STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155791	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blair Ridge Health Campus	269 Meadowview Dr Peru, IN 46970

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow their policy for reporting and investigating an allegation of misappropriation of medication, when one staff member gave another staff member a prescription medication from a residents private medication supply for 1 of 3 residents reviewed for misappropriation, (Resident M).The facility also failed to follow their policy regarding an allegation of abuse for 1 of 3 residents reviewed for abuse, (Resident H), where the allegation was not reported to the State Agency and was not thoroughly investigated.Finding includes:1.During an interview on 3/5/25 at 2:28 P.M., the Director of Nursing indicated she remembered in October of 2025, Licensed Practical Nurse (LPN) 2 instructed an unnamed nursing staff member to give Certified Nursing Assistant (CNA) 3, a Zofran (Ondansetron) for the CNA's stomachache, from Resident M's medication supply. The Director of Nursing indicated on 10/7/25 at 2:47 P.M., she sent a message to nursing staff through the facility communication application, Ready App, that Medication in the carts were for patient use only and that staff should not use medication for personal use. The Director of Nursing indicated she did not have a written statement of the event from CNA 7 or LPN2. The Director indicated the misappropriated Ondansetron was replaced by the pharmacy on 10/27/25. The Director of Nursing indicated she was not aware that the incident of misappropriation was a reportable incident so did not report the allegation of misappropriation to the State Agency.A printed copy of a text message between the Director of Nursing and LPN 2 dated 2/6/26 at 10:00 A.M., was provided by the Director of Nursing on 3/6/26 at 10:00 A.M. The message that indicated on an unknown date with an unknown initial message to which LPN 2 replied to the Director of Nursing on 10/7/25 at 2:48 P.M. and indicated, Does this include the.Zofran I gave somebody[?] LPN 2's text message was followed by a grimacing smiley face emoji and a laughing with tears smiley emoji. The Director of Nursing's' response text dated 10/8/25 at 7:56 A.M., indicated, We need additional statements. Can u come in[?] A form titled Teachable Moment, dated 10/8/25, was provided by the Director of Nursing on 3/6/26 at 10:00 A.M. and indicated LPN 2's teachable moment included the 5 rights of medication, medications in medication carts were for patient use only, and misappropriation of medications. The teachable moment was signed by the Director of Nursing and the Administrator.A document from the facility's Ready App text broadcast from the Director of Nursing to the nursing staff dated 10/7/25 at 2:47 P.M., was provided by the Director of Nursing on 2/6/26 at 10:00 A.M. The Ready App text broadcast indicated, Medication in the cart are for patient use only. Staff should not use medications for personal use. The application indicated 31 of 37 users read the message.On 3/10/26 at 11:05 A.M., Resident M's clinical record was reviewed. The resident was admitted to the facility from 10/1/25 to 10/29/26 with diagnoses that included but were not limited to hypertension and chronic obstructive pulmonary disease. Physician's Orders included but were not limited to Ondansetron 4 mg every 6 hours as needed for nausea and vomiting, dated 10/1/25 through10/8/2025.2.On 3/11/26 at 10:51 A.M., Resident H's clinical record was reviewed, diagnoses included but were not limited to dementia, weakness, and anxiety. Review of the most recent comprehensive Minimum Data Set (MDS) was a Quarterly assessment dated [DATE]. The MDS assessment indicated Resident H had mild cognitive impairment, demonstrated no negative behaviors, required substantial to maximal assistance for (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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	standing, transfers, and toileting.Resident H's Care Plans included but were not limited to, Profile Care Guide dated 7/23/24 with interventions that included approaches not limited to the extensive assistance of one person for transfers, the use of a walker, dated 4/9/25, and to encourage the resident to assume standing position slowly, dated 7/23/24.A Statement Witness Form dated 2/26/26, undocumented time, from the Employee Experience Manager, indicated the employee had been interviewed by the Director of Nursing. The statement indicated on 2/20/26 she was walking to her car in the parking lot when she received a text message from the Administrator who indicated she was needed to be the second person on a call to CNA 4. The document indicated the Administrator called CNA 4 and asked if there was anything the CNA could tell her about her shift on 2/20/26 ant that the Administrator let CNA 4 know there was an allegation and the CNA would be suspended pending an investigation. The document indicated CNA 4 indicated she would never hurt a resident.A Statement Witness Form dated 2/26/26, undocumented time, from LPN 9 indicated the employee had been interviewed by the Director of Nursing. LPN 9 indicated she worked 2/20/26 at 6:00 P.M. and received report from QMA 5 who reported that CNA 4 had yelled at Resident H. She indicated Resident H seemed to be upset in the afternoon and that QMA 5 had notified the appropriate people. CNA 10 reported she didn't know anything other than a CNA student said CNA 4 was being rude to her and to a resident. Re getting int the wheelchair. QMA 5 indicated she asked CNA 4 if the resident was walking that day and the CNA said he was not and he was hurting her back. QMA 5 indicated the resident was visibly upset, and when she asked the resident if he was okay, he replied no. QMA 5 indicated she reported the allegation to LPN 6. QMA 5 indicated the Administrator came to her and talked to her about the incident.A statement from QMA 5 taken by the Director of Nursing on 2/26/26 at 4: 39 P.M., indicated QMA 5 heard CNA 4 talking loudly in Resident H's room and believed she was speaking passive aggressively saying you need to stand up, you need to get up, stop doing that. If your're not going to stand then we'During an interview on 3/6/26 at 1:10 P.M., the Administrator indicated Certified Nursing Assistant (CNA) 4 never abused Resident H at any time. The Administrator indicated CNA 4 had been working with a trainee when on 2/20/26 at about 4:30 P.M., Qualified Nursing Aide (QMA) 5 reported that CNA 4 may have been verbally abusive to Resident H earlier that day. The Administrator indicated in response to the report, CNA 4 was immediately suspended pending an investigation, which the facility completed with no findings. The Administrator indicated the State was not notified of the allegation because abuse was not identified so there was nothing to report.On 3/9/26 at 2:38 P.M., during an interview with LPN 6, she indicated QMA 5 reported to her that CNA 4 was being mean to a resident but did not tell her who the resident was. LPN 6 indicated at about 4:30 P.M. on 2/20/25, she called the Administrator, who was in the building, and reported the allegation of abuse and indicated that QMA 5 reported CNA 4 had been mean to a resident. LPN 6 indicated the Administrator indicated she would take care of the concern and CNA 4 was suspended due to the allegation of abuse toward Resident H.On 3/9/26 at 2:52 P.M., during an interview with QMA 5, she indicated she notified the Administrator that CNA 4 had been verbally abusive to Resident H and to other staff. QMA 5 indicated she reported the allegation verbally as well as through a written statement that she was outside Resident H's door when she heard CNA 4 telling Resident H to, stop doing that! You need to stand up right now! If you don't stand up I'll put you in your wheelchair. QMA 5 indicated Resident H came out of his room and she asked the resident if he was okay. QMA 5 indicated the resident said he was not and was visibly upset. On 3/9/26 at 10:00 A.M., the Administrator provided the policy titled, Abuse, Neglect and Exploitation Procedural Guidelines, dated 1/19 and most recently reviewed on 11/19/25, and indicated it was the current facility policy. The policy indicated, .The Executive Director and the Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures.ABUSE is the willful infliction of.intimidation.with resulting .mental anguish.it includes verbal abuse.MISAPPROPRIATION OF PROPERTY-means the deliberate.use of a resident's belongings.without the resident's consent.staff is required to report concerns.to.Executive Director and Director of Health Services.The (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Executive Director is responsible for: 1. Notification to the State Department of Health.and/or local law enforcement agencies, as indicated.Protection.Suspend suspected employee(s) pending outcome of investigation.Investigation i. The Executive Director is accountable for investigating and reporting.Identifying and interviewing all involved persons. Providing complete & thorough documentation of the investigation.Indiana- Incidents must be reported within 24 hours online.An incident.shall be reported by a provider.who.becomes aware of or receives information about an alleged incident.This citation relates to Intakes 2655113 and 2791217410 IAC (Indiana Administrative Code) 3.1-28(a)(c)(d)(e)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided for a resident with dementia who had known exit seeking behaviors and was identified as an elopement risk, for 1 of 3 residents reviewed, who were at risk for elopement, (Resident G). This deficient practice resulted in the resident exiting onto facility grounds for 5 minutes before staff found the resident and brought him back inside the facility.Finding includes:During a review of a facility reported incident report, Incident Number 367, dated 2/22/26 at 5:20 P.M., reviewed on 3/5/2026 at 11:00 A.M., the report indicated Resident G had not been accounted for for approximately two minutes, based on employee interviews. The report indicated Resident G had remained on the facility campus throughout the incident.On 3/6/26 at 11:35 A.M., the Administrator provided a series of photographs, dated 2/22/26 beginning at 5:30 P.M. through 5:25 P.M. At 5:30 P.M., Resident G was pictured exiting the facility from the main entry door. He then turned left and followed the asphalt drive around the side of the building. Resident G was pictured outside the facility courtyard at 5:22 P.M. At 5:25 P.M. he was pictured being escorted back into the building through the doors near the courtyard area. Staff were pictured looking at the resident and calling out to him as other staff were noted going outside to collect the resident.Resident G's clinical record was reviewed on 3/6/26 at 1:43 P.M. Diagnoses included but were not limited to dementia with mood disturbances, depression with severe psychotic symptoms, and anxiety.The most recent comprehensive Minimum Data Set (MDS) assessment, dated 1/3/26, for a discharge with return anticipated return to the facility indicated Resident G demonstrated behaviors toward others, rejected care, and had exhibited wandering behaviors one to three of the previous 7 days. Resident G's Care Plans included but were not limited to; Resident demonstrates exit-seeking behaviors, dated 01/28/2026, and indicated the goal was Resident G would not elope from the facility and would be re-directed away from doors and exits as needed.An Observation Detail List Report form, dated 1/21/26 at 1:55 P.M., indicated Resident G was oriented to person but not to time or place and had a history of exit seeking.A physician's progress note, dated 2/18/26 at 11:21 A.M., indicated, Recent event: On 1/3/26 patient was having exit seeking behaviors and threatening self-harm. He had been refusing to sleep, medications.Resident G's Nursing Progress Note, dated 2/22/26 at 5:22 P.M., indicated Resident G had finished supper and had returned to his room where he put on his winter coat. Another resident and his family were visiting in the foyer at the front of the building where they noticed the resident leaving the building out the front door. Within two minutes, the Memory care staff had noticed the resident outside, opened an outside door and the resident had came back into the building willingly. Resident G had stated that was outside because he was going to talk to someone. The resident's hands were warm, as well as ears and face and he had not been injured and the assessment was negative for any injuries.During an interview on 3/6/26 at 11:35 A.M., the Administrator indicated the resident had walked out of the front doors and there had been approximately two minutes when the resident had not been visualized and was unsupervised. Although the resident had been wearing a magnetic alarm mechanism on his body, the mechanism failed to alarm when the resident opened the facility's front door and exited the building.On 3/9/26 at 11:30 A.M., the Corporate Compliance Nurse provided the policy, Guidelines: Elopement Risk Assessment and Prevention, dated 11/18/25, indicating it was the current facility policy. The policy indicated, The purpose of this policy is to:.implement prevention strategies for those identified as an elopement risk.a plan of care will be.implemented for each resident identified as having the potential to leave the facility unauthorized, requiring supervision for.wandering to an unsafe area.This citation relates to Intake 2790175410 IAC (Indiana Administrative Code) 3.1-27(a)(3)