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	11/25/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to timely dispose of outdated food and to ensure refrigerated items were not open to air with the potential to affect 53 of 53 residents residing at the facility.Findings include: On 11/18/25 at 11:00 a.m., the facility kitchen was observed with the Dietary Manager (DM). The walk-in refrigerator was observed to have a large roll of ground beef labeled with a date received of 10/24/25. The DM indicated the roll of ground beef had not been pulled from the freezer. The plastic casing of the ground beef roll indicated to use or freeze by 11/2/25. The DM indicated the ground beef would be thrown away. On 11/21/25 at 11:45 a.m., the walk-in refrigerator was observed with the DM. The walk-in refrigerator had a rack with multiple trays of bacon, a pan of chocolate cake, and trays with slices of cherry pie. All the trays were unwrapped and open to air. The dietary manager indicated that the cherry pie was for dinner that evening. The chocolate cake was from the day before, and the bacon was prepped for the next morning. The trays were not covered with plastic wrap. On 11/21/25 at 2:00 p.m., the Nurse Consultant (NC) provided the Storage Policy, last revised 7/10/25, that read .Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance .Refrigerated Storage . Food is covered, dated and stored loosely to permit air circulation . 3.1-21(i)(3)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain infection control practices by administering a pill medication that had been dropped on a medication cart and picked up with their bare hands, and ensure hand hygiene was performed prior to donning gloves for 8 of 20 randomly observed medication administrations. (Resident 4, Resident 10, Resident 28, Resident 40, Resident 51, Resident 53, Resident 56 and Resident 65) Findings include: 1 The clinical record for Resident 65 was reviewed on 11/20/25 at 11:26 a.m. The resident's diagnosis included, but was not limited to, heart failure. On 11/21/25 at 11:26 a.m., Registered Nurse (RN) 28 was observed administering medications to Resident 65. RN 28 performed hand hygiene using alcohol-based hand gel (ABHG) and prepared Resident 65's medications for administration. RN 28 entered Resident 65's room and administered the oral medications. She then assessed Resident 65's lungs using a stethoscope to listen to lung sounds. RN 28 picked up the plastic bag that contained the nebulizer set, sat the bag on the bedside table and went to the bathroom and donned a pair of gloves. RN 28 did not perform hand hygiene prior to donning the gloves. RN 28 then dispensed the nebulizer medication into the nebulizer handset, turned on the machine and handed the nebulizer handset to Resident 28. RN 28 doffed the disposable gloves and left the room. RN 28 performed hand hygiene using ABHG when she returned to the medication cart. 2. The clinical record for Resident 53 was reviewed on 11/12/25 at 11:34 a.m. The resident's diagnosis included, but was not limited to, diabetes. On 11/21/25 at 11:34 a.m., RN 28 was observed administering medications to Resident 53. RN 28 performed hand hygiene using ABHG and prepared Resident 53's medications. RN 28 entered Resident 53's room and administered the oral medications. She then obtained a pair of gloves and a paper towel from the bathroom. RN 28 put the paper towel on the bedside table and removed and prepared to obtain Resident 53's blood sugar. RN 28 donned the pair of gloves and performed the blood sugar check. RN 28 did not perform hand hygiene prior to donning the gloves. After the blood sugar was obtained, RN 28 removed the items used to check the blood sugar and doffed the gloves. She gathered the items and left the room. RN 28 performed hand hygiene when she returned the medication cart. 3.The clinical record for Resident 40 was reviewed on 11/19/25 at 10:00 a.m. The diagnoses for Resident 40 included, but were not limited to, epilepsy. An observation was made of a medication administration for Resident 40 with Registered Nurse (RN) 10 on 11/20/25 at 10:52 a.m. RN 10 was observed at the medication cart preparing the resident's oral medication and eye drops. During that time, RN 2 had donned gloves at the medication cart. She was observed touching her hair with her gloved hands. She then went to the resident's room and knocked on the door with her gloved hands. After, she administered the resident's medications and eye drops to the resident. There was no observation RN 10 had utilized hand hygiene prior to donning on her gloves nor changing of the gloves prior to the administration of the medications. 4. The clinical record for Resident 4 was reviewed on 11/19/25 at 10:15 a.m. The diagnoses for Resident 4 included, but were not limited to, type 2 diabetes mellitus. An observation was made of medication administration for Resident 4 with RN 10 on 11/20/25 at 10:58 a.m. RN 10 was observed preparing to obtain Resident 4's blood sugar reading utilizing a (continued on next page)

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	155759	A. Building B. Wing	11/25/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glucometer. During that time, RN 10 donned gloves and entered the resident's room. She obtained the resident's blood sugar reading and then doffed her gloves. There was no hand hygiene observed prior to donning the gloves. 5. The clinical record for Resident 10 was reviewed on 11/19/25 at 10:30 a.m. The diagnoses for Resident 10 included, but were not limited to, hypertension. An observation was made of a medication administration for Resident 10 with RN 10 on 11/19/25 at 11:00 a.m. RN 10 was observed pulling medications and eye drops from the medication cart. She then donned gloves and entered the resident's room. After, she administered the medications and eye drops to the resident with her gloved hands. There was no observation of hand hygiene prior to donning gloves. 6. The clinical record for Resident 28 was reviewed on 11/19/25 at 10:30 a.m. The diagnoses for Resident 28 included, but were not limited to, type 2 diabetes mellitus. An observation was made of a medication administration for Resident 28 with RN 10 on 11/19/25 at 11:05. RN 10 was observed preparing the resident's medication administration at the medication cart. During that time, she donned gloves to obtain the resident's blood sugar reading utilizing a glucometer. She then entered the resident's room and obtained the resident's blood sugar reading. There was no hand hygiene prior to donning the gloves. 7. The clinical record for Resident 51 was reviewed on 11/19/25 at 11:30 a.m. The diagnoses for Resident 51 included, but were not limited to, morbid obesity. An observation was made of a medication administration for Resident 51 with RN 10 on 11/20/25 at 11:09 a.m. RN 10 was observed preparing to obtain the resident's blood sugar reading utilizing a glucometer at the medication cart. She had donned gloves and entered the resident's room. After, she obtained the resident's blood sugar reading. There was no observation of hand hygiene prior to donning the gloves. 8. The clinical record for Resident 56 was reviewed on 11/19/25 at 12:00 p.m. The diagnoses for Resident 56 included, but were not limited to, cerebral palsy. An observation was made of a medication administration for Resident 56 with RN 10 on 11/20/25 at 11:22 a.m. RN 10 was observed preparing the medication at the medication cart. During that time, RN 10 had dropped a pill medication on top of the medication cart. She then picked up the pill medication with her bare hands and placed it in the medication cup. She then entered the resident's room and administered the medication. An interview was conducted with the Nurse Consultant on 11/21/25 at 1:31 p.m. She indicated the staff should be utilizing hand hygiene prior to donning gloves. A hand hygiene policy was provided by the NC on 11/21/25 at 2:36 p.m. It indicated, .The purpose of this policy is to: handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub.1. All health care workers shall utilize hand hygiene frequently and appropriately.3. Health Care Workers (HCW) shall use hand hygiene at times such as: c. before and after having direct physical contact with residents, d. after removing gloves, (continued on next page)

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	155759	A. Building B. Wing	11/25/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	worn per standard precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment. 3.1-18(l)

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	155759	A. Building B. Wing	11/25/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to monitor a resident's wound for 1 of 1 resident reviewed for skin conditions and ensure priming of 2 units of insulin prior to administration of insulin dosage utilizing an insulin flex pen for 2 of 2 residents observed during insulin administrations. (Resident 16, Resident 28 and Resident 51) Findings include: 1. The clinical record for Resident 28 was reviewed on 11/19/25 at 10:30 a.m. The diagnoses for Resident 28 included, but were not limited to, type 2 diabetes mellitus. A physician order, dated 7/15/25, indicated Resident 28 was to receive the following Humalog insulin sliding scale twice a day: blood sugar reading of 150 – 199 = 2 units of insulin, blood sugar reading of 200 – 249 = 4 units of insulin, blood sugar reading of 250 – 299 = 6 units of insulin, blood sugar reading of 300 – 349 = 8 units of insulin, and blood sugar reading of 400 or greater the staff was to call the medical provider. An observation was made of an insulin administration with Registered Nurse (RN) 10 on 11/20/25 at 11:38 a.m. RN 10 was observed pulling a Humalog flex pen for Resident 28 from her medication cart. She indicated the resident's blood sugar reading was 164. The resident would receive 2 units of insulin. RN 10 dialed up 2 units of insulin. She then went to the resident's room and administered the 2 units of insulin in the resident's abdomen. There was no observation of 2 units of priming of the insulin flex pen prior to dialing up the insulin administration units. 2. The clinical record for Resident 51 was reviewed on 11/19/25 at 11:30 a.m. The diagnoses for Resident 51 included, but were not limited to, morbid obesity. A physician order, dated 11/9/25, indicated the resident was to receive the following NovoLog insulin sliding scale before meals: blood sugar reading of 180 – 200 = 2 units of insulin, blood sugar reading of 201 – 220 = 4 units of insulin, blood sugar reading of 221 – 240 = 6 units of insulin, blood sugar reading of 241 – 260 = 8 units of insulin, blood sugar reading of 261 – 280 = 10 units of insulin, and blood sugar reading of greater than 300 the staff was to call the medical provider. An observation was made of an insulin administration with RN 10 on 11/20/25 at 11:42 a.m. RN 10 was observed pulling a NovoLog insulin flex pen from the medication cart. During that time, she (continued on next page)

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	155759	A. Building B. Wing	11/25/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 51's blood sugar reading was 267. The resident was going to receive 8 units of NovoLog insulin. RN 10 dialed up 8 units of insulin. After, she entered the resident's room and administered the 8 units of insulin in his abdomen. There was no observation of 2 units of priming of the insulin flex pen prior to dialing up the insulin administration dosage. An interview was conducted with the Nurse Consultant on 11/21/25 at 9:09 a.m. She indicated the staff should be following standard protocol for the insulin administration. A NovoLog insulin flex pen manufacture instructions were provided by the NC on 11/21/25 at 1:51 p.m. It indicated, .Giving the air shot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn dose selector to select 2 units.F. Hold your novolog flex pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.G. Keep the needle pointing upwards, press the push-button all the way in.The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. 3. The clinical record for Resident 16 was reviewed on 11/19/25 at 10:37 a.m. The resident's diagnosis included, but was not limited to, dementia. A care plan, initiated 7/23/25, indicated she was at risk for skin breakdown related to weakness, impaired mobility, and incontinence. The goal was for her skin to remain intact. The interventions included to conduct weekly skin assessments and avoid shearing skin during positioning, turning,and transferring. A Quarterly Minimum Data Set (MDS) Assessment, completed 9/17/25, indicated she had severe cognitive impairment. A progress note, dated 10/09/25 at 7:30 p.m., indicated during a transfer, Resident 16 had received a laceration to her left lower leg. She was sent to an acute care hospital to have the laceration assessed. A progress note, dated 10/9/25 at 11:33 p.m., indicated she had sutures to the laceration to her left lower leg which was to be treated with bacitracin and wrapped with a dressing. The sutures were to be removed in seven to ten days. A progress note, dated 10/20/25 at 4:09 p.m., indicated the stitches were removed from Resident 16's left, lower leg. Some drainage was present and steri-strips (thin bandages to keep a cut closed) were applied. A physician's order, dated 11/3/25, indicated to cleanse wound on left lower leg, with wound cleanser, pat dry, and apply collagen (type of wound dressing) to wound bed and cover with border dressing daily. The clinical record did not contain a description or measurements of Resident 16's left lower leg wound. On 11/20/25 at 2:18 p.m., the Wound Nurse (WN) was observed changing the dressing on Resident 16's left lower leg. The WN removed the old dressing and cleansed the wound. She measured the (continued on next page)

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	155759	A. Building B. Wing	11/25/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound to be 3 centimeters (cm) in length and 1.9 cm in width. The wound was observed to have 50 percent granulation (new) tissue and 50 percent slough (yellow non-viable) tissue. She applied collagen and a foam dressing. During an interview on 11/20/25 at 2:30 p.m., the WN indicated the wound on Resident 16's left lower leg had started as a laceration. There were no measurements of the wound until she measured it during the observed treatment. On 11/20/25, the DNS (Director of Nursing Services) provided the Guidelines for General Wound and Skin Care policy, approved 5/10/2017, that read .20. Document type of wound, location, stage [if applicable], length, width, depth in centimeters, base, drainage, periwound tissue, and treatment of the wound weekly using the wound/skin treatment flow sheet . 3.1-37(a)

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	155759	A. Building B. Wing	11/25/2025

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fall interventions were in place for a resident, prior to experiencing a fall in the bathroom for 1 of 2 residents reviewed for accidents. (Resident 53)The clinical record for Resident 53 was reviewed on 11/18/25 at 2:30 p.m. Her diagnoses included, but were not limited to, spinal stenosis and heart disease. She was admitted to the facility on [DATE] after a hospitalization for surgery on her back. The admission MDS (Minimum Data Set) assessment, dated 11/11/25, indicated she required substantial assistance with bathing, toileting, and taking on/taking off footwear. The fall care plan, dated 11/6/25, indicated the resident was at risk for falling related to weakness and impaired mobility. Interventions were to ensure the floor was free of liquids and foreign objects, starting 11/6/25, and to provide non-skid footwear, starting 11/6/25. An interview was conducted with Resident 53 on 11/18/25 at 2:40 p.m. She was sitting in a chair in her room. Family Member 20 was also present in the room during the interview. The resident indicated she fell in the bathroom yesterday morning, with an aide present, in her previous room. The aide, CRCA (Certified Resident Care Assistant) Student 21, was going to assist her with a shower. She was naked on the commode, barefoot, while CRCA Student 21 was running the water in the shower to warm it. Resident 53 mentioned being barefoot to CRCA Student 21. CRCA Student 21 informed her she'd be going immediately into the shower. Resident 53 informed CRCA Student 21 that there was water running all over the floor as the shower floor was even with the rest of the bathroom floor, and there was no towel on the floor. CRCA Student 21 informed her she would wipe the floor once she assisted her into the shower. Resident 53 stood up from the commode, holding onto the grab bar by the commode and, I started going down. When she stood up, she went down. CRCA Student 21 started grabbing towels right away and wiped up the water from the floor, before anyone else came into the room. They pressed the call light for assistance, but no one came, so CRCA Student 21 left to get help. Two staff members came to assist with getting her up from the floor. Resident 53 was quite sore the previous day. Staff placed ice packs on her back and used a cream to soothe the pain. She obtained a cut on her backside from the fall. The resident who lived in that room with her had many things of her own in the bathroom, including a plastic cabinet, and when she fell, she cut her back on the edge of the plastic cabinet. She had a bandage over it now. An interview was conducted with Family Member 20, on 11/18/25 at 2:40 p.m., in the presence of Resident 53. The family member indicated he didn't understand why Student 21 began running the water in the shower while Resident 53 was still on the commode and barefoot. These things led to an increased chance of her falling. Staff knew she was unstable. The nurse's note, dated 11/17/25 at 7:30 a.m., indicated Resident had witnessed fall in bathroom. Resident was preparing to transfer to wheelchair, and then get into shower. Since resident was about to get into shower, resident was not wearing footwear. CRCA Student states that resident's foot slid out from underneath her as she was about to get into wheelchair, and fell to the floor. Education provided to student to have non-skid socks on resident during any transfer. Student voices understanding. Resident did not hit her head. New laceration/abrasion on right buttock (see occurrence note). Denies any new pain. Son aware. DHS [Director of Health Services] aware. Note in MD folder. The Fall Event, dated 11/17/25, indicated she had a fall in the bathroom on 11/17/25 at 7:20 a.m., witnessed by CRCA Student 21. She was not wearing any footwear at the time of the fall. There was a laceration to her right buttock, caused by hitting a plastic shelf during the fall. The wound management entry, dated 11/17/25, indicated the resident had an abrasion to the upper, right buttock that measured 2.5 x 9 cm. The site was red. A dry dressing was applied over the site. An interview was conducted with Resident 53 in her room on 11/21/25 at 11:24 a.m. She indicated she was feeling pretty good, but she was sore across her back. When she fell on [DATE] in the bathroom of her previous room, she started out in (continued on next page)

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	155759	A. Building B. Wing	11/25/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed and was not wearing any socks or shoes. CRCA 21 assisted her out of bed and into her wheelchair and pushed her into the bathroom. After they got into the bathroom, she questioned not wearing any socks, and that was when CRCA 21 informed her it was okay, because she was going immediately into the shower. Resident 53 should have insisted she wanted to wear socks, but didn't. There were no towels down on the floor either, while the shower water was running and she was still on the commode. CRCA 21 did not put any towels down until after she fell. She had another shower yesterday and it went well. They didn't turn the water on until after she got into the shower and it only took a minute for it to warm up. The other room had an adjustable shower head in the shower too, just like her current shower, so staff could have pointed the water away from her to let it warm up, like they did for yesterday's shower. She was leery during yesterday's shower, but it went fine. An observation of Resident 53's shower and bathroom were made on 11/21/25 at 11:24 a.m. during the above interview. The shower head was removable. An interview was conducted with CRCA Student 21 on 11/20/25 at 2:36 p.m. She indicated she'd been a student at the facility since 10/10/25. During Resident 53's fall, she assisted Resident 53 from the commode and into her wheelchair to get into the shower. It looked like Resident 53 got her feet caught, and she went down. They had gotten her undressed already, and CRCA Student 21 thought she was still wearing her socks, but she noticed afterwards she was not. This was CRCA 21's first time assisting Resident 53. She was educated afterwards about ensuring there was a towel down, that the resident was wearing socks, and waiting for the nurse to come after a fall. The Fall Management Program Guidelines policy was provided by the Nurse Consultant on 11/21/25 at 9:24 a.m. It indicated, The purpose of this policy is to: [Name of facility] strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. [Name of facility] recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury.Care plan interventions should be implemented that address the resident's risk factors.3.1-45(a)(1)3.1-45(a)(2)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely develop a behavior plan of care and track behaviors for a resident who displayed verbal agitation and cursing at staff and other residents for 1 of 2 reviewed for hospitalizations. (Resident 10)Findings include: The clinical record for Resident 10 was reviewed on 11/18/25 at 9:52 a.m. The resident's diagnosis included, but were not limited to, major depressive disorder with psychotic symptoms. A care plan, dated 11/15/2022, indicated Resident 10 had a diagnosis of depression and was at risk for demonstrating signs and symptoms of depression, including: Verbalizations of distress, refusals to get out of bed, refusals of care, tearfulness, exhibiting self-hate, refusing to attend favorite activities, poor motivation, and self-care deficits. The goal was for him to be free from persistent, distressing signs and symptoms of depression. A Quarterly Minimum Data Set (MDS) Assessment, dated 8/15/25, indicated he was cognitively intact and displayed no behaviors.A progress note, dated 9/20/25 at 9:58 p.m., indicated Resident 10 had become angry and yelled at the nurse when she asked him if he wanted MiraLAX (medication to treat constipation) during the evening medication pass. Resident 10 had called the nurse a dumb***. Resident 10 had told the nurse it was always horrible when they worked and then continued to berate the nurse and his roommate. Resident 10 had indicated his roommate was a dumb*** as well. The nurse had left the room to deescalate the situation. A progress note, dated 10/04/25 at 12:09 p.m., indicated Resident 10 was overheard from the hallway cursing at his roommate. Resident 10 had stated is that right you stupid [expletive] and [expletive] you . Resident 10 consistently raises the volume of his television so that the roommate cannot hear his own television. The televisions could be heard from the nurse's station. A progress note, dated 10/04/25 at 12:27 p.m., indicated attempts to redirect Resident 10's behavior frustrated him more. Resident 10 became very angry. Management and family were notified.A progress note, dated 10/13/25 at 8:00 a.m., indicated Resident 10 was in the dining room waiting for breakfast. He thought that breakfast was taking too long and became angry, yelling at the kitchen staff and slamming his plate of food on the side of the table. He became upset that he did not get the food he had requested. Staff attempted to talk with Resident 10, and he headed back to his room yell at staff members better do something with those kitchen people. He continued to yell in the hallway. A progress note, dated 10/13/25 at 10:48 a.m., indicated the Executive Director and Social Services had been spoken to about Resident 10's behavior that started in the morning. Resident 10 continues to try to argue with roommate and was yelling out at staff members. The physician had been notified. A social services progress note, dated 10/13/25 at 11:45 a.m., indicated Resident 10's sister had been notified of recent behaviors including verbal aggression toward staff. His sister was in agreement to send Resident 10 to an inpatient psychiatric hospital for evaluation. The clinical record did not contain a physician's order or an order set to track or record Resident 10's verbal agitation or aggression toward staff or other residents. The clinical record did not include a care plan addressing Resident 10's verbal agitation or aggression toward staff or other residents. Resident 10 returned to the facility on [DATE].During an interview ow 11/19/25 at 3:00 p.m., Certified Resident Care Assistant (CRCA) 25 indicated Resident 10 would mumble under his breath and glare at staff if they entered the room wrong to care for his roommate. Resident 10 would become agitated a couple of time a week. The behavior had happened for quite some time prior to his hospitalization. During an interview on 11/19/25 at 3:02 p.m., Registered Nurse (RN) 26 indicated behaviors were to be tracked on the Medication Administration Record. During an interview on 11/21/25 at 9:44 p.m., RN 27 indicated Resident 10 would lash out at others and get very angry. He would lash out at whoever was around. Resident 10 would lash out and yell at his roommate. The staff would leave his room and re-approach at a later time. Resident 10 would calm down and act as if nothing had happened. Resident 10 had displayed these behaviors prior (continued on next page)

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	11/25/2025

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.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to his hospitalization, but not often. The nurses were to chart about behaviors episodes in the progress notes. On 11/20/25 at 2:08 p.m., the Nurse Consultant provided the Guidelines for Mental Health Wellness Program, reviewed 12/17/24, that read . Purpose To develop a Mental Health Wellness/ Behavior Management plan through the identification and elimination of causative factors and implementation of non-pharmacological interventions. Positive outcomes will be measured by behaviors being reduces, managed or eliminated thereby resulting in improved quality of life for each resident .10. The Mental Health Wellness/ Behavior Management Program shall consist of: a. A care plan initiated or updated with realistic, effective interventions which complements the resident's cognitive status, and incorporates their total care. i. Interventions are considered to be a form of preventative measures. Interventions may include structuring the environment and honoring prior life patterns. Communication to Social Services Director and Physician alerting them to new, exacerbated behaviors, current status, intervention effectiveness . 3.1-37(a)