STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155703	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Village Inc	1111 Church Ave Jasper, IN 47546

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's were treated with dignity and respect for 4 of 4 residents reviewed for call light response times. A resident was observed waiting on staff to answer her call light while she was in the bathroom and resident call light logs revealed long wait times. (Resident C, Resident G, Resident H, Resident F)Findings include: 1. During an observation on 5/8/26 at 5:36 A.M., Registered Nurse (RN) 20 was walking toward the medication cart from the nurse's station. A call light sounded. RN 20 went from the medication cart to look at the call light screen by the nurse's station which indicated room [ROOM NUMBER] was in the bathroom. RN 20 then went back to the medication cart, prepared a medication, and took it to room [ROOM NUMBER] at 5:38 A.M. At 5:47 A.M., RN 20 came out of room [ROOM NUMBER] and proceeded into room [ROOM NUMBER]. RN 20 came back out of the room at 5:49 A.M., and indicated Resident H requested more wipes.On 5/12/26 at 9:02 A.M., Resident H's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.The most recent Quarterly Minimum Data Set (MDS) assessment, dated 3/20/26, indicated Resident H was cognitively intact, a partial to moderate assist of staff (resident performs over half the effort) for toileting and showering, and supervision of staff for transfers.A current Bladder Incontinence Care Plan, last revised 4/27/26, indicated the goal for the resident was to keep her from having skin breakdown, urinary tract infection (UTI), impaired social interaction, or lowered self esteem secondary to incontinence. It included, but was not limited to, an intervention to provide incontinence care after each incontinent episode.On 5/11/26 at 11:22 A.M., Resident H's call light logs from 4/27/26 to 5/3/26 were provided by the Administrator and included the following wait times over 15 minutes:4/27/26 at 3:07 P.M., bedroom call light duration 45 minutes4/28/26 at 3:29 A.M., bedroom call light duration 23 minutes 5/1/26 at 1:10 P.M., bedroom call light duration 15 minutes5/1/26 at 7:05 P.M., bedroom call light duration 33 minutes5/3/26 at 7:53 P.M., bedroom call light duration 17 minutes 2. During an interview on 5/6/26 at 10:57 A.M., Resident C indicated sometimes she waited 30 minutes after using the bathroom for staff to answer her call light. At that time, she indicated the delay made her frustrated and helpless. At that time, she indicated she could understand 5-10 minutes but not longer if the residents were in the bathroom. On 5/11/26 at 9:54 A.M., Resident C's clinical record was reviewed.Diagnoses included, but was not limited to, infection of hardware and disruption of a surgical wound to her left leg. The most recent admission MDS assessment, dated 4/27/26, indicated Resident C was cognitively intact, continent of bowel and bladder, and needed substantial to maximum assistance of staff (staff performs over half the effort) for toileting, bed mobility, and transfers. A current Behavior Care Plan, created 4/26/26, indicated the resident has an anxiety disorder diagnosis and perseverating and frustration were her most common symptoms. Interventions included, but were not limited to, establish and maintain a calm and trusting relationship by listening to the resident; displaying warmth, answering questions directly, offering unconditional acceptance, and being available.On 5/11/26 at 11:22 A.M., Resident C's call light logs from 4/27/26 to 5/3/26 were provided by the Administrator and included the following wait times over 15 minutes:4/27/26 at 6:40 A.M., bathroom call light duration 18 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes4/27/26 at 9:06 A.M., bathroom call light duration 17 minutes4/27/26 at 10:43 A.M., bedroom call light duration 40 minutes4/27/26 at 2:59 P.M., bedroom call light duration 35 minutes4/27/26 at 5:08 P.M., bedroom call light duration 41 minutes4/27/26 at 6:56 P.M., bedroom call light duration 23 minutes4/27/26 at 7:27 P.M., bathroom call light duration 24 minutes4/27/26 9:41 P.M., bedroom call light duration 23 minutes4/28/26 at 1:03 A.M., bathroom call light duration 15 minutes4/28/26 at 5:45 A.M., bedroom call light duration 38 minutes4/28/26 at 12:07 P.M., bathroom call light duration 15 minutes4/28/26 at 7:20 P.M., bedroom call light duration 22 minutes4/28/26 at 8:53 P.M., bedroom call light duration 24 minutes4/29/26 at 12:58 A.M., bedroom call light duration 37 minutes4/29/26 at 6:19 A.M., bedroom call light duration 26 minutes4/29/26 at 11:33 A.M., bedroom call light duration 16 minutes4/29/26 at 5:04 P.M., bedroom call light duration 15 minutes4/29/26 at 6:55 P.M., bedroom call light duration 20 minutes4/29/26 at 8:24 P.M., bedroom call light duration 31 minutes4/29/26 at 10:46 P.M., bedroom call light duration 16 minutes4/29/26 at 11:40 P.M., bedroom call light duration 22 minutes4/30/26 at 6:34 A.M., bedroom call light duration 30 minutes4/30/26 at 7:14 P.M., bathroom call light duration 22 minutes5/2/26 at 7:54 P.M., bathroom call light duration 35 minutes5/2/26 at 9:40 P.M., bedroom call light duration 20 minutes5/2/26 11:49 P.M., bedroom call light duration 19 minutes5/3/26 at 12:57 A.M., bedroom call light duration 24 minutes5/3/26 at 6:50 A.M., bedroom call light duration 22 minutes5/3/26 at 2:22 P.M., bedroom call light duration 25 minutes5/3/26 at 4:00 P.M., bedroom call light duration 17 minutes5/3/26 at 5:17 P.M., bedroom call light duration 19 minutes5/3/26 at 6:03 P.M., bedroom call light duration 15 minutes 3. During an interview on 5/06/26 at 11:27 A.M., Resident G indicated after midnight, she had to wait longer for staff to assist her for toileting. At that time, she indicated she had waited 20 minutes to get off the toilet recently and almost got up herself because sitting there too long hurt her hip. On 5/12/26 at 8:48 A.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, a healing sacrum fracture. The most recent admission MDS assessment, dated 4/28/26, indicated Resident G was cognitively intact, continent of bowel and bladder, and needed partial to moderate assistance from staff for toileting and transfers. A current Behavior Care Plan, created 4/25/26, indicated the resident has an anxiety disorder diagnosis and restlessness and isolation were her most common symptoms. Interventions included, but were not limited to, establish and maintain a calm, trusting relationship by listening to the resident; displaying warmth, answering questions directly, offering unconditional acceptance, and being available.On 5/11/26 at 11:22 A.M., Resident G's call light logs from 4/27/26 to 5/3/26 were provided by the Administrator and included the following wait times over 15 minutes:4/28/26 at 6:33 A.M., bedroom call light duration 30 minutes4/28/26 at 7:08 A.M., bathroom call light duration 17 minutes4/28/26 at 7:17 P.M., bedroom call light duration 24 minutes4/28/26 at 9:41 P.M., bedroom call light duration 15 minutes4/30/26 at 5:09 P.M., bedroom call light duration 16 minutes5/2/26 at 8:54 A.M., bedroom call light duration 26 minutes5/3/26 at 6:30 P.M., bathroom call light duration 21 minutes5/3/26 at 8:46 P.M., bathroom call light duration 15 minutes 4. During an interview on 5/6/26 at 11:13 A.M., Resident F's family members indicated the resident had to wait greater than 30 minutes sometimes for staff to answer her call light and the resident agreed. On 5/11/26 at 10:43 A.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and depression. The most recent admission MDS assessment, dated 3/17/26, indicated Resident F was cognitively intact, incontinent of bowel and bladder, was totally dependent on staff for transfers, showers, and toileting, and needed substantial to maximum assist for bed mobility. A current Fall Risk Care Plan, last revised 3/16/26, indicated resident was at risk for falls related to: recentstroke, need for assistance with transfers and mobility. It included, but were not limited to, interventions to assist with Activities of Daily Living (ADLs) as needed and cue/remind resident to use call light to seek assistance if needed. On 5/11/26 at 11:22 A.M., Resident F's call light logs from 4/27/26 to 5/3/26 were provided by the Administrator and included the following wait times over 15 minutes:4/27/26 at 4:31 A.M., bedroom call light duration 30 minutes4/27/26 at 11:14 A.M., bedroom call light duration 28 minutes4/27/26 at 2:48 P.M., bedroom (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call light duration 44 minutes4/27/26 at 7:02 P.M., bedroom call light duration 44 minutes4/27/26 at 8:09 P.M., bedroom call light duration 16 minutes4/28/26 at 5:08 A.M., bedroom call light duration 24 minutes4/30/26 at 7:48 P.M., bedroom call light duration 19 minutes5/2/26 at 1:56 A.M., bedroom call light duration 17 minutes5/2/26 at 8:01 P.M., bedroom call light duration 35 minutes5/3/26 at 6:33 A.M., bedroom call light duration 26 minutes On 5/6/26 at 1:30 P.M., the facility grievances for the last 3 months were provided by the Administrator and included six specifically about call light response times being too long.During an interview on 5/8/26 at 5:24 A.M., Registered Nurse (RN) 20 indicated the busiest part of night shift (6:00 A.M.-6:00 P.M.) was between 6:00 P.M to 10:00 P.M. Call lights are probably answered slower because the nurse would be trying to do medication passes on both carts and Certified Nurse Aides (CNAs) were busy giving showers and putting residents to bed.During an interview on 5/8/26 at 10:29 A.M., the Administrator indicated if there was a concern or complaint, they would look at the call light logs but otherwise they don't audit them. After a call light has been on for 30 minutes or longer, the system would call the Director of Nursing (DON) and the Administrator to alert them.During an interview on 5/8/26 at 10:49 A.M., the Administrator indicated she contacted the call log company and the service that was supposed to call them if call light wait times were greater than 30 minutes was a paid service that they no longer had. She was unsure when it was discontinued. During an interview on 5/12/26 at 9:13 A.M., the Administrator indicated it would be hard to give a time frame of what an appropriate call light response time would be. At that time, she indicated some factors for longer wait times included, but were not limited to, waiting on another staff member to help if the resident was a two person assist and assisting another resident with a more pertinent concern. It was dependent on the resident and the situation. If the person was a two person assist, the first responding staff would leave the call light on and wait or go look for someone to come help them.During an interview on 5/12/26 at 9:45 A.M., Licensed Practical Nurse (LPN) 2 indicated the other nursing staff (unit managers and nurses) should help the CNAs perform their duties. They all have to work together to take good care of the residents.During an interview on 5/12/26 at 11:07 A.M., the DON indicated in regards to the call light grievances, the residents at the facility did not think the call lights were answered as fast as they should be. If there was a complaint, she would pull the call light log and go over it with the resident. Education on how staff answers the call lights was provided. For example, when staff have multiple lights, they give priority to those that need assistance first. At that time, she indicated when going over the times on the logs with the residents, most of the wait times were not concerning. If they do find times that were, they will educate the resident and/or staff. One of the grievances, dated 4/29/26, needed staff education because there was a newer nurse at that time who was unaware that when the CNAs were busy, she was responsible for answering call lights.On 5/12/26 at 12:03 P.M., a current non dated Resident Rights Policy was provided by the Administrator and indicated, [Company name] and its member communities are committed to protecting and promoting the rights of the residents who reside in our communities. It is our policy that residents shall be treated with kindness, respect, and dignity by associates, volunteers, contractors and visitors . This citation relates to Intake 2640082.410 Indiana Administrative Code (IAC) 16.2-3.1-3(t)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interivew and record review, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected the resident's medications for 3 of 5 residents reviewed for unnecessary medications. A resident was marked as receiveing an antibiotic but did not. A resident was marked as recieving an antiplatelet but did not. A resident was marked as recieving an anticoagulant but did not. (Resident 7, Resident F, Resident 23)Findings include:1. On 5/11/26 at 12:52 P.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and atrial fibrillation. The most recent Quarterly MDS assessment, dated 3/6/26, indicated Resident 7's cognition was moderately impaired and recieved an antiplatelet medication during the 7 day look back period. Resident 7's Physician's Orders were reviewed for the 7 day look back period and lacked an order for an antiplatelet medication. Resident 7's February and March 2026 Medication Administration Record (MAR) was reviewed for the 7 day look back period and lacked administration of an antiplatelet medication. 2. On 5/11/26 at 10:43 A.M.,Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, stroke and atrial fibrillation. The most recent admission MDS assessment, dated 3/17/26, indicated Resident F was cognitively intact and recieved an antibiotic during the 7 day look back period. Resident F's Physician's Orders for the 7 day look back period were reviewed and lacked an order for an antibiotic. Resident F's March 2026 MAR was reviewed and lacked administration of an antibiotic during the 7 day look back period. During an interview on 5/12/26 at 11:12 A.M., the MDS Coordinator indicated medications should not be listed on the MDS assessment if it was not given during the 7 day look back period. Resident 7 did not recieve an antiplatelet and Resident F did not recieve an antibiotic. At that time, the MDS Coordinator indicated for accuracy of the assessments, they would need to be modified to reflect those changes. 3. On 5/11/26 at 1:30 P.M., Resident 23's clinical record was reviewed. Diagnosis included, but was not limited to, atherosclerotic heart disease of native coronary artery. The most recent admission MDS assessment, dated 4/23/26, indicated an anticoagulant had been administered during the 7 day look back period for the assessment. Antiplatelet was not marked. Current physician orders included, but were not limited to: aspirin (an antiplatelet) 81mg (milligrams) once a day, dated 4/20/26. Resident 23's clinical record lacked an order for an anticoagulant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 23's April 2026 MAR indicated aspirin was administered on 4/21/26, 4/22/26, and 4/23/26. On 5/12/26 at 9:25 A.M., the MDS Coordinator indicated anticoagulant was marked on Resident 23's admission MDS assessment instead of antiplatelet and needed to be modified. At that time, she indicated the Resident Assessment Instrument (RAI) manual was used as a policy for entering MDS information.

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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, interview, and record review, the facility failed to follow the facility policy for medications administered during the medication time frame for 1 of 4 residents observed during a medication pass. A resident received an antibiotic after it was due. (Resident E)Finding includes:During an observation on 5/07/26 at 9:37 A.M., Resident E was sitting in her chair and indicated staff was often late getting her IV antibiotics started. It was supposed to start at 8:00 A.M During a medication administration observation on 5/7/26 at 9:48 A.M., Licensed Practical Nurse (LPN) 3 administered Resident E's IV antibiotic. On 5/11/26 at 12:50 P.M., Resident E's clinical record was reviewed. Diagnosis included, but was not limited to, surgical site infection. The most recent admission Minimum Data Set (MDS) assessment, dated 5/4/26 indicated Resident E was cognitively intact and received an antibiotic. Resident E's current Physician Order's included, but were not limited to:Cefepime (antibiotic) 1 gram in 100 milliliters (ml) intravenous (IV). Run 100 ml over 30 minutes at 8:00 A.M. and 8:00 P.M., start date 5/6/26 Resident E's Medication Administration Record (MAR) indicated Cefepime was given at 8:00 A.M. with a note that indicated on 5/7/26 at 9:50 A.M., charted late. Resident E's current care plans included, but were not limited to: Resident requires IV antibiotic related to surgical wound infection, has potential for complications. Interventions included, but were not limited to, administer IV medications as ordered, dated 5/4/26. During an interview on 5/11/26 at 10:41 A.M., the Administrator indicated there was an hour window for medications to be given from the time the medication was due. On 5/11/26 at 10:59 A.M., the Administrator provided an Administering Medications policy, revised April 2019 that indicated, .Medications are administered within one (1) hour of their prescribed time. This citation relates to Intake 2640082. 410 Indiana Administrative Code (IAC) 16.2-3.1-35(g)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to provide sanitary incontinence care for 2 of 2 observations of incontinence care. The nursing staff failed to change gloves after touching multiple items in the room before starting incontinence care and hands were not sanitized and gloves were not changed between dirty and clean tasks. (Resident 5, Resident 2)Findings include:1. During an observation on 5/12/26 at 9:33 A.M., incontinence care was provided by Licensed Practical Nurse (LPN) 4 and LPN 7 on Resident 5. Both LPNs applied antibacterial hand rub (ABHR) and put on gloves. Both LPNs pulled down the resident's blanket and unfastened the resident's incontinence pad. LPN 4 held Resident 5's right leg while LPN 7 wiped the resident's vaginal area with disposable wipes. Resident 5 was assisted to roll onto her left side while LPN 7 held her. LPN 4 wiped bowel movement off the resident's buttocks with disposable wipes and discarded the soiled incontinence pad. LPN 4 then grabbed the clean incontinence pad and touched the inside of the incontinence pad with soiled gloves while she positioned it under Resident 5. At that time, LPN 4 removed her soiled gloves, used ABHR, and put on clean gloves. Resident 5 was rolled on her back and LPN 7 pulled the the clean brief out from under the resident and touched the inside of the incontinence pad while she repositioned it. Both LPNs pulled off the resident's pants and LPN 4 took off Resident 5's left sock and put it back on. Both LPNs pulled the resident up in bed and pulled up the blankets. LPN 4 did not sanitize hands or change gloves during the entire process. After care was provided, both LPNs went to the bathroom to wash their hands. Near the bathroom door, a saturated disposable pad was laying on the roomate's recliner. The LPNs came out of the bathroom and went out of the room without disposing of the saturated pad on the recliner. 2. On 5/11/26 at 9:15 A.M., Registered Nurse (RN) 6 and Licensed Practical Nurse (LPN) 7 performed incontinence care on Resident 2. LPN 7 donned gloves, removed the nasal cannula oxygen tubing from the portable concentrator to the oxygen machine, pushed the mechanical lift under the wheelchair, hooked the lift pad up to the lift, used the lift remote to raise the lift, and then used both gloved hands to push Resident 2 from the wheelchair to the bed. Then, LPN 7 unhooked the lift pad from the mechanical lift, handed a trashcan with soiled gloves in it to RN 6, and then LPN 7 placed a clean incontinence pad on the bottom of the bed. LPN 7 used the same gloves to assist RN 6 to remove Resident 2's pants, unfasten the soiled incontinence pad, clean the resident's perineal area with 3 wipes, and then placed both gloved hands on Resident 2's right leg to help her roll to her left side. LPN 7 scooped the stool with the incontinence pad and removed the soiled brief and then wiped Resident 2's buttocks with 4 wipes. LPN 7 failed to perform hand hygiene and change gloves before she placed the clean incontinence pad under Resident 2. LPN 7 used her soiled gloves and moved Resident 2's oxygen tubing and then pulled Resident 2's shirt down. During an interview on 5/12/26 at 10:00 A.M., the Infection Preventionist (IP) indicated gloves should be changed if items are touched prior to incontinence care and hand hygiene should be performed and gloves changed between dirty and clean tasks. On 5/12/26 at 11:49 A.M., the Administrator provided a current, undated Incontinence Care Skills Validations checklist as their policy that indicated, Gather supplies and place on clean surface.Wash hands and apply gloves.Remove soiled brief and gloves, discard, perform hand hygiene and re-glove.Wash hands and change gloves.Provide for the residents safety and comfort. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(l) 410 IAC (Indiana Administrative Code) 16.2-3.1-18b(1)