STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 potentially hazardous materials were kept secure behind locked doors to prevent residents' potential access to the materials for 3 of 5 days of the survey. Findings include:1. On 12/1/25 at 8:20 a.m., the following was observed in a room near the front entrance of the facility: A room close to the front entrance, labeled Conference Room on a sign to the right of the door was ajar approximately 4-6 inches wide and unlocked. Inside the conference room on the table was a mostly white 16 ounce red-capped bottle sitting on the table; the label on the bottle indicated it was an Rx [Prescription] Destroyer drug disposal all-purpose formula. The bottle appeared mostly full with sticky residue noted around the cap and top of bottle. On the far side of the room from the door, on the floor near a plastic waste receptacle in a clear plastic bag, were eight more bottles of the same appearance and labeling, all full. The labels on the bottle also indicated Keep out of reach. and Always store in a secure location. No staff were noted in the immediate area.2. On 12/2/25 at 9:43 a.m., a door on the 600-hallway labeled Electrical Room with a sign to the left of the door labeled Mechanical Room across from a room labeled Social Services and closest to rooms [ROOM NUMBERS] was observed to be unlocked. No staff had a direct line of sight to the unlocked room at the time of the observation and multiple residents were noted to be moving through or near the area. On 12/3/25 at 9:50 a.m., a door on the 600-hallway labeled Electrical Room with a sign to the left of the door labeled Mechanical Room across from a room labeled Social Services and closest to rooms [ROOM NUMBERS] was observed to be unlocked. No staff had a direct line of sight to the unlocked room at the time of the observation and multiple residents were noted to be moving through or near the area.On 12/3/25 at 10:10 a.m., a door on the 600-hallway labeled Electrical Room with a sign to the left of the door labeled Mechanical Room across from a room labeled Social Services and closest to rooms [ROOM NUMBERS] was observed to be unlocked. No staff had a direct line of sight to the unlocked room at the time of the observation and multiple residents were noted to be moving through or near the area. Inside, the following was observed: In the first room area on the left side of the wall were two power supply panels, the top one labeled Power supply for double door leading to [NAME] Lane and the bottom one labeled Power supply for new smoker's door. A small closet-like room with no doors in frames opened into a second back room. In the small closet like room area were numerous exposed electric, internet, and other cables and cords. Above the first doorway entrance to the closet room above the door frame were several bare circular saw blades suspended on the wall. In the back-room area, there were more power control panels. A very large, paneled area on the left wall was labeled with Danger hazardous voltage, will cause severe injury and death' with four smaller levers in a square above a fifth labeled lever. The very back wall of the second larger room area also had an unlocked panel of electrical fuses. During an interview on 12/3/25 at 10:25 a.m., the Director of Plant Operations (DOPO) and Maintenance Tech 1 indicated that the Electrical Room/Mechanical Room should be kept locked at all times. During an interview on 12/4/25 at 1:22 p.m., the Administrator indicated that the drug disposal containers found in the unlocked Conference Room should have been kept in a secured area, and that the Electrical (continued on next page)

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

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

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(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 - Some	Room/Mechanical Room should be kept locked at all times. On 12/1/25 at 12:50 p.m., the Divisional Director of Clinical Operations (DDCO) provided a copy of an undated policy titled Hazardous Materials Storage and indicated it was the policy currently in use by the facility. A review of the policy indicated, hazardous materials, including but not limited to any chemicals or sharp objects kept out of reach of those who are unfamiliar with the materials or who might inadvertently become exposed or injured. On 12/4/25 at 1:45 p.m., the [NAME] President of Risk Management (VPORM) indicated that the facility did not have a specific policy that spoke directly to electrical type hazards, such as the exposed wires, power panels, and fuses, but that rooms containing such hazards should be kept locked. 3.1-45(a)(1)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure residents with enteral feedings physician's orders were followed and equipment was dated for 1 of 1 residents reviewed for enteral feedings. (Resident 6)Finding includes:On 12/1/25 at 10:36 a.m., Resident 6 was observed resting in bed. Next to the bed was a pole with an electronic pump device (kangaroo). Hanging from the pole was a 1000 ml (milliliter) plastic bottle of Osmolite (a type of nutritional supplement) 1.5 cal and was connected to the kangaroo pump but was not connected to Resident 6 at that time. The bottle was observed to be three fourths full of a brown colored liquid. The bottle and tubing was undated. During an interview at that time Resident 6 indicated that he did receive Osmolite 1.5 by G-tube.On 12/1/25 at 11:45 a.m., Resident 6's clinical record was reviewed. The diagnoses included, but were not limited to, intestinal bypass and anastomosis status (the surgical creation of a connection between two tubular structures, like blood vessels or loops of intestine), and noninfective gastroenteritis and colitis (inflammation of the digestive tract).A physician's order, initiated on 9/4/25, indicated Resident 6 had an order for Osmolite 1.2 cal to administer 355 ml every 6 hours by mouth as needed for supplement. During an interview on 12/2/25 at 10:26 a.m., Resident 6 indicated that he did not get any Osmolite by mouth because he had a feeding tube in place. Resident 6 indicated he did receive Osmolite 1.5 via the feeding tube a few days ago.During an interview on 12/3/25 at 8:12 a.m., the Divisional Director for Clinical Operations (DDCO) indicated that the weekend supervisor was on duty on 12/1/25 and Resident 6 had refused Osmolite 1.2 cal 355 ml by mouth, the weekend supervisor called and received an order to administer Osmolite 1.5 cal via G-tube but forgot to document the order or to put it in the electronic health record.On 12/2/25 at 1:20 p.m., the RN Consultant provided an undated copy of Policies and Standard Procedure, Subject: Physician Orders, and indicated it was the current policy in use by the facility. The policy indicated a provider may give a medical order over the telephone, and the nurse would transcribe the order into the electronic health record. On 12/3/25 at 2:42 p.m., the [NAME] President of Risk Management RN provided an undated copy of Policies and Standard Procedures, Subject, Enteral General Nutritional (tube feeding) Guidelines, and indicated it was the current policy in use by the facility. A review of the policy indicated to change syringes, tubing or bottles used for feeding daily, label and date items, verify the practitioner's order, including the prescribed route and prescribed formula, and label the administration set with the date and time of administration including the licensed nurse initials.3.1-47(a)(2)