STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springhurst Health Campus	628 N Meridian Rd Greenfield, IN 46140

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 2. The clinical record for Resident F was reviewed on 6/11/25 at 10:30 a.m. His diagnoses included, but were not limited to, Parkinson's disease. An interview was conducted with Family Member 4 on 6/11/25 at 10:38 a.m. She indicated there was an incident involving Resident F and CRCA (Certified Resident Care Assistant) 15 in March 2025 in his room. Resident F had bowel issues. It wasn't a happy situation, and CRCA 16 had to clean it up. CRCA 16 said it was gross right in front of him. They filed a grievance about it. Family Member 4 received a call back afterwards, stating the facility would be doing more staff training. The grievance log for the past six months was provided by Clinical Support on 6/12/25 at 10:48 a.m. There were only two grievances associated with Resident F, both dated 3/6/25, and both filed by Family Member 4. One was in regards to his room not being stocked with wipes, briefs, and trash bags, as there was an incident on 3/4/25, where none of these items were available. The grievance was resolved by the DHS (Director of Health Services.) The other grievance was in regards to Resident F needing fortified foods and non-dairy items in his diet. Neither of these grievances referenced a CRCA making any rude comments while caring for Resident F. An interview was conducted with the Director of Health Services (DHS) on 6/12/25 at 11:30 a.m. She indicated she spoke with Resident F when she resolved the 3/6/25 supplies in room grievance. She thought Resident F's family member was standing outside of his room, when Resident F had to use the restroom. Resident F had issues with his bowels, as his pancreas didn't' function well, and he had to take enzymes before meals. She thought the CRCA said something to Resident F about it, but she could not recall it exactly. She did not think there was any documentation regarding the CRCA caring for Resident F after having a bowel movement, as it was just a conversation. The DHS recalled having talked to the SSD (Social Services Director) about it but couldn't remember what was said. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Social Services Director (SSD) on 6/12/25 at 1:12 p.m. She indicated she received word the following day about a customer service incident regarding Resident F and CRCA 16. Another CRCA, whom the SSD could not recall, informed her that CRCA 16 was acting distressed, making gagging noises, towards Resident F when she was walking past his room or after providing care to him. The SSD spoke with Resident F regarding the incident. Resident F informed the SSD that CRCA did not do this in front of him. As far as the SSD knew, CRCA 16 was provided education on it. The SSD also thought there was an in-service. The SSD did not have any documentation regarding this alleged incident but filled out a grievance about it. The SSD reviewed the two, 3/6/25, grievances regarding Resident F from the grievance log. The SSD indicated she thought this incident was in relation the dietary concerns regarding dairy items. The SSD thought they had a quick IDT (Interdisciplinary team) meeting at the time and discussed dairy items contributing to the smell of Resident F's bowel movements. On 6/13/25 at 10:50 a.m., Clinical Support provided CRCA 16's 4/1/25 Employee Counseling Record Form completed by the DHS. It indicated CRCA 16 received a verbal warning for customer service, negative tone, and body language when speaking to a resident. It did not reference who the resident was or what the specific customer service, negative tone, or body language concerns were. An interview was conducted with the Clinical Support on 6/13/25 at 11:30 a.m. She indicated CRCA 16's 4/1/25 Employee Counseling Record Form was a result of Resident F's 3/6/25 family grievance. The Resident Rights Guidelines policy was provided by the Clinical Support on 6/13/25 at 10:50 a.m. It indicated, Our residents have a right to .a. Be treated with dignity and respect f. Be treated fairly, courteously and with respect by all staff. This citation relates to Complaint IN00461161, IN00461220, IN00460769, IN00461614, and IN00461308. 3.1-3(t) Based on interview and record review, the facility failed to promote a resident's dignity by not providing care with respect for 2 of 4 residents reviewed for dignity. (Resident E and Resident F) 1. The clinical record for Resident E was reviewed on 6/16/2025 at 1:20 p.m. The diagnoses included, but were not limited to, urinary tract infection and depression. A Minimum Data Set (MDS) assessment, dated 5/14/2025, indicated Resident E was cognitively intact, and needed substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and personal hygiene. A depression care plan for Resident E indicated the staff were to encourage the resident to voice their feelings and provide support. During an interview conducted between 6/10/25 to 6/17/25, Resident E indicated there were not enough staff on the night shift or in the early mornings. Many times, they are unable to get help with their activities or daily living when they get up and their call light will go up to an hour before someone answers. They stated when this happens it makes them feel unimportant and forgotten about. They indicated they have told staff, but staff say, they are busy, or they are the only CNA [certified nurse aide] on the floor.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a resident's call light was within reach for 1 of 1 resident reviewed for call light accessibility. (Resident 218) Findings include: During an observation and interview with Resident 218 on 6/11/25 at 9:59 a.m., Resident 218 was sitting in a wheelchair in the middle of her room. The call light was on the other side of the room on the floor beside her bed. Resident 218 indicated when staff would get her up during the day, she could never reach her call light and had no way of contacting staff when she needed help. She indicated every night she would get anxious before bed because staff would shut her door and she's not sure if she would have her call light or not, and if not, she had no way of contacting staff and had to yell out for help. During an observation and interview with Resident 218 on 6/12/25 at 10:15 a.m., Resident 218 was sitting in her wheelchair in the middle of her room. The call light was on the opposite side of the bed across the room. Resident 218 indicated she was glad someone came into her room because she needed to use the restroom but had no way to get a hold of anyone for help. The clinical record for Resident 218 was reviewed on 6/12/25 at 10:34 p.m. The diagnoses included, but were not limited to, dementia, orthostatic hypotension, and muscle weakness. The Brief Interview for Mental Status (BIMS) Evaluation, dated 6/7/25, indicated Resident 218 was cognitively intact. A Minimum Data Set (MDS) Functional Abilities Assessment, dated 6/10/25, indicated Resident 218 was dependent for toileting hygiene, and required substantial/maximal assistance with sitting to lying, lying to sitting on side of bed, sit to stand, toilet transfers, and utilized a wheelchair. The plan of care for Resident 218, dated 6/10/25, indicated the resident was at risk for falling related to weakness, medications, and incontinence. The interventions included, but were not limited to, keep the call light in reach. During an interview with Registered Nurse (RN) 3 on 6/12/25 at 10:17 a.m., she indicated it was any staff member's job who may enter the resident's room to ensure the call light was available and within reach for the resident. A Guidelines for Answering Call Lights policy was provided by MDS Support on 6/12/25 at 12:57 p.m. It indicated, .2. Ensure the call light is plugged in securely to the outlet and in reach of the resident . 3.1-3(v)(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 immediately report an allegation of abuse to the ED (Executive Director) and IDOH (Indiana Department of Health) for 2 of 2 residents reviewed for abuse. (Resident D and Resident H) Findings include: 1. The clinical record for Resident H was reviewed on 6/10/25 at 12:11 p.m. His diagnoses included, but were not limited to, dementia. The 6/2/25 admission Minimum Data Set (MDS) assessment indicated he was severely cognitively impaired. The 6/11/25 care plan indicated he expressed interest in compassionate touching and did not have capacity to give consent. The 6/6/25, 9:30 p.m. nurse's note for Resident H, recorded as a late entry on 6/7/25 at 7:45 a.m. by RN (Registered Nurse) 5, indicated, Resident was found in other residents room both were in w/c's [wheelchairs,] he was observed to have his hand on her leg and one on her shoulder. Residents were told that they need to be in common area with staff members and not in each others rooms. Both residents compliant with redirection. No injury noted, physically or mentally. ADHS [Assistant Director of Health Services] notified. 2. The clinical record for Resident D was reviewed on 6/10/25 at 12:03 p.m. Her diagnoses included, but were not limited to, dementia. The 5/13/25 admission MDS assessment indicated she was severely cognitively intact. The 6/11/25 care plan indicated she expressed interest in compassionate touching and did not have capacity to give consent. Resident D's 6/6/25, 9:30 p.m. nurse's note, recorded as a late entry on 6/7/25 at 7:45 a.m. by RN 5, indicated Resident was found in other residents room both were in w/c's, he was observed to have his hand on her leg and one on her shoulder. Residents were told that they need to be in common area with staff members and not in each others rooms . Both residents compliant with redirection. No injury noted, physically or mentally. ADHS notified. Resident D's 6/9/25, 4:38 p.m. IDT (Interdisciplinary Team) note, written by the DHS (Director of Health Services) indicated, Patient reviewed for visiting with other resident. Other resident entered room and they were having a conversation. He had his land on her leg and another on her shoulder. Patient is social and friendly. Encouraged to visit in common areas as she is confused at baseline. Patient followed by social services for psychosocial well being. An observation of Resident D and Resident H was made on 6/10/25 at 1:41 p.m. They were sitting in their wheelchairs in a common area across from the nurse's desk on their unit, visiting with each other and another resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with RN (Registered Nurse) 3 on 6/10/25 at 1:41 p.m., during the above observation. She indicated the three residents were like a little trio. They shared things like blankets, and said they were brother and sister or boyfriend and girlfriend. She stated, I'm just here observing them. Interviews were conducted with CRCA (Certified Resident Care Assistant) 6 on 6/11/25 at 1:06 p.m. and 6/11/25 at 1:49 p.m. She indicated she worked the evening of 6/6/25, and was the one who found Resident H in Resident D's room. It was dumbed (sic) down in the notes. They were both high functioning dementia patients, so they had to keep them up front by the nurse's station. It had been about five minutes since CRCA 6 laid eyes on Resident D and Resident H, before she saw them together in Resident D's room. Previously, they were together in the common area. She walked by Resident D's room while the nurse was passing medications. Resident H was touching Resident D's breasts, and his hand was almost going up her private area, up her right thigh. His hand was mid-thigh, on her right leg, going up it. He was touching her breast on the outside of her shirt, and she was not wearing any pants, as she had already taken them off. Resident H was in his wheelchair near the doorway, and Resident D was standing in front of him. They tried to keep an eye on Resident D. The facility constantly staffed that particular hallway with one CRCA, so it was hard to keep an eye on Resident D and Resident H with around 24 other residents on the hall. Resident D was standing in front of Resident H, not wearing any pants, but she was wearing her shirt. CRCA 6 asked them what they were doing. Resident D responded nothing. CRCA 6 had to pull them apart. CRCA 6 assisted Resident D back into her wheelchair, and assisted Resident H out of Resident D's room. Resident H responded by saying, Call the police. They're taking me away. Staff tried to keep them away from each other, and we eye them, but Resident D wanted to be around Resident H. I had never seen anything like this before. CRCA informed RN 5 of what she observed. RN 5 instructed CRCA to assist Resident H to bed, while RN 5 called the ADHS (Assistant Director of Health Services.) CRCA 6 was unsure what RN 5 reported to the ADHS. CRCA 6 was not told to do anything more than keep them apart. I know that's a reportable. The ED (Executive Director) was gone last week, and CRCA 6 was not sure where he was. CRCA 6 was the only staff member to witness the interaction between Resident D and Resident H. CRCA 6 informed RN 5 and the CRCA, who relieved her on the next shift, of what she observed. CRCA 6 informed the oncoming CRCA to keep Resident D and Resident H away from each other, because they were touching each other. CRCA 6 did not report this to the ED, because he did not usually answer his phone, so she did not try to call him. CRCA 6 received abuse training annually, and she knew this was reportable, because she'd been an aide for seven years. CRCA 6 was not instructed to keep Resident D and Resident H away from each other until after the incident on 6/6/25. No one from management ever asked her about the incident afterwards, or asked her to write a statement, or interviewed her about it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with RN 5 on 6/11/25 at 1:36 p.m. She indicated CRCA 6 found Resident D and Resident H together in Resident D's room the evening of 6/6/25. CRCA 6 was called to another hallway for a while that night. While RN 5 was passing medications, CRCA 6 noticed Resident D and Resident H were no longer sitting in the common area by the nurse's station, so CRCA 6 went into Resident D's room and there they both were. CRCA 6 informed RN 5 that Resident H had one hand on Resident D's shoulder, and the other on her leg. CRCA 6 did not inform her that Resident H was touching Resident D's breast, but did say chest area. CRCA 6 was upset when she came out of Resident D's room. I can't remember if she said chest or not, sorry. Then RN 5 called the ADHS, because she wasn't sure if it was a reportable incident. The ADHS had RN 5 look up both residents most recent cognitive assessments and informed her to make sure to keep them separated on the hall. Both cognitive assessments showed severe deficit. The ADHS called corporate, informed them, and was instructed to enter a note into each resident's medical record. RN 5 entered her notes, based on what she heard and what CRCA 6 said. RN 5 did not inform the ED, because he was out of town, so she started with the ADHS. RN 5 was not involved in physically separating Residents D and H that evening. By the time she came on the scene, both residents were each in their own rooms and had on regular attire. Resident D had the ability to put on and take off her own pants. CRCA 6 did not inform her that Resident D's pants were off. That would have been a whole situation My note would not have read like that had I known. An interview was conducted with the ADHS on 6/11/25 at 2:41 p.m. She indicated RN 5 called her the night of 6/6/25 and informed her that Resident H had his hands on Resident D's shoulder and leg, while conversing. RN 5 informed her they were fully clothed, and the encounter did not seem sexual in nature, just chatting, and that was it. The ADHS did not recall if she was informed of who actually found the residents together in Resident D's room. She normally clarified who witnessed an incident and talked to that person. The ADHS called corporate and informed them. An interview was conducted with the DHS, AIT (Administrator in Training,) Clinical Support, and MDS (Minimum Data Set) Support on 6/11/25 at 2:05 p.m. The DHS indicated Resident D and Resident H were close friends, who congregated in the common area. She looked into the 6/6/25 occurrence between Resident D and Resident H. Resident D would touch Resident H, and Resident H would touch back, but she thought it was just friendly. Resident D was very friendly. Resident H would put his hand on her (DHS) when he talked to her. To the DHS's knowledge, it was RN 5 who found Resident D and Resident H together in Resident D's room. The DHS did not speak with CRCA 6 about it, as she was unaware CRCA 6 was the one who found them, and she did not know Resident D's pants were not on at the time. The DHS read RN 5's note the following day and called RN 5 about it. CRCA 6 should have called her, the AIT, or the ED. The AIT, Clinical Support, and the MDS Support all indicated they were unaware Resident D's pants were off and that Resident H was touching Resident D's breast. The IDOH reportable incidents for the past six months were provided by Clinical Support on 6/11/25 at 9:30 a.m. There were no reportable incidents regarding the 6/6/25 occurrence between Resident D and Resident H. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse, Neglect, and Exploitation Procedural Guidelines policy was provided by Clinical Support on 6/10/25 at 12:30 p.m. It indicated, Identification .Any person with knowledge of or suspicion of suspected violations shall report immediately, without fear of reprisal The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent, they may appoint a designee. i. The Executive Director or designee must notify the resident(s)' physician(s) and family/resident representative. ii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies, which include the ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This citation relates to Complaint IN00461220. 3.1-28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to identify and initiate a thorough investigation into an alleged violation of abuse for 2 of 2 residents reviewed for abuse. (Residents D and H) Findings include: 1. Resident D's 6/6/25, 9:30 p.m. nurse's note, recorded as a late entry on 6/7/25 at 7:45 a.m. by RN 5, indicated Resident was found in other residents room both were in w/c's, he was observed to have his hand on her leg and one on her shoulder. Residents were told that they need to be in common area with staff members and not in each others rooms . Both residents compliant with redirection. No injury noted, physically or mentally. ADHS notifie Resident D's 6/9/25, 4:38 p.m. IDT (Interdisciplinary Team) note, written by the DHS (Director of Health Services) indicated, Patient reviewed for visiting with other resident. Other resident entered room and they were having a conversation. He had his land on her leg and another on her shoulder. Patient is social and friendly. Encouraged to visit in common areas as she is confused at baseline. Patient followed by social services for psychosocial well being. An observation of Resident D and Resident H was made on 6/10/25 at 1:41 p.m. They were sitting in their wheelchairs in a common area across from the nurse's desk on their unit, visiting with each other and another resident. An interview was conducted with RN (Registered Nurse) 3 on 6/10/25 at 1:41 p.m., during the above observation. She indicated the three residents were like a little trio. They shared things like blankets, and said they were brother and sister or boyfriend and girlfriend. She stated, I'm just here observing them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews were conducted with CRCA (Certified Resident Care Assistant) 6 on 6/11/25 at 1:06 p.m. and 6/11/25 at 1:49 p.m. She indicated she worked the evening of 6/6/25 and was the one who found Resident H in Resident D's room. It was dumbed (sic) down in the notes. They were both high functioning dementia patients, so they had to keep them up front by the nurse's station. It had been about five minutes since CRCA 6 laid eyes on Resident D and Resident H, before she saw them together in Resident D's room. Previously, they were together in the common area. She walked by Resident D's room while the nurse was passing medications. Resident H was touching Resident D's breasts, and his hand was almost going up her private area, up her right thigh. His hand was mid-thigh, on her right leg, going up it. He was touching her breast on the outside of her shirt, and she was not wearing any pants, as she had already taken them off. Resident H was in his wheelchair near the doorway, and Resident D was standing in front of him. They tried to keep an eye on Resident D. The facility constantly staffed that particular hallway with one CRCA, so it was hard to keep an eye on Resident D and Resident H with around 24 other residents on the hall. Resident D was standing in front of Resident H, not wearing any pants, but she was wearing her shirt. CRCA 6 asked them what they were doing. Resident D responded nothing. CRCA 6 had to pull them apart. CRCA 6 assisted Resident D back into her wheelchair, and assisted Resident H out of Resident D's room. Resident H responded by saying, Call the police. They're taking me away. Staff tried to keep them away from each other, and we eye them, but Resident D wanted to be around Resident H. I had never seen anything like this before. CRCA informed RN 5 of what she observed. RN 5 instructed CRCA to assist Resident H to bed, while RN 5 called the ADHS (Assistant Director of Health Services.) CRCA 6 was unsure what RN 5 reported to the ADHS. CRCA 6 was not told to do anything more than keep them apart. I know that's a reportable. The ED (Executive Director) was gone last week, and CRCA 6 was not sure where he was. CRCA 6 was the only staff member to witness the interaction between Resident D and Resident H. CRCA 6 informed RN 5 and the CRCA who relieved her on the next shift, of what she observed. CRCA 6 informed the oncoming CRCA to keep Resident D and Resident H away from each other, because they were touching each other. CRCA 6 did not report this to the ED, because he did not usually answer his phone, so she did not try to call him. CRCA 6 received abuse training annually, and she knew this was reportable, because she'd been an aide for seven years. CRCA 6 was not instructed to keep Resident D and Resident H away from each other until after the incident on 6/6/25. No one from management ever asked her about the incident afterwards, or asked her to write a statement, or interviewed her about it. An interview was conducted with RN 5 on 6/11/25 at 1:36 p.m. She indicated CRCA 6 found Resident D and Resident H together in Resident D's room the evening of 6/6/25. CRCA 6 was called to another hallway for a while that night. While RN 5 was passing medications, CRCA 6 noticed Resident D and Resident H were no longer sitting in the common area by the nurse's station, so CRCA 6 went into Resident D's room and there they both were. CRCA 6 informed RN 5 that Resident H had one hand on Resident D's shoulder, and the other on her leg. CRCA 6 did not inform her that Resident H was touching Resident D's breast, but did say chest area. CRCA 6 was upset when she came out of Resident D's room. I can't remember if she said chest or not, sorry. Then RN 5 called the ADHS, because she wasn't sure if it was a reportable incident. The ADHS had RN 5 look up both residents most recent cognitive assessments and informed her to make sure to keep them separated on the hall. Both cognitive assessments showed severe deficit. The ADHS called corporate, informed them, and was instructed to enter a note into each resident's medical record. RN 5 entered her notes, based on what she heard and what CRCA 6 said. RN 5 did not inform the ED, because he was out of town, so she started with the ADHS. RN 5 was not involved in physically separating Residents D and H that evening. By the time she came on the scene, both residents were each in their own rooms and had on regular attire. Resident D had the ability to put on and take off her own pants. CRCA 6 did not inform her that Resident D's pants were off. That would have been a whole situation My note would not have read like that had I known. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the ADHS on 6/11/25 at 2:41 p.m. She indicated RN 5 called her the night of 6/6/25, and informed her that Resident H had his hands on Resident D's shoulder and leg, while conversing. RN 5 informed her they were fully clothed, and the encounter did not seem sexual in nature, just chatting, and that was it. The ADHS did not recall if she was informed of who actually found the residents together in Resident D's room. She normally clarified who witnessed an incident and talked to that person. The ADHS called corporate and informed them. An interview was conducted with the DHS, AIT (Administrator in Training,) Clinical Support, and MDS (Minimum Data Set) Support on 6/11/25 at 2:05 p.m. The DHS indicated Resident D and Resident H were close friends, who congregated in the common area. She looked into the 6/6/25 occurrence between Resident D and Resident H. Resident D would touch Resident H, and Resident H would touch back, but she thought it was just friendly. Resident D was very friendly. Resident H would put his hand on her (DHS) when he talked to her. To the DHS's knowledge, it was RN 5 who found Resident D and Resident H together in Resident D's room. The DHS did not speak with CRCA 6 about it, as she was unaware CRCA 6 was the one who found them, and she did not know Resident D's pants were not on at the time. The DHS read RN 5's note the following day and called RN 5 about it. CRCA 6 should have called her, the AIT, or the ED. The AIT, Clinical Support, and the MDS Support all indicated none of them had spoken to CRCA 6 about the occurrence on 6/6/25, and none of them were aware Resident D's pants were off, or that Resident H was touching Resident D's breast. The IDOH reportable incidents for the past six months was provided by Clinical Support on 6/11/25 at 9:30 a.m. There were no reportable incidents regarding the 6/6/25 occurrence between Resident D and Resident H. 2a. The clinical record for Resident H was reviewed on 6/10/25 at 12:11 p.m. His diagnoses included, but were not limited to, dementia. The 6/2/25 admission MDS (Minimum Data Set) assessment indicated he was severely cognitively impaired. The 6/11/25 care plan indicated he expressed interest in compassionate touching and did not have capacity to give consent. The 6/6/25, 9:30 p.m. nurse's note for Resident H, recorded as a late entry on 6/7/25 at 7:45 a.m. by RN (Registered Nurse) 5, indicated, Resident was found in other residents room both were in w/c's [wheelchairs,] he was observed to have his hand on her leg and one on her shoulder. Residents were told that they need to be in common area with staff members and not in each others rooms . Both residents compliant with redirection. No injury noted, physically or mentally. ADHS [Assistant Director of Health Services] notified. 2b. The clinical record for Resident D was reviewed on 6/10/25 at 12:03 p.m. Her diagnoses included, but were not limited to, dementia. The 5/13/25 admission MDS Assessment indicated she was severely cognitively intact. The 6/11/25 care plan indicated she expressed interest in compassionate touching and did not have capacity to give consent. (continued on next page)

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	155767	A. Building B. Wing	06/17/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident D's 6/6/25, 9:30 p.m. nurse's note, recorded as a late entry on 6/7/25 at 7:45 a.m. by RN 5, indicated Resident was found in other residents room both were in w/c's, he was observed to have his hand on her leg and one on her shoulder. Residents were told that they need to be in common area with staff members and not in each others rooms . Both residents compliant with redirection. No injury noted, physically or mentally. ADHS notified. Resident D's 6/9/25, 4:38 p.m. IDT (Interdisciplinary Team) note, written by the DHS (Director of Health Services) indicated, Patient reviewed for visiting with other resident. Other resident entered room and they were having a conversation. He had his land on her leg and another on her shoulder. Patient is social and friendly. Encouraged to visit in common areas as she is confused at baseline. Patient followed by social services for psychosocial well being. An observation of Resident D and Resident H was made on 6/10/25 at 1:41 p.m. They were sitting in their wheelchairs in a common area across from the nurse's desk on their unit, visiting with each other and another resident. An interview was conducted with RN (Registered Nurse) 3 on 6/10/25 at 1:41 p.m., during the above observation. She indicated the three residents were like a little trio. They shared things like blankets, and said they were brother and sister or boyfriend and girlfriend. She stated, I'm just here observing them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews were conducted with CRCA (Certified Resident Care Assistant) 6 on 6/11/25 at 1:06 p.m. and 6/11/25 at 1:49 p.m. She indicated she worked the evening of 6/6/25 and was the one who found Resident H in Resident D's room. It was dumbed (sic) down in the notes. They were both high functioning dementia patients, so they had to keep them up front by the nurse's station. It had been about five minutes since CRCA 6 laid eyes on Resident D and Resident H, before she saw them together in Resident D's room. Previously, they were together in the common area. She walked by Resident D's room while the nurse was passing medications. Resident H was touching Resident D's breasts, and his hand was almost going up her private area, up her right thigh. His hand was mid-thigh, on her right leg, going up it. He was touching her breast on the outside of her shirt, and she was not wearing any pants, as she had already taken them off. Resident H was in his wheelchair near the doorway, and Resident D was standing in front of him. They tried to keep an eye on Resident D. The facility constantly staffed that particular hallway with one CRCA, so it was hard to keep an eye on Resident D and Resident H with around 24 other residents on the hall. Resident D was standing in front of Resident H, not wearing any pants, but she was wearing her shirt. CRCA 6 asked them what they were doing. Resident D responded nothing. CRCA 6 had to pull them apart. CRCA 6 assisted Resident D back into her wheelchair, and assisted Resident H out of Resident D's room. Resident H responded by saying, Call the police. They're taking me away. Staff tried to keep them away from each other, and we eye them, but Resident D wanted to be around Resident H. I had never seen anything like this before. CRCA informed RN 5 of what she observed. RN 5 instructed CRCA to assist Resident H to bed, while RN 5 called the ADHS (Assistant Director of Health Services.) CRCA 6 was unsure what RN 5 reported to the ADHS. CRCA 6 was not told to do anything more than keep them apart. I know that's a reportable. The ED (Executive Director) was gone last week, and CRCA 6 was not sure where he was. CRCA 6 was the only staff member to witness the interaction between Resident D and Resident H. CRCA 6 informed RN 5 and the CRCA who relieved her on the next shift, of what she observed. CRCA 6 informed the oncoming CRCA to keep Resident D and Resident H away from each other, because they were touching each other. CRCA 6 did not report this to the ED, because he did not usually answer his phone, so she did not try to call him. CRCA 6 received abuse training annually, and she knew this was reportable, because she'd been an aide for seven years. CRCA 6 was not instructed to keep Resident D and Resident H away from each other until after the incident on 6/6/25. No one from management ever asked her about the incident afterwards, or asked her to write a statement, or interviewed her about it. An interview was conducted with RN 5 on 6/11/25 at 1:36 p.m. She indicated CRCA 6 found Resident D and Resident H together in Resident D's room the evening of 6/6/25. CRCA 6 was called to another hallway for a while that night. While RN 5 was passing medications, CRCA 6 noticed Resident D and Resident H were no longer sitting in the common area by the nurse's station, so CRCA 6 went into Resident D's room and there they both were. CRCA 6 informed RN 5 that Resident H had one hand on Resident D's shoulder, and the other on her leg. CRCA 6 did not inform her that Resident H was touching Resident D's breast, but did say chest area. CRCA 6 was upset when she came out of Resident D's room. I can't remember if she said chest or not, sorry. Then RN 5 called the ADHS, because she wasn't sure if it was a reportable incident. The ADHS had RN 5 look up both residents most recent cognitive assessments and informed her to make sure to keep them separated on the hall. Both cognitive assessments showed severe deficit. The ADHS called corporate, informed them, and was instructed to enter a note into each resident's medical record. RN 5 entered her notes, based on what she heard and what CRCA 6 said. RN 5 did not inform the ED, because he was out of town, so she started with the ADHS. RN 5 was not involved in physically separating Residents D and H that evening. By the time she came on the scene, both residents were each in their own rooms and had on regular attire. Resident D had the ability to put on and take off her own pants. CRCA 6 did not inform her that Resident D's pants were off. That would have been a whole situation My note would not have read like that had I known. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the ADHS on 6/11/25 at 2:41 p.m. She indicated RN 5 called her the night of 6/6/25 and informed her that Resident H had his hands on Resident D's shoulder and leg, while conversing. RN 5 informed her they were fully clothed, and the encounter did not seem sexual in nature, just chatting, and that was it. The ADHS did not recall if she was informed of who actually found the residents together in Resident D's room. She normally clarified who witnessed an incident and talked to that person. The ADHS called corporate and informed them. An interview was conducted with the DHS, AIT (Administrator in Training,) Clinical Support, and MDS (Minimum Data Set) Support on 6/11/25 at 2:05 p.m. The DHS indicated Resident D and Resident H were close friends, who congregated in the common area. She looked into the 6/6/25 occurrence between Resident D and Resident H. Resident D would touch Resident H, and Resident H would touch back, but she thought it was just friendly. Resident D was very friendly. Resident H would put his hand on her (DHS) when he talked to her. To the DHS's knowledge, it was RN 5 who found Resident D and Resident H together in Resident D's room. The DHS did not speak with CRCA 6 about it, as she was unaware CRCA 6 was the one who found them, and she did not know Resident D's pants were not on at the time. The DHS read RN 5's note the following day and called RN 5 about it. CRCA 6 should have called her, the AIT, or the ED. The AIT, Clinical Support, and the MDS Support all indicated none of them had spoken to CRCA 6 about the occurrence on 6/6/25, and none of them were aware Resident D's pants were off, or that Resident H was touching Resident D's breast. The IDOH reportable incidents for the past six months was provided by Clinical Support on 6/11/25 at 9:30 a. m. There were no reportable incidents regarding the 6/6/25 occurrence between Resident D and Resident H. The Abuse, Neglect, and Exploitation Procedural Guidelines policy was provided by Clinical Support on 6/10/25 at 12:30 p.m. It indicated, Identification .Any person with knowledge of or suspicion of suspected violations shall report immediately, without fear of reprisal The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: iv. IMMEDIATELY notify the Executive Director. If the Executive Director is absent, they may appoint a designee Investigation i. The Executive Director is accountable for investigating and reporting Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. This citation relates to Complaint IN00461220. 3.1-28(e)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to timely transmit a Quarterly Minimum Data Set (MDS) assessment for 1 of 9 residents reviewed for MDS Assessments. (Resident 21) Findings include: The clinical record for Resident 21 was reviewed on 6/16/2025 at 11:40 a.m. The diagnosis included, but was not limited to, dementia. A Quarterly MDS assessment, had an assessment reference date (ARD) of 5/9/2025. This assessment was completed on 5/22/2025. An MDS transmission report, provided on 6/16/2025 at 2:20 p.m., indicated the Quarterly MDS assessment for Resident 21 with an ARD of 5/9/2025 was transmitted on 6/13/2025. During an interview, on 6/16/2025 at 1:35 p.m., MDS Support indicated they utilize the RAI (Resident Assessment Instrument) Manual for guidance on timeliness of MDS Assessments. For Quarterly assessments, they have 14 days to transmit the completed assessments, but this was not done because she was busy with end of month activities.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 assist dependent residents with shaving per preference and provide activities of daily living (ADL) care in a timely manner for 4 of 7 residents reviewed for activities of daily living. (Resident E, Resident G, Resident L, and Resident J) Findings include: 1. The clinical record for Resident E was reviewed on 6/16/2025 at 1:20 p.m. The diagnoses included, but were not limited to, urinary tract infection and depression. A Minimum Data Set (MDS) assessment, dated 5/14/2025, indicated Resident E was cognitively intact, utilized an indwelling urinary catheter, and needed substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and personal hygiene. An activities of daily living care plan, revised 6/2/2025, indicated to offer Resident E shaving on shower days and as needed. Resident E's shower days were Monday and Thursday. A depression care plan for Resident E indicated the staff were to encourage the resident to voice their feelings and provide support. During an interview and observation, on 6/10/2025 at 1:59 p.m., Resident E was sitting in his wheelchair. Resident E indicated he likes to wear a goatee but the staff here never have time to assist him with shaving the rest. He indicated he does not like to have the sides long. The areas he indicated were observed to have hair growth. Resident E said only one care assistant ever helps him shave, but she doesn't always have time either. He had not been assisted in shaving in over a week. During an observation on 6/11/2025 at 1:05 p.m., Resident E was observed to have continued facial hair growth in the areas he preferred to be shaved. He said that no one offered to assist him with shaving that morning. An interview was conducted with Certified Resident Care Assistant (CRCA) 11 on 6/16/2025 at 12:19 p.m. She indicated she was unable to get her work done there, including bathing and ADL needs for residents on the 200 hall, including Resident E. 2. During an observation and interview with Resident G on 6/11/25 at 11:18 a.m., Resident G was sitting in his room with facial hair all along his jawline and above his lip. Resident G indicated he had not had his face shaved in over two weeks and preferred to be shaved at least every other day. Resident G indicated he had been asking staff to shave him, but he was still waiting on them to do it. The clinical record for Resident G was reviewed on 6/12/25 at 2:16 p.m. The diagnoses included, but were not limited to, chronic kidney disease and generalized osteoarthritis. An admission MDS assessment, dated 5/20/25, indicated Resident G was moderately cognitively impaired and required partial/moderate assistance with personal hygiene. A skilled documentation note, dated 6/8/25, indicated Resident G was able to make his needs known. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation with Resident G on 6/12/25 at 2:13 p.m., Resident G was sitting in his room with a shaved face. Resident G indicated, they finally got around to it. Resident G indicated he had been asking staff to be shaved, but no one has had the time to do it. Resident G's roommate, Resident 7, was sitting in the room during this observation and interview. Resident 7 indicated Resident G had not had his face shaved since he had been at the facility, which he was admitted to on 5/26/25. Resident 7 indicated he had heard Resident G talking to staff about wanting his face shaved, but they just got to it yesterday. An admission MDS for Resident 7, dated 5/26/25, indicated Resident 7 was cognitively intact. The plan of care for Resident G, dated 5/30/25, indicated the resident required assistance to complete self-care and mobility functional tasks. The interventions included, but were not limited to, offer facial shaving on shower days, prn (as needed), or as requested. During an interview with the Administrator on 6/16/25 at 2:49 p.m., he indicated nursing staff were responsible for residents being shaved. 3. The clinical record for Resident L was reviewed on 6/13/25 at 11:08 a.m. The diagnoses included, but were not limited to, dislocation of internal right hip prosthesis, retention of urine, and polyneuropathy. During an interview with Resident L on 6/11/25 at 10:40 a.m., Resident L indicated she cannot get up to go to the bathroom by herself and has had to wait up to 45 minutes to get help. She had laid in bed several times waiting on her call light to be answered and had to wait so long that she had an incontinent accident in bed. Resident L indicated at the time it makes her feel anxious for trying to hold it and wait, then embarrassed afterwards, because it would not have happened if she could have gotten help sooner from the time she called out. They just don't have enough help. She indicated she was usually continent of urine but cannot always hold it. An admission MDS assessment, dated 5/17/25, indicated Resident L was cognitively intact, used a walker and wheelchair, and required substantial assistance with toileting, sitting to lying, lying to standing, and sitting to stand. A plan of care for Resident L, dated 5/30/25, indicated the resident experienced episodes of incontinence due to decreased mobility and required assistance with ADL care/toileting. The interventions included, but were not limited to, offer and assist with toileting as needed and/or per request. 4. The clinical record for Resident J was reviewed on 6/12/25 at 10:04 a.m. The diagnoses included, but were not limited to, anemia and atrial fibrillation. During an interview with Resident J on 6/11/25 at 10:14 a.m., Resident J indicated her call light takes a long time to be answered, and she has had several times when she was waiting and was incontinent and had to lay in a wet bed. Resident J indicated it was embarrassing and uncalled for. She indicated she was continent of urine but was unable to hold it for long periods of time. The admission MDS assessment, dated 5/9/25, indicated Resident J was cognitively intact and was dependent with toileting hygiene, lying to sitting on the side of the bed, and sitting to standing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note, dated 6/12/25, indicated Resident J was able to make her needs known and was continent of urine. This citation relates to complaints IN00461220, IN00461161, IN00460769, IN00461614, & IN00461308. 3.1-38(a)(2)(C) 3.1-38(a)(3)(A) 3.1-38(a)(3)(D)

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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. 3. The clinical record for Resident Q was reviewed on 6/11/25 at 11:00 a.m. The diagnoses included, but were not limited to, overactive bladder and urinary tract infection. An interview and observation were conducted with Family Member 7 on 6/11/25 at 11:05 a.m. She indicated Resident Q had a history of UTIs (urinary tract infections.) During her most recent care plan meeting a couple of weeks ago, they discussed Resident Q having a possible allergy to Bactrim, an antibiotic medication used to treat UTIs. The staff at the care plan meeting said they would chart it, but she wasn't sure what happened, because she was just prescribed it again a couple of days ago, and Resident Q's lips swelled up, like they did in April 2025, when she was prescribed it. At this time, Family Member 7 displayed two photographs on her cell phone. One, dated 4/13/25 at 11:38 a.m., was Resident Q with a very red, swollen, bottom lip. Family Member 7 indicated Resident Q had to have a cream applied to her lips for it. The other photograph, dated 6/9/25 at 7:44 p.m., was of Resident Q with a red, swollen, bottom lip, that was not quite as swollen as the 4/13/25 photograph. Family Member 7 indicated Resident Q received a dose of Bactrim earlier that day, on 6/9/25. The 5/27/25 Resident First Meeting Minutes (care plan meeting) observation did not reference discussing an allergy to Bactrim. It indicated the SSD (Social Services Director,) and DHS (Director of Health Services) were present at the meeting. An interview was conducted with the SSD on 6/12/25 at 1:06 p.m. She indicated she was at Resident Q's 5/27/25 care plan meeting, along with the DHS and Family Member 7. Someone mentioned Resident Q having a sensitivity to some type of medication, that she had a hive type reaction to it, but they didn't say it was a true allergy. She could not recall the name of the medication or what it was used for, just that Resident Q had an adverse reaction to it. As far as taking notes during the meeting, any of the staff could do it. The SSD reviewed her notes and indicated she didn't have any notes from the meeting, so she didn't think she took any for this particular meeting. She did not usually document any notes into a care plan meeting observation for long term care residents, only for residents who are in the facility for rehabilitation. An interview was conducted with the DHS on 6/12/25 at 2:20 p.m. She indicated she was present at Resident Q's 5/27/25 care plan meeting. She did not recall family discussing an allergy or sensitivity to Bactrim. If something like that were discussed, it would normally be handwritten, and she would inform the ADHS (Assistant Director of Health Services) to address it. The 4/7/25 nurse's note indicated, NP [Nurse Practitioner] starting resident on Bactrim DS 800-160 mg BID x [twice daily time] 7 days for UTI; daughter aware of new medication being started vs Macrobid. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/9/25 physician's note indicated, .Aphthous ulcer [also known as canker sores] 4/14/25: acute onset. Per nursing staff, resident with mouth pain. On exam, resident noted to have ulcer inside bottom lip. Treat with orajel bid x7 days. No other open areas noted. No signs of thrush on exam. Lips noted to be dry on exam, continue with moisturizing chap stick to lips 6/9/25: acute onset dysuria. Per staff, resident with complaints of dysuria. Hx [History] of chronic UTIs. Resident currently prescribed prophylactic Fosfomycin per Urology. Pleasantly confused on exam, this is baseline. UACS/CBC/CMP [urinalysis/culture and sensitivity/complete blood count/ complete metabolic panel] ordered. Obtain urine via in and out cath [catheter.] Due to history of chronic UTIs and urosepsis will go ahead and start bactrim ds 800/160mg bid x7 days. Adjust once final urine culture results. Hold fosfomycin while on ATB The June 2025 MAR (medication administration record) indicated the first dose of Bactrim DS was administered on 6/9/25. The second dose on 6/9/25 was not given due to family wants different atb [antibiotic] . The third dose was not administered, as it was discontinued due to the family refused her taking it. The 6/10/25, 8:19 a.m. nurse's note indicated to discontinue Bactrim per the nurse practitioner. The CCD (Continuing Care Document) listed Bactrim DS as an allergy with a rash reaction, starting 6/10/25. The Resident First Meeting Guidelines policy was provided by the Clinical Support on 6/13/25 at 10:50 a.m. It indicated, Director of Social Services will open the observation Trilogy Resident First Meeting Minutes prior to the scheduled meeting Director of Social Service will follow up on missing documentation and escalate to ED [Executive Director] if not completed timely At the meeting: .Solicit input from the resident and/or representative regarding care choices and changes to their routine. d. Add any input from the resident and/or representative into the narrative notes sections on the observation form The Resident First Meeting is a time to communicate information related to care needs and medical condition and seek input from the resident or representative A record of the meeting should be documented within the electronic health record by completing the Resident First Observation with each meeting. The observation will be the supportive documentation of the meeting. This citation relates to Complaint IN00461161, IN00461220, IN00460769, IN00461614, and IN00461308. 3.1-37(a) Based on interview and record review, the facility failed complete treatments as ordered (Resident M and Resident N) and failed to timely address a medication allergy (Resident Q) for 3 of 4 residents reviewed for quality of care. Findings include: 1. The clinical record for Resident N was reviewed on 6/17/2025 at 11:20 a.m. The diagnoses included, but were not limited to, diabetes and debility. An admission assessment, dated 6/12/2025, indicated Resident N had skin impairments upon admission and was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A skin care plan, dated 6/16/2025, indicated to complete Resident N's skin treatments as ordered. A physician's order, dated 6/12/2025, indicated for Resident N to have a foam dressing applied to the left buttocks every Monday, Wednesday, Friday, and as needed. The June 2025 Treatment Administration Record for Resident N indicated the treatment was not completed on 6/13/2025 with a reason of Not enough time. During an interview, on 6/16/2025 at 12:53 p.m., Registered Nurse (RN) 16 indicated she did not have enough time to get everything done in her shift. Specifically, on 6/13/2025, the day shift nurse did not have time to do the treatments for residents on her assignment, and she attempted to do as much as she could, but she couldn't get to Resident N's treatment. 2. The clinical record for Resident M was reviewed on 6/16/25 at 1:35 p.m. The diagnoses included, but were not limited to, acute respiratory failure with hypoxia and chronic pulmonary edema. During an interview with Registered Nurse (RN) 2 on 6/16/25 at 12:53 p.m., she indicated the day shift nurse on 6/13/25 was unable to do wound care/dressing changes on the 300 Hall, so these tasks were pushed off for her to complete on evening shift, and she was not able to do them because she just did not have the time. The physician's order, dated 6/10/25, indicated to apply Profore two step to bilateral lower extremities (BLE) due to edema and change every Tuesday and Friday. The Treatment Administration Record (TAR) for June 2025, indicated Resident M was scheduled for the Profore two step dressing change to the BLE on 6/13/25, and was charted as not completed by RN 2 with comments documented as not enough time/staff. During an interview with Resident M on 6/16/25 at 1:25 p.m., he indicated his leg dressings were changed yesterday, on 6/15/25. The admission Minimum Data Set (MDS) assessment, dated 4/14/25, indicated Resident M was cognitively intact. During an interview with RN 3 on 6/16/25 at 2:30 p.m., she indicated she did not know why Resident M's leg dressings were not changed on Friday as ordered. RN 3 indicated she went in yesterday (Sunday) and saw Resident M's leg dressings rolled down. She indicated finding out that they were not changed on Friday made sense to her after seeing the dressings rolled down. RN 3 indicated floor staff were responsible for doing treatments that were ordered and as needed. The Dressing Changes policy was provided by Clinical Support on 6/17/25 at 9:55 a.m. It indicated, .11. Follow doctor's recommendations for treatment .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview, observation, and record review, the facility failed to ensure a resident's catheter drainage bag and tubing were free of contact with the floor for 1 of 2 residents reviewed for catheters. (Resident E) Findings include: The clinical record for Resident E was reviewed on 6/16/2025 at 1:20 p.m. The diagnoses included, but were not limited to, urinary tract infection and depression. A Minimum Data Set Assessment, dated 5/14/2025, indicated Resident E was cognitively intact, utilized an indwelling urinary catheter, and needed substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and personal hygiene. A care guide care plan, initiated on 6/27/2024 and revised 6/13/2025, indicated to ensure Resident E's indwelling catheter did not touch the floor. A physician's order, dated 3/20/2025, indicated Resident E utilized an indwelling urinary catheter for neurogenic bladder. During an interview and observation, on 6/10/2025 at 1:59 p.m., Resident E was sitting in his wheelchair. The urinary catheter drainage bag and tubing were contacting the floor. Resident E indicated his catheter bag often drags the floor and has gotten caught under his wheelchair wheel before. During an observation, on 6/11/2025 at 1:05 p.m., Resident E was propelling himself in his wheelchair after lunch. Resident E's urinary catheter tubing noted to be looped down and contacting the floor. A policy, entitled Urinary Catheter Care, was provided by MDS Support on 6/16/2025 at 2:10 p.m. The policy indicated, .Be sure the catheter tubing and drainage bag are kept off of the floor . 3.1-41(a)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure sufficient nursing staff to provide activities of daily living (ADL) care, skin care treatments, and maintain residents' dignity. This deficient practice had the potential to affect 61 of 61 residents in the facility. Findings include: A confidential interview was conducted with a resident. They indicated there were not enough staff in the facility to help them. They forgot about them when they pressed their call light, and it made them feel unimportant. An interview was conducted with Resident P on 6/10/25 at 1:23 p.m. She indicated it took thirty minutes for staff to help her, after she pressed her call light. An interview was conducted with Resident S on 6/11/25 at 11:27 a.m. She indicated the facility was short staffed most of the time. An interview was conducted with Family Member 7 on 6/11/25 at 10:56 a.m. She indicated the facility was short staffed. The staff tried, but a lot of times, there was only one CRCA (Certified Resident Care Assistant) on duty for the hall, and one person couldn't do everything. The resident next door didn't get up until noon last Saturday. There was a time within the past three weeks that Resident Q had to wait 45 minutes for the CRCA to assist her to the restroom. Resident Q cried while waiting, saying she didn't do anything to deserve this. This made Family Member 7 cry too. The facility continued to accept more residents into the facility, but they couldn't take care of the ones they already had. The nurses felt the same way, and there were a lot of call-offs in the facility. An interview was conducted with Resident R on 6/10/25 at 1:51 p.m. She indicated staff called off a lot of the time. The call lights took a long time to be answered. She had incontinence accidents in bed, while waiting on her call light to be answered. She was incontinent and never knew when she had to go but would lay in bed soaked. It made her mad, ticked, having to wait so long on help. The Resident Council Meeting minutes for the past six months were provided by the Clinical Support on 6/12/25 at 10:47 a.m. The 12/9/24 minutes for the nursing department indicated, Can tell that they are short of help. The January 2025 council meeting was not held due to a Covid-19 outbreak. The 2/24/25 minutes for the nursing department indicated, Issues with medication not being on time and showers aren't on schedule The 3/17/25 minutes for the nursing department indicated, need more staff-aren't able to communicate with staff-not enough time for each resident; wish they listened for to [sic] concerns . The 4/21/25 minutes for the nursing department indicated, Need more: short staffed mostly nights and weekends. Call light waiting time seems a bit long ex. [example] waiting for pain pill and the nurse is assisting elsewhere-on another hall.) The 5/19/25 minutes for the nursing department indicated, Still seem a bit short however were educated on hiring and new scheduler starting. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A telephone interview was conducted with RN (Registered Nurse) 9 on 6/12/25 at 12:40 p.m. She indicated she worked at the facility as needed, usually two days a week. She came in to work the night shift of 6/7/25, from 11:00 p.m. to 7:00 a.m. She clocked in and looked at the schedule. There was no nurse for the 100 hall and only once CRCA. RN 9 would have been the only nurse for the entire facility. RN 9 did not think she could be responsible for all the residents in the health care center and the assisted living. There were only two CRCAs and one QMA (Qualified Medication Aide) for everything. RN 9 called the DHS (Director of Health Services,) but she did not answer. She then called the ED (Executive Director), but he did not answer. She waited at the facility close to an hour, before she decided not to stay. She finally received a call back from the ADHS (Assistant Director of Nursing) around 12:30 a.m. on 6/8/25. When RN 9 arrived to work the night of 6/7/25, she relieved RN 2. There was also an LPN (Licensed Practical Nurse,) LPN 10, who was on-call and had already been there for 16 hours and was not going to stay. RN 9 clocked out around midnight. After RN 9 got home, she had a text message from the ADHS on 6/7/25 at 11:52 p.m. that read verbatim SOS [a Morse code distress signal that indicates a need for help, an emergency, or distress.) WE HAVE NO NURSE IN THE BUILDING. I CANNOT GET AHOLD OF ANYONE. I AM UNABLE TO COME IN AGAIN TONIGHT. CAN ANYONE COME IN AND ASSIST? RN 9 had no idea when a nurse came to the building. RN 9 indicated RN 2 was still in the facility when RN 9 left. RN 9 was told later that LPN 10 came back to the building and clocked in. RN 9 felt like the DHS never responded, and the ED was basically the same way. They got to figure it out. Staffing had been an ongoing issue for a year to a year and a half. An interview was conducted with RN 2 on 6/16/25 at 12:53 p.m. She indicated she worked the evening shift (3:00 p.m. to 11:00 p.m.) of 6/7/25. She left the facility between 11:30 p.m. and midnight. LPN 10 was still in the facility when she left. RN 2 indicated she normally worked the 300 hall on evening shift and could not get some of her work done while on duty, like completing an admission assessment, a skin assessment, or nurses' notes. She couldn't answer call lights timely. There was usually only one nurse and one CRCA for the hall. She didn't always finish her Medicare charting timely and would usually have to finish the next day. Management sometimes told her to backchart. If she didn't get something done, it may not get done for a week or so, and they will tell us to backdate a week to the admission. There was an admission weight she was told to document as having been taken on admission, but it was really done a week later. RN 2 could not recall who the resident was, but it was within the past month. It's just hard to get help in there. They were always telling staff to come in early and leave late, but that wasn't really feasible. Sometimes wound care didn't get done timely. On her last shift the evening of 6/13/25, the day shift nurse could not get around to skin care treatments on the 300 hall, so it was pushed off onto her on evening shift. RN 9 couldn't get to it either for two residents on the evening shift, Resident M and Resident N, so she charted it as not done. It was supposed to be done on day shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with CRCA 6 on 6/16/25 at 11:52 a.m. She indicated she worked the evening of 6/7/25. She indicated LPN 10 was at the facility the entire night and never left. The staff didn't realize she was still there, as she was in the assisted living portion of the facility, in another physical building. RN 9 left the facility, because she thought she was going to be the only nurse working that night but didn't know at the time that LPN 10 was in the assisted living. When LPN 10 came back to the skilled nursing part of the facility from assisted living, she couldn't leave until another nurse, LPN 8 arrived around 2:00 a.m. LPN 10 took a nap before LPN 8 arrived, because the CRCAs were supposed to wake her up if they needed her. CRCA 6 indicated she was unable to get her work done timely, as there was only one aide on the hall most of the time. The schedule was horrible. We need staff and nurses. When they were short staffed, residents had more behaviors, would grow impatient with staff's inability to assist them timely. She often could not do all of the scheduled showers for residents and would push it off onto the next shift. The evening shift CRCAs did not get breaks. It's hectic there, and they just keep bringing in more residents. An interview was conducted with CRCA 11 on 6/16/25 at 12:19 p.m. She indicated she worked the night shift of 6/7/25. LPN 10 was trying to clock out, but management wouldn't let her. LPN 10 clocked out for a bit, but had to clock back in. LPN 10 took a nap for two or three hours, but nothing happened in that time frame. CRCA 11 indicated none of the staff can get their work done while at the facility. She couldn't' get showers done for her residents. I just clean them up, and tell them sorry. It was hard to give residents the care they deserved. She rushed during care. It was to the point residents knew she was working alone, so they understood. I hate having to rush. I want to be able to spend my time being able to talk to them, and give them the attention they deserve. She normally worked the 200 hall and covered all twenty-something residents when she was working by herself. She worked by herself the last two times she worked the evening shift on the 200 hall. Recently, it's been going around, that they are falsifying shower sheets. An interview was conducted with LPN 12 on 6/16/25 at 1:32 p.m. She indicated she received a call the morning of 6/8/25 that there was no nurse in the building. Staff cared and tried their best, but they didn't feel they had the support of leadership. They all knew there were holes in the schedule and allowed it. Their DHS was never available by phone, text, or messaging. LPN 12 usually worked later than her eight hour shift to complete her work. Oftentimes, there was only one nurse and one CRCA for a hall with around 25 residents. She normally worked every other weekend, on various halls in the facility. There were a lot of residents who required lifts for transfers on the 200 hall. The scheduler was frustrated. One of the CRCAs mentioned the scheduler cursed at her. It's a lot for everyone. An interview was conducted with the Scheduler on 6/16/25 at 2:10 p.m. She indicated she just began working as the scheduler this month. The scheduler prior to her quit. She thought the facility was without a scheduler for a month or two, so nurse management was doing the schedule. Before she became the scheduler, they had issues with staffing. Nurse managers were trying to do their jobs, plus working the floor. The night of 6/7/25, RN 9 refused to take shift, because the other nurse who was supposed to work, called in, and RN 9 didn't want to be only nurse with a QMA. Residents and family had been complaining about staffing issues, that call lights were not being answered timely. CNAs told her they couldn't get showers done on their scheduled shift. The time sheets for all nursing staff from 6/7/25 to 6/8/25 were provided by the Clinical Support on (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6/17/25 at 9:23 a.m. It indicated RN 9 was clocked in on 6/7/25 from 10:55 p.m. to 11:31 p.m. LPN 10 was clocked in on 6/7/25 from 6:57 a.m. to 6/8/25 at 12:30 a.m. and 6/8/25 from 1:10 a.m. to 10:13 p.m. LPN 8 was clocked in on 6/8/25 from 1:47 a.m. to 6/8/25 at 7:45 a.m. There was a forty-minute gap of time from 6/8/25 at 12:30 a.m. to 6/8/25 at 1:10 a.m. that no nurse was clocked in as working at the facility. LPN 10 was unavailable for interview. An interview was conducted with the ADHS on 6/17/25 at 10:26 a.m. She indicated LPN 10 was clocked out during those 40 minutes to take a nap but never left the campus. During this recertification and complaint survey, 6/10/25 to 6/17/25, three deficiencies were cited at an isolated or pattern level - F677 E, F684 D, and F550 D. 1. Cross reference F677 - Activities of Daily Living (ADL). Four of seven residents reviewed were not provided ADL care related to shaving and receiving care timely. 2. Cross reference F684 - Quality of Care. Three residents did not have skin care treatments completed as ordered and a medication allergy/sensitivity addressed timely. 3. Cross reference F550 - Dignity. Two residents were not treated with respect and dignity in regards to incontinence care. This citation relates to Complaints IN00461161, IN00461220, IN00460769, IN00461614, and IN00461308. 3.1-17(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow hospital discharge orders to discontinue medication upon readmission for 1 of 4 residents reviewed for quality of care. (Resident J) The clinical record for Resident J was reviewed on 6/12/25 at 10:04 a.m. The diagnoses included, but were not limited to, anemia and atrial fibrillation. During an interview with Resident J on 6/11/25 at 12:51 p.m., Resident J indicated she had just returned from the hospital yesterday after having blood loss and thought she had been told they were going to hold all of her blood thinners for a while. The admission Minimum Data Set (MDS) assessment, dated 5/9/25, indicated Resident J was cognitively intact. The hospital Discharge summary, dated [DATE], was provided by MDS Support on 6/12/25 at 12:57 p.m. It indicated Resident J had a discharge diagnosis of acute blood loss anemia and discontinue aspirin 81 mg po (by mouth) daily. The Medication Administration Record (MAR) for June 2025, indicated aspirin 81 mg po was given 6/11/25. A plan of care for Resident J, dated 5/13/25, indicated the resident was at risk for excessive bleeding and bruising related to medications. The intervention included, but was not limited to, administering medication as per the current physician's orders. A plan of care for Resident J, dated 5/26/25, indicated the resident had potential for experiencing symptoms of fatigue, weakness, and confusion related to anemia. The intervention included, but was not limited to, administering medications as ordered. During an interview with the Director of Health Services (DHS) on 6/12/25 at 10:52 a.m., she indicated she did not know why Resident J received her aspirin. The DHS indicated when the resident went to the hospital her orders were not discontinued in the computer system, so when she returned all of her previous orders showed up on her MAR. The DHS indicated that when a resident returns from the hospital, they have an admission checklist to go over for any new orders or discontinued orders and two nurses are to check them. The Guidelines for admission Nursing Assessment and Data Collection policy was provided by MDS support on 6/12/25 at 12:57 p.m. It indicated, .3. The observation and data collection shall include identification of risk factors through assessment, observation, and review of pertinent documentation that may contribute to additional complications, medical decline or safety concerns . 3.1-25(b)