STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observations, interviews, and record review, the facility failed to provide documented responses, follow-up, or written resolutions to several recurring concerns raised by the Resident Council. This practice failed to ensure residents' concerns were acknowledged and resolved, and resulted in continued unmet needs related to environmental, dietary, nursing, and activity services and had the potential to affect 5 of 5 residents who participated in the Resident Council Meeting. Findings include:On 12/3/25 at 10:09 a.m., the Resident Council Meeting Minutes were reviewed from January 2025 through November 2025. There were repeated concerns with minimal or no response from the facility. This concerns included, but were not limited to, the following: 1. Maintenance Concerns:Residents consistently reported unresolved maintenance issues across several months, including: Cold water during showers Very cold dining room temperatures Broken lights, leaking bathrooms, damaged nightstands, missing trash cans Furniture repairs not completedNo documented response or resolution appeared in the Action Forms or minutes. 2. Nursing Issues:Residents consistently reported concerns with nursing which included, but were not limited to: Medication refusals not respected by nursing staff. Staff ignoring call lights or slow call-light response across several months. Residents missing showers or not being assisted as requested. No documented response or resolution appeared in the Action Forms or minutes. 3. Dietary Concerns:Residents consistently reported dietary concerns which included, but were not limited to: Poor quality meals Small portions Untimely delivery of room-tray meals Cold foodNo documented evidence showed the facility responded in writing or provided corrective action. 4. Activities Concerns:Residents repeatedly asked for and/or had recurring concerns which included, but were not limited to: Weekend activity staffing Activities starting on time More creative or challenging activities Activity Staff engagement Off Campus outings More resident involvement with activitiesNo documented evidence showed the facility responded in writing or provided corrective action. 5. Resident Store Request:In February, residents requested opening a resident-run store in the activity room. There was no documented response. During a Resident Council Meeting interview, on 12/4/25 at 10:30 a.m., the Resident Council President, Secretary, and three other residents who regularly attended the meetings were present. The above issues/concerns were discussed and the group indicated there were several concerns that had not been addressed. Overall, the Resident Council felt that they were not listened to or taken seriously. The Resident Council expressed their continued concerns and repeated requests related to ongoing maintenance, laundry, dining/dietary and Activity Programming. During the meeting, the residents expressed their continued interest in wanting to establish a Resident-Run store in the activity room for things like Bingo prizes, and to avoid having to use the more expensive vending machines. During an interview on 12/5/25 at 11:45 a.m., the Administrator indicated he was the main staff responsible for ensure Resident Council concerns/suggestions were responded to or follow up on. The Administrator indicated he attended many of the meetings and did his best to address the concerns, but some were missed. On 12/3/25 at 2:30 p.m., the Regional Director of Operations provided a copy of current facility policy titled, Resident Council, revised 3/1/16. The policy indicated, .The Resident Council is an independent, organized group of residents who meet on a regular basis to create change, address quality and dignity of care provided in the facility, plan (continued on next page)

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
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities and discuss other matters brought before the council. The role of the Resident Council is to improve the quality of life of the residents who reside in the facility and to take part in actions to maintain a positive living environment. A designated staff member is appointed by the administrator and council members and acts as an advisor to the group and assists the council president and secretary as needed. The facilitator creates the environment and the enthusiasm that encourages action to happen within the council. It is vital to establish an atmosphere of trust and responsibility for concerns to be voiced. This encourages members to openly discuss issues that impact them and/or other residents. If a resident has a personal concern, they are afforded a private time and place to share that concern.to the Staff Facilitator. The council group members who voice a concern usually expect a timely response about the resolution to their concern. This must happen. The Administrator monitors this process. 3.1-3(k)3.1-3(l)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide activities as scheduled on the posted monthly activity calendar, failed to deliver activities with adequate staff engagement or supervision, and failed to implement a structured, individualized or meaningful activity program to meet the needs of residents with dementia. This deficient practice had the potential to affect 21 of 21 residents who resided in the secured memory care unit and 5 of 5 residents who attended and participated in the Resident Council Meeting. Findings include:1. The facility failed to provide activities as scheduled on the activity calendar. The posted calendar for Monday through Friday listed the following routine activities each day:11:00 a.m. Daily Chronicle, 1:30 p.m. Daily Prayer & Scripture, 2:30 p.m. daily activity (balloon toss, bowling, tic-tac-toe, etc.), 4:00 p.m. Snack & Chat, and a 5:00 p.m. evening activity such as bingo or a white board game. On Tuesday 12/2/25 the calendar listed the following activities: 10:30 a.m., Coffee Social, 11:00 a.m. Daily Chronicle, 11:45 a.m. Nails, 1:30 p.m. Daily Prayer & Scripture, 2:30 p.m. Bowling, 3:00 p.m. Color by Number, 4:00 p.m. Snack & Chat, and 5:00 p.m. Bingo. Observations on 12/2/25 indicated the following: No Coffee Social was observed. The daily Chronicle was not read/discussed. No Daily Prayer or Scripture was provided. At 1:52 p.m. Activity Assistant (AA) 9 was observed on her personal cell phone while 5 residents sat unoccupied around the tables. There was a puddle of liquid on the floor beneath a resident's chair that was not being cleaned up. No Color by Number was provided. On Wednesday 12/03/2025 the calendar listed the following: 10:30 a.m. Coffee Social, 11:00 a.m. Daily Chronicle, 11:45 a.m. Hand Washing, 1:30 p.m. Daily Prayer & Scripture, 2:30 p.m. Balloon Toss, 3:00 p.m. Sing Along, 4:00 p.m. Snack & Chat, and 5:00 p.m. [NAME] Board Game.During observations on 12/3/25 the following was observed: At 10:32 a.m., only two residents were present in the activity room with the television on, and no other residents were invited to participate in the scheduled coffee social. They were provided coffee, but no social/discussion/visiting/reminiscing aspect was facilitated. At 11:05 a.m., no activities were occurring, and no activity staff were present in the room. No Hand Washing activity was observed/provided. At 1:32 p.m., prayer was conducted; however, the television was left on, no scripture was read, no residents participated and no additional residents were observed to be invited. The 2:30 p.m. Balloon Toss did not occur. The 3:00 p.m. Sing Along did not occur. On Thursday 12/4/25 the activity calendar listed the following activities: 10:30 a.m. Coffee Social, 11:00 a.m., Daily Chronicle, 11:45 a.m. Thursday Crafting, and 2:30 p.m. Tic-Tac-Toe. On Thursday 12/4/25, the following was observed: No Coffee Social was observed. The Daily Chronicle was not read/discussed. No Daily Prayer or Scripture was provided. Between 11:21 a.m. and 12:19 p.m., no crafting activity occurred. Residents were seated with coloring books but were not actively engaged or led in any structured craft. At 3:09 p.m., the Gift Ball Game had already been completed, and only one resident was actively engaged in a table top Tic-Tac-Toe game. 2. On 12/2/25 at 1:52 p.m., AA 9 was observed using her personal cell phone while residents sat without engagement. On 12/3/25 at 11:05 a.m., no activity or nursing staff were present in the main dining room. Only an unidentified hospice aide sat with two residents while the rest of the residents sat idle. On 12/3/25 at 11:37 a.m., AA 7 left the main dining room while 5 residents were left unsupervised and unoccupied. She was gone for more than 10 minutes. On 12/03/25 at 12:04 p.m. no activity or nursing staff were present in the main dining room while 7 residents were seated unoccupied. On 12/3/25 at 1:37 p.m., the activity aide was observed working on a laptop rather than facilitating activities. On 12/4/25 at 1:32 p.m., AA 7 read a short, printed prayer without turning the TV off. No scripture was read/discussed. 3. The facility failed to individualize activities to meet the needs of residents with dementia.Observations during the survey showed that activities were not adapted to meet cognitive, behavioral, and sensory needs: Resident 56 made repeated attempts to stand, reached across tables, and fidgeted due to lack of meaningful engagement; staff did not provide individualized sensory items or mobility-based activities targeted to her needs. Cross Reference F604 and F744. Multiple residents were left with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	only the television playing for extended periods of time.Multiple residents were not invited to attend activities that did take place.Activity programming lacked dementia-stage specific (early, middle late) adaptations.No integrated sensory programming was available/facilitated. 4. On12/3/25 at 10:09 a.m., the Resident Council Minutes were reviewed and revealed, repeated requests to change/improve/add activities to the facility programming.In January 2025 the residents complained of being sad and lonely especially over the weekend. Throughout the year, there were repeated requests to include off-campus outings.Age and culturally appropriate accommodations such as X-Box and Apple TV Games were requested. Several months complained that activities often started late, therefore there wasn't as much time, or activities scheduled did not happen at all.The residents are frustrated when a staff led activity is started late. Sometimes we feel anxious waiting for the activity to begin. We just leave and return to our rooms. February 2025, .7 out of 11 residents attending the meeting stated we need to have activity led programs especially on the weekends, ideas are; baking and cooking, challenging things to do, painting. April 2025, .When the residents shared future activity requests ie; cinema, park, grilling outside/eating outside, socializing, your [Administrator's] response was, ?I am going to have an answer but you might not like the answer.' Why? [Administrator] addressed his statement. He wanted the residents to know that he may not be able to grant requests immediately. Funding is an issue. July 2025, .Residents continue to ask for activity outings. October 2025, .Discussed Activity Staff accountability, follow the activity calendar strictly. During a Resident Council Meeting Interview on 12/4/25 at 10:30 a.m., The Resident Council President, Secretary, and three other residents who regularly attended the meetings were present. The above issues/concerns were discussed and the group indicated there were several concerns that had not been addressed. Overall, Resident Council felt that they were not listened to or taken seriously. The Resident Council expressed their continued requests for Activity Program improvement. They provided ideas which included, but were not limited to: Resident Volunteer led activities for the memory care unit, more weekend activities led by staff, more meaningful/purposeful engaging such as helping arrange, decorate and collaborate activities, outdoor walking path, baking/cooking activities, volunteers coming in to teach new skills/lessons, animal therapy/pet visits, live music, and X-Box/Apple games for younger residents. During an interview on 12/5/25 at 11:45 a.m., the Administrator and Social Service Director indicated the activity department and life enrichment programming for the facility needed improvement. The Administrator expressed his desire to start a new Dementia-specific program in the coming New Year, and the entire activity department was to receive additional education and training to help improve the program. The Administrator wanted to focus on hiring additional staff for more meaningful and enthusiastic engagement. A Dementia Care and Services/Programming policy was requested but not provided. The Administrator indicated that a focus moving forward was to establish Dementia-Centered programming and implement a new policy with current best practices special care needs. 3.1-33(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observations, interviews, and record review, the facility failed to provide individualized, person-centered dementia care for multiple residents with cognitive impairment by: Responding to behaviors with restraint-like practices instead of dementia-appropriate interventions, using as needed (PRN) medications before nonpharmacological interventions, and failing to provide meaningful activities or engagement. This deficient practice had the potential to effect 21 of 21 residents residing on the secured memory care unit.Findings include:1. During a continuous observation on 12/1/25 from 11:00 a.m., until lunch was served around 12:45 p.m., Resident 56 was observed in the main dining/activity room. She had been moved from her wheelchair and placed in a large, heavy, wooden chair which was pushed all the way to the table. Resident 56 made repeated attempts to stand, but she was unable to move the chair, so she sat back down. She was not offered activity engagement, sensory stimulation, and/or other meaningful interventions. During a continuous activity observation on 12/2/25 from 2:30 p.m. until 2:50 p.m., the following was observed: Resident 56, was seated quietly at a table and interacted with place mats and a doll before the scheduled bowling activity began. When the bowling activity started, noise and stimulation in the room increased (pins falling, cheering, plastic balls hitting the floor). Resident 56 was observed to have increased signs of overstimulation and anxiety as she started to make repeated attempts to stand and walk away or grab at the activity materials. Staff failed to recognize Resident 56's increased signs of distress and repeatedly told her to sit back down, until she was eventually moved to a table at the back of the room, but positioned in a heavy chair stuck under the table so she could not move freely. Staff continued the same Bowling activity and did not redirect Resident 56 to a quieter area or provide an individualized, calming alternative. During a continuous observation on 12/3/25 from 11:00 a.m. until 12:00 p.m. the following was observed: Resident 56 was seated in a wheelchair in the main dining/activity room. She made repeated attempts to stand up from her wheelchair. Eventually, an unidentified Hospice aide, and Activity Aide (AA) 7 placed Resident 56 into a larger, heavier chair and lifted the table to wedge the arms of the chair underneath, preventing her from pushing back or standing. She appeared frustrated, as evidence by, pursing her lips, curling her hand into a fist, shaking her head no, and feeling/searching around the edge of the table for a solution. Resident 56 was not offered a sensory alternative, a waking break, or other person-centered intervention. On 12/3/25 at 3:30 p.m., Resident 56's record was reviewed. She was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to; dementia with behavioral disturbance and generalized anxiety. A review of the resident's nursing progress notes revealed Ativan/Lorazepam administration with no documented rationale and/or no documented person-centered nonpharmacological interventions/redirections attempted for the following dates: On 2/4/25 at 10:00 a.m., as needed (PRN) Lorazepam administered with no documented rationale and no details on attempted redirection strategies. On 2/5/25 at 7:24 a.m., PRN Lorazepam administered for Resident restless, going in and out of peers rooms, also trying to get into staff pockets. No documented details on attempted redirection strategies provided. On 2/6/25 8:29 a.m., PRN Lorazepam administered for Resident was agitated to calm her down and prevent from hurting self. No documented details on attempted redirection strategies provided. On 2/7/25 at 8:12 a.m., PRN Lorazepam administered for Resident was agitated. No documented details on attempted redirection strategies provided. On 2/18/25 at 12:16 p.m., PRN Lorazepam administered for Resident with agitation/anxiety, pacing very fast up and down hall. No documented details on attempted redirection strategies provided. On 2/21/25 at 4:57 a.m., PRN Ativan administered for pacing up and down hallway at a fast pace and entering other resident's room. Later at 6:26 a.m., the PRN was charted as ineffective as Resident 56 continued to pace the hallway with redirection unsuccessful. No documented details on attempted redirection strategies provided. On 2/24/25 at 11:04 p.m., PRN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ativan administered for up pacing hallway at a fast pace. No documented details on attempted redirection strategies provided. On 3/5/25 at 8:05 a.m., PRN Ativan administered for walking dangerously fast, going in and out of peers rooms, taking pictured off the wall, trying to grab medication cards off med cart, redirection only increases agitation, PRN given. No documented details on attempted redirection strategies provided. On 3/17/25 at 12:00 p.m., PRN Lorazepam (Ativan) administered with no documented rationale and no alternative interventions. On 3/31/25 at 7:19 p.m., PRN Lorazepam administered for resident agitated and pacing up and down the hall rapidly. No documented details on attempted redirection strategies provided. On 4/2/25 at 1:39 p.m., PRN Lorazepam administered for, Resident with agitation and running up and down the hall. No documented details on attempted redirection strategies provided. On 4/9/25 at 2:03 a.m., PRN Lorazepam administered for Resident up wandering, trying to go in different resident's room. No documented details on attempted redirection strategies provided. On 4/22/25 at 9:30 a.m., PRN Lorazepam administered for, Resident agitated, bending over and walking fast, running at times. No documented details on attempted redirection strategies provided. On 4/23/25 at 11:30 a.m. PRN Lorazepam administered for, Resident walking fast, almost running up and down hall, leaning forward with hands behind back. No documented details on attempted redirection strategies provided. On 4/30/25 at 10:30 a.m., PRN Lorazepam administered for, Resident anxious/running up and down hall. No documented details on attempted redirection strategies provided. On 5/1/25 at 1:18 a.m., PRN Lorazepam administered with no documented rationale and no details on attempted redirection strategies. On 5/1/25 at 10:11 p.m., PRN Lorazepam administered for, trotting down the hall not easily redirected. No documented details on attempted redirection strategies provided. On 5/12/25 at 7:58 p.m., PRN Lorazepam administered for, Resident with increased anxiety and running up and down main hall. No documented details on attempted redirection strategies provided. On 6/9/25 at 7:15 a.m., PRN Lorazepam administered for, running up and down hall; almost fell a couple times, resident became agitated with any redirection. No documented details on attempted redirection strategies provided. On 7/2/25 at 2:37 p.m., PRN Lorazepam administered for, Resident running up and down hall agitated. (No details on attempted redirection strategies). At 6:49 p.m., the PRN was documented as ineffective. On 7/5/25 at 9:30 a.m. PRN Lorazepam administered for, running up and down hall; almost fell a couple times, resident became agitated with any redirection. No documented details on attempted redirection strategies provided. On 7/21/25 at 7:00 a.m., PRN Lorazepam administered for, Resident running up and down main 200 hall, anxious. No documented details on attempted redirection strategies provided. On 7/30/25 at 1:53 p.m., PRN Lorazepam administered for, complaint of agitation and running up and down the hall, lack of safety awareness. No documented details on attempted redirection strategies provided. On 8/5/25 at 2:46 a.m., PRN Lorazepam administered for, Resident up wandering into others rooms, redirection semi-successful, resident get agitated with staff when they redirect her and her pace is getting quicker. No documented details on attempted redirection strategies provided. On 8/11/25 at 12:36 p.m., PRN Lorazepam administered for, Resident is anxious. No documented details on attempted redirection strategies provided. On 8/20/25 at 10:30 a.m., PRN Lorazepam administered for, Resident running up and down hall, agitated if staff tried to slow resident down. No documented details on attempted redirection strategies provided. On 8/27/25 at 7:30 a.m., PRN Lorazepam administered for, Resident running up and down hall, agitation with redirection. No documented details on attempted redirection strategies provided. Resident 56 had a comprehensive care plan, initiated on 6/22/22, which indicated, she had episodes of wandering (but not trying to elope) as evidence by walking the halls throughout the day and at night. Interventions included, but were not limited to: Document any wandering activity and interventions attempted. Did the interventions work or fail. She had a comprehensive care plan, initiated 1/11/23, which indicated she had limited activity involvement as a result of: Cognitive impairment secondary her diagnosis of dementia and She takes pleasure in walking for most of her available free time. Interventions include, but were not limited to: Provide activity programming consistent with physical & psychosocial (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abilities. This includes: energy level, cognitive functioning, medical condition & mood/behavior patterns, and Develop an activity plan centering around the resident's interests & history that takes lifetime values, attitudes, leisure patterns & psychosocial well-being into consideration. She had a comprehensive care plan, initiated on 4/22/24, which indicated, she was at risk for behavioral disturbances related to her diagnoses of schizoaffective bipolar type and required the use of an antipsychotic medication. An intervention for this plan of care indicated, one on one as needed. She had a comprehensive care plan, initiated on 2/8/21, which indicated, she was at risk for increased anxiousness related to her diagnosis of generalized anxiety disorder and used an anxiolytic medication. Interventions for this plan of care included, but were not limited to: encourage family involvement, monitor for effectiveness of interventions, offer choices. Cross reference F604. 2. Throughout the survey period minimal to no activity engagement was observed in the secured memory care unit. No dementia-friendly and/or sensory stimulation programming was observed. Throughout the week activities that were listed on the calendar were not implemented.Staff were not observed to ask/invite residents to participate. According to the Activity Calendar, every morning at 10:30 was Coffee Social. Although coffee was offered to residents already in the main activity/dining room, no meaningful social interaction, conversation, remising etc. was facilitated. The Daily Chronicle was scheduled every morning for 11:00 a.m. Although a few singles pages of the Daily Chronicle were printed off and observed on the dining room table tops on 12/3/25 only, reading/reviewing the chronicle was not observed. On Monday, Wednesday, and Friday, Handwashing was listed as an activity at 11:45 a.m., and was never observed. Scripture and Prayer were listed as a daily activity for 1:30 p.m. and only conducted on one day as observed. On 12/3/25 at 3:00 p.m., Sing Along was the scheduled activity, but was not implemented. On 12/4/25 at 1:32 p.m., Activity Aide 7, read off a printed prayer that lasted less than two minutes. No scripture was read. During an interview on 12/5/25 at 11:45 a.m., the Administrator and Social Service Director indicated the activity department and life enrichment programming for the facility needed improvement. The Administrator expressed his desire to start a new Dementia-specific program in the coming New Year, and the entire activity department was to receive additional education and training to help improve the program. The Administrator wanted to focus on hiring additional staff for more meaningful and enthusiastic engagement. A Dementia Care and Services/Programming policy was requested but not provided. The Administrator indicated that a focus moving forward was to establish Dementia-Centered programming and implement a new policy with current best practices special care needs. 3.1-37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to ensure residents were free from the use of physical restraints when staff placed a resident, (Resident 56) in a heavy immobile chair and positioned the table over the arms of the chair to prevent her from standing or moving freely. This deficient practice constituted a restraint by restricting the resident's ability to move freely for 1 of 1 resident reviewed for restraints. Findings include: On 12/1/25 at 11:03 a.m., Resident 56 was observed in the main dining/activity room. She had been moved from her wheelchair and placed in a large, heavy, wooden chair which was pushed all the way up to the table so the chair arms were placed under the table. Resident 56 made repeated attempts to stand, but she was unable to move the chair, so she sat back down. On 12/2/25 at 2:30 p.m., Resident 56 was seated in her wheelchair at a table during a scheduled bowling activity. As the activity began, she attempted multiple times to stand. Staff repeatedly told her to sit down and I can't let you go anywhere. Activity Aide (AA) 8 and Certified Nursing Aide (CAN) 11 moved Resident 56 to a large wooden chair at the back of the room. They pushed the chair tightly against the table and lifted the table up to slide the armrests underneath, immobilizing the chair. Resident 56 attempted to stand several times, but the chair could not move. She appeared frustrated, as evidence by, pursing her lips, curling her hand into a fist, shaking her head no, and feeling/searching around the edge of the table for a solution. During a continuous observation on 12/3/25 from 11:00 a.m. until 12:00 p.m. the following was observed: Resident 56 was seated in a wheelchair in the main dining/activity room. She made repeated attempts to stand up from her wheelchair. Eventually, an unidentified Hospice aide, and AA 7 placed Resident 56 into a larger, heavier chair and lifted the table to wedge the arms of the chair underneath, preventing her from pushing back or standing. She appeared frustrated, as evidence by, pursing her lips, curling her hand into a fist, shaking her head no, and feeling/searching around the edge of the table for a solution. During an interview on 12/4/25 at 3:09 p.m., AAs 7 and 10 indicated, Resident 56 was hard to redirect and wanted to stand up and walk constantly, but they were afraid she would fall so staff put her in the two heavy wooden chairs because Resident 56 couldn't not move those by herself, and it kept her from getting up without assistance. On 12/3/25 at 3:30 p.m., Resident 56's record was reviewed. She was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to; dementia with behavioral and generalized anxiety.The record lacked any physician order, assessment or care plan for the use of physical restraints. She had a comprehensive care plan, initiated 2/8/21, which indicated she was at high risk for falls related to impaired mobility and impaired cognition. Interventions included, but were not limited to, staff to assist with transfers when they observe her trying to transfer. She had a comprehensive care plan, initiated 1/11/23, which indicated she had limited activity involvement as a result of: Cognitive impairment secondary her diagnosis of dementia and She takes pleasure in walking for most of her available free time. Interventions include but were not limited to; Provide activity programming consistent with physical & psychosocial abilities. This includes: energy level, cognitive functioning, medical condition & mood/behavior patterns. On 12/4/25 at 3:28 p.m., the Regional Director of Operations (RDO) provided a copy of current facility policy titled, Guidelines for Physical Restraints/Seclusion, dated 5/17/23. The policy indicated, It is the policy of the facility to use physical restraint only as a last resort and only after every other alternative to a physical restraint (based on assessment) that seemed to have the potential for being used successfully, has been tried, and has failed. A physical restraint is NEVER to be used for staff convenience or for discipline. If the resident cannot remove the physical restraint device on command-and using the proper technique for removal-the device is considered a physical restraint. 3.1-3(w)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to properly reconcile medications for a resident who was discharging home for 1 of 3 residents reviewed (Resident 67). Findings include: On 12/2/25 a record review was completed for Resident 67. She had the following diagnoses which included but were not limited to congestive heart failure, chronic kidney disease, arthritis, physical debility, and low back pain. She discharged home on 9/16/25. The record indicated the resident was sent home with medications. The record lacked documentation of the reconciliation of the resident's medications at discharge. The resident had a discharge care plan indicating she wanted to return home. The resident's Medication Administration Record indicated she took the following medications:a.) Aspirin 81mgb.) Atorvastatin 20mg (for high cholesterol)c.) Folic acid (a supplement)d.) Methotrexate 2.5mg (for arthritis)e.) Montelukast 10mg (for asthma)f.) Spironolactone (diuretic)g.) Torsemide 20mg (diuretic)h.) Vitamin D3 50mcg (micrograms) (a supplement)i.) Breztri aerophere 4.8 mcg/act (actuation) (asthma)j.) Eliquis 2.5mg (blood thinner)k.) Metoprolol succinate extended release 24 hr (hour) 25mg (for heart failure)l.) Certrazine 10mg (for allergies) On 12/3/25 at 11:30 a.m., during an interview, the Regional Nurse Consultant (RCS) indicated the medications went home with the resident but she could not find the reconciliation documentation. A policy was requested and was not provided at the time of exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to code the resident's Minimum Data Set (MDS) assessment correctly for the types of medications that residents receive for 3 of 5 residents reviewed for accuracy (Resident 3, 69, and 6). Findings include:1. A record review was completed for Resident 3 on 12/3/25 at 11:36 a.m. She had the following diagnoses which included, but were not limited to, heart failure, depression, type 2 diabetes mellitus (DM), neuropathy (nerve pain), and hypertension. Resident 3 had an order, dated 10/2/25, for furosemide (a diuretic) 40 milligrams (mg) daily for Congestive Heart Failure (CHF). She had an order, dated 10/2/25, for metformin HCl 500 mg two times daily for DM. Her MDS, dated [DATE], did not indicate she was taking a diuretic or an oral hypoglycemic (blood sugar) medication. She had a care plan, dated 10/6/25, indicating she had a diagnosis of DM type II with risk for hypo/hyperglycemia (low or high blood sugar). She had a care plan, dated 10/6/25, indicating she was at risk for dehydration related to diuretic therapy. 2. A record review was completed for Resident 69. She had the following diagnoses which included, but were not, limited to anxiety disorder, low back pain, esophagitis (inflammation of esophagus), pain, and major depressive disorder. Her MDS, dated [DATE], indicated she received hypnotic medication. Resident 69's record lacked an order for a hypnotic. 3. On 12/3/25 a record review was completed for Resident 6. He had the following diagnoses which included but were not limited to dementia, chronic kidney disease, depression, and essential hypertension. He was prescribed an antidepressant, citalopram hydrobromide 10 mg one time daily dated 11/22/25. He was prescribed an oral hypoglycemic agent, sitagliptin 25 mg daily. His MDS, dated [DATE], did not indicate he was receiving an antidepressant or a hypoglycemic agent. He had a care plan, dated 9/17/23, diagnosed diabetes with risk for hypo/hyperglycemia. On 12/3/25 at 11:36 a.m., during an interview, the Regional Clinical Director indicated they were aware of some MDS coding issues and were working on it. She also indicated there was no policy for MDS accuracy. They referred to the RAI (Rai Instrument Assessment) for information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a new level of care assessment for a resident when her 30 days expired for 1 of 5 residents reviewed for PASRR (Pre-admission Screening and Resident Review) (Resident 69). Findings include:On [DATE] at 10:38 a.m., A record review was completed for Resident 69. She had the following diagnoses which included, but were not limited to, anxiety disorder, low back pain, esophagitis (inflammation of esophagus), pain, and major depressive disorder. She had a level 1 PASRR dated [DATE]. The PASRR indicated she was approved to have a 30-day exempt. She should have had a new level of care assessment for any date past [DATE] if she remained in the facility. On [DATE] at 11:32 a.m., during an interview, the Regional Nurse Consultant (RCS) indicated she would investigate it. No additional information was provided by the survey exit. An undated policy, titled, Guidelines for PASRR Process was provided by the RNC on [DATE] at 10:30 a.m. It indicated, .PASRR is a federally mandated process that requires all states to pre-screen all residents regardless of their payer source or age who are seeking admission to a Medicaid funded nursing facility. 3.1-16(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident was clean and appropriately dressed and groomed and failed to ensure a resident's bedding was appropriately changed when soiled for 1 of 1 resident reviewed for concerns with Activities of Daily Living (ADLs) (Resident 13). Findings include:On 12/1/25 at 10:47 a.m. Resident 13's room was observed. There were several brown stains on the sheets and the room smelled strongly of body odor. Resident 13 was observed as he self-propelled out of the bathroom in his wheelchair. He had on a navy-blue shirt with a basketball on it and a pair of red basketball shorts were around his thighs, revealing that the resident was not wearing anything underneath the shorts. The Resident had below the knee amputations on both legs, so when he self-transferred into the bed, he would scoot his bare bottom across the sheets. He indicated he did all his own ADL care normally, but the staff would help if he needed them too. On 12/2/25 at 2:41 p.m. Resident 13 was observed as he lay in bed awake and resting. The resident had his blanket wrapped around his legs, so his pants were unable to be seen, but he had on the same shirt as the observation on 12/1/25. He also had what appeared to be the same sheets as were on his bed as the observation on 12/1/25, based on the stains observed. The resident's pillowcase also appeared to be soiled. A yellow, brown colored ring was observed around where his head lay on the pillow. On 12/3/25 at 12:38 p.m. Resident 13 was observed as he sat up at the side of the bed eating his lunch. The resident was wearing the same navy-blue shirt and red basketball shorts as were observed initially on 12/1/25 and then again on 12/2/25 making this the third day in a row he was observed wearing the same outfit. Additionally, his pillowcase and sheets appeared to have been the same as the two days prior, based on the stains observed. On 12/4/25 at 12:04 p.m. Resident 13 was observed as he lay in bed with his eyes closed. The resident's lower body was covered but his shirt appeared to be different than the shirt he had been wearing on previous observations. However, his sheets and pillowcase appeared to be the same as the three days prior, based on the stains observed. On 12/3/25 at 2:13 p.m. Resident 13's medical record was reviewed. He was a long-term care resident whose diagnoses included, but were not limited to, schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia with a mood disorder like bipolar) and major depressive disorder. Resident 13's most current Minimum Data Set (MDS) assessment, dated 9/5/25, indicated his ADL assistance level for all tasks were supervision (oversight, encouragement or cueing) and set up help. Resident 13 had an active order for behavior monitoring every shift that was recorded on the Medication Administration Record. The behaviors to be monitored included but were not limited to refusal of care. Resident 13's MAR for the month of June was reviewed and showed that the resident had not exhibited any behaviors for the entire month. A shower sheet, dated 6/7/25, indicated Resident 13 had refused a shower. The record lacked documentation for this refusal and any subsequent interventions used. Resident 13's MAR for the month of August was reviewed and showed that the resident had not exhibited any behaviors for the entire month. A shower sheet, dated 8/2/25, indicated Resident 13 had refused a shower. The record lacked documentation for this refusal and any subsequent interventions used. Resident 13's MAR for the month of September was reviewed and showed that the resident had not exhibited any behaviors for the entire month. A shower sheet, dated 9/9/25, indicated Resident 13 had refused a shower. A shower sheet, dated 9/16/25, indicated Resident 13 had refused a shower.A shower sheet, dated 9/30/25, indicated Resident 13 had refused a shower because he took one himself in the sink. The record lacked documentation for those refusals and any subsequent interventions used. No shower sheets for the month of October were provided. Resident 13's MAR for the month of November was reviewed and showed that the resident had not exhibited any behaviors for the entire month. A shower sheet, dated 11/2/25, indicated Resident 13 had refused a shower.A shower sheet, dated 11/12/25, indicated Resident 13 had refused a shower.A shower sheet, dated 11/16/25, indicated Resident 13 had refused a shower.A shower sheet, dated 11/19/25, indicated Resident 13 had refused (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a shower.A shower sheet, dated 11/21/25, indicated Resident 13 had refused a shower.A shower sheet, dated 11/23/25, indicated Resident 13 had refused a shower.A shower sheet, dated 11/26/25, indicated Resident 13 had refused a shower.The record lacked documentation for those refusals and any subsequent interventions used. During an interview on 12/5/25 at 11:30 a.m. the Regional Nurse Consultant (RNC) indicated she was recently made aware of the ADL concerns with Resident 13 and they were planning to reeducate all staff on appropriate monitoring and documentation of behaviors, because it did not reflect the resident's actual condition or behaviors. On 12/5/25 at 10:55 a.m. a copy of a current facility policy titled, Activities of Daily Living (Routine Care), was provided. This policy indicated, . Residents are given routine daily care and HS [bedtime] care by a C.N.A. or a nurse to promote hygiene, provide comfort and provide a home like environment. ADL care is provided throughout the day evening and night as care planned and/or as needed. ADL care of the resident includes: Assisting the resident and personal care such as bathing, showering, showering, dressing.hair care.Assisting in maintenance of.immediate environment of the resident. Monitoring for any.behavioral changes in the resident. Do all required ADL documentation required per policy and regulations. 3.1-38(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure there was consistent communication between the facility and the dialysis center regarding the residents' care for 2 of 2 residents (Residents 24 and 6) reviewed for dialysis services. Findings include:1. On 12/2/25 at 2:41 p.m. Resident 24 was observed in his room as he sat in his wheelchair speaking with another resident. Resident 24 indicated the staff did not do any type of assessment or vitals when he got back from dialysis treatments, they only welcomed him back and helped him get settled when needed. On 12/3/25 at 9:18 a.m. Resident 24's medical record was reviewed. He was a long-term care Resident whose diagnoses included but were not limited to end stage renal disease (kidney disease). Resident 24 had an active order initiated on 4/10/24 that indicated he would receive dialysis treatment every Monday, Wednesday, and Friday. The medical record lacked documentation of communication between the facility and the dialysis center. 2. On 12/3/25 at 9:50 a.m., a record review was completed for Resident 6. He had the following diagnoses which included but were not limited to dementia, chronic kidney disease, depression, and essential hypertension. His medical record lacked documentation of communication to the local hospital regarding his vital signs and assessments with dialysis. During an interview on 12/4/25 at 11:54 a.m. the Regional Director of Operations (RDO) indicated they do not have a communication form that they used consistently right now, but they realized the lack of communication and were planning to look at the process they currently had and would overhaul it. 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpha Home - A Waters Community	2640 Cold Spring Rd Indianapolis, IN 46222

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 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. Based on record review and interview, the facility failed to obtain a urine culture and sensitivity after a resident was found on the floor next to her bed for 1 of 3 residents reviewed (Resident 2).Findings include: On 12/4/25 at 11:48 a.m., a record review was completed for Resident 2. She had the following diagnoses which included but were not limited to history of cardiac arrest, type 2 diabetes, neuropathy (nerve pain), hypertension, generalized anxiety, and muscle weakness.On 7/25/25 at 6:56 p.m., Resident 2 was found on the floor next to her bed. She was not injured. The Interdisciplinary team recommended labs, a complete blood count (CBC), basic metabolic profile (BMP), a urinalysis (UA), and a culture and sensitivity (C&S). The facility completed the STAT (as soon as possible) CBC, BMP, and urine. It was recommended to obtain another C&S. On 7/25/25 the labs were complete, and a culture was indicated with results to follow. The culture was not completed. On 12/4/25 at 2:01 p.m., during an interview with the Regional Nurse Consultant (RCS), she indicated the lab was unable to get a C&S and recommended obtaining another urine sample. She indicated this was not completed and Resident 2 was started on a prophylactic antibiotic to treat the urinary tract infection.A policy titled, Guideline for Incidents/Accidents/Falls was provided by the RCS on 12/4/25 at 2:45 p.m. It indicated, The nurse will notify the resident's attending physician/Nurse Practitioner, Director of Nursing (DON), Administrator, and the resident's responsible party/power of attorney (POA). The physician will be notified of changes of condition related to the fall that may have been identified. Orders for treatment and any interventions will be obtained.3.1-49(c)