STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allisonville Meadows	10312 Allisonville Rd Fishers, IN 46038

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 51984 Based on interview and record review, the facility failed to follow a resident's choices for 1 of 1 resident reviewed for choices. (Resident 30) Findings include: The clinical record for Resident 30 was reviewed on 3/21/25 at 1:07 p.m. The diagnoses included, but were not limited to, muscle weakness, and obesity. A Minimum Data Set (MDS) assessment indicated Resident 30 was cognitively intact. An interview was conducted with Resident 30 on 3/19/25 at 11:33 a.m. She indicated there were days she did not get put to bed until 9:30 p.m.-10:00 p.m. Resident 30's preference was to be put to bed between 7:15 p.m. to 7:30 p.m. An interview with Unit Manager (UM) 9, on 3/21/25 at 1:57 p.m., indicated she did not see preferences in Resident 30's care plan about choices for bedtime. She indicated there should be a care plan in place for Resident 30's choice of bedtime. A document entitled Preferences for Customary Routine and Activities, completed on 4/22/24, noted Resident 30 indicated it was very important for her to choose her own bedtime and it be just after dinner. During an interview with Certified Nurse Aide (CNA) 8 on 3/21/25 at 2:47 p.m., they indicated Resident 30 does want to be put to bed after evening meal between 7:15 p.m.-7:30 p.m., but it does not happen at times due to other situations happening. 3.1-3(u)(1)

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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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 51750 Based on interview and record review, the facility failed to ensure facility staff (Qualified Medication Aide 6 and Certified Nurse Aide 2) notified the nurse on duty of a resident experiencing a fall (Resident D) and timely notify the resident's physician of a fall with injury, resulting in Resident D experiencing moderately strong pain and a delay in the treatment of a left humerus fracture, for 1 of 2 residents reviewed for falls, and to timely inform a physician of a significant change in a lab value for 1 of 2 residents reviewed for hospitalization (Resident B). This deficient practice was corrected on 2/19/25, prior to the start of the survey, and was therefore past noncompliance. The facility implemented a systemic plan that included the following actions: in-service education to nursing staff related to the policy and procedure regarding physician notification pertaining to fall incidents and laboratory results, reviewed all fall incidents for January 2025 to February 7, 2025 and laboratory results for January 2025 to February 18, 2025 to identity potential residents, and conducted a review of residents with physician orders for laboratory work and residents with fall incidents to ensure the medical provider had been notified and documented with ongoing review presented to the Quality Assessment and Assurance (QAA) Committee for review. Findings include: 1. The clinical record for Resident D was reviewed on 3/19/25 at 11:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set (MDS) assessment, dated 2/21/25, indicated Resident D was moderately cognitively impaired. A nursing progress note, dated 1/22/25 at 12:19 p.m., written by Registered Nurse (RN) 1, indicated at approximately 10:00 a.m., Resident D stated to the nurse he was having pain in his left shoulder. The nurse assessed the resident's skin and observed bruising and swelling on his left shoulder and a skin tear to his left elbow that was approximately two centimeters (cm) in length and 0.5 cm in width. The nurse cleansed the wound with a wound cleanser and a non-adhesive dressing was applied. The nurse notified the physician about the resident's left shoulder pain and received a new order for an x-ray of the left shoulder and clavicle to be performed as soon as possible. On 1/22/25 at 7:45 p.m., an Interdisciplinary Team (IDT) fall note indicated the date and time Resident D sustained a fall was on 1/21/25 at 8:30 p.m. The fall had been self-reported by the resident, he was unable to give details of the fall but stated he fell the evening before and complained of left arm and shoulder pain. Injuries sustained included a left humerus fracture. The resident was transferred to the emergency room (ER) for evaluation and treatment. A change of condition including new pain was noted. On 1/22/25 at 11:40 a.m., RN 1 documented a pain rating of 6 out of 10 for Resident D. The determined root cause of the fall was poor safety awareness, an intervention put into place was a fall mat placed next to the resident's bed. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Hospital records, dated 1/22/25, indicated Resident D was admitted to the ER for an evaluation related to a fall from which he was having significant left shoulder pain. The resident also had a laceration to the left elbow and head, and loss of consciousness. The ER physician indicated the resident had a loss of consciousness in the bath the morning of 1/22/25, due to pain. Musculoskeletal assessment indicated tenderness to palpation about the left shoulder and left proximal humerus with extreme limited range of motion. An x-ray of the left shoulder performed, on 1/22/25, at the ER indicated a left proximal humerus fracture (a break in the upper part of the arm bone near the shoulder). The hospital physical therapist indicated Resident D would likely require subacute rehab again. A referral to orthopedic surgery was ordered and the resident was discharged back to the facility in stable condition. A facility reported incident was submitted to the Indiana Department of Health, on 1/23/25, by the Executive Director (ED) for a resident with an unwitnessed fall and sustained injury. An investigation file was provided by the ED on 3/20/25 at 1:30 p.m. The investigation file included a copy of the incident report, fall event, IDT fall note, witness statements from staff, and an interview with the resident. In an undated statement the ED interviewed Resident D regarding the fall he self-reported on 1/22/25. Resident D indicated he got out of his bed because he heard people talking in the hallway the night of 1/21/25. Two female staff members picked him up and put him back in bed. In a statement, dated 1/22/25, Certified Nurse Aide (CNA) 2 indicated she had been working the evening, of 1/21/25, and was walking down the hall to go on break when she overheard someone say, Hey can you help me? One of the other staff, Qualified Medication Aide (QMA) 6, came out of a room at the end of the hallway and asked to help her with a resident who had fallen. Resident D was sitting on the floor with his back against the wall near the bathroom and his legs out in front of him. The resident did not indicate he was in pain to the CNA, and she thought the nurse had already been in to see him. In a statement, dated 1/27/25, RN 20 indicated she was not notified of any falls on her shift on the date of 1/21/25. Resident D had not complained of any pain or reported any falls to her. In a statement, dated 1/23/25, Licensed Practical Nurse (LPN) 5 indicated he was not notified of any falls for Resident D, and was unaware of any falls that occurred during his evening shift. LPN 5 indicated he had been in Resident D's room multiple times that night, and the resident did not mention to him he had fallen or was in pain. In a statement, dated 1/22/25, CNA 3 indicated Resident D complained of left-sided weakness and pain while providing care. The Resident indicated he fell on night shift sometime, and he would continue to shower. As CNA 3 was transferring the resident into the shower chair, the resident had a fainting spell for about 20 seconds. Once she had gotten help he started becoming alert again and did not know what had happened. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/19/25 at 11:45 a.m., Resident D's Representative indicated the in January, the resident had fallen out of bed and broken his left humerus. She did not find out about the fall until she arrived at the facility, on 1/22/25, to accompany the resident to a doctor's appointment. When she arrived, the resident was yelling out in pain complaining his arm hurt, had a cut on his head, and his left shoulder appeared deformed. Resident D's Representative went to the nurse's station to ask what had happened, and staff could not provide an answer for her. In an interview with RN 1, on 3/21/25 at 10:49 a.m., she indicated, on 1/22/25, she had first seen Resident D when administering his morning medications between 8:00 a.m. and 9:00 a.m. The resident mentioned having pain in his shoulder, but did not say anything about the fall. She did not notice any physical injury to his head but noticed a bruise on his arm. In an interview with CNA 3, on 3/21/25 at 11:16 a.m., she indicated on the morning of 1/22/25, sometime after breakfast, Resident D had told her he had fallen the night before. He indicated two aides had helped put him back in bed. CNA 3 notified RN 1 that Resident D had self-reported a fall. CNA 3 indicated to RN 1 the resident had a shower due and that he wished to go through with it. RN 1 indicated to CNA 3 to go ahead and give the resident a shower. CNA 3 did not believe RN 1 went and looked at the resident at that time. CNA 3 attempted to transfer the resident so he could shower, the resident began having seizure-like activity. His eyes rolled to the back of his head, and he urinated on himself. CNA 3 found another aide for assistance so she could report the incident to the nurse. CNA 3 indicated she did notice a knot on the resident's head, and Resident D's Representative had arrived at the facility once they had got Resident D back into bed. During an interview on 3/24/25 at 11:47 a.m., Nurse Practitioner (NP) 13 indicated if there was an injury associated with a fall the medical provider wanted to be called right away. On 3/21/25 at 10:01 a.m., the ED provided the Fall Management Policy, dated 7/2001, last revised 8/2022, it indicated It is the policy of [name of corporation] to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls .Post fall 1. Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided .2. If the resident experienced an injury from the fall, contact the DNS/ED per facility policy. 3. The physician will be contacted immediately, if there are injuries, and orders will be obtained . 40287 2. The clinical record for Resident B was reviewed on 3/20/25 at 9:43 a.m. The diagnoses included, but were not limited to, urinary tract infection, diarrhea, and dementia. A care plan, initiated 1/24/25, indicated Resident B required assistance with toileting due to weakness, decreased mobility, incontinence, and diarrhea. The goal was for her to be free of adverse effects of incontinence. The interventions included, but were not limited to, assist with elimination, observe for signs of a urinary tract infection, such as decreased output, concentrated urine, change in mental status, and fever, and document abnormal findings and notify the physician. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	A Physician's Progress Note, dated 1/29/25, indicated Resident B was seen related to a low-grade fever and mild tachycardia (high heart rate). Her temperature was 99.7 degrees Fahrenheit, and her pulse was between 100 and 110 beats per minute. She had complained about some loose stools. The plan included encouraging oral hydration and obtain a basic metabolic panel (BMP). The BMP results, dated 1/30/25, included a creatinine level (measurement of kidney function) of 0.6 which was within normal limits and Blood Urea Nitrogen (BUN) of 13 which was within normal limits. A physician's order, dated 2/5/25, indicated obtaining a BMP lab STAT (right away). The BMP results, dated 2/5/25, included a creatinine level of 3.3; which was above normal limits and a BUN of 35; which was above normal limits. The BMP results were signed by the Nurse Practitioner as being seen/reviewed on 2/7/25. A physician's order, dated 2/7/25, indicated Resident B was to receive one liter of normal saline (an intravenous fluid) at 50 milliliters (ml) an hour through a midline (type of intravenous access). An Acute Visit Progress Note, dated 2/8/25, indicated Resident B was being seen due to receiving one liter of normal saline and was starting to perk up. The plan included treating her acute kidney injury with a second bag of one liter of normal saline and obtaining a BMP on 2/10/25. During an interview on 3/20/25 at 11:08 a.m., Family Member (FM) 30 indicated she had visited Resident B, on 2/6/25, and had found Resident B looking dehydrated, with sunken eyes, lethargic, and very dry. FM 30 had a meeting with facility staff, on 2/7/25, and had insisted that intravenous fluids be started. She had not been made aware that a BMP had been drawn, on 2/5/25, and that Resident B's creatinine and BUN levels had risen. She was upset the lab results had not been acted on sooner. During an interview on 3/24/25 at 2:11 p.m., the Nurse Consultant (NC) indicated the change in Resident B's, 2/5/25, BMP results should have been called to the physician when they were received. During an interview on 3/25/25 at 1:23 p.m., Nurse Practitioner (NP) 13 indicated she had seen Resident B's, 2/5/25, BMP results on 2/7/25. She would have started intravenous fluids earlier if she had been made aware of the results prior to 2/7/25. A Change of Condition Policy was provided by the Director of Nursing (DON) on 3/25/25 at 2:09 p.m. It indicated It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place . Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician . All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly . This citation relates to Complaint IN00455520. 3.1-5(a)(1) 3.1-5(a)(2) (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	3.1-5(a)(3)

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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. 40287 Based on observation, interview, and record review, the facility failed to ensure a resident's hair was shampooed at least weekly, properly positioned a resident to reduce the risk of skin shearing, and to provide timely incontinence care and not utilizing double briefing for 4 of 11 residents reviewed for Activities of Daily Living (ADL) care. (Resident D, Resident G, Resident L and Resident 20) Findings include: 1. The clinical record for Resident L was reviewed on 3/18/25 at 3:17 p.m. The diagnoses included, but were not limited to, history of traumatic brain injury and diabetes. A care plan, initiated 2/7/25, indicated she required assistance with ADL care including bed mobility, transfers, eating, and toileting related to weakness from a recent hospital stay. The goal was for her to improve her current functional status. The approaches included, but were not limited to, a mechanical lift for transfers with assistance of two staff, assist with bed mobility as needed, and assist with toileting and incontinent care as needed. A Quarterly Minimum Data Set (MDS) assessment, completed 2/21/25, indicated she was cognitively intact. She required total assistance with transfers, bed mobility, personal hygiene, and showers. On 3/18/25 at 3:17 p.m., Resident L indicated she had been receiving bed baths. She preferred two people assisted with bed mobility since the grab bars on her bed were smaller than she would like. At times, she felt incontinent care was lacking. On 3/21/25 at 8:55 a.m., Resident L was observed in her bed. Her hair had flakes of dry skin and there was a crust of loose dry skin on her scalp. She indicated her hair had not been washed in two weeks. She would like to have it washed more often. During an observation on 3/21/25 at 2:45 p.m., Resident L was observed in her bed after being transferred with the mechanical lift. Certified Nurse Aide (CNA) 14 and CNA 15 were in the room preparing to provide care. Resident L was lying at the top of the bed on four disposable incontinent pads. The base of her head was resting on the headboard, and her head was flexed forward with her chin down toward her chest. CNA 15 indicated Resident L had been positioned high in the bed so when the head of the bed was elevated Resident L would slide down to the right position in the bed. CNA 14 began raising the head of the bed and when the head of the was elevated to approximately 45 to 60 degrees, Resident L quickly slid down the bed to a sitting position. CNA 15 indicated Resident L had slid down to the proper position in bed. On 3/21/25 at 3:22 p.m., the Director of Nursing (DON) provided the February and March 2025 shower reports for Resident L, which indicated she received a complete bed bath on the following days: 2/11/25, 2/14/25, 2/18/25, 2/21/25, 2/28/25, 3/4/25, 3/7/25, 3/11/25, and 3/18/25. The shower reports did not indicate her hair had been washed with any of the complete bed baths received. (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 on 3/24/25 at 2:30 p.m., the Nurse Consultant (NC) indicated residents should not intentionally slide down the bed to the proper position due to the increased risk of shearing to the skin. 51750 2. The clinical record for Resident D was reviewed on 3/19/25 at 11:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly MDS assessment, dated 2/21/25, indicated Resident D was moderately cognitively impaired. A care plan, dated 11/29/24, last revised on 2/24/25, indicated Resident requires assistance with toileting due to: Muscle weakness, impaired mobility due to surgical repair of right femur fracture, incontinence, age, impaired cognition, Alzheimer's dementia, benign prostatic hyperplasia, and pain. The goal was for Resident D to remain free of adverse effects of incontinence. Interventions included, but were not limited to, to check for incontinence every two hours and as needed. On 3/18/25 at 10:46 a.m., Resident D was observed laying in bed while watching television with a fall mat parallel to his bed. During an interview on 3/19/25 at 11:45 a.m., Resident D's Family Member indicated there were times when he was laying in bed for an hour in urine before he got changed. During an interview on 3/24/25 at 9:53 a.m., Resident D's Family Member indicated she arrived at the facility, on 3/23/25, to visit the resident. She noticed his brief needed changed. She put on his call light and a nurse came to the room and turned the call light off and indicated an aide would come in to change the resident's brief. An aide never came. So, Resident D's Family Member found a brief and wipes and changed him herself. After having put his call light on and nobody had arrived later that day, Resident D's Family Member went out to the nurse's station and three CNAs were just standing there congregating. She indicated staff were not checking his brief every two hours. During an interview on 3/24/25 at 2:50 p.m., the facility Nurse Consultant indicated staff should be performing incontinent checks on residents every two hours. The urinary output for the resident was charted once on 3/17/25 at 10:28 a.m., once on 3/18/25 at 2:21 p.m., and once on 3/19/25 at 2:33 p.m. On 3/21/25 at 3:37 p.m., the DON provided a Bowel and Bladder Program Policy, dated 3/2010, last revised 5/2019, it indicated If a resident is totally incontinent and unable to be placed on a toilet or bedpan, resident should be checked and changed every two hours. 51984 3. The clinical record for Resident 20 was reviewed on 3/20/25 at 3:14 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly MDS assessment, dated 1/22/25, indicated Resident 20 was moderately cognitively impaired. A current care plan, last reviewed/revised on 1/23/25, indicated Resident 20 required staff assistance with ADLs with an intervention of assistance and/or monitoring AM/PM care, nutrition, hydration, and elimination. An interview was conducted with Resident 20 on 3/19/25 at 2:30 p.m. Resident 20 indicated she did not get changed frequently. She got changed four times a day and had to wait up to three hours to get changed at times. Resident 20 indicated she was always double briefed and was under the impression that double briefing was a standard of care. An observation with Resident 20 in her room started, on 3/20/25 at 9:30 a.m., while Resident 20 finished breakfast. At 9:44 a.m., Resident 20 pushed her call light button to alert staff that she needed assistance. At 9:48 a.m., Licensed Practical Nurse (LPN) 10 came into Resident 20's room to see what she needed. Resident 20 indicated she needed to be changed. LPN 10 told her she would get someone to help her. At 10:01 a.m., a CNA went into Resident 20's room and removed her breakfast tray. No communication between the CNA and Resident 20 occurred. At 10:02 a.m., another CNA went into Resident 20's room and checked on her and her roommate. No communication between the CNA and the residents occurred. At 10:05 a.m., the Executive Director (ED) went into Resident 20's room. Resident 20 indicated to the ED she needed to be changed. The ED indicated he would look for someone to assist her. At 10:07 a.m., the ED exited the room to look for a staff member to assist Resident 20 with getting cleaned up. At 10:12 a.m., a CNA went into Resident 20's room and looked around and walked back out. No communication between the CNA and Resident 20 occurred. At 10:14 a.m., Resident 20 pushed her call light again to request assistance in being changed. At 10:15 a.m., Unit Manager (UM) 9 and LPN 10 went into Resident 20's room to check on the resident. Resident 20 requested to be changed. UM 9 and LPN 10 gathered supplies, performed hand hygiene, and donned gloves. When UM 9 removed the outer blue brief, another brief was seen in between Resident 20's legs. The brief in-between her legs was white. UM 9 indicated two briefs were placed on residents who requested double briefs, and a care plan was in place for this preference. UM 9 indicated Resident 20 was on hospice and hospice may have care planned two briefs to be placed on the resident. 52119 4. The clinical record for Resident G was reviewed on 3/21/25 at 10:00 a.m. The diagnoses included, but were not limited to, dementia and bowel and bladder incontinence. A care plan, created on 1/2/25, indicated Resident requires assistance with toileting due to: Weakness, Age, Dementia, Incontinence . The care plan approaches included, Assist with incontinent care as needed .Check every 2 hours for incontinence . A Quarterly MDS assessment, dated 2/17/25, indicated the resident was dependent on staff for toileting hygiene. On 3/20/25 at 10:24 a.m., Resident G was observed sitting in her wheelchair in the activities room next to Family Member (FM) 31. (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 on 3/20/25 at 10:27 a.m., FM 31 indicated the resident was incontinent of bowel and bladder but could sometimes tell when she needed to have a bowel movement. The staff did not check her brief for wetness every two hours, only when she told them she needed to have a bowel movement. He had arrived that morning, approximately 20-30 minutes prior, and her brief had not been checked or changed since he arrived. During a continuous observation on 3/20/25 from 10:24 a.m. to 11:14 a.m., no staff were observed to check Resident G's brief or assisted her with toileting. During an interview on 3/20/25 at 1:05 p.m., FM 31 indicated he had been seated next to Resident G the entire time, and she had not been changed or checked for incontinence. On 3/24/25 at 1:48 p.m., the Nurse Consultant (NC) provided the Vitals Report which contained documentation of Resident G's episodes of incontinence between 2/1/25 and 3/24/25. On 3/20/25, the staff documented the resident was incontinent that morning, at 9:37 a.m., with a large amount of urine. The next documented incontinent episode was 1:50 p.m., with a large amount of urine. During an interview on 3/24/25 at 12:10 p.m., the ED indicated there was not an ADL Care Policy. The facility followed the standards of care. An interview with the NC, on 3/24/25 at 2:50 p.m., indicated staff should be performing incontinence checks every two hours. 3.1-38(a)(2)(C) 3.1-38(a)(3)(A) 3.1-38(a)(3)(B)

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	155786	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allisonville Meadows	10312 Allisonville Rd Fishers, IN 46038

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51750 Based on observation, interview, and record review, the facility failed to ensure a resident (Resident D) who had fallen the night of 1/21/25, was assessed by a licensed nurse and the licensed nurse was made aware of the fall incident by the facility staff (Qualified Medication Aide 6 and Certified Nurse Aide 2), who had assisted the resident back to bed, and ensure the resident had continued monitoring afterwards. The resident experienced moderately strong pain, had skin impairments, and was later hospitalized and identified with a fractured humerus at the hospital for 1 of 3 residents reviewed for falls. This deficient practice was corrected on 2/12/25, prior to the start of the survey, and was therefore past noncompliance. The facility implemented a systemic plan that included the following actions: in-service education to nursing staff related to the policy and procedure regarding fall incidents, reviewed all fall incidents for January until February 7, 2025 to identity potential residents, and conducted an review of residents with fall incidents to ensure assessments, resident profiles, fall interventions, and follow-up with the medical provider have been completed and documented with ongoing review presented to the Quality Assessment and Assurance (QAA) Committee for review. Findings include: The clinical record for Resident D was reviewed on 3/19/25 at 11:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. The Admission Minimum Data Set (MDS) assessment, dated 12/03/24, indicated Resident D was severely cognitively impaired. The resident had impairment in the range of motion of his lower extremity, on one side of his body. The resident's functional status of toilet transfers and sit-to-stand function was dependent assistance. The resident required partial to moderate assistance with mobility in rolling left and right, and required substantial to maximal assistance when transferring from a sit-to-lying, and lying-to-sit position. Resident D utilized a walker and a wheelchair to assist with mobility. A Quarterly MDS assessment, dated 2/21/25, indicated Resident D was moderately cognitively impaired. The resident had impairment in the range of motion of his upper and lower extremity on one side of his body. The resident's functional status of toilet transfers and sit-to-stand function was substantial to maximal assistance. The resident required substantial to maximal assistance with mobility in rolling left and right, and required substantial to maximal assistance when transferring from a sit-to-lying, and lying-to-sit position. Resident D utilized a wheelchair to assist with mobility. A fall care plan, initiated on 11/29/24, indicated the resident was at risk for falls due to a history of falls at home resulting in a right femur fracture, muscle weakness, Alzheimer's dementia, syncope and collapse. The goal was for the resident's fall risk factors to be reduced in an attempt to avoid significant fall related injury. The interventions included, but were not limited to, the use of a low air loss bed with bolsters, a fall mat on the floor next to bed (left side), anti-rollback devices to wheelchair, anti-tipper devices to wheelchair, touchpad call light, call light to be within reach, environmental changes, non-skid footwear, personal items in reach, therapy screen, and to be up and moving freely in wheelchair with assistance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A care plan, initiated on 11/29/24, indicated the resident was a new admission to the facility and required implementation of services that included, but were not limited to, assistance with activities of daily living related to weakness, fall with fracture, recent surgery, poor cognition, impaired mobility, and unsteady gait. The goal for the resident was to achieve the highest desired practicable level of physical/emotional/psychosocial well-being and functional status. Interventions included, but were not limited to, assistance with transfers, ambulation, bed mobility, toileting and/or incontinent care, eating/drinking, and bathing/hygiene, including oral/dental care, and provide fall prevention interventions. An Activities of Daily Living (ADLs) care plan, initiated on 11/29/24, indicated the resident required assistance with ADLs that included, but were not limited to, bed mobility, transfers, eating and toileting related to muscle weakness, impaired mobility, age, and a recent fall at home with right femur fracture. The goal was for the resident to improve their current functional status. Interventions included, but were not limited to, assist with ambulation as needed, assist with bed mobility as needed, and assist with transfers as needed. A nursing progress note, dated 1/22/25 at 12:27 a.m., written by Licensed Practical Nurse (LPN) 5, indicated a Certified Nurse Aide (CNA) was in Resident D's room to get clothes and a brief for the resident's roommate. Resident D was in bed and complained of being woken up and the lights being turned on. The resident did not complain of signs or symptoms of pain, and made no request for pain medication. A nursing progress note, dated 1/22/25 at 12:19 p.m., written by Registered Nurse (RN) 1, indicated at approximately 10:00 a.m., Resident D stated to the nurse he was having pain in his left shoulder. The nurse assessed the resident's skin and observed bruising and swelling on his left shoulder and a skin tear to his left elbow that was approximately two centimeters (cm) in length and 0.5 cm in width. The nurse cleansed the wound with a wound cleanser and a non-adhesive dressing was applied. The nurse notified the physician about the resident's left shoulder pain and received a new order for an x-ray of the left shoulder and clavicle to be performed as soon as possible. On 1/22/25 at 7:45 p.m., an Interdisciplinary Team (IDT) fall note indicated the date and time Resident D sustained a fall was on 1/21/25 at 8:30 p.m. The fall had been self-reported by the resident, he was unable to give details of the fall but stated he fell the evening before and complained of left arm and shoulder pain. Injuries sustained included a left humerus fracture. The resident was transferred to the emergency room (ER) for evaluation and treatment. A change of condition including new pain was noted. On 1/22/25 at 11:40 a.m., RN 1 documented a pain rating of 6 out of 10 for Resident D. The determined root cause of the fall was poor safety awareness, an intervention put into place was a fall mat placed next to the resident's bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Hospital records, dated 1/22/25, indicated Resident D was admitted to the ER for an evaluation related to a fall from which he was having significant left shoulder pain. The resident also had a laceration to the left elbow and head, and loss of consciousness. The ER physician indicated the resident had a loss of consciousness in the bath the morning of 1/22/25, due to the pain. Musculoskeletal assessment indicated tenderness to palpation about the left shoulder and left proximal humerus with extreme limited range of motion. An x-ray of the left shoulder performed, on 1/22/25, at the ER indicated a left proximal humerus fracture (a break in the upper part of the arm bone near the shoulder). The hospital physical therapist indicated Resident D would likely require subacute rehab again. A referral to orthopedic surgery was ordered and the resident was discharged back to the facility in stable condition. A facility reported incident was submitted to the Indiana Department of Health, on 1/23/25, by the Executive Director (ED) for a resident with an unwitnessed fall and sustained injury. On 1/23/25, Nurse Practitioner (NP) 13 ordered oxycodone 2.5 milligrams (mg) for mild pain and oxycodone 5 mg for moderate pain. On 1/23/25 at 5:15 p.m., RN 24 indicated in a nursing progress note that Resident D required extensive assistance of two nurses to provide incontinence care. Resident D's Representative requested nurses perform the task due to the resident screaming at the aides who previously attempted to provide care. RN 24 noted Even with extra care with turning and repositioning, resident complained of severe pain. Oxycodone 5 mg was administered by RN 24 immediately after care. In a nursing progress note, dated 1/24/25, the facility Nurse Consultant (NC), indicated she attempted to assess bruising and skin tear to left upper extremity. Resident with sling in place and unwilling to remove for assessment at this time. On 1/26/25 at 12:18 p.m., LPN 23 indicated in a progress note that Resident D had declined to shower because of shoulder pain and was given a pain pill for relief. On 1/27/25 at 11:04 a.m., NP 22 indicated in a progress note that Resident D .is being seen by requested primary care for ongoing pain to left upper arm, which is uncontrolled, following a fall .complains of pain frequently . will discontinue oxycodone today and start Norco 5-325 mg Q4 [every 4] hours . An investigation file was provided by the ED on 3/20/25 at 1:30 p.m. The investigation file included a copy of the incident report, fall event, IDT fall note, witness statements from staff, and an interview with the resident. In an undated statement the ED interviewed Resident D regarding the fall he self-reported on 1/22/25. Resident D indicated he got out of his bed because he heard people talking in the hallway the night of 1/21/25. Two female staff members picked him up and put him back in bed. In a statement, dated 1/23/25, LPN 5 indicated he was not notified of any falls for Resident D, and was unaware of any falls that occurred during his evening shift. LPN 5 indicated he had been in Resident D's room multiple times that night, and the resident did not mention to him he had fallen or was in pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a statement, dated 1/22/25, Qualified Medication Aide (QMA) 6 indicated she did not witness Resident D fall or discover him on the floor. She had asked another employee (CNA 2) to assist her in moving the resident's legs up off the floor as they were off his bed, but the resident was still in bed. In a statement, dated 1/22/25, CNA 2 indicated she had been working the evening of 1/21/25 and was walking down the hall to go on break when she overheard someone say, Hey can you help me? One of the other staff (QMA 6) came out of a room at the end of the hallway and asked to help her with a resident who had fallen. Resident D was sitting on the floor with his back against the wall near the bathroom and his legs out in front of him. The resident did not indicate he was in pain to the CNA, and she thought the nurse had already been in to see him. In a statement, dated 1/22/25, CNA 3 indicated Resident D complained of left-sided weakness and pain while providing care. The resident indicated he fell on night shift sometime, and he would continue to shower. As CNA 3 was transferring the resident into the shower chair the resident had a fainting spell for about 20 seconds. Once she had gotten help, he started becoming alert again and did not know what had happened. In a statement, dated 1/22/25 at 11:55 a.m., LPN 21 indicated Resident D's representative was at the resident's bedside and had talked to Resident D, around 8:15 p.m., the evening prior. She indicated two female CNAs had picked the resident up off the floor and proceeded to ask what all follow-up had been done and why was nothing documented related to a fall. In a statement, dated 1/23/25, QMA 19 indicated to their knowledge, Resident D had not fallen and had not complained of any pain the times he was in his room or mention falling. In a statement, dated 1/27/25, RN 20 indicated she was not notified of any falls on her shift on the date of 1/21/25. Resident D had not complained of any pain or reported any falls to her. On 1/28/25, Resident D attended a consultation with an orthopedic specialist regarding the proximal fracture of his left humerus. On 1/31/25, nine days following Resident D's fall, a wound treatment order was placed instructing staff to cleanse the resident's left elbow with normal saline, pat dry, and cover with a dry dressing daily and as needed. On 2/04/25, Resident D underwent a total left shoulder replacement to surgically repair the proximal fracture of his left humerus. On 2/06/25, nursing staff began charting numerical pain scale ratings for Resident D. Prior to this date the last charted pain scale rating was documented, on 1/22/25, the morning following the resident's fall. A pain care plan, last revised on 2/25/25, indicated the resident was at risk for pain related to recent left humerus fracture, pressure ulcer to coccyx, and recent fall resulting in right femur fracture with surgical repair. The goal was for the resident to be free from adverse effects of pain. Interventions included, but were not limited to, the resident's left upper extremity to remain non weight bearing, assist with positioning for comfort, and administer medications as ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A care plan, initiated on 3/18/25, indicated the resident sustained a left humerus fracture due to a fall. The goal was for the resident's fracture to heal without complications. The intervention included was to administer pain medication as needed, and to notify the physician of any changes. On 3/18/25 at 10:46 a.m., Resident D was observed laying in bed while watching television with a fall mat parallel to his bed. During an interview on 3/19/25 at 11:45 a.m., Resident D's Representative indicated, in January, the resident had fallen out of bed and broken his left humerus. She did not find out about the fall until she arrived at the facility, on 1/22/25, to accompany the resident to a doctor's appointment. When she arrived, the resident was yelling out in pain complaining that his arm hurt, had a cut on his head, and his left shoulder appeared deformed. Resident D's Representative went to the nurse's station to ask what had happened, and staff could not provide an answer for her. She indicated the fracture was serious enough requiring surgery, setting back his rehab for his earlier sustained femur fracture. During a confidential interview on 3/19/25 at 12:05 p.m., they indicated, the morning of 1/22/25, Resident D had yelled out in pain saying Oh no when the aide attempted to get him up for his shower. The aide looked at the resident, laughed, and then left the room. The aide came back to try again, and Resident D indicated that his shoulder hurt. During an interview with the ED on 3/20/25 at 3:39 p.m., he indicated a fall had not been reported to nursing or management staff on the evening of 1/21/25. We (facility management) estimate the fall occurred at approximately 8:30 p.m. on 1/21/25. The following day, (1/22/25) around 11:00 a.m., Resident D was going to get a shower and demonstrated some pain. That was when the resident self-reported the fall to CNA 3. The shower was not provided since he reported pain. CNA 3 then reported the fall to RN 1, and she assessed him. Once RN 1 assessed him and the provider was notified, the resident was sent to the ER. Resident D's representative was then notified. QMA 6 found the resident on the ground and did not report the fall. When questioned about the incident, QMA 6 denied it happened. In an interview with the facility NC, on 3/20/25 at 3:50 p.m., she indicated Resident D's representative requested he be sent to the ER, and an x-ray was performed there. The resident had some decline since that fall occurred on 1/21/25. Prior to the fall, he could turn himself; pain inhibited him from turning after the humerus fracture. Resident D was incontinent and there would have been a check and change (check for incontinence) every two hours. On 1/21/25 at 9:19 p.m., urine output was charted, at 12:27 a.m. on 1/22/25, LPN 5 went into Resident D's room, and at 4:25 a.m. on 1/22/25, a bowel movement was charted. In an interview with RN 1, on 3/21/25 at 10:49 a.m., she indicated, on 1/22/25, she had first seen Resident D when administering his morning medications between 8:00 a.m. and 9:00 a.m. The resident mentioned having pain in his shoulder, but did not say anything about the fall. She did not notice any physical injury to his head but noticed a bruise on his arm. The resident told CNA 3 during shower time (the morning of 1/22/25) that he had fallen the evening before and that two aides helped him back to bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview with CNA 3, on 3/21/25 at 11:16 a.m., she indicated on the morning of 1/22/25, sometime after breakfast, Resident D had told her he had fallen the night before. He indicated two aides had helped put him back in bed. CNA 3 notified RN 1 that Resident D had self-reported a fall. CNA 3 indicated to RN 1 the resident had a shower due and that he wished to go through with it. RN 1 indicated to CNA 3 to go ahead and give the resident a shower. CNA 3 did not believe RN 1 went and looked at the resident at that time. CNA 3 attempted to transfer the resident so he could shower, the resident began having seizure-like activity, his eyes rolled to the back of his head, and he urinated on himself. CNA 3 found another aide for assistance so she could report the incident to the nurse. CNA 3 indicated she did notice a knot on the resident's head. Resident D's representative arrived at the facility once they had gotten Resident D back into bed after his episode. QMA 6 was unavailable for interview. On 3/21/25 at 10:01 a.m., the ED provided the Fall Management Policy, dated 7/2001, last revised 8/2022, it indicated It is the policy of [name of corporation] to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls .Post fall 1. Any resident experiencing a fall will be assessed immediately by the charge nurse for possible injuries and necessary treatment will be provided .2. If the resident experienced an injury from the fall, contact the DNS/ED per facility policy. 3. The physician will be contacted immediately, if there are injuries, and orders will be obtained . 3.1-37(a)

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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. 51750 Based on interview and record review, the facility failed to accurately document urinary output as ordered for a resident with an indwelling catheter for 1 of 1 resident reviewed for catheters. (Resident E) Findings include: The clinical record for Resident E was reviewed on 3/19/25 at 11:45 a.m. The diagnoses included, but were not limited to, obstructive and reflux uropathy (a blockage in the urinary tract). A Quarterly Minimum Data Set (MDS) assessment, dated 2/07/25, indicated Resident E was severely cognitively impaired. A care plan, dated 7/06/25, indicated Resident E required assistance with morning and evening care. The goal was for the resident to have Activities of Daily Living (ADLs) needs met. Interventions included, but were not limited to, documentation of bowel and urinary output every shift. A physician order, dated 3/14/25, indicated Foley catheter (indwelling tube that drains urine from the bladder) care, nurse to record output every shift. The recorded urine output was not documented for two out of three shifts on 2/15/25, and one out of three shifts on 2/16/25 and 2/17/25. Urinary output was not documented for any shift on 3/21/25 and 3/22/25. Urine output volume was documented as Large on 3/15/25 and 3/16/25, Medium on 3/20/25, and Large on 3/23/25. During an interview on 3/24/25 at 2:50 p.m., the facility Nurse Consultant (NC) indicated nursing should be documenting urinary output by milliliter (mL) for residents with indwelling urinary catheters. On 3/21/25 at 3:37 p.m., the Director of Nursing (DON) provided a Bowel and Bladder Program Policy, dated 3/2010, last revised 5/2019, it indicated .Urinary output from indwelling urinary catheters will be documented. It is recommended that catheter care be performed every shift or as indicated per physician orders . 3.1-41(a)(2)

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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** 34850 Based on interview and record review, the facility failed to ensure the availability of medications to administer as ordered for 1 of 1 resident reviewed for care planning and 1 of 5 residents reviewed for unnecessary medications. (Resident 47 and Resident 182) Findings include: 1. The clinical record for Resident 182 was reviewed on 3/18/25 at 3:30 p.m. The diagnoses included, but were not limited to, pneumonia. The resident was admitted to the facility on [DATE]. An interview was conducted with Resident 182's Representative on 3/18/25 at 3:22 p.m. He indicated Resident 182 was admitted to the facility at approximately 5:00 p.m., on 3/17/25. The resident was still waiting, as of that afternoon, for the facility's pharmacy to deliver the resident's medications. A physician order, dated 3/17/25, indicated Resident 182 was to receive 5 milligrams of finasteride (medication for benign prostatic hyperplasia) once a day. A physician order, dated 3/17/25, indicated the resident was to receive 500 milligrams of hydroxyurea (oral anticancer medication) once a day. A physician order, dated 3/17/25, indicated the resident was to receive 500 milligrams of levofloxacin (antibiotic) twice a day. A physician order, dated 3/17/25, indicated the resident was to receive 25 milligrams of metoprolol (blood pressure medication) once a day. A physician order, dated 3/17/25, indicated the resident was to receive 0.4 milligrams of tamsulosin (medication for benign prostatic hyperplasia) once a day. A physician order, dated 3/17/25, indicated the resident was to receive 200-62.5-25 micrograms of Trelegy inhaler once a day. The March 2025 Medication Administration Record (MAR) indicated the following days that the resident's medications were not available to administer: 5 milligrams of finasteride - 3/18/25 and 3/19/25 = documented as awaiting for pharmacy, 500 milligrams of hydroxyurea - 3/18/25, 3/19/25, and 3/20/25 = documented as awaiting for pharmacy, 500 milligrams of levofloxacin - 3/17/25 - 8:00 p.m. dosage and 3/18/25 - 8:00 a.m. dosage = documented as awaiting for pharmacy, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	25 milligrams of metoprolol - 3/18/25 = documented as awaiting for pharmacy, 0.4 milligrams of tamsulosin - 3/18/25 = documented as awaiting for pharmacy, and 200-62.5 -25 micrograms of Trelegy inhaler - 3/19/25, 3/19/25, and 3/20/25 = documented as awaiting for pharmacy. An interview was conducted with the Nurse Consultant on 3/24/25 at 2:47 p.m. She indicated the pharmacy had not received all Resident 182's medication orders that were sent over to them upon admission, on 3/17/25. The pharmacy delivers medications at 9:00 p.m. and 3:00 a.m. The staff recognized, on 3/20/25, that the resident's medications were not here yet. They should have followed up earlier to obtain the medications. 51984 2. The clinical record for Resident 47 was reviewed on 3/24/25 at 10:53 a.m. The diagnoses included, but were not limited to, chronic pain. A Quarterly Minimum Data Set assessment indicated Resident 47 was moderately cognitively impaired. A physician's order, dated 12/27/24, indicated the resident was to receive a buprenorphine 15 microgram/hour patch (pain patch) every Friday. The old patch was to be removed before placing the new patch on. The March 2025 MAR for Resident 47 indicated the buprenorphine patch was not administered on 3/14/25 and 3/21/25. An interview was conducted with Unit Manager (UM) 9 on 3/24/25 at 11:06 a.m. She indicated when the last patch was placed, the nurse was to request and re-order from the pharmacy. If the pharmacy was out of stock, they ordered it from their supplier, then it was sent to the pharmacy for delivery to the facility. This patch was not in the facility's EDK (emergency drug kit; a collection of essential medications and supplies used in emergency situations to provide immediate care). A Re-ordering medications policy was provided by the Nurse Consultant on 3/23/25 at 3:45 p.m. It indicated . Purpose of Policy: To provide a procedure for re-ordering medications .Procedure: Medications should be re-ordered when there is a 3-day supply remaining on the card .Medications are to be re-ordered using the re-supply button in matrix .Effect of Non-Compliance: Medications unavailable for resident use. A medication policy was provided by the Executive Director on 3/25/25 at 9:19 a.m. It indicated .6.1 If any item ordered by facility is not received, and the reason for missing item is not evident, facility should contact pharmacy immediately . 3.1-25(g)(2) 3.1-25(g)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allisonville Meadows	10312 Allisonville Rd Fishers, IN 46038

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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. 40287 Based on observation, interview, and record review, the facility failed to ensure hand hygiene was performed when gloves were changed when performing incontinent care for 1 of 8 residents reviewed for activities of daily living, failed to maintain infection control while providing catheter care for 1 of 1 resident reviewed for catheter care, failed to ensure staff performed hand hygiene during coffee service, and to ensure medication carts were cleaned after touched by residents for 3 of 3 residents randomly observed. (Resident E, Resident F, Resident G, Resident H and Resident L) Findings include: 1. The clinical record for Resident L was reviewed on 3/18/25 at 3:17 p.m. The diagnoses included, but were not limited to, history of traumatic brain injury and diabetes. A care plan, initiated 2/7/25, indicated she required assistance with Activities of Daily Living (ADL) care including bed mobility, transfers, eating, and toileting related to weakness from a recent hospital stay. The goal was for her to improve her current functional status. The approaches included, but were not limited to, a mechanical lift for transfers with assistance of two staff, assist with bed mobility as needed, and assist with toileting and incontinent care as needed. A Quarterly Minimum Data Set (MDS) assessment, completed 2/21/25, indicated she was cognitively intact. She required total assistance with toileting. On 3/18/25 at 3:17 p.m., Resident L indicated she felt that incontinent care was lacking and was concerned about getting a urinary tract infection due to the poor incontinent care at times. During an observation on 3/21/25 at 2:45 p.m., Certified Nurse Aide (CNA) 14 provided incontinent care for Resident L. CNA 14 performed hand hygiene and prepared a basin of warm water and gathered supplies. CNA 14 then donned a pair of disposable gloves. She donned a gown and then donned a second pair of gloves. CNA 14 began performing incontinent care by undoing the incontinence brief and pulling the brief down. CNA 14 cleansed the perineal area of Resident L and removed the outer set of gloves and donned a new pair of disposable gloves over the gloves which remained on her hands. No hand hygiene was performed. CNA 14 then cleansed Resident L's buttocks and prepared the soiled brief to be removed. CNA 14 removed the outer pair of gloves and donned another pair of gloves over the existing gloves on her hands. No hand hygiene was performed. CNA 14 then applied barrier cream to Resident L's buttocks. Resident L was rolled to her back and CNA 14 doffed the outer pair of gloves, donned another pair of gloves on top of the existing gloves on her hands, and applied barrier cream to Resident L's peri area. During an interview on 3/21/25 at 3:15 p.m., the Corporate Infection Preventionist indicated the use of double gloves was not the policy of the facility and that hand hygiene should have been performed. 51750 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The clinical record for Resident E was reviewed on 3/19/25 at 11:45 a.m. The diagnoses included, but were not limited to, obstructive and reflux uropathy (a blockage in the urinary tract). A Quarterly MDS assessment, dated 2/07/25, indicated Resident E was severely cognitively impaired. A care plan, dated 7/26/24, last reviewed/revised on 2/11/25, indicated the Resident is at risk of transferring or becoming colonized with a Multidrug-Resistant Organism (MDRO) and requires enhanced barrier precautions (EBP) due to an indwelling medical device. The goal of the care plan was for the Resident to be compliant with enhanced precautions to decrease the risk of MDRO transmission during high contact activities. Interventions included, but were not limited to, use standard precautions including hand hygiene in addition to EBP and wear gown and gloves prior to high contact resident care activities. During an observation of urinary catheter care on 3/24/25 at 11:50 a.m., CNA 4 performed hand hygiene before donning a gown and gloves. With gloves on, CNA 4 reached into her pocket and removed two trash bags, pulled a privacy curtain closed, touched the resident's bathroom doorknob and sink handle, and touched the resident's bedside table. CNA 4 then placed clean washcloths in a basin of water with soap. CNA 4 removed her gloves and applied new gloves without the use of hand hygiene. She proceeded to cleanse the catheter tubing with the previously touched washcloths. CNA 4 did not doff her gloves, perform hand hygiene, and apply new gloves after touching high traffic surfaces before touching the clean washcloths and providing care. 52119 3. During a random observation of coffee being passed on 3/20/25 at 11:38 a.m., CNA 16 did not perform hand hygiene before initiating passing coffee to residents. She handed cups of coffee to several residents. CNA 16 then held the hand of a resident to lead her towards the back of the activities room, where another staff member assisted the resident to the restroom. She did not perform hand hygiene after. CNA 7 touched a resident's clothes and arm to assist her and then grabbed a clean cup and filled it with water and handed it to another resident. CNA 7 did not perform hand hygiene after touching the resident. During an interview with Family Member (FM) 31 on 3/20/25 at 11:38 a.m., he indicated he rarely saw the staff wash their hands or use hand sanitizer when he was present. 4. During a random observation on 3/21/25 at 8:47 a.m., Resident F placed her dirty breakfast plate on the medication cart surface in the activities room. She touched various surfaces on the cart. After several minutes, Qualified Medication Aide (QMA) 17 noticed Resident F touching the medication cart. She attempted to redirect Resident F, who became angry and swatted her arm at QMA 17. QMA 17 indicated as long as Resident F was safe, sometimes it was best to let her be, so she doesn't get too agitated. Resident F wandered away after several more minutes. On 3/21/25 at 8:57 a.m., QMA 17 went to the medication cart to retrieve medication for another resident. QMA 17 did not wipe down any surface of the medication cart before placing clean medication cups on the cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a random observation on 3/21/25 at 9:23 a.m., Resident H began touching the medication cart located in the hallway outside the activities room. No staff intervened. Resident H walked away after several minutes. On 3/21/25 at 9:32 a.m., an unidentified CNA went up to the cart to pour a cup of water for a resident. She did not wipe down any of the items or any surface of the cart. On 3/24/25 at 8:56 a.m., the ED provided the Hand Hygiene Policy, last reviewed 12/2021, which indicated . to provide a standardized approach to Hand hygiene to reduce or minimize the transmission of infection from potential microorganisms on the hands of all employees . Moments of hand hygiene .Before touching a resident, Before Clean/Aseptic procedure, After body fluid exposure risk, After touching a resident, After touching resident surroundings .Indication for Hand-rubbing but not limited to: Before having direct contact with a resident and/or equipment .Before the starting [sic] a medication preparation, After each resident contact and after contact with a resident's belongings, environmental surfaces, touching items on the floor, and resident care equipment, after contact with a resident's intact skin .Before and after removing glove . After touching self or clothing during meal service . This citation relates to complaint IN00455520. 3.1-18(b)(1) 3.1-18(l)