STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155812	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbrooke of Crawfordsville	517 Concord Road Crawfordsville, IN 47933

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident had their predetermined advance directive preference of Do Not Resuscitate (DNR) when she was changed to a full code status upon admission for 1 of 3 residents reviewed for advanced directives (Resident 69). Findings include:On 11/18/25 at 12:02 p.m., Resident 69's record was reviewed. She admitted to the facility on [DATE]. Her comprehensive care plan indicated she had diagnoses which included, but was not limited to, Parkinson's disease (a progressive, incurable neurological disorder that affects movement, causing symptoms like tremors, slowness of movement and rigidity caused by loss of brain cells).Upon her admission she had a living will, dated 2/27/1992, which indicated, she did not want her life to be artificially prolonged.If at any time I have an incurable injury, disease, or illness certified in writing to be a terminal condition by my attending physician has determined that my death will occur within a short period of time, and the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the provision of appropriate nutrition and hydration and the administration of medication and the performance of any medical procedures necessary to provide me with comfort care or to alleviate pain. The document was scanned into her record on 11/17/25.A comprehensive care plan was initiated on 11/18/25 which indicated she desired to be a full code.SA physician's order was added to her record on 11/17/25 for a Full Code. During an interview on 11/20/25 at 1:29 p.m., the Director Nursing Services (DNS) indicated all resident were admitted with a full code status unless they had signed physician's order such as an Out of Hospital (OOH) or Physician's Order for Scope of Treatment (POST). The DNS indicated there could be a phone call made to the physician for a code status and witnessed by two nurses as needed. She indicated she was not aware the resident had a living will. The clinical team did not get the Living Wills in the admission packets. They got them from the family at the time of admission.A policy titled Guidelines for Advanced Directives was provided by the DNS on 11/19/25 at 2:30 p.m. It indicated, Advanced Directives will be reviewed with the resident and/or resident representative by the Admissions Representative or designee at the time of admission 3.1-4(d)3.1-4(e)3.1-38(f)3.1-4(l)(4)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure that a resident's code status matched the comprehensive care plan for 1 of 5 residents reviewed for advance directives (Resident 12). Findings include: On 11/19/25 at 10:54 a.m., Resident 12's record was reviewed. She had the following diagnoses which included, but were not limited to, asphasia (difficulty speaking), dysphagia (difficulty swallowing), cystitis (bladder infection), Parkinson's disease, muscle weakness, and history of falling.Resident 12 had a physician's order for do not resuscitate (DNR) dated 7/22/25.Her comprehensive care plan indicated she desired a full code status dated 7/16/25.On 10/19/25 at 2:00 p.m., the Director of Nursing Services (DNS) provided a copy of the full code care plan.A policy titled, Comprehensive Care Plan Guideline, was provided by the Executive Director on 11/18/25 at 5:04 p.m. It indicated, .A comprehensive care plan will be developed within 7 days of completion of the comprehensive assessment (MDS 3.0).3.1-35(c)(2)

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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. Based on record review and interview, the facility failed to ensure a medication was withheld based upon the physician ordered parameter set for that medication. This deficient practice had the potential to effect 1 of 5 residents reviewed for unnecessary medications, (Resident 12). Findings include:On 11/19/25 at 10:54 a.m., Resident 12's record was reviewed. She had the following diagnoses aphasia (a language disorder that affects the ability to communicate), dysphagia (difficulty swallowing), supraventricular tachycardia (rapid regular heartbeat caused by faulty electrical signals in the heart's upper chamber), muscle weakness, and history of falling.She had an order, dated 7/16/25 for metoprolol tartrate tablet (an immediate-release selective beta-blocker medication primarily used to treat high blood pressure, chest pain, and to reduce the risk of death or heart attack after an acute myocardial infarction) , 25 milligrams (mg) amount 1/2 tablet, oral. Special instructions indicated to hold for systolic blood pressure (SBP- top BP reading) less than 100 or pulse less than 60 two times daily.On 11/11/25 metoprolol was administered for a blood pressure of 99/61.On 10/18/25 metoprolol was administered for a blood pressure of 98/62.On 11/20/25 at 1:39 p.m., the Director of Nursing Services (DNS) indicated the medication was given outside of the ordered parameters. A policy titled, Guideline for Medication Orders was provided by the DNS on 11/20/25 at 2:00 p.m. It indicated, .Telephone or verbal order for drugs must include: the name and strength of the drug, the quantity or specific duration of the drug, the dosage and frequency of administration, route of administration, diagnosis for use, dated and time order received.3.1-37

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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 interview and record review, the facility failed to ensure a resident's fall interventions were followed to prevent the potential for accidents when she was left alone in the bathroom and transferred with only one staff member on three separate occasions for 1 of 5 residents reviewed for falls (Resident 32). Findings include:On 11/19/25 at 9:52 a.m., Resident 32's record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, dementia, hemiplegia and hemiparesis (muscle weakness/paralysis) following cerebral infarction (stroke) affecting left non-dominant side, and anxiety.Resident 32's nursing progress notes were reviewed.1. From 1/1/25 until 4/17/25, Resident 32 had already experienced three falls in her bathroom. She had a witnessed fall on 3/8/25 and 3/16/25, then an unwitnessed fall on 3/29/25 in which she sustained a skin tear injury.A nursing progress note, date 4/17/25 at 1:28 p.m., indicated Resident 32 had been assisted to the toilet and then attempted to get up without calling for assistance. She was found laying on the bathroom floor face down and sustained a 1.1 centimeter (cm) skin tear to her right first finger and a 4 cm abrasion to her left upper cheek.An Interdisciplinary Team (IDT) progress note, dated 4/18/25 at 9:22 a.m., indicated the new intervention put in place was for staff not to leave the resident in the bathroom unattended.After the fall on 4/17/25 and new intervention not to be left unattended in the bathroom, there were three more instances where she was left alone.On 6/2/25 at 10:02 p.m., Resident 32 was upset with an aide for not coming back to assist her, while she was in the bathroom, having been left alone for an indeterminable amount of time.On 6/13/25 at 3:16 a.m., Resident 32 had not been feeling well and requested to use the bathroom for a bowel movement, and the not indicated, did use call light for assistance back to her chair, having been left alone in the bathroom for an indeterminable amount of time.On 8/21/25 at 7:43 p.m., Resident 32 put her bathroom light on after she had been assisted to the toilet. She was found on the floor with no staff present.2. From 1/1/25 until 7/22/25, Resident 32 was lowered to the floor on 8 separate occasions, (2/4/25, 3/16/25, 4/26/25, 5/10/25, 5/14/25, 6/18/25, 6/25/25, 7/22/25).An IDT progress note, dated 5/14/25 at 8:50 a.m., indicated Resident 32 had a witnessed fall during a transfer when her knees buckled and she needed to be lowered to the floor. The new intervention put into place at that time was for her to be a 2-person assist with transfers until therapy can assess for safe transfers.On 6/18/25 at 7:31 a.m., Resident 32 was being assisted by only one aide when she let go of the grab bar and her wheelchair was too far away, so the aide had to lower the resident to the floor. The aide who transferred the resident alone, was given a teachable moment, on 6/19/25.On 6/25/25 at 11:44 a.m., Resident 32 was again, being assisted by only one aide during a transfer when she was lowered to the floor. The aide who transferred the resident alone was given a teachable moment on 6/26/25.On 7/22/25 at 2:16 a.m., Resident 32 was being transferred by only one aide in the bathroom when her legs gave out and the aide had to lower her to the floor. Resident 32 sustained a small, raised area to the left side of her head. The aide who transferred the Resident alone, was given a teachable moment, on 7/24/25.During an interview on 11/20/25 at 1:23 p.m. with the Executive Director (ED) and Director of Nursing (DON) present, the DON indicated Resident 32 was impulsive and often transferred without staff knowledge, but that when new interventions were placed, it was her expectation for all staff to implement those interventions which could be found on the Resident's Care Profile.On 11/19/25 at 3:00 p.m., the ED provided a copy of current facility policy titled, Fall Management Program Guidelines, reviewed 11/19/25. The policy indicated, The purpose of this policy is to. maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. THS recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours. Discuss risks and interventions with resident and/or responsible party and communicate Interventions during shift report.3.1-45(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to continue nutritional and pharmaceutical supplements for a malnourished resident who was not yet at her goal of achieving and maintaining an ideal body weight resulting in continued weight loss for 1 of 2 residents reviewed for weight loss and nutrition (Resident 46). Findings include:On 11/20/25 at 11:33 a.m. Resident 46's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, dementia, malnourishment, and adult failure to thrive.Resident 46 was admitted to the facility on [DATE], the first recorded weight was on 11/4/25 and it was 98.4 pounds. At the time of her admission the resident was put on a mechanical soft diet (a texture-modified diet for people who have difficulty chewing or swallowing) and she had an active order to be weighed weekly.An admission nutrition assessment note, dated 10/31/24, indicated Resident 46 had a Body Mass Index (BMI) of 20, her nutrition goal was a BMI of 22 and to maintain a stable weight. The Dietician recommended to add Ensure once a day between breakfast and lunch, with the direction to increase the amount to twice a day if intake was good.On 11/1/24 an order for the resident to receive Ensure once a day was added.Resident 46 had recorded weights on 11/10/24, 11/17/24 and 11/24/24 which were all low 100-pound weights.On 11/27/24 the order for weekly weights was discontinued and an order for monthly weights was added.On 12/5/24 there was a recorded weight of 94 pounds. This was a 4.5% decrease in weight in one month.A Nurse Practitioners (NP) note, dated 12/6/24, indicated she wanted Resident 46 to be reevaluated by the Dietitian.On 12/12/24 an order for Mirtazapine (an antidepressant that can be used in low doses to increase appetite.) 7.5 milligrams daily was added.A Critical at Risk (CAR) note, dated 12/12/24, indicated Resident 46 had an 8.7-pound weight loss in twelve days. The new intervention was to put the resident on fortified foods.A progress note, dated 12/13/24, indicated the order for the Dietician to reevaluate Resident 46 had been discontinued and needed to be reordered.A progress note, dated 12/18/24, indicated the Assistant Director of Nursing Services (ADNS) added the order for the Dietician to reevaluate Resident 46.A nutrition note, dated 12/18/24, indicated Resident 46 had a BMI of 19 and variable intakes at meals, on average she would eat 26-50%. She would drink, on average, 51-75% of her Ensure. The weight history in the note indicated the resident had a 4-pound weight loss in the last thirty days, which was a 4.2% loss, deeming it not a significant loss. There were no new recommendations at this time.A nutrition follow-up note, dated 1/2/25, indicated Resident 46's current weight was 94.4, this weight was taken 12/6/25. She had a BMI of 19, poor intakes at meals, averaging 1-25% per meal and was averaging 76-100% of her ensure. The new intervention was to increase the order for Ensure to three times a day.On 1/3/25 the order for Ensure once a day was discontinued and a new order for Ensure three times a day was added. On 1/5/25 there was a recorded weight of 94.6 pounds. This was the only weight recorded for the month of January.The weight history in a nutrition note, dated 1/15/25, indicated Resident 46 had an 8.5-pound weight loss in the last forty-five days which was a 9% loss, deeming it a significant loss. The note indicated the new goal for Resident 46 was to get weight up to at least admission weight, if not weight prior to the loss.An NP note, dated 1/21/25, indicated Resident 46's weights had been stable over the last month. No new recommendations were given at this time.On 1/25/25 an order for Resident 46 to receive a shake made of ice cream and cranberry juice at every meal was added.A nutrition note, dated 2/4/25, indicated the Dietician spoke with several dietary staff members to ensure Resident 46 was getting the ice cream and cranberry juice shake at every meal. The note indicated the Assistant Director of Food Services (ADFS) would speak to all dietary staff about the importance of the resident receiving this supplement at every meal.On 2/5/25 there was a recorded weight of 84.4 pounds. This was a 10.8% decrease in weight in one month.A nutrition note on 2/12/25 indicated Resident 46's current weight was 84.4 pounds, and her BMI was 17. The weight history in the note indicated the Resident had a 10.2-pound weight loss in the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last thirty days, which was a 12.1% loss, deeming it a significant loss. The Resident also had a 14-pound weight loss in the last ninety days, which was a 16.6% loss, deeming it a significant loss. The note indicated the Resident had poor intake at meals, averaging 1-25% and her supplement intakes averaged 26-50%.On 3/5/25 there was a recorded weight of 89.9 pounds.On 3/7/25 there was an order of 90 milliliters of MedPass supplement (a high-calorie, high-protein nutritional shake given to individuals with malnutrition or other conditions requiring extra nutrition) three times a day added.On 3/21/25 there was an order for weekly weights added.On 3/23/25 there was a recorded weight of 82.8 pounds. Compared to Resident 46's weight on 2/5/25, this was a 2% decrease.On 3/24/25 there was a recorded weight of 81.2 pounds. Compared to Resident 46's weight on 2/5/25, this was a 3.8% decrease.On 3/30/25 there was a recorded weight of 80.2 pounds. Compared to Resident 46's weight on 2/5/25, this was a 5% decrease.On 4/5/25 there was a recorded weight of 77.6 pounds. This was a 13.7% decrease in weight in one month.An NP note dated 4/8/25 indicated Resident 46 was not at goal, and her weights were trending down. The note indicated Mirtazapine had been discontinued at some point, and she indicated it would be restarted at 7.5 milligramsOn 4/8/25 the order for Mirtazapine 7.5 milligrams daily was discontinued and an order for Mirtazapine 15 milligrams daily was added.On 4/13/25 and 4/20/25 there was a recorded weight of 80.6A Dietician note dated 4/18/25 indicated her current weight was 80.6 which was a significant loss of 9.3 pounds in one month, 14 pounds in three months and 19 pounds in 6 months. The recommendation was to add 60 milliliters of MedPass supplement to the current ordered amount of 90 milliliters.On 4/20/25 the order for weekly weights was discontinued and the order for monthly weights resumed.On 4/25/25 there was an order for 60 milliliters of MedPass supplement three times a day added. This was a separate order from the 90-milliliter dose. In total at this time the Resident was ordered to receive 150 milliliters of MedPass supplement three times a day.On 5/5/25 there was a recorded weight of 80.2 pounds.An NP note, dated 6/4/25, indicated Resident 46's weights had been stable in the 80s for one month and she wanted the current interventions to continue.On 6/5/25 there was a recorded weight of 82 pounds.At this time the nutritional supplements Resident 46 had ordered were 150 milliliters of MedPass three times a day, Ensure three times a day, an ice cream and cranberry juice shake at meals, fortified foods and 15 milligrams of Mirtazapine daily.On 6/7/25 the order for 60 milliliters of MedPass supplement three times a day was discontinued.A weight note, dated 6/18/25, indicated Resident 46 was receiving Ensure and 60 milliliters of MedPass supplement three times a day. She had varied intakes at meals averaging 45-50%. The new recommendation was to discontinue the order for Ensure three times a day.At this time the ordered amount of MedPass supplement was 90 milliliters three times a day.On 6/19/25 the order for Ensure three times a day was discontinued.On 7/5/25 there was a recorded weight of 84.2 pounds.A weight note dated 7/18/25 indicated Resident 46 was receiving 60 milliliters of MedPass supplement three times a day, averaging 51-75% intake. She had varied intakes at meals averaging 25-75% intake.At this time the ordered amount of MedPass supplement was 90 milliliters three times a day.A Guidestar psychiatric note, dated 7/25/25, indicated the plan of care was to discontinue Mirtazapine because a decrease in this antidepressant can affect oral meal consumption.On 7/25/25 the order for Mirtazapine 15 milligrams daily was discontinued.At this time the nutritional supplements Resident 46 had ordered were 90 milliliters of MedPass three times a day, an ice cream and cranberry juice shake at meals and fortified foods.On 8/5/25 there was a recorded weight of 80 pounds. This was a 5% decrease in weight in one month.A nutrition note, dated 8/7/25, indicated Resident 46 had a significant weight loss of 5% in the last thirty-one days and she was receiving 60 milliliters of MedPass supplement three times a day, averaging 51-75% intake. The new recommendation was to increase MedPass supplement to 90 milliliters three times a day.At this time the ordered amount of MedPass supplement was 90 milliliters three times a day.A Interdisciplinary Team (IDT) note indicated Resident 46's family was concerned about her difficulty with eating meals, so they requested to downgrade her diet to pureed.A significant change life enrichment assessment dated [DATE] indicated Resident 46's favorite activities were (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	watching tv, but she was very hypersensitive to noise.On 8/18/25 the order for a mechanical soft diet was discontinued and a new order for a pureed diet was added.On 8/21/25 an order for weekly weights was added.On 8/24/25 there was a recorded weight of 79 pounds.On 8/31/25 there was a recorded weight of 77.2 pounds. Compared to Resident 46's weight on 8/5/25 this was a 3.5% decrease in weight.On 9/4/25 there was a recorded weight of 78.2 pounds.On 9/7/25 there was a recorded weight of 77 pounds. Compared to Resident 46's weight on 8/5/25 this was a 3.8% decrease in weight.A CAR note, dated 9/10/25, indicated Resident 46 had a 1.2-pound weight loss in the last three days. The note indicated the current interventions were not effective, and the new intervention was to offer chocolate Ensure because that flavor was the Residents preference.On 9/10/25 the order for 90 milliliters of MedPass three times a day was discontinued and an order for Resident 46 to receive chocolate Ensure three times a day was added.On 9/14/25 there was a recorded weight of 78 pounds.On 9/15/25 there was a recorded weight of 78.8 pounds.An NP note dated 9/22/25 indicated Resident 46's weight loss and poor appetite had improved, and to continue the current ordered interventions.On 10/7/25 there was a recorded weight of 82.8 pounds.On 10/15/25 there was a recorded weight of 79.8 pounds.On 10/19/25 there was a recorded weight of 82.6 pounds.On 10/26/25 there was a recorded weight of 79.6 poundsA CAR note, dated 10/31/25, indicated Resident 46 had a 3-pound weight loss. The new intervention was a medication review.On 11/2/25 there was a recorded weight of 76.8 pounds. This is a 7.3% decrease in weight in one month.On 11/4/25 an order for Mirtazapine 7.5 milligrams daily was added. A CAR note dated 11/5/25 indicated Resident 46 had a 2.8-pound weight loss. The new intervention was to add Mirtazapine 7.5 milligrams daily.At this time the nutritional supplements Resident 46 had ordered were chocolate Ensure three times a day, ice cream and cranberry juice shake at meals, fortified foods and Mirtazapine 7.5 milligrams daily.On 11/9/25 there was a recorded weight of 78.2 pounds.On 11/16/25 there was a recorded weight of 79.4 pounds.A care plan dated 11/3/25 and last revised 11/19/25 indicated the Resident had a significant weight loss. The approaches to this problem included, but were not limited to, providing supplements as ordered.A care plan, dated 10/31/24, indicated the Resident was malnourished or was at risk of malnutrition. The goal for this problem included but was not limited to achieving and maintaining an optimal weight by 1/31/26.On 11/17/25 at 11:42 a.m. approximately 35 Residents were observed eating lunch in the dining room. Resident 46 was observed sitting at a table with other residents who also needed help eating. Resident 46 appeared restless and uninterested in eating her meal.On 11/18/25 at 11:35 a.m. approximately 30 residents, including Resident 46, were observed as they were served lunch.On 11/21/25 at 12:13 p.m. Registered Nurse (RN) 11 was observed as she helped Resident 46 drink her ice cream and cranberry juice shake. The resident appeared agitated, constantly moving and having a hard time concentrating on drinking the shake. RN 11 indicated the resident had just come back from lunch in the dining room. She indicated Resident 46 ate in the dining room for most of her meals, but she wouldn't eat much.During an interview on 11/21/25 at 2:38 p.m. Resident 46's regular NP indicated if the resident was gaining weight she would have been ok to trial coming off of Mirtazapine, but she would have wanted to see that medication restarted if the resident was consistently losing weight, or if she was staying under 80 pounds after being off of the medication for a month or two. She was unsure when she was notified of the consistent weight loss but that's when she would have restarted the medication. During an interview on 11/21/25 at 2:57 p.m. the psych NP from Guidestar indicated the NP who discontinued the Mirtazapine is no longer with Guidestar, so she looked through Resident 46's notes to try and help figure things out. She indicated she wasn't sure why the NP chose to discontinue the medication as opposed to decreasing it. The psych NP indicated the NPs are taught to monitor the residents' weights and she would have done so if it had been her overseeing Resident 46's care. She indicated she would expect to restart the medication if the resident's weight was consistently trending down over a month or two. During an interview on 11/21/2025 at 3:12 p.m. the Registered Dietician (RD) Director indicated she didn't see Resident 46 regularly but was familiar with her and her condition. She indicated she would have been (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ok with discontinuing the Mirtazapine when they did because the therapeutic dose was 7.5 milligrams and the resident was ordered 15 milligrams. She could not say why they chose to discontinue the medication as opposed to decreasing it to the therapeutic dose. The RD Director indicated they probably discontinued the Ensure due to low acceptance rates when it was offered. She indicated the resident didn't trigger for significant weight loss during the time of discontinuing both the medication and Ensures, and with the ice cream and cranberry juice shakes and MedPass supplement the resident was taking, she believed those made up for the Ensure being discontinued. After the order for Ensure three times a day was discontinued on 6/19/25, Resident 46 triggered for significant weight loss once 8/7/25 before it was reordered on 9/10/25. After the order for Mirtazapine 15 milligrams daily was discontinued on 7/25/25 Resident 46 was weighed twelve times before it was restarted on 11/4/25. Of those twelve weights nine of them were under 80 pounds. 3.1-46

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Wellbrooke of Crawfordsville	517 Concord Road Crawfordsville, IN 47933

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to provide effective individualized person-centered care for a resident who exhibiting dementia-related behaviors, including repeated attempts to undress, restlessness, and signs of discomfort for 1 of 3 resident reviewed for dementia care (Resident 46). Findings include:On 11/18/25 from 9:40 until 10:30 a.m., Resident 46 was observed. She was seated in a reclined Broda wheelchair, pulled up close to a common table a the nurses station, and the chair was locked in place. Resident 46 was slouched down in her seat, and leaned to the far left of the chair. During this continuous observation, Resident 46 attempted to undress herself, at one point she pulled her shirt up and over her head, which exposed her breasts as she was not wearing a bra. She was not redirected or offered activities/interventions. Staff, residents, and visitors were coming and going through the common area able to observed Resident 46.On 11/18/25 from 1:30 p.m., until 2:30 p.m., Resident 46 was observed. She was seated in her reclined Broda wheelchair, pulled up close to the nurses' station. During this continuous observation, she repeatedly pulled at her pants legs to pull the material up past her knees. She also continue to try unbutton and pull at her shirt which exposed her stomach and breasts. She was not redirected or offered activities/interventions. Staff, residents, and visitors were coming and going through the common area able to observed Resident 46.During a continuous observation on 11/19/25 from 9:20 a.m., until 11:00 a.m., the following was observed:At 9:20 a.m., Resident 46 was observed, as above, at the common table nurses' station. She was observed to be restless and exhibited signs of restlessness/anxiety as she continually sat up, leaned forward, sighed deeply, grunted, pulled her sweater over her head which exposed both breasts as she was not observed to have a bra on. She pulled her legs up to her chest and wiggled in her chair.At 9:23 a.m., she repeatedly fidgeted with the edge of her sweater and pulled it over her head.At 9:26 a.m., Staff briefly pulled the sweater back on, but no follow-up intervention or assessment (e.g., discomfort, heat, pain, toileting need, anxiety) was performed.At 9:31 a.m., Resident 46 again removed her sweater entirely; staff replaced it but did not address the cause or offer meaningful engagement or comfort measures.At 9:40 a.m., Resident 46 was taken to a volunteer-led Bible Study activity where she was seated 1:1 with an activity aide for engagement.At 10:00 a.m., the Activity Aide brought Resident 46 back to the common area nurses station. Around this time, a volunteer came to the nurse's station with a Therapy Pet Dog. Staff did not ensure that the Therapy Pet got to visit with Resident 46.During an interview on 11/19/25 at 10:20 a.m. the previous Administrator who was visiting stopped to say hello to Resident 46, who was fidgeting with a blanket on het lap and indicated the resident loved to fold clothes.From 10:26-10:46 a.m., Resident 46 fidgeted and repositioned herself so that she got both her legs out from under the table and rested them on top of the common table. She pulled her pants legs and pulled her socks off.Until 11:00 a.m., when she was taken to the main dining room for lunch, Resident 46 continued to exhibit signs of restlessness/anxiety/discomfort; constantly pulling at her clothing, pinching/pulling the edges of her blanket, pulling the blanket up and down the table, aggressively scratching the back of her head, deep sighs, occasional grunts and undirected speech, what is this? I don't know. What now?During a continuous observation on 11/21/25 from 9:05 a.m., until 11:30 a.m., Resident 46 was observed. She was seated in her reclined Broda chair, locked in place at the common area nurses station table. She appeared less anxious and less hyperactive, but exhibited signs of discomfort and tiredness as she repeatedly scootched in her chair. She sighed deeply. Moved from side to side in her chair. Leaned forward and rested her head on the table in front of her. At some times her eyes were closed and she appeared to be asleep. Then she would open her eyes and sign deeply, occasionally grunt, or loosely pick at her clothes/blanket. No activities or interventions were observed/offered until she was taken to the main dining room for lunch.Throughout the survey period, Resident 46 was repeatedly parked at the nurses' station table (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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She is grabbing at anything she can reach and repeats please without being able to verbalize what is wrong. She continues to deny pain but says please and reaches out grabbing nurses hair, quickly letting go, then grabs name badge and continues to reach out for anything she can grab. She stops periodically, answering questions. She replies no when asking if she is in pain and if she would like to get out of bed.On 7/29/25 at 1:08 p.m., Resident had some anxiousness this morning moving around in her geri chair and grunting while doing so.On 10/18/25 at 6:12 p.m., Resident has been antsy this shift. She attempts to pull shirt off while sitting at nurses station and when assisted by nurse in calming manor, she grabs nurses arm, digging nails into it says stop it through gritted teeth. She then starts to hit arm but it is not with much force. She is difficult to redirect at that time. PRN Ativan utilized at this time. Activities attempted to distract and effective at this time.On 10/18/25 9:18 p.m., During rounds, resident is seen stripping clothing off in bed, including brief. When CNA [certified nursing assistant] turns the corner the resident says razzle dazzled. She is assisted out of bed at this and sitting at the nurses station. She continues to fidget with clothing and blanket.On 10/21/25 at 10:27 a.m., Resident continues to present with increased anxiety, resident yelling out, taking socks off, messing with stuff on table, pushing common area table over with BLE [bilateral lower extremities], putting BLE on top of table.On 10/24/25 at 2:54 a.m., Majority of evening, resident rested in her broda chair, awake, messing with clothing and blanket.On 10/24/25 at 8:28 p.m., Resident has remained very active in her broda chair this evening. Constantly fidgeting with her blanket or clothes.She had a comprehensive care plan, initiated 11/26/24 with a target goal of 2/28/26, which indicated, my ability to make decisions regarding my daily activity engagement may be altered due to my diagnosis of dementia. I have a history of enjoying: being read to, animal therapy, and practicing my Christian religion. Interventions for this plan of care included, but were not limited to: It is important to me to be around animals. I have 2 cats of my own but please include me in visits involving pet therapy. Provide one-to-one assistance to promote success as needed. I have a sensitivity to loud noises, such as music. Please provide me with calming, individualized activities for me either in my room, at the nurse's station, or near the campus fireplace.She had one care plan, initiated on 8/14/25 with a target goal date of 2/28/26, which indicated, Resident presents with a diagnosis of Anxiety Disorder and remains on anti-anxiety medication, and a second care plan imitated on 11/2/24 with the same target goal date which indicated, Resident has a dx of anxiety disorder by s/s are well controlled.Resident 46's full care plan set lacked implementation and/or revision to address her behaviors of unsafe positioning in her Broda chair, pulling her clothes off, and constant fidgeting with her clothes or scratching her head.A Significant Change Life Enrichment Assessment, dated 8/13/25, indicated one of her favorite activities was to watch TV but was also very hyper sensitive to noise.On 11/21/25 at 10:44 a.m., a Visiting Activity Director (AD) provided a copy of Resident 46's activity participation log. The AD indicated the there was a dot beside the activity, it indicated the Resident had participated.Resident 46's activity logs was reviewed for the survey week and revealed the following:On 11/18 at 10:26 a.m. - she was coded as having participated in - sensory basket. During a continuous observation on 11/18/25 from 9:40 until 10:30 a.m., (as indicated above) Resident 46 was not offered a Sensory Basket.On 11/19 at 9:00 a.m. - she was coded as having participated int - Bible Study with Pat. During a continuous observation on 11/19/25 as indicated above, Resident 46 was not taken to the activity (continued on next page)

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