STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Strategies	505 N Gavin St Muncie, IN 47303

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from verbal abuse and neglect from staff when a CNA refused to answer a resident's call light, refused to provide personal hygiene assistance, and told the resident to not use his call light for 1 of 3 residents reviewed for abuse. (Resident 10). This deficient practice resulted in the resident being afraid of the CNA (CNA 9), being left in soiled bedding, and being tearful and crying.Finding includes:During an interview, on 5/17/26 at 1:04 p.m., Resident 10 indicated he had filed a complaint about CNA 9 and did not know what was going on with the complaint. He was very upset and speaking with his voice high. He had reported to the facility that he had his call light on, and CNA 9 came into his room and told him he was on his call light too much. She yelled at him. She left him in a urine-soaked bed all night. He had not received care until the next shift. This was not the first time this had happened. He had told another CNA, who then completed the paperwork for him to file a grievance. He indicated he was still very upset and wanted to be assured that this behavior would not happen again. He pointed at Activity Assistant 8 and indicated she knew who took the statement from him and what happened. During an interview, on 5/17/26 at 1:07 p.m., Activity Assistant 8 indicated CNA 11 had taken the written statement for Resident 10's grievance. During an interview, on 5/17/26 at 1:08 p.m., LPN 3 indicated she had been present when CNA 11 had written a grievance form for Resident 10. She believed the CNA placed the grievance form in the Administrator, Social Service Designee, or DON's mailbox. During an interview, on 5/17/26 at 1:10 p.m., the Administrator indicated he had no knowledge of Resident 10's concern or a filed grievance. He would look into the matter and provide answers. During an interview on 5/17/26 at 1:59 p.m., the Administrator indicated CNA 11 completed the grievance form on behalf of Resident 10 and his concerns. She had put the form in the Social Service Designee's and the Administrator's mailboxes. She had not called to inform leadership of a report of neglect and/or abuse. The facility had now reported the allegation and began their investigation. CNA 9 was suspended pending investigation. Review of a Resident/Family Concern/Grievance Form, dated 5/16/26 at 7:10 a.m. indicated Resident 10 had a concern of grievance from 5/15/26 as follows: The form was completed by CNA 11. The allegation was that CNA 9 had yelled at the resident and told him to turn off his call light. She told him not to use his call light for the rest of the night because she didn't have time to keep coming to his room. Review of a written statement of a phone conversation with CNA 11, dated 5/17/26, indicated the following: The Administrator and Social Service Director spoke with CNA 11 regarding the Report of Concern form from Resident 10. CNA 11 stated that LPN 4 and CNA 10 were both present when he made the complaint against CNA 9. CNA 11 stated she filled out the form and put it in Social Service's mailbox. Management discussed with CNA 11 the accepted procedure for reporting. Review of a 5/17/26 investigation statement from CNA 10 indicated the following; Resident 10 stated that CNA 9 was always rude and refusing to change his colostomy (an opening in the abdomen to reroute the intestine) bag. Resident 10 said he told CNA 9 to not provide care to him, because she came into his room and stated he always had his call light on. On 5/16/26, CNA 10 did provide care to Resident 10 (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 0600 Level of Harm - Actual harm Residents Affected - Few	in place of CNA 9 per the resident's request. CNA 10 did hear Resident 10 tell CNA 9 to get out of his room. Resident 10 was upset and had also been upset on 5/16/26. CNA 10 did tell the nursing staff and wrote a statement about what was said at that time. During an interview on 5/20/26 at 10:05 a.m., the DON indicated she was not aware of what prior written statement CNA 10 was referencing. She would investigate the matter and provide more information. On 5/20/26 at 10:10 a.m., the DON provided a 5/15/26 written statement from CNA 10. She indicated she hadn't read the 5/15/26 statement until a couple of minutes ago. It had been in her mailbox, and she hadn't associated the two events. The 5/15/26, written statement from CNA 10 was provided by the DON on 5/20/26 at 10:10 a.m., and indicated CNA 10 was out with residents for smoke break. CNA 9 was sitting in a chair. There were call lights on for Resident 10's room and another resident's room. CNA 10 asked CNA 9 to answer the call lights. CNA 9 told her it was Resident 10's call light and she knew his [colostomy] bag wasn't full and he always had his call light on. The other resident needed a patch and there wasn't anything she could do about it. An activities staff member and a laundry staff member were also present. CNA 10 told CNA 9 there were 45 minutes until dinner, so answering the call lights would make sure the residents didn't need anything else. CNA 9 said no, so CNA 10 proceeded to smoke. The activities staff member answered the call lights and came back out and said Resident 10 needed his colostomy bag burped (opened enough to let gas out). Another CNA ended up emptying Resident 10's colostomy bag because CNA 9 left his bag open and it leaked all over. Another CNA pulled CNA 9 aside and tried to explain in private about Resident 10's concern and how to seal the bag. CNA 9 sat outside the whole time to chat. She walked past lights. CNA 10 told the Dietary Manager that CNA 9 needed retrained or more help and what had happened. CNA 10 proceeded to assist Resident 10 because his sheets were wet. CNA 9 sat at the nursing station and then went to ask Resident 10 what he needed, and he told her to leave. Resident 10 was pretty upset and crying tears. During a phone interview, on 5/20/2026 at 10:31 a.m., CNA 10 indicated the following: She wrote a statement regarding her concerns with Resident 10's care on 5/15/26. She put the statement in the DON's mailbox as the DON instructed. She didn't know if what occurred was abuse or neglect. Care was not provided, and the resident cried and was distressed. Because she did not know if what occurred was abuse or neglect, she did know it was wrong, so she went to the Dietary Manager, who was the only department head in the building, and told her about the concerns with CNA 9 refusing to answer Resident 10's call light and withholding care. The Dietary Manager called the DON and they both spoke with her. She reported her concerns to the DON and was asked to write a statement. The event happened between 3:45 p.m. and 4:30 p.m. During the event, she herself provided care to Resident 10. Resident 10's bed had been saturated with urine, and he was distressed and cried. During a phone interview with the Dietary Manager, on 5/20/26 at 10:57 a.m., she indicated the following: The evening of 5/15/26 CNA 10 and some other staff were upset about how CNA 9 was providing care and her failure to provide care. CNA 20 was also upset about the care given to Resident 10. CNA 20 said the resident was crying and upset and didn't want CNA 9 in his room. The Dietary Manager called the DON and told her about the concerns. She then passed the phone to CNA 10, who told the DON about her concerns with CNA 9 failing to provide care and providing incorrect care to Resident 10. At the end of the call, the Dietary Manager was instructed to have all staff who were present for the events complete written statements and place their statements in the DON's mailbox. A 5/15/26, written investigation statement by CNA 20 indicated the following: Around 4:00 p.m., CNA 9 was told to stay on the hall while the other CNAs went out to smoke. CNA 9 was outside ignoring call lights. CNA 9 spoke about resident business out loud in front of other residents and was complaining about residents and call lights. CNA 20 went inside to answer the call lights. When she got to Resident 10's room, his colostomy bag had been left with the clip not properly closed. Resident 10 told CNA 20 that CNA 9 had asked the resident how to close it and then made him do it. CNA 20 went outside and pulled CNA 9 to the side and told her how to properly close the clip. CNA 9 indicated she had never been trained to close a colostomy bag. CNA 9 continued to complain about Resident 10's call light. CNA 20 had to (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	change Resident 10 bedding two days back-to-back because CNA 9 forces him to sleep in urine covered sheets. One day she refused him a brief. Resident 10 is scared. CNA 9 is neglectful. An undated written investigation statement from Activity Assistant 8 indicated she answered Resident 10's call light on the day in question. The resident indicated he needed his colostomy bag checked. CNA 20 went to assist the resident. CNA 9 complained that Resident 10 always has his call light on. The Activity Assistant explained that the light needed to be answered, no matter how often the resident turned it on. Resident 10 called for the Activity Assistant as she walked by his room. He indicated to her that CNA 9 wouldn't help him and he started to get upset and teary eyed and he was worried that CNA 9 would be assigned to care for him all night. She reassured him. He was in tears, saying he was scared. During an interview on 5/20/2026 at 11:06 a.m., the DON indicated she did not remember any mention of withholding care or neglect of Resident 10 during the phone call on 5/15/25. She thought everyone was upset about colostomy care. A 5/17/26 written investigation statement by LPN 3 indicated she was off work on Friday 5/15/26 and when she came into work on 5/16/26, she saw CNA 11 talking to Resident 10 with a grievance form, however, did not ask about what the grievance was about. A written, undated, investigation statement by LPN 4 indicated Resident 10 came up to the writer and stated CNA 9 was always rude and did not want to help him. A 5/15/26 at 5:39 p.m. screenshot text from CNA 9 to the Business Office Manager indicated Resident 10 began screaming and yelling at her to get out, but she had not been in his room since she got there because another aide was assigned to him. He kept cussing her out and screaming at her and calling her inappropriate names because he was upset that she didn't answer the call light the second he turned it on and got upset she was helping another resident and wasn't giving him attention. A 5/17/26 telephone interview from CNA 9 indicated the following: CNA 20 took [room number] and she went in when the call light came on. As CNA 9 was walking past Resident 10's room to go to the common room, the resident started screaming at her to get out of his room and calling her inappropriate names. CNA 9 wasn't even in his room, just walking by to go to the common area. He continued calling her inappropriate names to other people, telling them that she wasn't taking care of him. Another time, the resident put on his light and started screaming help, but CNA 9 didn't hear him because she was changing another resident. Resident 10 got mad and told people she wasn't taking care of him, but she was getting another resident ready for bed and just had not gotten to him yet. CNA 9 was unavailable for interview during the survey dates. CNA 20 was unavailable for interview during the survey dates. The nurse staffing schedule for Thursday 5/14/26, Friday 5/15/26, and Saturday 5/17/26 indicated CNA 9 worked each day. During the three days, she worked from 2:00 p.m. to 10:00 p.m. She had not been sent home pending investigation of the allegation on 5/15/26. Resident 10's clinical record was reviewed on 5/18/25 at 11:58 a.m. Current diagnoses included mild intellectual disabilities, post-traumatic stress disorder, blindness of the right eye, low vision of left eye, anxiety disorder, major depressive disorder, and ileostomy. A 4/21/26, admission, Minimum Data Set (MDS) assessment indicated the resident had mild cognitive impairment, usually understood others, had unclear speech, was understood by others, usually understood, and had displayed no maladaptive behaviors during the assessment period. A current, 4/21/26, care plan indicated a problem/need regarding potential/actual impairment to skin integrity that may affect tissue perfusion, ileostomy status, anemia, nail dystrophy. Approaches to this need included assistance with routine toileting as needed and check routinely for incontinence and provide incontinent care as needed, notify nurse of redness or irritation. A current, 4/21/26, care plan indicated a problem/need regarding a diagnosis of anxiety with a history of symptoms such as increase in heart rate, racing thoughts, thinking about the same thing without being able to shift focus. A current, 4/21/26, care plan indicated a problem/need regarding depression with a history of symptoms such as tearfulness, sadness, and isolation. A current, September 2022, facility policy titled, Identifying Types of Abuse, provided by the DON via email on 5/21/26 at 10:48 a.m., indicated the following: Neglect/Deprivation of Goods and Services by Staff.Neglect is the failure of the facility, its employees or service providers to provide goods and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Mental and Verbal Abuse.Examples of mental and verbal abuse include, but are not limited to:.threatening residents, including but not limited to, depriving a resident of care. The following situation are recognized as those that are likely to cause psychosocial harm.When facility staff as punishment, threaten to.withhold care from the resident. A current, Indiana Department of Health Policy, titled Long-Term Care Abuse and Incident Reporting Policy, effective date: 12/8/22-9/1/27, provided by the DON via email on 5/21/26 at 10:48 a.m., and identified as a facility policy indicated: Alleged violation: Alleged violation is a situation or occurrence that is observed or reported by staff.but has not yet been investigated and if verified, could be noncompliance with the federal requirements.Deprivation of goods and services by staff: The deprivation of goods and services by staff is a form of abuse in which residents are deprived by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Choose not to do it or acknowledge the request. Abuse and incidents will be reported and submitted to the Indiana Department of Health in compliance with federal and/or state rules and regulations.Ensure that all alleged violations involving abuse, neglect.are reported immediately, but no later than two hours after the allegation is made. Instructions For Submitting an Incident Report:.h. Immediate action taken to respond to the event and protect the resident. i. Preventative measures taken while the investigation is in progress. 410 IAC (Indiana Administrative Code) 16.2-3.1 -27(a)410 IAC 16.2-3.1-27(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of verbal abuse and neglect to the Administrator immediately to allow for implementation of the facility's abuse prohibition policy, and also resulting in a delay of reporting to the Indiana Department of Health immediately or no later than two hours of the abuse allegation for 1 of 3 residents reviewed for abuse (Resident 10). Findings include:During an interview, on 5/17/26 at 1:04 p.m., Resident 10 indicated he had filed a complaint about CNA 9 and did not know what was going on with the complaint. He was very upset and speaking with his voice high. He had reported to the facility that he had his call light on, and CNA 9 came into his room and told him he was on his call light too much. She yelled at him. She left him in a urine-soaked bed all night. He had not received care until the next shift. This was not the first time this had happened. He had told another CNA, who then completed the paperwork for him to file a grievance. He indicated he was still very upset and wanted to be assured that this behavior would not happen again. He pointed at Activity Assistant 8 and indicated she knew who took the statement from him and what happened. During an interview, on 5/17/26 at 1:07 p.m., Activity Assistant 8 indicated CNA 11 had taken the written statement for Resident 10's grievance. During an interview, on 5/17/26 at 1:08 p.m., LPN 3 indicated she had been present when CNA 11 had written a grievance form for Resident 10. She believed the CNA placed the grievance form in the Administrator, Social Service Designee, or DON's mailbox. During an interview, on 5/17/26 at 1:10 p.m., the Administrator indicated he had no knowledge of Resident 10's concern or a filed grievance. He would look into the matter and provide answers. During an interview on 5/17/26 at 1:59 p.m., the Administrator indicated CNA 11 completed the grievance form on behalf of Resident 10 and his concerns. She had put the form in the Social Service Designee's and the Administrator's mailboxes. She had not called to inform leadership of a report of neglect and/or abuse. The facility had now reported the allegation and began their investigation. CNA 9 was suspended pending investigation. Review of a Resident/Family Concern/Grievance Form, dated 5/16/26 at 7:10 a.m. indicated Resident 10 had a concern of grievance from 5/15/26 as follows: The form was completed by CNA 11. The allegation was that CNA 9 had yelled at the resident and told him to turn off his call light. She told him not to use his call light for the rest of the night because she didn't have time to keep coming to his room. Review of a written statement of a phone conversation with CNA 11, dated 5/17/26, indicated the following: The Administrator and Social Service Director spoke with CNA 11 regarding the Report of Concern form from Resident 10. CNA 11 stated that LPN 4 and CNA 10 were both present when he made the complaint against CNA 9. CNA 11 stated she filled out the form and put it in Social Service's mailbox. Management discussed with CNA 11 the accepted procedure for reporting. Review of a 5/17/26 investigation statement from CNA 10 indicated the following; Resident 10 stated that CNA 9 was always rude and refusing to change his colostomy (an opening in the abdomen to reroute the intestine) bag. Resident 10 said he told CNA 9 to not provide care to him, because she came into his room and stated he always had his call light on. On 5/16/26, CNA 10 did provide care to Resident 10 in place of CNA 9 per the resident's request. CNA 10 did hear Resident 10 tell CNA 9 to get out of his room. Resident 10 was upset and had also been upset on 5/16/26. CNA 10 did tell the nursing staff and wrote a statement about what was said at that time. During an interview on 5/20/26 at 10:05 a.m., the DON indicated she was not aware of what prior written statement CNA 10 was referencing. She would investigate the matter and provide more information. On 5/20/26 at 10:10 a.m., the DON provided a 5/15/26 written statement from CNA 10. She indicated she hadn't read the 5/15/26 statement until a couple of minutes ago. It had been in her mailbox, and she hadn't associated the two events. The 5/15/26, written statement from CNA 10 was provided by the DON on 5/20/26 at 10:10 a.m., and indicated CNA 10 was out with residents for smoke break. CNA 9 was sitting in a chair. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were call lights on for Resident 10's room and another resident's room. CNA 10 asked CNA 9 to answer the call lights. CNA 9 told her it was Resident 10's call light and she knew his [colostomy] bag wasn't full and he always had his call light on. The other resident needed a patch and there wasn't anything she could do about it. An activities staff member and a laundry staff member were also present. CNA 10 told CNA 9 there were 45 minutes until dinner, so answering the call lights would make sure the residents didn't need anything else. CNA 9 said no, so CNA 10 proceeded to smoke. The activities staff member answered the call lights and came back out and said Resident 10 needed his colostomy bag burped (opened enough to let gas out). Another CNA ended up emptying Resident 10's colostomy bag because CNA 9 left his bag open and it leaked all over. Another CNA pulled CNA 9 aside and tried to explain in private about Resident 10's concern and how to seal the bag. CNA 9 sat outside the whole time to chat. She walked past lights. CNA 10 told the Dietary Manager that CNA 9 needed retrained or more help and what had happened. CNA 10 proceeded to assist Resident 10 because his sheets were wet. CNA 9 sat at the nursing station and then went to ask Resident 10 what he needed, and he told her to leave. Resident 10 was pretty upset and crying tears. During a phone interview, on 5/20/26 at 10:31 a.m., CNA 10 indicated the following: She wrote a statement regarding her concerns with Resident 10's care on 5/15/26. She put the statement in the DON's mailbox as the DON instructed. She didn't know if what occurred was abuse or neglect. Care was not provided, and the resident cried and was distressed. Because she did not know if what occurred was abuse or neglect, she did know it was wrong, so she went to the Dietary Manager, who was the only department head in the building, and told her about the concerns with CNA 9 refusing to answer Resident 10's call light and withholding care. The Dietary Manager called the DON and they both spoke with her. She reported her concerns to the DON and was asked to write a statement. The event happened between 3:45 p.m. and 4:30 p.m. During the event, she herself provided care to Resident 10. Resident 10's bed had been saturated with urine, and he was distressed and cried. During a phone interview with the Dietary Manager, on 5/20/26 at 10:57 a.m., she indicated the following: The evening of 5/15/26 CNA 10 and some other staff were upset about how CNA 9 was providing care and her failure to provide care. CNA 20 was also upset about the care given to Resident 10. CNA 20 said the resident was crying and upset and didn't want CNA 9 in his room. The Dietary Manager called the DON and told her about the concerns. She then passed the phone to CNA 10, who told the DON about her concerns with CNA 9 failing to provide care and providing incorrect care to Resident 10. At the end of the call, the Dietary Manager was instructed to have all staff who were present for the events complete written statements and place their statements in the DON's mailbox. A 5/15/26, written investigation statement by CNA 20 indicated the following: Around 4:00 p.m., CNA 9 was told to stay on the hall while the other CNAs went out to smoke. CNA 9 was outside ignoring call lights. CNA 9 spoke about resident business out loud in front of other residents and was complaining about residents and call lights. CNA 20 went inside to answer the call lights. When she got to Resident 10's room, his colostomy bag had been left with the clip not properly closed. Resident 10 told CNA 20 that CNA 9 had asked the resident how to close it and then made him do it. CNA 20 went outside and pulled CNA 9 to the side and told her how to properly close the clip. CNA 9 indicated she had never been trained to close a colostomy bag. CNA 9 continued to complain about Resident 10's call light. CNA 20 had to change Resident 10 bedding two days back-to-back because CNA 9 forces him to sleep in urine covered sheets. One day she refused him a brief. Resident 10 is scared. CNA 9 is neglectful. An undated written investigation statement from Activity Assistant 8 indicated she answered Resident 10's call light on the day in question. The resident indicated he needed his colostomy bag checked. CNA 20 went to assist the resident. CNA 9 complained that Resident 10 always has his call light on. The Activity Assistant explained that the light needed to be answered, no matter how often the resident turned it on. Resident 10 called for the Activity Assistant as she walked by his room. He indicated to her that CNA 9 wouldn't help him and he started to get upset and teary eyed and he was worried that CNA 9 would be assigned to care for him all night. She reassured him. He was in tears, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saying he was scared. During an interview on 5/20/2026 at 11:06 a.m., the DON indicated she did not remember any mention of withholding care or neglect of Resident 10 during the phone call on 5/15/25. She thought everyone was upset about colostomy care. A 5/17/26 written investigation statement by LPN 3 indicated she was off work on Friday 5/15/26 and when she came into work on 5/16/26, she saw CNA 11 talking to Resident 10 with a grievance form, however, did not ask about what the grievance was about. A written, undated, investigation statement by LPN 4 indicated Resident 10 came up to the writer and stated CNA 9 was always rude and did not want to help him. A 5/15/26 at 5:39 p.m. screenshot text from CNA 9 to the Business Office Manager indicated Resident 10 began screaming and yelling at her to get out, but she had not been in his room since she got there because another aide was assigned to him. He kept cussing her out and screaming at her and calling her inappropriate names because he was upset that she didn't answer the call light the second he turned it on and got upset she was helping another resident and wasn't giving him attention. A 5/17/26 telephone interview from CNA 9 indicated the following: CNA 20 took [room number] and she went in when the call light came on. As CNA 9 was walking past Resident 10's room to go to the common room, the resident started screaming at her to get out of his room and calling her inappropriate names. CNA 9 wasn't even in his room, just walking by to go to the common area. He continued calling her inappropriate names to other people, telling them that she wasn't taking care of him. Another time, the resident put on his light and started screaming help, but CNA 9 didn't hear him because she was changing another resident. Resident 10 got mad and told people she wasn't taking care of him, but she was getting another resident ready for bed and just had not gotten to him yet. CNA 9 was unavailable for interview during the survey dates. CNA 20 was unavailable for interview during the survey dates. The nurse staffing schedule for Thursday 5/14/26, Friday 5/15/26, and Saturday 5/17/26 indicated CNA 9 worked each day. During the three days, she worked from 2:00 p.m. to 10:00 p.m. She had not been sent home pending investigation of the allegation on 5/15/26. Resident 10's clinical record was reviewed on 5/18/25 at 11:58 a.m. Current diagnoses included mild intellectual disabilities, post-traumatic stress disorder, blindness of the right eye, low vision of left eye, anxiety disorder, major depressive disorder, and ileostomy. A 4/21/26, admission, Minimum Data Set (MDS) assessment indicated the resident had mild cognitive impairment, usually understood others, had unclear speech, was understood by others, usually understood, and had displayed no maladaptive behaviors during the assessment period. A current, 4/21/26, care plan indicated a problem/need regarding potential/actual impairment to skin integrity that may affect tissue perfusion, ileostomy status, anemia, nail dystrophy. Approaches to this need included assistance with routine toileting as needed and check routinely for incontinence and provide incontinent care as needed, notify nurse of redness or irritation. A current, 4/21/26, care plan indicated a problem/need regarding a diagnosis of anxiety with a history of symptoms such as increase in heart rate, racing thoughts, thinking about the same thing without being able to shift focus. A current, 4/21/26, care plan indicated a problem/need regarding depression with a history of symptoms such as tearfulness, sadness, and isolation. A current, September 2022, facility policy titled, Identifying Types of Abuse, provided by the DON via email on 5/21/26 at 10:48 a.m., indicated the following: Neglect/Deprivation of Goods and Services by Staff.Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Mental and Verbal Abuse.Examples of mental and verbal abuse include, but are not limited to:.threatening residents, including but not limited to, depriving a resident of care. The following situation are recognized as those that are likely to cause psychosocial harm.When facility staff as punishment, threaten to.withhold care from the resident. A current, Indiana Department of Health Policy, titled Long-Term Care Abuse and Incident Reporting Policy, effective date: 12/8/22-9/1/27, provided by the DON via email on 5/21/26 at 10:48 a.m., and identified as a facility policy indicated: Alleged violation: Alleged violation is a situation or occurrence that is observed or reported by staff.but has not yet been investigated and if verified, could be noncompliance with the federal (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requirements.Deprivation of goods and services by staff: The deprivation of goods and services by staff is a form of abuse in which residents are deprived by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Choose not to do it or acknowledge the request. Abuse and incidents will be reported and submitted to the Indiana Department of Health in compliance with federal and/or state rules and regulations.Ensure that all alleged violations involving abuse, neglect.are reported immediately, but no later than two hours after the allegation is made. Instructions For Submitting an Incident Report:.h. Immediate action taken to respond to the event and protect the resident. i. Preventative measures taken while the investigation is in progress. 410 IAC (Indiana Administrative Code) 16.2-3.1 -28(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their policy to immediately begin an investigation of an allegation of staff to resident verbal abuse and neglect, including taking action to protect residents and implementing preventative measures pending investigation for 1 of 3 residents reviewed for abuse (Resident 10). Findings include:During an interview, on 5/17/26 at 1:04 p.m., Resident 10 indicated he had filed a complaint about CNA 9 and did not know what was going on with the complaint. He was very upset and speaking with his voice high. He had reported to the facility that he had his call light on, and CNA 9 came into his room and told him he was on his call light too much. She yelled at him. She left him in a urine-soaked bed all night. He had not received care until the next shift. This was not the first time this had happened. He had told another CNA, who then completed the paperwork for him to file a grievance. He indicated he was still very upset and wanted to be assured that this behavior would not happen again. He pointed at Activity Assistant 8 and indicated she knew who took the statement from him and what happened. During an interview, on 5/17/26 at 1:07 p.m., Activity Assistant 8 indicated CNA 11 had taken the written statement for Resident 10's grievance. During an interview, on 5/17/26 at 1:08 p.m., LPN 3 indicated she had been present when CNA 11 had written a grievance form for Resident 10. She believed the CNA placed the grievance form in the Administrator, Social Service Designee, or DON's mailbox. During an interview, on 5/17/26 at 1:10 p.m., the Administrator indicated he had no knowledge of Resident 10's concern or a filed grievance. He would look into the matter and provide answers. During an interview on 5/17/26 at 1:59 p.m., the Administrator indicated CNA 11 completed the grievance form on behalf of Resident 10 and his concerns. She had put the form in the Social Service Designee's and the Administrator's mailboxes. She had not called to inform leadership of a report of neglect and/or abuse. The facility had now reported the allegation and began their investigation. CNA 9 was suspended pending investigation. Review of a Resident/Family Concern/Grievance Form, dated 5/16/26 at 7:10 a.m. indicated Resident 10 had a concern of grievance from 5/15/26 as follows: The form was completed by CNA 11. The allegation was that CNA 9 had yelled at the resident and told him to turn off his call light. She told him not to use his call light for the rest of the night because she didn't have time to keep coming to his room. Review of a written statement of a phone conversation with CNA 11, dated 5/17/26, indicated the following: The Administrator and Social Service Director spoke with CNA 11 regarding the Report of Concern form from Resident 10. CNA 11 stated that LPN 4 and CNA 10 were both present when he made the complaint against CNA 9. CNA 11 stated she filled out the form and put it in Social Service's mailbox. Management discussed with CNA 11 the accepted procedure for reporting. Review of a 5/17/26 investigation statement from CNA 10 indicated the following; Resident 10 stated that CNA 9 was always rude and refusing to change his colostomy (an opening in the abdomen to reroute the intestine) bag. Resident 10 said he told CNA 9 to not provide care to him, because she came into his room and stated he always had his call light on. On 5/16/26, CNA 10 did provide care to Resident 10 in place of CNA 9 per the resident's request. CNA 10 did hear Resident 10 tell CNA 9 to get out of his room. Resident 10 was upset and had also been upset on 5/16/26. CNA 10 did tell the nursing staff and wrote a statement about what was said at that time. During an interview on 5/20/26 at 10:05 a.m., the DON indicated she was not aware of what prior written statement CNA 10 was referencing. She would investigate the matter and provide more information. On 5/20/26 at 10:10 a.m., the DON provided a 5/15/26 written statement from CNA 10. She indicated she hadn't read the 5/15/26 statement until a couple of minutes ago. It had been in her mailbox, and she hadn't associated the two events. The 5/15/26, written statement from CNA 10 was provided by the DON on 5/20/26 at 10:10 a.m., and indicated CNA 10 was out with residents for smoke break. CNA 9 was sitting in a chair. There were call lights on for Resident 10's room and another resident's room. CNA 10 asked CNA 9 to answer the call lights. CNA 9 told her it was Resident 10's call light and she knew his [colostomy] (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bag wasn't full and he always had his call light on. The other resident needed a patch and there wasn't anything she could do about it. An activities staff member and a laundry staff member were also present. CNA 10 told CNA 9 there were 45 minutes until dinner, so answering the call lights would make sure the residents didn't need anything else. CNA 9 said no, so CNA 10 proceeded to smoke. The activities staff member answered the call lights and came back out and said Resident 10 needed his colostomy bag burped (opened enough to let gas out). Another CNA ended up emptying Resident 10's colostomy bag because CNA 9 left his bag open and it leaked all over. Another CNA pulled CNA 9 aside and tried to explain in private about Resident 10's concern and how to seal the bag. CNA 9 sat outside the whole time to chat. She walked past lights. CNA 10 told the Dietary Manager that CNA 9 needed retrained or more help and what had happened. CNA 10 proceeded to assist Resident 10 because his sheets were wet. CNA 9 sat at the nursing station and then went to ask Resident 10 what he needed, and he told her to leave. Resident 10 was pretty upset and crying tears. During a phone interview, on 5/20/26 at 10:31 a.m., CNA 10 indicated the following: She wrote a statement regarding her concerns with Resident 10's care on 5/15/26. She put the statement in the DON's mailbox as the DON instructed. She didn't know if what occurred was abuse or neglect. Care was not provided, and the resident cried and was distressed. Because she did not know if what occurred was abuse or neglect, she did know it was wrong, so she went to the Dietary Manager, who was the only department head in the building, and told her about the concerns with CNA 9 refusing to answer Resident 10's call light and withholding care. The Dietary Manager called the DON and they both spoke with her. She reported her concerns to the DON and was asked to write a statement. The event happened between 3:45 p.m. and 4:30 p.m. During the event, she herself provided care to Resident 10. Resident 10's bed had been saturated with urine, and he was distressed and cried. During a phone interview with the Dietary Manager, on 5/20/26 at 10:57 a.m., she indicated the following: The evening of 5/15/26 CNA 10 and some other staff were upset about how CNA 9 was providing care and her failure to provide care. CNA 20 was also upset about the care given to Resident 10. CNA 20 said the resident was crying and upset and didn't want CNA 9 in his room. The Dietary Manager called the DON and told her about the concerns. She then passed the phone to CNA 10, who told the DON about her concerns with CNA 9 failing to provide care and providing incorrect care to Resident 10. At the end of the call, the Dietary Manager was instructed to have all staff who were present for the events complete written statements and place their statements in the DON's mailbox. A 5/15/26, written investigation statement by CNA 20 indicated the following: Around 4:00 p.m., CNA 9 was told to stay on the hall while the other CNAs went out to smoke. CNA 9 was outside ignoring call lights. CNA 9 spoke about resident business out loud in front of other residents and was complaining about residents and call lights. CNA 20 went inside to answer the call lights. When she got to Resident 10's room, his colostomy bag had been left with the clip not properly closed. Resident 10 told CNA 20 that CNA 9 had asked the resident how to close it and then made him do it. CNA 20 went outside and pulled CNA 9 to the side and told her how to properly close the clip. CNA 9 indicated she had never been trained to close a colostomy bag. CNA 9 continued to complain about Resident 10's call light. CNA 20 had to change Resident 10 bedding two days back-to-back because CNA 9 forces him to sleep in urine covered sheets. One day she refused him a brief. Resident 10 is scared. CNA 9 is neglectful. An undated written investigation statement from Activity Assistant 8 indicated she answered Resident 10's call light on the day in question. The resident indicated he needed his colostomy bag checked. CNA 20 went to assist the resident. CNA 9 complained that Resident 10 always has his call light on. The Activity Assistant explained that the light needed to be answered, no matter how often the resident turned it on. Resident 10 called for the Activity Assistant as she walked by his room. He indicated to her that CNA 9 wouldn't help him and he started to get upset and teary eyed and he was worried that CNA 9 would be assigned to care for him all night. She reassured him. He was in tears, saying he was scared. During an interview on 5/20/2026 at 11:06 a.m., the DON indicated she did not remember any mention of withholding care or neglect of Resident 10 during the phone call on 5/15/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She thought everyone was upset about colostomy care. A 5/17/26 written investigation statement by LPN 3 indicated she was off work on Friday 5/15/26 and when she came into work on 5/16/26, she saw CNA 11 talking to Resident 10 with a grievance form, however, did not ask about what the grievance was about. A written, undated, investigation statement by LPN 4 indicated Resident 10 came up to the writer and stated CNA 9 was always rude and did not want to help him. A 5/15/26 at 5:39 p.m. screenshot text from CNA 9 to the Business Office Manager indicated Resident 10 began screaming and yelling at her to get out, but she had not been in his room since she got there because another aide was assigned to him. He kept cussing her out and screaming at her and calling her inappropriate names because he was upset that she didn't answer the call light the second he turned it on and got upset she was helping another resident and wasn't giving him attention. A 5/17/26 telephone interview from CNA 9 indicated the following: CNA 20 took [room number] and she went in when the call light came on. As CNA 9 was walking past Resident 10's room to go to the common room, the resident started screaming at her to get out of his room and calling her inappropriate names. CNA 9 wasn't even in his room, just walking by to go to the common area. He continued calling her inappropriate names to other people, telling them that she wasn't taking care of him. Another time, the resident put on his light and started screaming help, but CNA 9 didn't hear him because she was changing another resident. Resident 10 got mad and told people she wasn't taking care of him, but she was getting another resident ready for bed and just had not gotten to him yet. CNA 9 was unavailable for interview during the survey dates. CNA 20 was unavailable for interview during the survey dates. The nurse staffing schedule for Thursday 5/14/26, Friday 5/15/26, and Saturday 5/17/26 indicated CNA 9 worked each day. During the three days, she worked from 2:00 p.m. to 10:00 p.m. She had not been sent home pending investigation of the allegation on 5/15/26. Resident 10's clinical record was reviewed on 5/18/25 at 11:58 a.m. Current diagnoses included mild intellectual disabilities, post-traumatic stress disorder, blindness of the right eye, low vision of left eye, anxiety disorder, major depressive disorder, and ileostomy. A 4/21/26, admission, Minimum Data Set (MDS) assessment indicated the resident had mild cognitive impairment, usually understood others, had unclear speech, was understood by others, usually understood, and had displayed no maladaptive behaviors during the assessment period. A current, 4/21/26, care plan indicated a problem/need regarding potential/actual impairment to skin integrity that may affect tissue perfusion, ileostomy status, anemia, nail dystrophy. Approaches to this need included assistance with routine toileting as needed and check routinely for incontinence and provide incontinent care as needed, notify nurse of redness or irritation. A current, 4/21/26, care plan indicated a problem/need regarding a diagnosis of anxiety with a history of symptoms such as increase in heart rate, racing thoughts, thinking about the same thing without being able to shift focus. A current, 4/21/26, care plan indicated a problem/need regarding depression with a history of symptoms such as tearfulness, sadness, and isolation. A current, September 2022, facility policy titled, Identifying Types of Abuse, provided by the DON via email on 5/21/26 at 10:48 a.m., indicated the following: Neglect/Deprivation of Goods and Services by Staff.Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Mental and Verbal Abuse.Examples of mental and verbal abuse include, but are not limited to:.threatening residents, including but not limited to, depriving a resident of care. The following situation are recognized as those that are likely to cause psychosocial harm.When facility staff as punishment, threaten to.withhold care from the resident. A current, Indiana Department of Health Policy, titled Long-Term Care Abuse and Incident Reporting Policy, effective date: 12/8/22-9/1/27, provided by the DON via email on 5/21/26 at 10:48 a.m., and identified as a facility policy indicated: Alleged violation: Alleged violation is a situation or occurrence that is observed or reported by staff.but has not yet been investigated and if verified, could be noncompliance with the federal requirements.Deprivation of goods and services by staff: The deprivation of goods and services by staff is a form of abuse in which residents are deprived by staff of goods or services that are (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	necessary to attain or maintain physical, mental, and psychosocial well-being. Choose not to do it or acknowledge the request. Abuse and incidents will be reported and submitted to the Indiana Department of Health in compliance with federal and/or state rules and regulations.Ensure that all alleged violations involving abuse, neglect.are reported immediately, but no later than two hours after the allegation is made. Instructions For Submitting an Incident Report:.h. Immediate action taken to respond to the event and protect the resident. i. Preventative measures taken while the investigation is in progress.410 IAC (Indiana Administrative Code) 16.2-3.1 -28(d)410 IAC 16.2-3.1-28 (e)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure residents and/or their representatives were informed of and given notice of transfer/discharge and bed hold documents for 2 of 4 residents reviewed for hospitalization. (Residents 26 and 42) Findings include: 1.Resident 42's record was reviewed on 3/19/26 at 9:10 a.m. Medical diagnoses included alcohol dependence, anxiety, and traumatic brain injury.A 10/7/25 social service note indicated the resident was transported to a neuropsychiatric hospital at 4:50 p.m. A notice of transfer/discharge was not signed by the resident or representative.A 2/5/26 social service note indicated the resident was transported to a neuropsychiatric hospital at 3:01 a.m. A notice of transfer/discharge was not signed by the resident or representative.A 3/5/26 nurse's note indicated resident 42 was transported to a neuropsychiatric hospital at 8:12 p.m. The record lacked a notice of transfer/discharge and bed hold policy for this date.The record lacked resident and/or representative notification regarding notice of transfer/discharge and bed hold policy.2.Resident 26's record was reviewed on 3/19/26 at 9:56 a.m. Medical diagnoses included dementia, insomnia, and hypertension.A 2/23/26 social service note indicated the resident was sent to an inpatient psychiatric hospital at 3:46 a.m. A notice of transfer/discharge and bed hold policy was not signed by the resident or representative.During an interview, on 5/21/26 at 9:32 a.m., QMA 15 indicated when a resident was sent to the hospital, a medication list and bed hold policy was given to the emergency medical technicians (EMTs). She could not recall if the documents needed to be given to a resident or representative.During a 5/21/26 interview at 10:06 a.m., LPN 16 indicated residents were sent to an outside hospital with a medication list and bed hold policy. This paperwork was given to the EMTs. She could not recall if the documents needed to be given to the resident or representative.During an interview, on 5/21/26 at 10:07 a.m., the Social Services Director indicated nursing staff were supposed to send residents to the hospital with a medication list, notice of transfer/discharge, and bed hold policy. The paperwork was given to the EMTs and a copy placed in the medical records office. Family and resident representatives were notified of the transfer.An Indiana State Form 49669 titled Notice of Transfer and Discharge, provided by the DON via email on 5/20/26 at 3:53 p.m. and identified as the form used by the facility for resident transfers and discharges indicated as follows: .A transfer and discharge notice must include the effective date, where the resident was to be discharged to, the reason for transfer or discharge, and the resident's appeal rights .410 Indiana Administrative Code 16.2-3.1-12(a)(6)(A)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. A. Based on observation, interview, and record review, the facility failed to utilize infection prevention and control measures regarding contact isolation during insulin administration for 1 of 10 residents reviewed for medication administration. (Resident 11)B. Based on observation and interview, the facility failed to utilize infection prevention and control measures while handling medications with bare hands for 1 of 10 residents reviewed for medication administration. (Resident 36)C. Based on observation and interview, the facility failed to utilize infection prevention and control measures regarding enhanced barrier precautions (EBP) during catheter care for 1 of 3 residents reviewed for enhanced barrier precautions. (Resident 1)Findings include: A. During an observation, on 5/17/26 at 11:46 a.m., LPN 3 entered Resident 11's contact isolation room wearing only gloves and obtained the resident's blood glucose. She doffed her gloves, returned the glucometer to a barrier on the medication cart in the hallway, and performed hand hygiene. LPN 3 prepared the resident's insulin, donned gloves, and re-entered the resident's contact isolation room without a gown. She leaned in against the resident's bed sheets with her pant leg, cleansed the skin of the resident's right upper arm, and administered the insulin. The contact isolation sign above the resident's bed indicated everyone must don a gown and gloves prior to entry to the resident's room. During an interview, on 5/17/26 at 1:46 p.m., LPN 3 indicated Resident 11 was in contact isolation due to a MRSA (Methicillin-resistant Staphylococcus aureus) wound infection. The resident's right lateral foot wound required a wound VAC (vacuum-assisted closure for wound healing). She believed the contact isolation should have been followed during wound care instead of insulin administration. On 5/17/26 at 2:08 p.m., LPN 3 indicated she found out personal protective equipment for contact isolation rooms must be donned prior to entering the resident's room and providing care. Resident 11's clinical record was reviewed on 5/17/26 at 2:37 p.m. Diagnoses included type 2 diabetes mellitus with foot ulcer. Current orders included contact barrier precautions every shift for right lateral foot wound drainage (3/30/26). Discontinued orders included doxycycline hyclate (broad spectrum antibiotic)100 mg tablet twice daily for MRSA for 28 administrations (2/26/26). A current care plan, initiated 11/3/25, indicated the resident had a right foot diabetic foot ulcer with enhanced barrier precautions. Interventions included a wound vac to the right foot (3/26/26). The care plan was last revised on 3/26/26. The comprehensive care plan lacked revisions related to a MRSA wound infection with contact isolation. A progress note, dated 5/17/26 at 8:46 a.m., indicated the resident remained on contact isolation with a wound vac to the right foot. The wound vac had foul odorous drainage suctioned into the canister. During an interview, on 5/17/26 at 4:01 p.m., the DON indicated Resident 11 was in contact isolation due to a MRSA wound infection. Staff were required to don a gown and gloves prior to entering residents' rooms with contact isolation. On 5/17/26 at 4:35 p.m., the DON indicated Resident 11's comprehensive care plan should have been updated with contact isolation precautions related to the MRSA wound infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, revised 4/2019, titled Administering Medications, provided by the DON on 5/17/26 at 4:24 p.m., indicated the following: Policy Statement. Medications are administered in a safe and timely manner, and as prescribed. 25. Staff follows established facility infection control procedures (e.g. isolation precautions, etc.) for the administration of medications, as applicable. B1. During an observation, on 5/17/26 at 1:01 p.m., LPN 4 opened the drawers to the East Unit medication cart and popped Resident 36's medications into a medication cup without performing hand hygiene. The medications included quetiapine fumarate (schizophrenia) 25 mg half a tablet, buspirone (anxiety) 15 mg one tablet, ropinirole (Parkinson's disease) 0.25 mg one tablet, and divalproex sodium (seizures) delayed release oral capsule 125 mg four capsules. LPN 4 removed the quetiapine fumarate from the medication cup with her bare fingers and placed it into the vanilla pudding. She crushed the buspirone and ropinirole and placed it into the pudding. LPN 4 used her bare hands to open the four quetiapine fumarate capsules and poured the contents into the pudding. The contaminated medications were administered to Resident 36 on 5/17/26 at 1:05 p.m. Resident 36's clinical record was reviewed on 5/17/26 at 3:38 p.m. Diagnoses included Parkinson's disease, paranoid schizophrenia, general anxiety disorder, major depressive disorder, and mood disorder due to known physiological condition with manic features. Current orders included quetiapine fumarate 25 mg give 0.5 tablet in the afternoon (2/28/26), divalproex sodium delayed release 125 mg give four capsules by mouth three times a day (2/28/26), ropinirole hydrochloride 0.25 mg three time a day (8/24/24), and buspirone hydrochloride 15 mg three times a day. During an interview, on 5/17/26 at 3:26 p.m., LPN 4 indicated she should not have handled medications with her bare hands due to cross contamination. On 5/17/26 at 4:01 p.m., the DON indicated staff should not handle medications with their bare hands. A current facility policy, revised 4/2019, titled Administering Medications, provided by the DON on 5/17/26 at 4:24 p.m., indicated the following: Policy Statement. Medications are administered in a safe and timely manner, and as prescribed. 25. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. C. During a general facility observation, on 5/20/26 at 1:09 p.m., Resident 1 was resting in a low bed. An EBP sign on the resident's door read as follows: EVERYONE MUST: clean their hands including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy Wound Care: any skin opening requiring a dressing. During a catheter care observation, on 5/21/26 at 10:20 a.m., CNA 14 entered Resident 1's room wearing gloves. CNA 14 opened the spout of Resident 1's catheter collection bag and emptied the urine into a graduated cylinder. Hand hygiene was performed and the resident's blankets were adjusted. During an interview concurrent with the observation, the Infection Preventionist (IP) and CNA 14 indicated that a gown was supposed to be worn during high contact care for residents on enhanced (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E064	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Strategies	505 N Gavin St Muncie, IN 47303

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	barrier precautions. A current facility policy titled Enhanced Barrier Precautions, revised December 2024, and provided by the DON on 5/17/26 at 4:24 p.m. indicated the following: .1.Enhance barrier precautions (EBPs refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organism (MDROs) during high contact resident care activities. 2. Enhanced barrier precautions apply when: .b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained.5. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies.6. Examples of secretions or excretions include wound drainage, fecal incontinence or diarrhea, or other discharged from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen 7. EBPS employ targets gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing high contact resident care activities (as opposed to before entering the room).8 Examples of high-contact resident care activities required the use of gown and gloves for EBPs include: .i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.).16. Staff are trained prior to caring for residents on EBPs. 17. Signs are posted on the door or wall outside the resident's rooms which communicate the type of precautions and PPE required. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(a) 410 IAC 16.2-3.1-18(l)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure the Indiana Department of Health Annual Survey Report was readily available for review for residents and visitors without requiring to request the report from a staff member. Findings include:During a Resident Group Interview, on 5/19/26 at 9:55 a.m., the residents indicated they did not know where the Indiana Depart of Health Survey Report was available for review. Two residents indicated they would like to review the annual survey report and did not know where it was located.During an observation, on 5/19/26 at 10:40 a.m., a framed sign posted on the wall by the entrance/exit front doors adjacent to the nurses station, approximately 8 inches by 10 inches, had multiple lines of information listed. The sign was posted over 6 feet high. The last line of posted information indicated the Annual Survey results were available at the nurse's desk.During an interview and observation, on 5/19/26 at 10:46 a.m., LPN 3 indicated she believed the Indiana Depart of Health Annual Survey Report binder was located somewhere behind the nurse's station/desk. She looked around the area and found the binder located under the nurse's desk. She indicated residents and guests were not allowed behind the nurse's desk. They would need to ask a staff member for the report binder and the staff member would have to obtain the binder for them. During an interview and observation, on 5/21/26 at 9:25 a.m., QMA 12 indicated the Annual Survey Binder was located behind the nurse's station behind the desk. She looked around her surroundings and located the binder. She indicated residents, their representatives, and guests could not go behind the nurse's desk. They could not access the survey binder for themselves. They would have to have an employee obtain the survey binder for them. During an interview and observation, on 5/21/26 at 9:27 a.m., the Administrator indicated the Indiana Department of Health Annual Survey Report Binder was located behind the nurse's desk at the nurse's station. He walked behind the desk. He looked at a bookshelf under the desk, taking a few moments to locate the binder. He indicated residents, their representatives, and guests were not allowed behind the nurse's station and would have to request a staff member obtain the survey binder for their review. He also indicated the sign regarding the location of the survey binder was located about 6 feet high and could be difficult for individuals in wheelchairs to read. A current, October 2025, facility policy titled, Resident Rights, provided by the DON via email indicated the following: Federal and state laws guarantee certain basic rights to all residents. the resident's right to.w. examine survey results; State rules: 410 IAC (Indiana Administrative Code) 16.2-3.1(b)(2)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure daily staff posting was readily accessible and visible to residents and visitors for 5 of 5 days reviewed for staff posting. Findings include: During a general facility observation on 5/17/26 at 10:18 a.m. the daily staff posting was framed on a wall behind the nurse's station and located such that it could not be read without entering the nurse's station.During a general facility observation on 5/18/26 at 10:10 a.m. the daily staff posting was framed on a wall behind the nurse's station and located such that it could not be read without entering the nurse's station.During a general facility observation on 5/19/26 at 8:03 a.m. the daily staff posting was framed on a wall behind the nurse's station and located such that it could not be read without entering the nurse's station.During a general facility observation on 5/20/26 at 8:34 a.m. the daily staff posting was framed on a wall behind the nurse's station and located such that it could not be read without entering the nurse's station.During a general facility observation on 5/21/26 at 8:58 a.m. the daily staff posting was framed on a wall behind the nurse's station and located such that it could not be read without entering the nurse's station.During an interview, on 5/20/26 at 8:29 a.m., QMA 15 indicated she was unable to read the daily staff posting from her position at the medication cart in front of the nurse's station (approximately eight (8) feet from the wall where the staff posting was affixed).During an interview, on 5/20/26 at 9:28 a.m., LPN 3 indicated she was unable to read the daily staff posting from her position in front of the nurse's station. (approximately eight (8) feet from the wall where the staff posting was affixed).During an interview, on 5/20/26 at 10:17 a.m., QMA 12 indicated she was unable to read the daily staff posting from her position in front of the nurse's station. (approximately eight (8) feet from the wall where the staff posting was affixed).During an interview, on 5/21/26 at 9:32 a.m., the Administrator indicated he was unable to read the daily staff posting from his position in front of the nurse's station (approximately eight (8) feet from the wall where the staff posting was affixed). He indicated residents and visitors were not allowed to go behind the desk in the nurse's station to read the daily staff posting.A current facility policy, titled, Posting Direct Care Daily Staff Numbers, revised August 2022, provided by the DON on 5/21/26 at 10:41 a.m., indicated the following: .1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.4. The form may by typed or handwritten. If completed electronically, the recorded information will be a minimum font size of 12 points. If the information is handwritten, it must be legibly printed in black ink and written so that staffing data can be easily seen and read by residents, staff, visitors, or others who are interested in our facility's daily staffing information.