STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155759	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Oaks Health Campus	601 W Cr 200 S New Castle, IN 47362

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review, the facility failed to report a fall with injuries of unknown source for 1 of 3 residents reviewed for reporting. (Resident B) Findings include:The clinical record for Resident B was reviewed on 4/27/26 at 12:25 p.m. The diagnoses included, but were not limited to, pulmonary embolism (blockage in a lung artery), prosthetic heart valve, and hyperlipidemia (abnormally high fats/cholesterol in the blood). The admission Minimum Data Set (MDS) assessment, dated 2/27/26, indicated Resident B was cognitively intact, used a walker/wheelchair for ambulation, required partial/moderate assistance with toileting, and was at risk for falls. A progress note, dated 4/16/26 at 6:15 a.m., indicated Resident B was found on the floor in the bathroom without a pulse with a small amount of blood noted under Resident B's head. During an interview with the Director of Health Services (DHS) and Executive Director (ED) on 4/28/26 at 11:53 a.m., they indicated Resident B had a small laceration to her forehead after the fall and with the medical director indicated the resident's fall was from a cardiac event, they did not report it to the department of health. During an interview with the Coroner on 4/28/26 at 2:25 p.m., the Coroner indicated he was called by EMS (Emergency Medical Services) the morning of 4/16/26, and told he did not need to investigate the scene because nothing was suspicious or un-natural about the death, but once the family had got to view her body more thoroughly at the funeral home, they found what appeared to be a quarter to half dollar shaped deep laceration to the left side of the resident's forehead. Photos of Resident B were provided by Funeral Director 12 on 4/29/26 at 12:43 p.m. The photos indicated there was a deep cut on the middle left side of forehead before the hair line where there was a quarter sized area where tissue and blood were visible. Funeral Director 12's written report, dated 4/20/26, indicated the Funeral Director Intern who arrived to pick up Resident B's body noticed a clear shower cap was placed over the residents head. Upon examining it further found a large open wound to Resident B's forehead above the left eye. The injury was approximately 2 inches in diameter and exposed the skull. This Citation relates to intake 2988395.

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
	155759	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Oaks Health Campus	601 W Cr 200 S New Castle, IN 47362

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to supervise a resident in the restroom who was high risk for falls, resulting with the resident having a fall, for 1 of 3 residents reviewed for accidents. (Resident B) Findings include:The clinical record for Resident B was reviewed on 4/27/26 at 12:25 p.m. The diagnoses included, but were not limited to, chronic congestive heart failure (long-term condition where the heart's pumping efficiency decreases, causing blood back up, fluid to accumulate in tissues, and insufficient oxygen delivery to organs), atherosclerotic heart disease (condition where plaque builds up in the heart's arteries), and type 2 diabetes mellitus. The admission Minimum Data Set (MDS) assessment, dated 2/27/26, indicated Resident B was cognitively intact, used a walker/wheelchair for ambulation, required partial/moderate assistance with toileting, and was at risk for falls. A progress note, dated 4/16/26 at 6:15 a.m., indicated Resident B was found on the floor in the bathroom without a pulse. A witness statement, dated 4/16/26, indicated Licensed Practical Nurse (LPN) 5 assisted Resident B to the toilet and left the resident alone to finish. The LPN instructed the resident to use the call light when she was finished. During an interview on 4/27/26 at 12:00 p.m., Certified Resident Care Assistant (CRCA) 3 indicated she was doing her rounds the morning of 4/16/26 around 6:15 a.m. to 6:20 a.m., she found Resident B lying on the floor unresponsive in the bathroom. CRCA 3 indicated she was unaware that Resident B was in the bathroom, but the resident would use the call light for help. CRCA 3 indicated Resident B's call light was not on. During an interview with Registered Nurse (RN) 4 on 4/27/26 at 12:21 p.m., the RN indicated she was called to Resident B's room around 6:15 a.m. by CRCA 3 and found Resident B on the floor in the bathroom unresponsive. A family interview was conducted on 4/27/26 at 10:35 a.m. The family member indicated when they received the call about Resident B's passing, the nurse on the phone told them she had only left Resident B for 5 minutes. A plan of care, dated 2/23/26, indicated Resident B was at risk for falls related to weakness. The interventions included, but were not limited to, staff to assist with transfers as needed. A Fall Management Guidelines policy was provided by the Executive Director (ED) on 4/28/26 at 12:24 p.m. It indicated,.mitigate fall risk factors and implement preventative measures. This Citation relates to intake 2988395 410 IAC (Indiana Administrative Code) 3.1-45(a)