STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENCE VILLAGE OF FISHERS SOUTH	9745 OLYMPIA DR, FISHERS, , 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake 465534. Intake 465534 - State deficiencies related to the allegation(s) are cited at R0052, R0091, and R0217. Survey Dates: November 5 and 6, 2025. Facility Number: 002999 Residential Census: 92 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 13, 2025.	R 0000	The submission of the Plan of Correction does not indicate an admission by Independence Village of Fishers South that the findings and allegations contained herein are an accurate and true representation of the Quality of Care provided to the residents of Independence Village of Fishers South. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the Credible Allegation of Compliance with all State requirements governing the operations of this Community.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be	R 0052	1 The identified resident was affected by the deficient practice.	12/01/2025

	free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from abuse, resulting in fear, anxiety, frustration, discomfort, and inability to sleep for 1 of 5 residents reviewed for abuse. (Resident B) Findings include: The follow-up incident report, dated 10/24/25, indicated on 10/17/25 the family of Resident B reported an incident that took place in the apartment of Resident B. The family had a camera in the apartment and they witnessed an incident between Resident B and Resident D that took place between the hours of 6:00 p.m. and 7:45 p.m. on 10/16/25. The video showed Resident D in the apartment of Resident B displaying several behaviors that would be considered inappropriate in a sexual manner. Resident D tried several times to remove clothing		2 The community realizes that all residents have the potential to be affected by the deficient practice. 3 The community will provide resident rights in-service for staff with a completion date no later than December 1st, 2025. In addition, we will conduct monthly in-service with a focus on Resident Rights and continue discussions with all staff with regard to resident rights. 4The executive director will monitor this daily by reviewing and signing the 24-hour report provided by the Wellness Director. This will ensure that all incidents are addressed and proper action is taken. The Executive Director and Wellness Director will continue to monitor residents for any change in conditions that may lead to any change in behavior.	

	from Resident B, and on two occasions was successful in pulling down the pants of Resident B. It was also witness that Resident D watched as Resident B went to the bathroom to urinate. Resident D asked questions of Resident B that clearly made Resident B uncomfortable. The Immediate Action Taken section of the report indicated the staff were interviewed and asked if any other incidents similar to this had been witnessed. The family of Resident D was notified and informed they would need to provide 24 hour care to stay with Resident D, and he would need to eat all meals in his apartment and to stay away from Resident B. Resident D was interviewed about the incident. The ED was going to begin the discharge process for Resident D to ensure all residents were safe. The Preventive Measures Taken section of the report indicated Resident D would receive 24 hour care to ensure he did not enter any other resident apartments or converse with Resident B. Both residents would be on two hour checks to ensure safety. The follow up section of the report indicated the ED made the determination that Resident D would need to vacate the community as he posed a risk to others in the community. Resident D would continue to have one on one			

	care until his family found alternate housing. An interview was conducted with Resident B's Family Member 3, on 11/5/25 at 2:18 p.m. He indicated he checked the camera in Resident B's room periodically. They happened to check it around 11:00 p.m. the night of 10/16/25. They saw some things that made them uncomfortable, that occurred that same day around 6:00 p.m., so they watched the video and went to the facility immediately afterwards at 12:30 in the morning on 10/17/25. They left a note that they needed to speak with the ED in the morning. He let the ED watch the video, and she was concerned with what she saw, so she did an investigation. Family Member 3 never previously saw anything like what he saw on the camera the night of 10/16/25. It went on for close to an hour and a half. Resident B was in "a weakened mental and physical state." His mind wasn't what it used to be. Resident D followed Resident B into his room and informed him he noticed Resident B walking slowly, and wanted to make sure he made it back to his room safely, "a predatory way of being sexual with my dad." Resident D kept trying to get Resident be to "loosen up,"			

	saying 'Take off your coat. Aren't you hot? You're losing weight. Let me check those pants. Are you circumcised? The camera in the room picked up when a person entered the room. Resident D kept being inappropriate and weird. Resident D got his underwear down, and Resident B realized it wasn't right. Resident D suggested Resident B go to the bathroom. Resident B went to the bathroom to urinate, and Resident D "followed, peeking around the corner, looking at him." Family Member 3 was uncomfortable watching the video. Resident B got to the point he realized Resident D was not acting right and asked Resident D to leave. Resident D left the room, but came back 15 minutes later, because he forgot his phone and drink. Resident D got his stuff and immediately left the room. Family Member 3 pressed charges with the city police, because he was concerned Resident D may have done this before. Resident B got up three or four times that night to make sure his door was locked, and he usually didn't lock his door, so Family Member 3 knew Resident B was scared. Resident D actually made physical contact with Resident B, grabbed his waist band of his sweat pants, had his hand on Resident B's knee, and helped take his pants and underwear down, which is when Resident B			

	realized something wasn't right. Resident B was "shook up," over the incident. Resident B called his best friend and told him about it. When Family Member 3 arrived at the facility the next day, Resident B said he was afraid he was "the guy from last night." Resident B told him about it, as well as the nursing staff. The next night, Resident B said he need to buy a Billy club 'in case that guy comes back.' Resident B went to church the following Sunday, and was telling people at church about it. Family Member 3 had discussed a few weeks prior to this incident, moving his dad into the memory care unit of the facility. He ended up moving onto the memory care unit about a week ago. The investigation included a written statement, dated 10/17/25, from CNA (Certified Nursing Assistant) 2. It indicated she assisted Resident B with a shower on 10/17/25. During the shower, Resident B continued to talk about Resident D coming into his room the previous night, asking him to engage in inappropriate activities, and asking him if he wanted to "try some stuff," had him pull his pants down. Resident B was very upset. An interview was conducted with CNA 8 on 11/6/25 at 10:09 a.m. He indicated he'd worked			

	at the facility for over two years as a CNA. Resident D would get "really friendly, like in my bubble." CNA 8 thought Resident D was bisexual, liked other men, but "hadn't really" hit on him. Resident D would shake his hand over excessively, pat him the back, "touch me." Resident D was in Resident B's room and did some things he wasn't supposed to do, but CNA 8 suspected Resident D was bisexual before the incident involving Resident B, because of the way Resident D interacted with CNA 8. "I would say for months he's acted like this." Resident D would jokingly talk about inappropriate things, lift his shirt up to see what kind of boxers he was wearing. This was six plus months ago. CNA 8 did not tell anyone about it, because it made him feel uncomfortable. CNA 8 got along with Resident D, but Resident D would "try to push the boundaries." CNA 8 was assertive, but it was "kind of weird." Staff who worked in the kitchen would discuss Resident D's sexuality a long time ago, "like a year ago." CNA 8 did not discuss this with the ED or WD, because he was uncomfortable and scared. CNA 8 did not want Resident D to be "penalized," because he thought he was a good person, but he overstepped his boundaries. Resident D tried to see his boxers "a couple of times,"			

since he began working there.

An interview was conducted with the EC (Executive Chef) on 11/6/25 at 10:15 a.m. He indicated Server 7 informed him that Resident D spoke with him appropriately. Server 7 texted him to inform him of the incident. The EC informed the ED about it and forwarded the text messages to her. He never heard anything else about it after that. He informed Server 7 to not go to Resident D's table anymore. There hadn't been any incidents since that he was aware of.

During the 11/6/25, 10:15 a.m. interview with the EC, the EC provided his cell phone for review of the 10/13/25, 7:35 p.m. text message he received from Server 7. The text message indicated Server 7 sat down at Resident D's table in the dining room to converse with Resident D, like he always did, when he wasn't busy working. The conversation started with Resident D asking about Server 7's tattoos, then about working out, asking Server 7 to pick him up and take him to the gym with him. Resident D started to ask him if he had chest hair, pubic hair, and if he was circumcised or not. Resident D told Server 7 to show him his chest hair, and asked if his shirt was untucked. When Resident D noticed Server 7's shirt was not

	untucked, he told Server 7 to lift up his shirt. He then told Server 7 he wanted him to make him a peanut butter and jelly sandwich to go. Server 7 informed Resident D he'd have one of the nursing staff bring him the sandwich, to which Resident D informed him he would like for Server 7 to personally go to his room. Server 7 did not make the sandwich or bring anything to his room. An interview was conducted with the ED and WD (Wellness Director) on 11/6/25 at 11:29 a.m. The ED indicated she found out about the incident the following day. She was shocked, when the family presented the video to her. She spoke with Resident D, who denied anything occurred. Resident D was currently still receiving one on one supervision and scheduled to move out of the facility tomorrow. An interview was conducted with CNA 2 on 11/6/25 at 10:33 a.m. She indicated when she assisted Resident B with his shower on 10/17/25, he was "worked up" because of the incident that happened the night before. He was "real worried" about his door being locked, and making sure "that weird guy" didn't come into his room. Resident B informed CNA 2 that Resident D wanted to "put the			

	cream on me" and "does it better than you guys." Resident B just kept talking about it "over and over," getting him to go to the bathroom, and putting the cream on him. CNA 2 could tell Resident B was "frustrated and cautious, worried it would happen again." Resident B moved from the assisted living side of the facility into the memory care unit about a week ago, and since he'd been on the memory care unit, he hadn't mentioned the incident. An observation and interview was conducted with Resident B in his new room on the memory care unit of the facility with CNA 2 on 11/6/25 at 10:38 a.m. He was sitting in a chair at the table. He appeared pleasant and calm and had a good rapport with CNA 2. He indicated he was doing okay and that staff treated him well. The clinical record for Resident D was reviewed on 11/5 at 11:00 a.m. His diagnoses included, but were not limited to: depression, insomnia, and anxiety. The SLUMS (Saint Louis University Mental Status) Evaluation, dated 3/28/25, indicated the resident had normal cognitive function. The Service Plan, dated 3/19/25, indicated he was			

	oriented to person, place, time and situation. The Wellness Evaluation, dated 10/7/25, indicated he communicated clearly; and understood and expressed wants and needs. The clinical record for Resident B was reviewed on 11/5/25 at 11:18 a.m. His diagnoses included, but were not limited to: dementia, hypertension, and type 2 diabetes. The SLUMS Evaluations, dated 7/4/25 and 10/7/25, indicated he had a diagnosis of dementia. The Wellness Evaluation, dated 9/8/25, indicated in regard to his reasoning ability, he may exhibit sun-downing behavior, resistance to care, occasional wandering, or routinely exhibited anxious behavior requiring staff attention. The Global Deterioration Scale, dated 10/30/25, indicated the resident had moderately severe dementia. He no longer survived without some assistance. He may forget details of his phone number, address, names of close family members, or the schools he attended. He was unable to perform some activities of daily living. The Abuse, Neglect, or Financial Exploitation policy was provided by the ED on 11/5/25			

	at 11:02 a.m. It indicated, "The purpose of the Abuse, Neglect, or Financial Exploitation policy is to outline the process for the prevention, investigation, and reporting of abuse, neglect or financial exploitation....Abuse-any physical or mental injury or sexual assault inflected on a resident, other than by accidental means, in an establishment....The community will address situations in which abuse, neglect or exploitation are more likely to occur. This includes, but is not limited to, the following: ...Supervision of staff to identify and address any inappropriate behaviors...Care planning of residents with special needs and/or behavior expressions that might lead to conflict, or neglect. Examples of special needs and/or behavior expressions may include refusal or resistance to care, entering other residents' rooms uninvited, exit seeking, self-injury, and communication difficulties." This Citation relates to Complaint IN00465534.			

	Based on interview and record review, the facility failed to ensure a resident was free from abuse, resulting in fear, anxiety, frustration, discomfort, and inability to sleep for 1 of 5 residents reviewed for abuse. (Resident B) Findings include: The follow-up incident report, dated 10/24/25, indicated on 10/17/25 the family of Resident B reported an incident that took place in the apartment of Resident B. The family had a camera in the apartment and they witnessed an incident between Resident B and Resident D that took place between the hours of 6:00 p.m. and 7:45 p.m. on 10/16/25. The video showed Resident D in the apartment of Resident B displaying several behaviors that would be considered inappropriate in a sexual manner. Resident D tried several times to remove clothing from Resident B, and on two occasions was successful in pulling down the pants of Resident B. It was also witness that Resident D watched as Resident B went to the bathroom to urinate. Resident D asked questions of Resident B that clearly made Resident B uncomfortable. The Immediate Action Taken section of the report indicated the staff were interviewed and asked if any			

	other incidents similar to this had been witnessed. The family of Resident D was notified and informed they would need to provide 24 hour care to stay with Resident D, and he would need to eat all meals in his apartment and to stay away from Resident B. Resident D was interviewed about the incident. The ED was going to begin the discharge process for Resident D to ensure all residents were safe. The Preventive Measures Taken section of the report indicated Resident D would receive 24 hour care to ensure he did not enter any other resident apartments or converse with Resident B. Both residents would be on two hour checks to ensure safety. The follow up section of the report indicated the ED made the determination that Resident D would need to vacate the community as he posed a risk to others in the community. Resident D would continue to have one on one care until his family found alternate housing. An interview was conducted with Resident B's Family Member 3, on 11/5/25 at 2:18 p.m. He indicated he checked the camera in Resident B's room periodically. They happened to check it around 11:00 p.m. the night of 10/16/25. They saw some things			

	that made them uncomfortable, that occurred that same day around 6:00 p.m., so they watched the video and went to the facility immediately afterwards at 12:30 in the morning on 10/17/25. They left a note that they needed to speak with the ED in the morning. He let the ED watch the video, and she was concerned with what she saw, so she did an investigation. Family Member 3 never previously saw anything like what he saw on the camera the night of 10/16/25. It went on for close to an hour and a half. Resident B was in "a weakened mental and physical state." His mind wasn't what it used to be. Resident D followed Resident B into his room and informed him he noticed Resident B walking slowly, and wanted to make sure he made it back to his room safely, "a predatory way of being sexual with my dad." Resident D kept trying to get Resident be to "loosen up," saying 'Take off your coat. Aren't you hot? You're losing weight. Let me check those pants. Are you circumcised? The camera in the room picked up when a person entered the room. Resident D kept being inappropriate and weird. Resident D got his underwear down, and Resident B realized it wasn't right. Resident D suggested Resident B go to the bathroom. Resident B went to			

	the bathroom to urinate, and Resident D "followed, peeking around the corner, looking at him." Family Member 3 was uncomfortable watching the video. Resident B got to the point he realized Resident D was not acting right and asked Resident D to leave. Resident D left the room, but came back 15 minutes later, because he forgot his phone and drink. Resident D got his stuff and immediately left the room. Family Member 3 pressed charges with the city police, because he was concerned Resident D may have done this before. Resident B got up three or four times that night to make sure his door was locked, and he usually didn't lock his door, so Family Member 3 knew Resident B was scared. Resident D actually made physical contact with Resident B, grabbed his waist band of his sweat pants, had his hand on Resident B's knee, and helped take his pants and underwear down, which is when Resident B realized something wasn't right. Resident B was "shook up," over the incident. Resident B called his best friend and told him about it. When Family Member 3 arrived at the facility the next day, Resident B said he was afraid he was "the guy from last night." Resident B told him about it, as well as the nursing staff. The next night, Resident B said he need to buy a Billy club 'in case that guy			

comes back.' Resident B went to church the following Sunday, and was telling people at church about it. Family Member 3 had discussed a few weeks prior to this incident, moving his dad into the memory care unit of the facility. He ended up moving onto the memory care unit about a week ago.

The investigation included a written statement, dated 10/17/25, from CNA (Certified Nursing Assistant) 2. It indicated she assisted Resident B with a shower on 10/17/25. During the shower, Resident B continued to talk about Resident D coming into his room the previous night, asking him to engage in inappropriate activities, and asking him if he wanted to "try some stuff," had him pull his pants down. Resident B was very upset.

An interview was conducted with CNA 8 on 11/6/25 at 10:09 a.m. He indicated he'd worked at the facility for over two years as a CNA. Resident D would get "really friendly, like in my bubble." CNA 8 thought Resident D was bisexual, liked other men, but "hadn't really" hit on him. Resident D would shake his hand over excessively, pat him the back, "touch me." Resident D was in Resident B's room and did some things he wasn't supposed to do, but CNA 8 suspected Resident D was

	bisexual before the incident involving Resident B, because of the way Resident D interacted with CNA 8. "I would say for months he's acted like this." Resident D would jokingly talk about inappropriate things, lift his shirt up to see what kind of boxers he was wearing. This was six plus months ago. CNA 8 did not tell anyone about it, because it made him feel uncomfortable. CNA 8 got along with Resident D, but Resident D would "try to push the boundaries." CNA 8 was assertive, but it was "kind of weird." Staff who worked in the kitchen would discuss Resident D's sexuality a long time ago, "like a year ago." CNA 8 did not discuss this with the ED or WD, because he was uncomfortable and scared. CNA 8 did not want Resident D to be "penalized," because he thought he was a good person, but he overstepped his boundaries. Resident D tried to see his boxers "a couple of times," since he began working there. An interview was conducted with the EC (Executive Chef) on 11/6/25 at 10:15 a.m. He indicated Server 7 informed him that Resident D spoke with him appropriately. Server 7 texted him to inform him of the incident. The EC informed the ED about it and forwarded the text messages to her. He never heard anything else about it			

	after that. He informed Server 7 to not go to Resident D's table anymore. There hadn't been any incidents since that he was aware of.			

	During the 11/6/25, 10:15 a.m. interview with the EC, the EC provided his cell phone for review of the 10/13/25, 7:35 p.m. text message he received from Server 7. The text message indicated Server 7 sat down at Resident D's table in the dining room to converse with Resident D, like he always did, when he wasn't busy working. The conversation started with Resident D asking about Server 7's tattoos, then about working out, asking Server 7 to pick him up and take him to the gym with him. Resident D started to ask him if he had chest hair, pubic hair, and if he was circumcised or not. Resident D told Server 7 to show him his chest hair, and asked if his shirt was untucked. When Resident D noticed Server 7's shirt was not untucked, he told Server 7 to lift up his shirt. He then told Server 7 he wanted him to make him a peanut butter and jelly sandwich to go. Server 7 informed Resident D he'd have one of the nursing staff bring him the sandwich, to which Resident D informed him he would like for Server 7 to personally go to his room. Server 7 did not make the sandwich or bring anything to his room. An interview was conducted with the ED and WD (Wellness Director) on 11/6/25 at 11:29 a.m. The ED indicated she found out about the incident the			

following day. She was shocked, when the family presented the video to her. She spoke with Resident D, who denied anything occurred. Resident D was currently still receiving one on one supervision and scheduled to move out of the facility tomorrow.

An interview was conducted with CNA 2 on 11/6/25 at 10:33 a.m. She indicated when she assisted Resident B with his shower on 10/17/25, he was "worked up" because of the incident that happened the night before. He was "real worried" about his door being locked, and making sure "that weird guy" didn't come into his room. Resident B informed CNA 2 that Resident D wanted to "put the cream on me" and "does it better than you guys." Resident B just kept talking about it "over and over," getting him to go to the bathroom, and putting the cream on him. CNA 2 could tell Resident B was "frustrated and cautious, worried it would happen again." Resident B moved from the assisted living side of the facility into the memory care unit about a week ago, and since he'd been on the memory care unit, he hadn't mentioned the incident.

An observation and interview was conducted with Resident B in his new room on the memory

	care unit of the facility with CNA 2 on 11/6/25 at 10:38 a.m. He was sitting in a chair at the table. He appeared pleasant and calm and had a good rapport with CNA 2. He indicated he was doing okay and that staff treated him well. The clinical record for Resident D was reviewed on 11/5 at 11:00 a.m. His diagnoses included, but were not limited to: depression, insomnia, and anxiety. The SLUMS (Saint Louis University Mental Status) Evaluation, dated 3/28/25, indicated the resident had normal cognitive function. The Service Plan, dated 3/19/25, indicated he was oriented to person, place, time and situation. The Wellness Evaluation, dated 10/7/25, indicated he communicated clearly; and understood and expressed wants and needs. The clinical record for Resident B was reviewed on 11/5/25 at 11:18 a.m. His diagnoses included, but were not limited to: dementia, hypertension, and type 2 diabetes. The SLUMS Evaluations, dated 7/4/25 and 10/7/25, indicated he had a diagnosis of dementia.			

	The Wellness Evaluation, dated 9/8/25, indicated in regard to his reasoning ability, he may exhibit sun-downing behavior, resistance to care, occasional wandering, or routinely exhibited anxious behavior requiring staff attention. The Global Deterioration Scale, dated 10/30/25, indicated the resident had moderately severe dementia. He no longer survived without some assistance. He may forget details of his phone number, address, names of close family members, or the schools he attended. He was unable to perform some activities of daily living. The Abuse, Neglect, or Financial Exploitation policy was provided by the ED on 11/5/25 at 11:02 a.m. It indicated, "The purpose of the Abuse, Neglect, or Financial Exploitation policy is to outline the process for the prevention, investigation, and reporting of abuse, neglect or financial exploitation....Abuse-any physical or mental injury or sexual assault inflected on a resident, other than by accidental means, in an establishment....The community will address situations in which abuse, neglect or exploitation are more likely to occur. This includes, but is not limited to, the following: ...Supervision of staff to identify and address any			

	inappropriate behaviors...Care planning of residents with special needs and/or behavior expressions that might lead to conflict, or neglect. Examples of special needs and/or behavior expressions may include refusal or resistance to care, entering other residents' rooms uninvited, exit seeking, self-injury, and communication difficulties." This Citation relates to Complaint IN00465534.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review, the facility failed to implement their Abuse, Neglect, or Financial Exploitation policy	R 0091	deficient practice. 2 The community realizes that all residents have the potential to be affected by the deficient practice. 3 The Executive Director will immediately implement the process of attaching all interviews or statements to reported incidents. This will include, but is not limited to, resident statements, staff statements or any other witness statements.	11/24/2025

	to obtain written statements from witnesses and a resident involved for 2 of 5 residents reviewed for abuse. (Residents B and D) Findings include: The Abuse, Neglect, or Financial Exploitation policy was provided by the ED on 11/5/25 at 11:02 a.m. It indicated, "Investigation...The person investigating the incident should consider the following actions: a. Interview the resident, the accused, and witnesses. Witnesses generally include anyone who witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members), and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident...c. Obtain written statements from the resident, if possible, the accused, and each witness." The follow-up incident report, dated 10/24/25, involving Resident B and Resident D with the documented investigation were provided by the ED (Executive Director) on 11/5/25 at 11:02 a.m. The follow-up incident report, dated 10/24/25, indicated on 10/17/25 the family of Resident B reported an incident that took		in the Incident reporting binder in the Executive Director's office.	

	place in the apartment of Resident B. The family had a camera in the apartment and they witnessed an incident between Resident B and Resident D that took place between the hours of 6:00 p.m. and 7:45 p.m. on 10/16/25. The video showed Resident D in the apartment of Resident B displaying several behaviors that would be considered inappropriate in a sexual manner. Resident D tried several times to remove clothing from Resident B, and on two occasions was successful in pulling down the pants of Resident B. It was also witness that Resident D watched as Resident B went to the bathroom to urinate. Resident D asked questions of Resident B that clearly made Resident B uncomfortable. The Immediate Action Taken section of the report indicated the staff were interviewed and asked if any other incidents similar to this had been witnessed. The family of Resident D was notified and informed they would need to provide 24 hour care to stay with Resident D, and he would need to eat all meals in his apartment and to stay away from Resident B. Resident D was interviewed about the incident. The ED was going to begin the discharge process for Resident D to ensure all residents were safe. The Preventive Measures Taken			

	section of the report indicated Resident D would receive 24 hour care to ensure he did not enter any other resident apartments or converse with Resident B. Both residents would be on two hour checks to ensure safety. The follow up section of the report indicated the ED made the determination that Resident D would need to vacate the community as he posed a risk to others in the community. Resident D would continue to have one on one care until his family found alternate housing. An interview was conducted with Resident B's Family Member 3, on 11/5/25 at 2:18 p.m. He indicated he checked the camera in Resident B's room periodically. They happened to check it around 11:00 p.m. the night of 10/16/25. They saw some things that made them uncomfortable, that occurred that same day around 6:00 p.m., so they watched the video and went to the facility immediately afterwards at 12:30 in the morning on 10/17/25. They left a note that they needed to speak with the ED in the morning. He let the ED watch the video, and she was concerned with what she saw, so she did an investigation. Family Member 3 never previously saw anything like			

	what he saw on the camera the night of 10/16/25. It went on for close to an hour and a half. Resident B was in "a weakened mental and physical state." His mind wasn't what it used to be. Resident D followed Resident B into his room and informed him he noticed Resident B walking slowly, and wanted to make sure he made it back to his room safely, "a predatory way of being sexual with my dad." Resident D kept trying to get Resident be to "loosen up," saying 'Take off your coat. Aren't you hot? You're losing weight. Let me check those pants. Are you circumcised? The camera in the room picked up when a person entered the room. Resident D kept being inappropriate and weird. Resident D got his underwear down, and Resident B realized it wasn't right. Resident D suggested Resident B go to the bathroom. Resident B went to the bathroom to urinate, and Resident D "followed, peeking around the corner, looking at him." Family Member 3 was uncomfortable watching the video. Resident B got to the point he realized Resident D was not acting right and asked Resident D to leave. Resident D left the room, but came back 15 minutes later, because he forgot his phone and drink. Resident D got his stuff and immediately left the room. Family Member 3 pressed charges with the city			

	police, because he was concerned Resident D may have done this before. Resident B got up three or four times that night to make sure his door was locked, and he usually didn't lock his door, so Family Member 3 knew Resident B was scared. Resident D actually made physical contact with Resident B, grabbed his waist band of his sweat pants, had his hand on Resident B's knee, and helped take his pants and underwear down, which is when Resident B realized something wasn't right. Resident B was "shook up," over the incident. Resident B called his best friend and told him about it. When Family Member 3 arrived at the facility the next day, Resident B said he was afraid he was "the guy from last night." Resident B told him about it, as well as the nursing staff. The next night, Resident B said he need to buy a Billy club 'in case that guy comes back.' Resident B went to church the following Sunday, and was telling people at church about it. Family Member 3 had discussed a few weeks prior to this incident, moving his dad into the memory care unit of the facility. He ended up moving onto the memory care unit about a week ago. The investigation did not include written statements from Family Member 3 or Resident D.			

	An interview was conducted with the ED on 11/6/25 at 11:29 a.m. She indicated Family Member 3 showed her the video on 10/17/25 around 10:00 a.m., the day after the incident occurred. It was shocking when family presented it to her. She did not obtain written statements from Family Member 3, Resident D, or Resident B. Looking back, it could have been a good idea to get a written statement from Family Member 3. Resident D probably would have been able to provide one too. This Citation relates to Complaint IN00465534. Based on interview and record review, the facility failed to implement their Abuse, Neglect, or Financial Exploitation policy to obtain written statements from witnesses and a resident involved for 2 of 5 residents reviewed for abuse. (Residents B and D) Findings include: The Abuse, Neglect, or Financial Exploitation policy was provided by the ED on 11/5/25 at 11:02 a.m. It indicated, "Investigation...The person investigating the incident should consider the following actions: a. Interview the resident, the accused, and witnesses. Witnesses generally include			

	anyone who witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members), and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident...c. Obtain written statements from the resident, if possible, the accused, and each witness." The follow-up incident report, dated 10/24/25, involving Resident B and Resident D with the documented investigation were provided by the ED (Executive Director) on 11/5/25 at 11:02 a.m. The follow-up incident report, dated 10/24/25, indicated on 10/17/25 the family of Resident B reported an incident that took place in the apartment of Resident B. The family had a camera in the apartment and they witnessed an incident between Resident B and Resident D that took place between the hours of 6:00 p.m. and 7:45 p.m. on 10/16/25. The video showed Resident D in the apartment of Resident B displaying several behaviors that would be considered inappropriate in a sexual manner. Resident D tried several times to remove clothing from Resident B, and on two occasions was successful in pulling down the pants of			

	Resident B. It was also witness that Resident D watched as Resident B went to the bathroom to urinate. Resident D asked questions of Resident B that clearly made Resident B uncomfortable. The Immediate Action Taken section of the report indicated the staff were interviewed and asked if any other incidents similar to this had been witnessed. The family of Resident D was notified and informed they would need to provide 24 hour care to stay with Resident D, and he would need to eat all meals in his apartment and to stay away from Resident B. Resident D was interviewed about the incident. The ED was going to begin the discharge process for Resident D to ensure all residents were safe. The Preventive Measures Taken section of the report indicated Resident D would receive 24 hour care to ensure he did not enter any other resident apartments or converse with Resident B. Both residents would be on two hour checks to ensure safety. The follow up section of the report indicated the ED made the determination that Resident D would need to vacate the community as he posed a risk to others in the community. Resident D would continue to have one on one care until his family found alternate housing.			

	An interview was conducted with Resident B's Family Member 3, on 11/5/25 at 2:18 p.m. He indicated he checked the camera in Resident B's room periodically. They happened to check it around 11:00 p.m. the night of 10/16/25. They saw some things that made them uncomfortable, that occurred that same day around 6:00 p.m., so they watched the video and went to the facility immediately afterwards at 12:30 in the morning on 10/17/25. They left a note that they needed to speak with the ED in the morning. He let the ED watch the video, and she was concerned with what she saw, so she did an investigation. Family Member 3 never previously saw anything like what he saw on the camera the night of 10/16/25. It went on for close to an hour and a half. Resident B was in "a weakened mental and physical state." His mind wasn't what it used to be. Resident D followed Resident B into his room and informed him he noticed Resident B walking slowly, and wanted to make sure he made it back to his room safely, "a predatory way of being sexual with my dad." Resident D kept trying to get Resident be to "loosen up," saying 'Take off your coat. Aren't you hot? You're losing weight. Let me check those			

	pants. Are you circumcised? The camera in the room picked up when a person entered the room. Resident D kept being inappropriate and weird. Resident D got his underwear down, and Resident B realized it wasn't right. Resident D suggested Resident B go to the bathroom. Resident B went to the bathroom to urinate, and Resident D "followed, peeking around the corner, looking at him." Family Member 3 was uncomfortable watching the video. Resident B got to the point he realized Resident D was not acting right and asked Resident D to leave. Resident D left the room, but came back 15 minutes later, because he forgot his phone and drink. Resident D got his stuff and immediately left the room. Family Member 3 pressed charges with the city police, because he was concerned Resident D may have done this before. Resident B got up three or four times that night to make sure his door was locked, and he usually didn't lock his door, so Family Member 3 knew Resident B was scared. Resident D actually made physical contact with Resident B, grabbed his waist band of his sweat pants, had his hand on Resident B's knee, and helped take his pants and underwear down, which is when Resident B realized something wasn't right. Resident B was "shook up," over the incident. Resident B			

	called his best friend and told him about it. When Family Member 3 arrived at the facility the next day, Resident B said he was afraid he was "the guy from last night." Resident B told him about it, as well as the nursing staff. The next night, Resident B said he need to buy a Billy club 'in case that guy comes back.' Resident B went to church the following Sunday, and was telling people at church about it. Family Member 3 had discussed a few weeks prior to this incident, moving his dad into the memory care unit of the facility. He ended up moving onto the memory care unit about a week ago. The investigation did not include written statements from Family Member 3 or Resident D. An interview was conducted with the ED on 11/6/25 at 11:29 a.m. She indicated Family Member 3 showed her the video on 10/17/25 around 10:00 a.m., the day after the incident occurred. It was shocking when family presented it to her. She did not obtain written statements from Family Member 3, Resident D, or Resident B. Looking back, it could have been a good idea to get a written statement from Family Member 3. Resident D probably would have been able to provide one too.			

	This Citation relates to Complaint IN00465534.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation	R 0217	1 The identified resident was affected by the deficient practice. 2 The community realizes that all residents have the potential to be affected by the deficient practice. 3 The Executive Director and Wellness director will refer to the Service Plan SOP when a change of condition is identified. In the SOP it is required that any description of service be noted in the service plan and a copy be provided to the resident/family. Any updates will be added to the service plan once any adjustments are identified. The occurrence tool will be used with all incidents and staff will be notified of any changes or updates. 4 The Executive Director and Wellness Director will implement a weekly	11/21/2025

	indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to revise a resident's service plan to address his sexually inappropriate comments and need for increased supervision for 1 of 5 residents reviewed for abuse. (Resident D) Findings include: The clinical record for Resident D was reviewed on 11/5 at 11:00 a.m. His diagnoses included, but were not limited to: depression, insomnia, and anxiety. The 10/24/25 follow-up incident report indicated on 10/17/25 the family of Resident B reported an incident that took place in the apartment of Resident B. The family had a camera in the apartment and they witnessed an incident between Resident B and Resident D that took place between the hours of 6:00 p.m. and 7:45 p.m. on 10/16/25. The video showed Resident D in the apartment of Resident B displaying several behaviors that would be considered		cadence meeting to review all incidents for the last 7 days. With the use of the occurrence tool all items will be review and marked completed, all incidents will be discussed and addressed, and all documentation will be completed as described in the Service Plan SOP.	

inappropriate in a sexual manner. Resident D tried several times to remove clothing from Resident B, and on two occasions was successful in pulling down the pants of Resident B. It was also witness that Resident D watched as Resident B went to the bathroom to urinate. Resident D asked questions of Resident B that clearly made Resident B uncomfortable. The Immediate Action Taken section of the report indicated the staff were interviewed and asked if any other incidents similar to this had been witnessed. The family of Resident D was notified and informed they would need to provide 24 hour care to stay with Resident D, and he would need to eat all meals in his apartment and to stay away from Resident B. Resident D was interviewed about the incident. The ED was going to begin the discharge process for Resident D to ensure all residents were safe. The Preventive Measures Taken section of the report indicated Resident D would receive 24 hour care to ensure he did not enter any other resident apartments or converse with Resident B. Both residents would be on two hour checks to ensure safety. The follow up section of the report indicated the ED made the determination that Resident D would need to vacate the community as he

posed a risk to others in the community. Resident D would continue to have one on one care until his family found alternate housing.

An interview was conducted with LPN (Licensed Practical Nurse) 4 on 11/5/25 at 1:17 p.m. She indicated Resident D had behaviors of going into other residents' rooms and being inappropriate. He was supposed to have one-on-one care and eat meals in his room. The one one one care was to be provided by home health. Nursing staff was supposed to stop him from going into other resident's rooms if they saw it.

An interview was conducted with QMA (Qualified Medication Aide) 5 on 11/5/25 at 1:43 p.m. She indicated other nursing staff informed her of an incident between Resident D and Resident B and was told they were to keep the two of them separated. He was also supposed to receive one-on-one supervision right now.

An interview was conducted with CNA (Certified Nursing Assistant) 6 on 11/5/25 at 2:51 p.m. She indicated she heard about Resident D making sexually inappropriate comments to Server 7 who worked in the kitchen.

An interview was conducted

with the EC (Executive Chef) on 11/6/25 at 10:15 a.m. He indicated Server 7 informed him that Resident D spoke with him appropriately. Server 7 texted him to inform him of the incident. The EC informed the ED about it and forwarded the text messages to her. He never heard anything else about it after that. He informed Server 7 to not go to Resident D's table anymore. There hadn't been any incidents since that he was aware of.

During an interview on 11/6/25 at 10:15 a.m., the EC provided his cell phone for review of the 10/13/25, 7:35 p.m. text message he received from Server 7. The text message indicated Server 7 sat down at Resident D's table in the dining room to converse with Resident D, like he always did, when he wasn't busy working. The conversation started with Resident D asking about Server 7's tattoos, then about working out, asking Server 7 to pick him up and take him to the gym with him. Resident D started to ask him if he had chest hair, pubic hair, and if he was circumcised or not. Resident D told Server 7 to show him his chest hair, and asked if his shirt was untucked. When Resident D noticed Server 7's shirt was not untucked, he told Server 7 to lift up his shirt. He then told Server 7 he wanted him to make him a

peanut butter and jelly sandwich to go. Server 7 informed Resident D he'd have one of the nursing staff bring him the sandwich, to which Resident D informed him he would like for Server 7 to personally go to his room. Server 7 did not make the sandwich or bring anything to his room.

An interview was conducted with CNA 8 on 11/6/25 at 10:09 a.m. He indicated he'd worked at the facility for over two years as a CNA. Resident D would get "really friendly, like in my bubble." CNA 8 thought Resident D was bisexual, liked other men, but "hadn't really" hit on him. Resident D would shake his hand over excessively, pat him the back, "touch me." Resident D was in Resident B's room and did some things he wasn't supposed to do, but CNA 8 suspected Resident D was bisexual before the incident involving Resident B, because of the way Resident D interacted with CNA 8. "I would say for months he's acted like this." Resident D would jokingly talk about inappropriate things, lift his shirt up to see what kind of boxers he was wearing. This was six plus months ago. CNA 8 did not tell anyone about it, because it made him feel uncomfortable. CNA 8 got along with Resident D, but Resident D would "try to push the boundaries." CNA 8 was

assertive, but it was "kind of weird." Staff who worked in the kitchen would discuss Resident D's sexuality a long time ago, "like a year ago." CNA 8 did not discuss this with the ED or WD, because he was uncomfortable and scared. CNA 8 did not want Resident D to be "penalized," because he thought he was a good person, but he overstepped his boundaries. Resident D tried to see his boxers "a couple of times," since he began working there.

An interview was conducted with the ED and WD on 11/6/25 at 11:29 a.m. The ED indicated she investigated the allegation Server 7 made on 10/13/25 of Resident D making inappropriate comments to him. She spoke to Resident D, who denied the allegations and informed her he didn't' eat dinner in the dining room. She also spoke with Server 7 and informed him not to serve food to Resident D's table, if he was uncomfortable. The ED could not corroborate whether or not what Server 7 claimed was true. The following day, she received the allegation from Family Member 3 regarding Resident B. She did not interview CNA 8 and was unaware of his conversations and encounters with Resident D. If they had known, they could have addressed it then. If CNA 8 had informed her, she would have

addressed it immediately and wouldn't have taken it lightly. They may have initiated psychological services for Resident D, possibly considered discharge. Resident D was currently receiving one on one supervision provided by home health services, combined with facility staff, until his discharge scheduled for 11/7/25. Resident D's service plan did not reference his inappropriate comments or his need for increased supervision. Resident B's family sent her a picture of Resident D at the facility, not receiving one on one care on Saturday, 11/2/25, so she looked into why he wasn't receiving it. She was unsure what happened, but heard Resident D told home health to leave the facility, so she thought maybe that was what happened.

The WD indicated there were no indications Resident D would "do something like this." They have an open door policy when it came to reporting residents' behaviors. They told staff they needed to know these things, so they could help the resident, staff, and everyone involved. There needed to be boundaries between residents and staff. Nursing staff knew there was a need for increased monitoring. Resident D did not currently receive psychological services. The WD reviewed Resident D's

service plan at this time and indicated, there was nothing on his service plan to address his inappropriate comments or increased monitoring and supervision.

The Service Plan, dated 3/19/25, indicated he was oriented to person, place, time and situation. It did not reference or address his sexually inappropriate comments or need for increased monitoring and supervision.

The Resident Evaluation and Service Plan policy was provided by the ED on 11/6/25 at 12:28 p.m. It indicated, "The purpose of the Service Plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences....Service Plans: ...When to complete: The Service Plan is reviewed and updated at least annually and when a resident's needs or preferences change."

This Citation relates to Complaint IN00465534.

Based on interview and record review, the facility failed to revise a resident's service plan to address his sexually inappropriate comments and need for increased supervision for 1 of 5 residents reviewed for abuse. (Resident D)

Findings include:

The clinical record for Resident D was reviewed on 11/5 at 11:00 a.m. His diagnoses included, but were not limited to: depression, insomnia, and anxiety.

The 10/24/25 follow-up incident report indicated on 10/17/25 the family of Resident B reported an incident that took place in the apartment of Resident B. The family had a camera in the apartment and they witnessed an incident between Resident B and Resident D that took place between the hours of 6:00 p.m. and 7:45 p.m. on 10/16/25. The video showed Resident D in the apartment of Resident B displaying several behaviors that would be considered inappropriate in a sexual manner. Resident D tried several times to remove clothing from Resident B, and on two occasions was successful in pulling down the pants of Resident B. It was also witness that Resident D watched as Resident B went to the bathroom to urinate. Resident D asked questions of Resident B that clearly made Resident B uncomfortable. The Immediate Action Taken section of the report indicated the staff were interviewed and asked if any other incidents similar to this had been witnessed. The family of Resident D was notified and

informed they would need to provide 24 hour care to stay with Resident D, and he would need to eat all meals in his apartment and to stay away from Resident B. Resident D was interviewed about the incident. The ED was going to begin the discharge process for Resident D to ensure all residents were safe. The Preventive Measures Taken section of the report indicated Resident D would receive 24 hour care to ensure he did not enter any other resident apartments or converse with Resident B. Both residents would be on two hour checks to ensure safety. The follow up section of the report indicated the ED made the determination that Resident D would need to vacate the community as he posed a risk to others in the community. Resident D would continue to have one on one care until his family found alternate housing.

An interview was conducted with LPN (Licensed Practical Nurse) 4 on 11/5/25 at 1:17 p.m. She indicated Resident D had behaviors of going into other residents' rooms and being inappropriate. He was supposed to have one-on-one care and eat meals in his room. The one one one care was to be provided by home health. Nursing staff was supposed to stop him from going into other

resident's rooms if they saw it.

An interview was conducted with QMA (Qualified Medication Aide) 5 on 11/5/25 at 1:43 p.m. She indicated other nursing staff informed her of an incident between Resident D and Resident B and was told they were to keep the two of them separated. He was also supposed to receive one-on-one supervision right now.

An interview was conducted with CNA (Certified Nursing Assistant) 6 on 11/5/25 at 2:51 p.m. She indicated she heard about Resident D making sexually inappropriate comments to Server 7 who worked in the kitchen.

An interview was conducted with the EC (Executive Chef) on 11/6/25 at 10:15 a.m. He indicated Server 7 informed him that Resident D spoke with him appropriately. Server 7 texted him to inform him of the incident. The EC informed the ED about it and forwarded the text messages to her. He never heard anything else about it after that. He informed Server 7 to not go to Resident D's table anymore. There hadn't been any incidents since that he was aware of.

During an interview on 11/6/25 at 10:15 a.m., the EC provided his cell phone for review of the

10/13/25, 7:35 p.m. text message he received from Server 7. The text message indicated Server 7 sat down at Resident D's table in the dining room to converse with Resident D, like he always did, when he wasn't busy working. The conversation started with Resident D asking about Server 7's tattoos, then about working out, asking Server 7 to pick him up and take him to the gym with him. Resident D started to ask him if he had chest hair, pubic hair, and if he was circumcised or not. Resident D told Server 7 to show him his chest hair, and asked if his shirt was untucked. When Resident D noticed Server 7's shirt was not untucked, he told Server 7 to lift up his shirt. He then told Server 7 he wanted him to make him a peanut butter and jelly sandwich to go. Server 7 informed Resident D he'd have one of the nursing staff bring him the sandwich, to which Resident D informed him he would like for Server 7 to personally go to his room. Server 7 did not make the sandwich or bring anything to his room.

An interview was conducted with CNA 8 on 11/6/25 at 10:09 a.m. He indicated he'd worked at the facility for over two years as a CNA. Resident D would get "really friendly, like in my bubble." CNA 8 thought Resident D was bisexual, liked

other men, but "hadn't really" hit on him. Resident D would shake his hand over excessively, pat him the back, "touch me." Resident D was in Resident B's room and did some things he wasn't supposed to do, but CNA 8 suspected Resident D was bisexual before the incident involving Resident B, because of the way Resident D interacted with CNA 8. "I would say for months he's acted like this." Resident D would jokingly talk about inappropriate things, lift his shirt up to see what kind of boxers he was wearing. This was six plus months ago. CNA 8 did not tell anyone about it, because it made him feel uncomfortable. CNA 8 got along with Resident D, but Resident D would "try to push the boundaries." CNA 8 was assertive, but it was "kind of weird." Staff who worked in the kitchen would discuss Resident D's sexuality a long time ago, "like a year ago." CNA 8 did not discuss this with the ED or WD, because he was uncomfortable and scared. CNA 8 did not want Resident D to be "penalized," because he thought he was a good person, but he overstepped his boundaries. Resident D tried to see his boxers "a couple of times," since he began working there.

An interview was conducted with the ED and WD on 11/6/25 at 11:29 a.m. The ED indicated

she investigated the allegation Server 7 made on 10/13/25 of Resident D making inappropriate comments to him. She spoke to Resident D, who denied the allegations and informed her he didn't' eat dinner in the dining room. She also spoke with Server 7 and informed him not to serve food to Resident D's table, if he was uncomfortable. The ED could not corroborate whether or not what Server 7 claimed was true. The following day, she received the allegation from Family Member 3 regarding Resident B. She did not interview CNA 8 and was unaware of his conversations and encounters with Resident D. If they had known, they could have addressed it then. If CNA 8 had informed her, she would have addressed it immediately and wouldn't have taken it lightly. They may have initiated psychological services for Resident D, possibly considered discharge. Resident D was currently receiving one on one supervision provided by home health services, combined with facility staff, until his discharge scheduled for 11/7/25. Resident D's service plan did not reference his inappropriate comments or his need for increased supervision. Resident B's family sent her a picture of Resident D at the facility, not receiving one on one care on Saturday, 11/2/25, so she

looked into why he wasn't receiving it. She was unsure what happened, but heard Resident D told home health to leave the facility, so she thought maybe that was what happened.

The WD indicated there were no indications Resident D would "do something like this." They have an open door policy when it came to reporting residents' behaviors. They told staff they needed to know these things, so they could help the resident, staff, and everyone involved. There needed to be boundaries between residents and staff. Nursing staff knew there was a need for increased monitoring. Resident D did not currently receive psychological services. The WD reviewed Resident D's service plan at this time and indicated, there was nothing on his service plan to address his inappropriate comments or increased monitoring and supervision.

The Service Plan, dated 3/19/25, indicated he was oriented to person, place, time and situation. It did not reference or address his sexually inappropriate comments or need for increased monitoring and supervision.

The Resident Evaluation and Service Plan policy was provided by the ED on 11/6/25

	at 12:28 p.m. It indicated, "The purpose of the Service Plan is to provide a description of the services that will be provided to the resident based on their individual needs and preferences....Service Plans: ...When to complete: The Service Plan is reviewed and updated at least annually and when a resident's needs or preferences change." This Citation relates to Complaint IN00465534.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREChristine N Bright	TITLEExecutive Director	(X6) DATE11/26/2025