STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155708	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Nursing Home	1109 E National Highway Washington, IN 47501

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent a resident with a history of exit-seeking behavior and elopement from exiting the facility and leaving the property for 1 of 1 resident reviewed for elopement. This deficient practice resulted in an elopement that occurred on the evening of August 30, 2025. The resident was located with the assistance of the local police department, approximately 0.6 miles from the nursing facility, hiding behind an air conditioning unit near the intersection of National Highway and State Road 57. This Immediate Jeopardy began on August 30, 2025, when the facility failed to ensure Resident C did not exit the facility property by climbing a gazebo and jumping over a fence that enclosed an outside courtyard. Another resident observed Resident C and notified nursing staff, who notified the local law enforcement. Resident C was located between two buildings, hiding behind an outdoor air conditioning unit. When approached, the Resident ran from the officer. Resident C was apprehended prior to running into traffic on National Highway. The Director of Nursing (DON) was notified of the Immediate Jeopardy on 9/3/25 at 3:55 P.M.(Resident C) Finding includes: During record review on 9/3/25 at 11:00 A.M., Resident C's diagnoses included, but were not limited to, anxiety, depression, unspecified psychosis, schizophrenia, and pedophilia.Resident C's most recent annual MDS (Minimum Data Set) assessment, dated 6/20/25, indicated the resident was rarely to never understood. The resident had moderately impaired cognitive skills related to daily function. The resident required supervision for mobility and transfers. Resident C's care plan included, but was not limited to, Resident at risk for elopement due to history of isolated incident to leave the facility unattended (initiated 4/3/24). Most recent interventions included but were not limited to monitoring for wandering and anxiety (revised 5/13/25). Resident C's most recent Psychiatric-Mental Health Nurse Practitioner (PMHNP) visit notes, dated 5/15/25, indicated Resident C presented with mental health disorders characterized as schizophrenia and depression. The resident had received psych services in a hospital setting since an incarceration in 2001. A general assessment of mental status and alertness indicated the resident was alert and oriented to person, place, and time.Resident C's most recent elopement assessment, dated 6/19/25, indicated the resident had a history of leaving the facility without informing staff and that no personal safety alarms or devices were used as an intervention. Resident C's nurse's progress notes included, but were not limited to:7/22/25 at 1:10 P.M. - Resident C exhibited exit-seeking behaviors and paranoia were noted. 7/23/25 at 3:36 P.M. - Staff received orders to send Resident C to the hospital for behavioral evaluation due to a change in behavior. Two Emergency Medical Technicians (EMTs) arrived at the facility to transport the resident. Resident C ran to the courtyard and began to climb over the concrete wall. Staff accompanied Resident C in the facility yard and walked down the street with him. Resident C then walked into a clinic alongside the street and locked himself in a bathroom. The resident eventually calmed down and was transported for evaluation without injury. 7/25/25 at 2:28 P.M. - Resident C was noted to scoot chairs over closer to the wall outside, resident showing exit-seeking behaviors at this time. Staff was monitoring the resident closely. 8/30/25 at 6:45 P.M. - The nurse was alerted by another resident that Resident C had climbed the gazebo in the outside courtyard, jumped over the wall, and run towards the East. At the time of the incident, the nurse was in another resident's room helping the Emergency Medical Service (EMS) transfer another resident. Police were dispatched to locate resident C. A police report, dated 8/30/25, indicated an initial call was received at 6:59 P.M. that Resident C had run away from the facility. At 7:14 P.M. , Resident C was seen by a vape store near Highway 57. At 7:25 P.M., Resident C was located by law enforcement behind an air conditioning unit at the vape store. The police report included, I located the male subject hiding behind an AC unit. He was behind the vape store between buildings. The male subject ran, and I gave chase. He was apprehended prior to running into traffic on National (Highway).During an observation on 9/3/25 at 11:30 A.M., two unlocked double doors near a common area and nurses' station led to a walled-off courtyard. A gazebo inside the courtyard was observed being approximately two feet away from a concrete wall. The outside concrete wall was approximately 66 inches tall. During an interview on 9/3/25 at 11:45 A.M., QMA 5 indicated that Resident C had climbed the gazebo and jumped the courtyard wall on 7/23/25 when EMTs arrived at the facility to transport him to a hospital. The resident did the same on 8/30/25 when the EMS arrived for another resident. QMA 5 indicated the resident was frightened by the EMTs. During an interview on 9/3/25 at 11:50 A.M., the Director of Nursing (DON) indicated Resident C had jumped the courtyard wall on 8/30/25 and left the facility property. Resident C had also jumped the courtyard

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure adequate pharmaceutical services were available to provide physician prescribed routine medications to 1 of 3 residents reviewed for pharmacy services. Following a change in a resident's routine medications, the facility failed to obtain an ordered routine medication which resulted in multiple missed doses of the medication. (Resident C) Finding includes:During record review on 9/3/25 at 11:00 A.M., Resident C's diagnoses included, but were not limited to, anxiety, depression, unspecified psychosis, schizophrenia, and pedophilia. Resident C's most recent annual MDS (Minimum Data Set) assessment, dated 6/20/25, indicated the resident was rarely to never understood. The resident had moderately impaired cognitive skills related to daily function. The resident received antipsychotic medication routinely. Resident B's physician orders included, but were not limited to, Geodon oral capsule 40 milligrams (MG), give 40 mg by mouth two times a day related to schizophrenia and anxiety (continued 8/13/25). Resident B's Medication Administration Record (MAR) for August 2025 indicated the resident did not receive the prescribed medications Geodon oral capsule 40 MG on 8/22/25 (two doses), 8/26/25 (two doses), 8/27/25 (afternoon dose), 8/28/25 (two doses), and 8/29/25 (afternoon dose).Resident B's nurse's progress notes included but were not limited to:8/22/25 at 9:36 A.M. - Medication unavailable.8/22/25 at 12:50 A.M. - Medication unavailable.8/26/25 at 9:26 A.M. - (Medication) not in stock. 8/26/25 at 1:26 P.M. - (Medication) not in stock.8/27/25 at 2:16 P.M. - (Medication) not available.8/28/25 at 9:07 A.M. - (Medication) not available. 8/28/25 at 12:11 P.M. - (Medication) not available. 8/29/25 at 12:55 P. M. - Medication not available. During an interview on 9/8/25 at 10:05 A.M., LPN 8 indicated that the facility had trouble receiving routine medications from a particular pharmacy due to residents' payor source. LPN 8 indicated if a resident's routine medication is not available, nursing staff should check the facility's emergency drug kit for the medication. If the resident does not receive a routine medication, staff should document the missed dose and notify the physician. During an interview on 9/8/25 at 10:15 A.M., the Director of Nursing (DON), indicated the facility had difficulty obtaining Resident C's ordered Geodon medication from the pharmacy. On 9/8/25 at 11:00 A.M., the DON supplied a facility policy titled, Medication Ordering and Receiving from Pharmacy, dated 05/2014. The policy included, .4. If the medication is not available, calls/faxes (sic) the pharmacy, using the after-hours emergency number(s) if necessary . D. Medications are not borrowed from other residents. The ordered medications is obtained either from the emergency box or from the provider pharmacy .This citation relates to intake 2606469.3.1-25(a)

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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. Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and homelike environment in 1 of 2 resident shower rooms, 1 of 2 dining rooms, and 1 of 2 halls observed and clean linens were not covered during transport in resident halls. Overhead air vents contained a build up of dust in and around the vent, a dining room floor was uneven and flooring was raised or warped, and a shared shower room contained multiple broken floor tiles, appeared unclean, and contained a small swarm of gnats and flies near the commode. (North Unit, South Unit, North Unit dining room, and Middle-hall shower room, Resident D)Findings include:1. During an observation on 9/3/25 at 3:25 P.M., the North Unit dining room had a towel draped on the floor under an in-wall air conditioning unit. The flooring between the air conditioning unit and the entrance to the dining room was uneven, warped, and cracked. During an observation on 9/8/25 at 10:10 A.M., the North Unit dining room flooring between the air conditioning unit and the entrance to the dining room was uneven, warped, and cracked. 2. During an observation on 9/3/25 at 3:35 P.M., clean linens were being transported through the South Unit to a linen closet near an exit door. The linens were transported in an open laundry basket on top of a cart on wheels.3. During an interview on 9/4/25 at 3:26 P.M., Resident D indicated the shared shower room in the middle hall that connected the North and South Units required maintenance and the maintenance staff could not keep up with tasks in the facility. During an observation on 9/4/25 at 3:35 P.M., the shared shower room in the middle hall contained three broken tiles near the base of the commode. The base of the commode appeared unclean and there were approximately seven gnats and one fly swarming around the commode. An overhead vent appeared to be rusted and contained a build-up of dust in and around the vent. During an observation on 9/8/25 at 10:08 A.M., the shared shower room in the middle hall contained three broken tiles near the base of the commode. The base of the commode appeared unclean and there were approximately seven gnats and one fly swarming around the commode. An overhead vent appeared to be rusted and contained a build-up of dust in and around the vent. 4. During an observation on 9/8/25 at 10:15 A.M., an overhead vent on the North Unit Hall near an exit door to a facility courtyard contained a build-up of dust in and around the vent. On 9/8/25 at 11:00 A.M., the Director of Nursing (DON) supplied a facility policy titled, Environment and Physical Standards, dated 6/25/25. The policy included, (a) The facility must be: .(4) maintained; to protect the health and safety of residents, personnel, and the public . (f) The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public . (g) Personnel shall handle, store, process, and transport linen in a manner that prevents the spread of infection as follows: .(2) Clean linen from a commercial laundry shall be delivered to a designated clean area in a manner that prevents contamination . This citation relates to intake 2606469.3.1-19(a)(4)3.1-19(f)(5)3.1-19(g)(2)