilities must submit mental status change referrals within 14 days of the significant change event. Examples of a mental status change event include: A new mental health diagnosis that is not listed on previous Level I or Level II.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to identify targeted behaviors and individualized interventions to clinically support the use of an antipsychotic medication for 2 of 2 residents reviewed for chemical restraints. (Residents 2 and 3) 1.During an observation on 5/12/26 at 10:02 a.m., Resident 2 was asleep in his wheelchair and the television was on. On 5/14/26 at 11:18 a.m., Resident 2 was sitting in his wheelchair in his room talking with a visitor. He laughed intermittently and waved to staff passing by. On 5/18/26 at 10:45 a.m., Resident 2 was up and dressed, sitting in his wheelchair in the living area, watching television. He was quiet and slept intermittently. Resident 2's clinical record was reviewed on 5/14/26 at 10:05 a.m. Diagnoses included senile degeneration of the brain (2/3/26), depression (9/8/23), unspecified dementia (unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety) (9/11/23), anxiety disorder (9/24/25), delusional disorder (9/2/25), and other sexual disorders (5/27/25). Current physician orders included lorazepam (anti-anxiety) 0.5 mg by mouth every four hours as needed for anxiety/restlessness. Targeted behaviors for anxiety included wandering into other residents' rooms, increased scratching, tiredness, decreased appetite, restlessness, yelling out for help continuously, unable to get adequate sleep due to yelling out throughout the night (3/24/26). Risperidone (antipsychotic) 0.5 mg give by mouth two times a day related to delusional disorders. Targeted behaviors included increased agitation and anxiety, and excessive yelling out (11/18/25). An annual Minimum Data Set (MDS) assessment, dated 9/18/25, indicated Resident 2 exhibited no delusions or hallucinations. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds – this type of behavior occurred daily. Those behaviors significantly disrupted care or the resident's living environment. A quarterly MDS assessment, dated 12/19/25, indicated Resident 2 exhibited no delusions, hallucinations, or behaviors. A quarterly MDS assessment, dated 1/6/26, indicated Resident 2 exhibited no delusions, hallucinations, or behaviors. A Significant Change Minimum Data Set (MDS) assessment, dated 2/6/26, indicated the following conditions/care areas were triggered: cognitive loss/dementia, urinary incontinence, psychotropic drug use, falls, nutritional status, pressure wound(s), dental care, pain, and anxiety, depression, and psychotic disorder (other than schizophrenia). A quarterly MDS assessment, dated 3/25/26, indicated Resident 2 exhibited no delusions, hallucinations, or behaviors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, initiated 9/12/23, indicated Resident 2 was at risk for pain related to general pain/discomfort, gout, angina pectoris, vitamin D deficiency, hypertension, GERD, and depression. Interventions included administering medications as ordered, anticipating the resident's need for pain relief and responding immediately to any complaint of pain, evaluating the effectiveness of pain interventions, reviewing for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, identifying, recording, and treating the resident's existing conditions which may increase pain, monitoring/documenting probable cause of each pain episode, removing/limiting causes where possible, monitoring/documenting side effects of pain medication, observing for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria (emotional discomfort), nausea, vomiting, dizziness, and falls, monitoring/recording pain characteristics every shift and as needed, monitoring/recording/reporting to nurse any signs or symptoms of non-verbal pain (vocalizations like grunting, moaning, yelling out, silence), and mood/behavior changes (irritability, restlessness, aggressiveness). A current care plan, initiated 12/18/23 and revised on 4/9/26, indicated Resident 2 had a behavior problem and might state that he has thoughts of being better off dead related to dementia (denies any plans of self-harm). The resident might wander into his old room and other residents' rooms, had a tendency to make animal noises and yell out marching commands like Hut, 2, 3, 4 and Beep!, Here, Polly [NAME], come here!, Help me!, Help me find my wife!, and Have mercy on me! He might make inappropriate sexual comments to staff about taking their clothes off. He had no signs or symptoms of distress. He might yell out for help or make animal noises in the common area and/or his room but denied needing assistance. He might beg family and staff to take him home. Interventions included administering medications as ordered, monitoring/documenting side effects and effectiveness (5/30/25), anticipating and meeting the resident's needs, assisting the resident toa quiet, calm space/room, providing reassurance and validating his feelings (4/9/26), providing opportunities for positive interactions/attention, stopping and talking with him when passing by (12/18/23), praising any indication of his progress/improvement in behavior, and providing a program of activities of interest to the resident. A current care plan, initiated 9/18/23 and revised on 1/19/24, indicated Resident 2 had impaired cognitive function/dementia or impaired thought processes. Interventions included asking yes/no questions to determine his needs, communicating with the resident/family/caregivers regarding his capabilities and needs, and cueing, reorienting, and supervising as needed. A current care plan, initiated 9/18/23 and revised on 8/19/25, indicated Resident 2 used an antidepressant medication related to depression. Interventions included administering antidepressant medications as ordered, monitoring/documenting side effects and effectiveness every shift, educating the resident/family/caregivers about risks, benefits, and side effect and/or toxic symptoms, monitoring/documenting/reporting, as needed, adverse reactions to antidepressant therapy, changes in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in activities of daily living ability, continence, no voiding, constipation, fecal impaction, diarrhea, gain changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyes. Targeting behaviors for depression included constant worry, repetitive verbalization, and yelling out. Effective interventions were offering tv/music, visitors, or walking with the resident. A current care plan, initiated 4/25/24 and revised 8/13/25, indicated Resident 2 used anti-anxiety (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications related to anxiety. Interventions included administering anti-anxiety medications as ordered, monitoring for side effects and effectiveness every shift, and monitoring the resident for safety. The resident was taking anti-anxiety medications which were associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looked like dementia and increased the risk of falls, broken hips, and legs. Targeted behaviors for anxiety included wandering into other residents' rooms, increased scratching, tiredness, decreased appetite, restlessness, yelling out for help continuously, and lack of sleep due to yelling out throughout the nights. Effective interventions included medications as needed, redirection, walking with the resident around the facility or outdoors when weather permitted, reassurance, and television/radio. A current care plan, initiated 9/5/25, indicated Resident 2 used psychotropic medications related to behavior management. Interventions included administering psychotropic medications as ordered, monitoring for side effects and effectiveness every shift, monitoring/documenting/reporting, as needed, any adverse reactions of psychotropic medications (unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person, and monitoring/recording occurrences of target behavior symptoms and documenting per facility protocol. Targeted behaviors for antipsychotic use included increased agitation/anxiety, and excessive yelling out. Effective interventions included television/music, family visits, and offering the resident a nap after lunch. A risk management note, dated 7/10/25 at 10:14 p.m., indicated the IDT met to review Resident 2's behavior of continuously yelling out throughout the shift (Beep! and making sounds like an owl.) Multiple attempts to redirect were not always successful. The resident was reoriented to time/situation, would quiet for a minute, then repeat the outbursts. A behavior note, dated 7/14/25 at 5:57 p.m., indicated the resident repeated phrases spoken to him. He was pleasantly confused and had several visitors. He enjoyed having someone to talk to but would repeat what the other person said to him. A behavior note, dated 7/14/25 at 11:31 p.m., indicated the resident yelled loudly Help me! during medication pass. When asked what he needed, he replied Nothing, I just like to yell it!. The resident was educated about the importance of using his call light to make his needs known. He demonstrated the ability to use the call light and verbalized he understood the instruction. He continued to yell Help! while staff was still in the room. A risk management note, dated 7/24/25 at 9:22 p.m., indicated the IDT met to review Resident 2's behavior of yelling out. The resident would repeat phrases spoken to him, or other comments like Have mercy on me!, Help me, Lord, Beep! Beep!, or Whoo! Whoo! The resident stated he just liked to yell those things. He was noted in the common area giggling and yelling out I'm going do it! Here it goes! You hear that fart? That was a good one! He propelled his wheelchair saying Beep! Beep! I'm coming through! Interventions such as redirection, reorienting to time/situation, snacks, television, drinks, 1:1 with staff, a quiet environment, were successful for a time. After a short period, he would resume yelling out. The 1:1 was very successful, resulting in the resident calming. A psychiatric progress note, dated 7/29/25 at 5:10 p.m., indicated a follow-up visit for a recent medication change. Oral hydroxyprogesterone (hormone) was previously discontinued due to increased symptoms of yelling out, which might be an underlying side effect of the medication. The resident was seen for follow-up on continued sexually inappropriate behaviors. He was making inappropriate and rude sexual comments to the nursing staff. That behavior was ongoing. He also displayed a worsening cognitive deficit. The plan was to resume the medroxyprogesterone acetate (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(hormone) injections every two weeks. Changes since the last visit included the resident saying Whoo! repeatedly during the night. He told staff he was an owl. Staff were unable to redirect the resident and when they left the room, he would start the Whoo! again. He was later heard yelling Help!. When staff offered to help, the resident denied any need. Staff were able to redirect the resident each time, but he would resume yelling when staff left the room. Once Resident 2 was up for the day and taken to the common area, he was calm and quiet. No hallucinations or delusions were reported by staff. A psychiatric progress note, dated 8/5/25 at 10:53 a.m., indicated Resident 2 had occasional inappropriate verbalizations. Overall, his advancing cognitive deficit was consistent with dementia. Staff were to continue to redirect the resident. There were no signs or symptoms of hallucinations or delusions. A risk management note, dated 8/7/25 at 10:01 p.m., indicated the Interdisciplinary Team (IDT) met to review Resident 2's behavior for the risk reference period of 7/31/25 through 8/6/25. The resident showed signs of socially inappropriate/disruptive behavior, and repetitive verbalizations. These were tendencies for Resident 2. Music and television were not successful. The resident had a recent medication change and was prescribed medroxyprogesterone acetate injections every 14 days. Care plans were updated and staff would continue to follow and support as needed. A psychiatric progress note, dated 8/12/25 at 1:18 p.m., indicated the psychiatric nurse practitioner followed up with Resident 2 for increased symptoms of restlessness and anxiety. He had increased yelling out, especially at night. The symptoms had been ongoing for a week or two. Resident 2 had previously been started on medroxyprogesterone which appeared to help with his sexually inappropriate behaviors. A short-term trial of alprazolam was started and would be monitored for effectiveness and side effects. Resident 2 denied delusions, hallucinations, paranoia, anxiety, and depression. No obvious signs of hallucinations or delusions were reported by staff. Current psychiatric diagnoses included depression, and the resident was not receiving any psychotropic medications at that time. A behavior note, dated 8/24/25 at 5:55 a.m., indicated the resident was yelling loudly Help me, God help me! When asked what he needed, Resident 2 laughed and said Nothing. A behavior note, dated 8/24/25 at 5:32 p.m., indicated the resident started yelling, Help me! Help me! Nursing staff asked resident what he needed help with, and resident stated, I don't know. Nursing staff tried to redirect the resident, but he continued to call out. A behavior note, dated 8/29/25 at 12:01 a.m., indicated Resident 2 yelled Help me, help me! When asked what was wrong, he did not respond, just started to yell the same thing again. The behavior continued for a few hours, and he could not be redirected. A behavior note, dated 8/29/25 at 5:08 p.m., indicated Resident 2 yelled Help me! most of that shift. He slept minimally throughout the night and did not rest during the day. He continued to yell out even when his son was present in the room. Pharmacological and non-pharmacological interventions were ineffective. A behavior note, dated 9/2/25 at 5:37 p.m., indicated Resident 2 was taken to the common area where he began to yell out Help! Someone, help me! Staff asked what he needed but the resident was unable to answer, shrugged his shoulders, and as soon as staff walked away, he began to yell out again. He (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was redirected and offered a snack. Interventions were effective but short lived. The resident was given a PRN (as needed) alprazolam with positive effect, slept for 20 minutes, and afterwards was pleasant and participated in activities. A behavior note, dated 9/15/25, indicated Resident 2 was calling out help me during that shift. Staff reassured the resident, but he continued to yell out repeatedly. He was left alone with the door cracked to ensure safety. He did quiet down but had several occurrences of yelling out help me, even with family sitting at his bedside. A psychosocial note, dated 10/14/25 at 12:56 p.m., indicated Resident 2 appeared confused and repeated the same statements. After some time, he became anxious and said Help me. He was easily redirected. The social worker offered support and companionship and would continue to build a relationship with the resident. The resident did not exhibit hallucinations, delusions, mood changes, depression, or anxiety. A psychiatric note, dated 10/28/25 at 11:33 a.m., indicated Resident 2 was visited for a routine psychiatric follow-up. The resident was previously started on risperidone with a dose increase due to ongoing symptoms of agitation and yelling out. He was also started back on PRN (as needed) alprazolam for 14 days. He was very confused and had cognitively declined. The resident was unable to answer most of the psychiatric NP's question. He had noted behavior(s) of yelling Help me! He responded well to therapy with risperidone with a reduction in his symptoms. The plan included continuation of PRN alprazolam. The resident denied delusions, hallucinations, paranoia, anxiety, and depression. Staff did not report hallucinations or delusions. For depression, risperidone 0.5 mg was continued and for sexually inappropriate behavior(s), medroxyprogesterone acetate injections was continued. The NP would consider adding a mood stabilizer for continued symptoms of anxiety and yelling out. A progress note, dated 11/15/25 at 8:10 a.m., indicated an aide alerted the nurse about the need for an assessment of Resident 2. The left side of his face was drooping, and he had weakness in his left hand and foot. He was able to respond to questions clearly. He was sent to the emergency room for evaluation and treatment. A progress note, dated 11/15/25 at 2:53 p.m., indicated the hospital called and reported the resident was being admitted with a diagnosis of stroke. A progress note, dated 11/22/25 at 1:00 a.m., indicated Resident 2 was alert and able to recognize staff names and/or faces. No delirium was exhibited. He exhibited verbal behavior symptoms and had no symptoms of depression. A progress note, dated 12/2/25 at 4:19 a.m., indicated Resident 2 was able to recognize staff names and/or faces, was oriented to self, unable to recall a situation that occurred less than 5 minutes prior, was exhibiting verbal behavior symptoms of yelling out Help me! at times. He did not display any distress. He was pleasant and cooperative with care. A risk management note, dated 1/4/26 at 11:37 p.m., indicated the IDT met to review the resident behaviors. Resident 2 continued to yell out Help me! When staff asked the resident if he had pain, he replied yes and acetaminophen was given, with positive results of pain relief. A psychiatric progress note, dated 1/6/26 at 9:56 a.m., indicated the resident was being evaluated for a possible GDR of risperidone 0.5 mg twice daily for underlying delusional disorder. He continued to have ongoing restlessness, anxiety, yelling out, and was sometimes difficult to redirect. After (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewing the patient's current medication therapy as well as recent mood and behavior, along with a review of nursing documentation and pharmacy recommendations, a GDR would be contraindicated. A reduction in Resident 2's antipsychotic medication would likely result in increased symptoms of unstable mood, restlessness, anxiety, and/or insomnia. His mood and behavior would be closely monitored. The resident denied delusions, hallucinations, paranoia, anxiety, and depression. His mood was noted to be calm, he made good eye contact, his appetite was good, his judgement was fair, his attention span was good, and he had no obvious or reported signs of hallucinations or delusions. A Gradual Dose Reduction (GDR) Request and Risk versus Benefit Statement, dated 1/6/26 and provided by the DON on 5/18/26 at 10:12 a.m., indicated risperidone 0.5 mg by mouth twice a day was due for a gradual dose reduction. No prior reductions were attempted. The behaviors indicated were increased agitation and anxiety and excessive yelling out. The provider's response indicated Resident 2 was not a candidate for a dose reduction at that time because a GDR attempt would likely result in persistent distress or worsening symptoms. A psychiatric progress note, dated 1/13/26 at 1:45 p.m., indicated Resident 2 was very confused and cognitively declined. He had periods of intermittent anxiety. He would continue risperidone 0.5 mg twice a day as ordered. There were no reports of hallucinations or delusions. A progress note, dated 4/22/26 at 3:02 a.m., indicated lorazepam 0.5 mg was given, as needed, for anxiety/restlessness. Targeted behaviors for anxiety included wandering into other residents' rooms, increased scratching, tiredness, decreased appetite, restlessness, yelling out for help continuously, or unable to get adequate sleep due to yelling out through the night. The prn administration of the medications was documented as effective. Resident was resting in bed with eyes closed. No distress was noted. The clinical record lacked documentation of non-pharmacological interventions attempted prior to administering lorazepam. A progress note, dated 4/26/26 at 6:39 p.m., indicated lorazepam 0.5 mg was given. Targeted behaviors included wandering into other residents' rooms, increased scratching, tiredness, decreased appetite, restlessness, yelling out for help continuously, unable to get adequate sleep due to yelling out through the night. The resident had signs and symptoms of restlessness. The clinical record lacked documentation of non-pharmacological interventions attempted prior to administering lorazepam. A progress note, dated 4/29/2026 at 6:31 p.m., indicated lorazepam 0.5 mg was given. Targeted behaviors included wandering into other residents' rooms, increased scratching, tiredness, decreased appetite, restlessness, yelling out for help continuously, unable to get adequate sleep due to yelling out through the night. The resident had signs and symptoms of restlessness. The clinical record lacked documentation of non-pharmacological interventions attempted prior to administering lorazepam. A document titled Behavior Monitoring and Interventions, between the dates of 4/19/26 and 5/16/26, indicated Resident 2 did not exhibit any behaviors on 24 out of the 25 days monitored. During an interview with Psychiatric NP 16, on 5/18/26 at 9:48 a.m., he indicated Resident 2 was treated with risperidone for agitation and screaming out all night, which were typical dementia behaviors. The (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation and interview, the facility failed to ensure insulin pen needles were primed prior to administration according to manufacturer's instructions and professional standards to ensure the full dosage was received for 1 of 14 residents reviewed for medication administration. (Resident 17)Findings include:On 5/13/26 at 6:58 p.m., during a medication administration observation, LPN 4 administered 32 units of insulin glargine (long acting insulin) to Resident 17. LPN 4 did not prime the pen needle before administration. Upon completion of administration, LPN 4 indicated she did not prime insulin pen needles before administration.On 5/14/26 at 12:39 p.m., the DON indicated staff should prime the insulin pen before administration.Resident 17's clinical record was reviewed on 5/14/26 at 10:44 a.m. Diagnoses included diabetes mellitus and a physician order for insulin glargine inject 32 units at bedtime.A facility document, titled Insulin Injections, provided by the Infection Control Nurse, on 9/25/23 at 11:35 a.m., indicated the following under the heading Administering Insulin .6) Inject the insulin: Let go of the skin pinch before you inject the insulin. Push the plunger with your thumb at a moderate, steady pace until the insulin is fully injected. If using a syringe, keep the needle in the skin for 5 seconds. If using a pen, keep the needle in the skin for 10 seconds. Insulin Pens from the Centers for Disease Control and Prevention (CDC) website at https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections was accessed on 5/19/26 at 9:01 a.m., guidance included: .6. Prime the insulin pen. Priming means removing air bubbles from the needle. It ensures that the needle is open and working. You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear. You may need to repeat this step until a drop appears.Basaglar (insulin glargine) Insulin Pen Instructions for use, retrieved from https://uspl.lilly.com/basaglar/basaglar.html#ug0 was accessed on 5/19/26 at 9:05 a.m., indicated the following: .Priming your Pen: Prime before each injection. Priming means removing the air from the needle and cartridge that may collect during normal use. It is important to prime your pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6. To prime your Pen, turn the Dose Knob to select 2 units. Step 7. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8. 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 the priming steps, but not more than 4 times. If you still do not see insulin, change the Needle and repeat the priming steps. Small air bubbles are normal and will not affect your dose.410 Indiana Administrative Code (IAC) 16.2-3.1-48(c)(1)

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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. A. Based on observation, interview, and record review, the facility failed to provide adequate supervision for a cognitively impaired resident to prevent repeated falls for 1 of 4 residents reviewed for falls (Resident 45).B. Based on interview, observation, and record review, the facility failed to provide safe bed mobility assistance for a dependent resident which resulted in the resident being rolled out of the bed and onto the floor by staff for 1 of 4 residents reviewed for falls (Resident 7). Findings include: A1. During an observation, on 5/11/26 at 12:16 p.m., Resident 45 sat in a wheelchair in the dining room at a table. His face was bruised on the right side of his face, around his eye. On 5/12/26 at 10:20 a.m., Resident 45 attempted to stand on his own three times. CNA 14 attempted to assist the resident to a wheelchair. She was unable to complete the transfer on her own and asked CNA 15 to assist her with the resident's transfer. Once the resident was transferred, he immediately stood up again and was unwilling to sit down. CNA 14 asked him if he needed to use the restroom. He nodded, and then sat down in the wheelchair. Resident 45's clinical record was reviewed on 5/13/26 at 9:29 a.m. Diagnoses included traumatic subdural hemorrhage without loss of consciousness (1/26/26), traumatic subdural hemorrhage without loss of consciousness status unknown (5/4/26), fracture of orbital floor right side (5/4/26),maxillary fracture, unspecified side (5/4/26), aphasia (1/29/26), cognitive communication deficit (1/29/26), dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, metabolic encephalopathy, unsteadiness on feet, and muscle weakness (generalized). Orders included furosemide (diuretic) 20 milligrams (mg) daily for edema (4/7/26), sertraline (antidepressant) 100 mg daily (3/25/26), and lorazepam (antianxiety) 0.5 mg twice a day, metoprolol tartrate (for blood pressure) 37.5 mg twice a day – hold for systolic blood pressure less than 110, heart rate less than 60 (started 4/17/26 and discontinued 5/4/26), cyclobenzaprine (muscle relaxant) 10 mg three times a day for left shoulder pain (4/8/26), hydralazine (for blood pressure) 10 mg three times a day – hold for systolic blood pressure less than 110, heart rate less than 60 (3/31/26), hydrocodone acetaminophen (opioid pain reliever) 7.5/325 mg three times a day for pain (1/23/2026), morphine sulfate (opioid pain reliever) 20 mg/mL (milliliters) – give 0.25 mL two times a day for pain, and nonslip strips to floor at exiting side of bed, in front of recliner, in front of toilet, and in front of bathroom sink. Verify placement and replace If missing or peeling (4/20/26). An admission Minimum Data Set (MDS) assessment, dated 1/30/26, indicated the resident was moderately cognitively impaired. He demonstrated verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others for one to three days during the seven-day assessment period. The behaviors put the resident at significant risk for physical illness or injury, significantly interfered with the resident's care, significantly interfered with the resident's participation in activities or social interactions, and significantly disrupted care or living environment. He rejected care for 1 to 3 days of the assessment period. He required supervision/cueing assistance with toileting hygiene. He required supervision/touching assistance with transfers and walking 10 to 50 feet. He was occasionally incontinent of bladder. He indicated he had occasional pain rated 6 of 10 on a 0 to 10 scale. The pain rarely or not at all affected sleep, day-to-day activities, and therapy activities. He had a fall in the last month prior to admission. He had two or more falls with no injury (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital. The IDT would review and reassess intervention upon the resident's return to the facility. A CT (computed tomography) scan of the head, on 4/29/26 at 1:16 p.m., indicated the following: a right frontal subdural hematoma (collection of blood) measuring 5 mm (millimeters) in thickness, was mildly increased from a 1/22/26 scan, a right frontal scalp contusion with soft tissue swelling, and right maxillary sinus disease. A CT scan of the face, on 4/29/26 at 1:18 p.m., indicated the following: acute fractures of the anterior and posterior walls of the right maxillary sinus, nondepressed fracture of the right orbital floor, and a prominent hematoma in the right periorbital soft tissues. A hospital Trauma History and Physical, dated 4/29/26, indicated the resident was found to have 5 mm right subdural intracranial hemorrhage as well as a right orbital floor fracture and maxillary sinus fractures. A repeat CT (computed tomography) scan of the brain approximately six hours after the initial scan showed a slightly increased right subdural intracranial hemorrhage at 6 mm thickness. A progress note, dated 5/4/26 at 4:54 p.m., indicated the resident returned to the facility from the hospital. He answered questions appropriately but was notably confused. He was unsteady and required assistance from two staff members. Bruising remained to the right side of his face. Fifteen-minute monitoring was initiated. A progress note, dated 5/6/26 at 6:50 p.m., indicated the resident had exited the dining room using his rolling walker and wearing nonskid socks less than 15 minutes prior to being found seated on the floor in front of his room. The resident stated he was 'trying to configure with everything here,' gesturing toward his walker and the closed door to his room. Two staff members assisted him to a standing position and transferred him to his recliner. No injuries were observed. Staff encouraged the resident to use his pendant to request assistance prior to ambulating. A care plan intervention, initiated on 5/6/26, indicated the resident was to be checked every 15 minutes. An IDT progress note, dated 5/7/26 at 8:35 a.m., indicated the team met to review the resident's fall in the common area. The immediate interventions included providing standby assistance with ambulation and continued 15-minute checks. Care plan interventions, initiated on 5/7/26, included standby assistance with ambulation and a therapy evaluation for the appropriate durable medical equipment for ambulation. A progress note, dated 5/9/26 at 12:10 p.m., indicated the resident was seated in the dining room. He stood up, turned, and attempted to take a step, lost his balance, then fell to the floor. He landed on his left side. No injuries were observed. He required extensive assistance of two staff members for transfer to his wheelchair. A care plan intervention, initiated on 5/9/26, indicated the resident was to sit with staff during meals, and staff was to encourage the resident to stay in the common area as he allowed. A progress note, dated 5/10/26 at 3:30 p.m., indicated the resident was observed on his knees in front of his wheelchair in the common area. He was assisted back to his chair and to the restroom. The resident returned to the common area with staff assistance. A cushion and a non-slip pad was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed in his wheelchair. No new injuries were observed. A progress note, dated 5/10/26 at 7:15 p.m., indicated the resident was in the common area and stood up partially from his wheelchair. He then sat down on the floor and rolled onto his side. No new injuries were observed. A progress note, dated 5/11/26 at 4:44 a.m., indicated during 15-minute checks, the resident was found in different locations in his room. He moved from his wheelchair to his recliner to his bed. A progress note, dated 5/11/26 at 9:20 a.m., indicated the resident was observed by housekeeping staff falling in the common area. The resident was found seated on the floor on his buttocks with his legs positioned in a near–crossˆlegged manner. Blood was noted on the top of his right sock over the great toe, and upon removal of his sock a skin tear was observed on the right foot. A provider progress note, dated 5/11/26 at 11:30 a.m., indicated the resident was seen for a follow up to a witnessed fall. The resident had experienced a significant decline in mentation and increased confusion since his hospitalization. The recommended plan was to continue physical and occupational therapy and reassess for potential hospice referral. A care plan intervention, initiated on 5/11/26, indicated a cushion and non-slip pad was to be placed in the resident's wheelchair. A progress note, dated 5/12/26 at 2:44 p.m., indicated the resident was admitted to hospice care. An IDT progress note, dated 5/12/26 at 5:09 p.m., indicated the team met to review the resident's fall. The immediate intervention was to place the resident on one-on-one monitoring until further notice. During an observation, on 5/13/26 at 12:06 p.m., the resident sat in his recliner with his eyes closed. CNA 6 sat in a chair near the resident and indicated she was providing one on one supervision for the resident. During an observation, on 5/14/26 at 3:28 p.m., the resident, with his eyes closed, sat in his recliner with his feet elevated in his room. During an observation, on 5/15/26 at 9:28 a.m., the resident sat in his recliner in his room with legs curled up on the seat of the recliner on their right side. His eyes tracked the television. A progress note, dated 5/15/26 at 10:20 a.m., indicated the resident was lying on the floor in front of his restroom. He lay on his left side with his left arm under his body and his legs were extended. He was lifted to a sitting position, then to a standing position. No injuries were observed. He was transferred from sitting in his recliner to sitting in a high-backed reclining wheelchair and taken to the activity area. During an interview, on 5/18/26 at 9:58 a.m., CNA 24 indicated the resident had previously been placed on oneˆonˆone supervision to reduce fall risk. Although he was no longer on oneˆonˆone supervision at the time of the interview, he remained on 15ˆminute safety checks, which were documented on a log at the nurse's station. She stated that when the resident became restless or began moving around, she toileted him as needed. She also attempted to keep him in the common area to allow for closer observation. The resident wore a pendant around his neck to request assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When in bed, the bed was kept in the lowest position with a fall mat placed beside it. All interventions were documented in the Kardex within the electronic medical record (EMR). During an interview, on 5/18/26 at 10:02 a.m., CNA 25 indicated the resident had recently begun using a high-backed reclining chair as a fallˆprevention measure. To further reduce fall risk, she brought the resident to the common area to participate in activities. He enjoyed watching television. She indicated the resident frequently monitored staff presence and appeared aware of when staff were not in view, at which point he would attempt to stand. She indicated that all fallˆprevention interventions were listed in the Kardex within the EMR. During an interview on 5/18/26 at 10:09 a.m., RN 26 indicated the resident remained on 15ˆminute safety checks. To reduce his fall risk, his bed was kept in the lowest position with a fall mat placed beside it when he was in bed. When he sat in a chair, his walker was positioned in front of him to ensure that, if he attempted to stand, he could access it safely. She indicated she closely monitored him and, when he permitted, staff kept him in the common area and engaged him in activities. He had been moved to the assistˆdining area following a fall in the dining room. Although he was able to feed himself, he occasionally attempted to rise and ambulate without assistance. Staff attempted to keep him within view, engaged him in activities, and provided routine toileting. She indicated he appeared very anxious when he first returned from the hospital. She thought he knew he was changing and declining. He had recently been admitted to hospice services. During an interview, on 5/18/26 at 2:21 p.m., Unit Manager 3 indicated, to reduce the resident's fall risk, staff encouraged him to come to the common area and participate in activities. Following each fall, staff closely assessed his room for potential fall hazards. His bed was required to remain in the lowest position with a fall mat placed beside it when he was in bed. Fifteenˆminute safety checks were initiated whenever the resident was in his room. She reported that the resident had been provided a call pendant and educated on its use; however, according to the callˆlog report, he had not used it. He often waited until staff were out of sight before attempting to get up. The resident was placed on oneˆtoˆone supervision for several days as a fallˆprevention measure. Therapy evaluated his walker to determine whether alternative equipment was needed. Although therapy services were initiated, the therapist reported significant difficulty engaging the resident in participation. The resident received oneˆonˆone supervision from 5/11/26 through 5/14/26. He had recently been placed on hospice services, with hospice staff visiting at least twice weekly. Attempts were made to obtain hospice volunteers to sit with him, but availability was limited. During an interview, on 5/18/26 at 2:26 p.m., the Director of Nursing (DON) indicated, to reduce the resident's fall risk, staff attempted to provide standby assistance, encouraged his participation in therapy with the goal of strengthening, and implemented environmental safety measures including positioning the bedside table against the wall and placing nonskid strips on the floor near the recliner, toilet, sink, and bed. The resident experienced additional falls following his 4/29/26 hospital stays, specifically on 5/6/26, 5/9/26, 5/10/26, 5/11/26, and 5/15/26. Oneˆtoˆone supervision was initiated for several days after the fall on 5/11/26. The resident continued with 15-minute safety checks. A current facility policy, revised 3/2018, titled Falls – Clinical Protocol, provided by the Administrator on 5/18/26 at 4:20 p.m., indicated the following: .the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation.If interventions have been (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's history of cerebral palsy, contractures, overall limited mobility, and increased risks due to anticoagulation use. An updated intervention was implemented for two-person assistance for all bed mobility to ensure safety and prevent recurrence. Staff was to be re-educated on proper transfer technique, and addition assistance was to be requested as needed. A provider's progress note, dated 3/24/26 at 2:38 p.m., indicated Resident 7 had cerebral palsy, was wheelchair bound, and used a mechanical lift for transfers. Resident 7 was seen for chin and lip bruising. The resident indicated she had a witnessed fall with staff during an assisted transfer. No damage was observed to her teeth, mouth pain, or difficulty swallowing. A chin bruise, noted 3/22/26, measured 5.5 cm long x 4 cm wide, dark purple/black in color, and no hematoma. A lip bruise, noted 3/22/26, measured 0.8 cm long x 4 cm wide, presented as a dark purple bruise, and no hematoma. During an interview, on 5/13/26 at 4:20 p.m., the left side of Resident 7's bed was against the wall. Assist rails were not present on the bed. Resident 7 indicated one staff member was present at the time of her fall. The staff member had rolled her quickly onto her right side which caused her to face the staff member. The staff member held onto her with one hand while she attempted to reach over her to hold the bed pan with the other hand. She was rolled too fast and she rolled off the bed. The bed was at a relatively higher height and she fell hard against the floor. She hit her head on the floor. She was not lowered to the floor. She thought she just about got knocked out from hitting her head so hard. It was normal to have one staff member assist her with personal care. During an interview, on 5/15/26 at 4:44 p.m., LPN 21 indicated she was unable to recall much about Resident 7's fall, including what staff member was involved. She believed there was only one staff member present at the time of the incident and the staff member rolled the resident towards themselves rather than the wall. The staff member tried to stop the fall but Resident 7 fell between the staff member and the bed. They finished dressing the resident on the floor before getting her up. During an interview, on 5/18/26 at 3:14 p.m., CNA 19 indicated Resident 7 was dependent for all care and a mechanical lift was used for transfers. The resident preferred to use the toilet rather than a bedpan. After the fall, staff was instructed that two staff members were needed to provide care to Resident 7. During an interview, on 5/18/26 at 4:37 p.m., QMA 20 indicated she was not present at the time of Resident 7's fall. She was informed of the fall by CNA 22. When she entered the room, the resident was on her belly. She assisted the nurse and obtained the resident's vital signs. Resident 7 was dependent for care and it was routine for one staff member to assist the resident with her care. During an interview, on 5/18/26 at 4:50 p.m., CNA 22 indicated Resident 7 preferred to eliminate her bowels and bladder while sitting on the toilet, however Resident 7's mechanical lift pad was soiled and the resident was placed on a bedpan. The left side of Resident 7's bed was against the wall. After Resident 7 indicated she was ready to be taken off the bedpan, she rolled Resident 7 onto her right side. Resident 7 was facing CNA 22 and the bed pan was behind the resident towards the wall. The momentum of rolling Resident 7 towards her, caused the resident to bump into her, which caused her upper body to go backwards away from the resident. Resident 7 rolled out of the bed and briefly landed on CNA 22's knees prior to falling to the floor. Resident 7 complained of chin pain after the incident. She should have rolled Resident 7 towards the wall to ensure safety and easier removal of the bedpan. During an interview, on 5/18/26 at 4:58p.m., the DON indicated Resident 7 was rolled out of her bed (continued on next page)

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