STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELKHART PLACE ASSISTED LIVING	2024 COUNTY ROAD 24, ELKHART, , 46517

(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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00460167, IN00461478, IN00462430 and IN00462845. Complaint IN00460167- State deficiencies related to the allegations are cited at R0057. Complaint IN00461478 - No deficiencies related to the allegations are cited. Complaint IN00462430 - State deficiencies related to the allegations are cited at R0036 & R0349. Complaint IN00462845 - No deficiencies related to the allegations are cited. Survey dates: July 14 & 15, 2025 Facility number: 004353 Residential Census: 29	R 0000		

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/24/2025			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify the MD/NP of a change in condition for 1 of 4 residents reviewed for quality of care. (Resident D) Finding includes: A review of a facility reported Incident, dated 6/26/2025, reported to the Indiana Department of Health, indicated Resident D's family member had contacted the facility with concerns regarding Resident	R 0036	Residents of the Community have the potential to be affected by the alleged deficiency. The resident affected by the change in condition was reviewed, and the provider was notified immediately. The QMA involved is no longer employed at the Community. Resident charts were reviewed by the Director of Nursing to identify any missed notifications and ensure no additional residents were affected. Nursing staff and QMAs received training by the Executive Director on July 31, 2025, regarding timely provider notification and required follow-up procedures. Weekly audits of provider notification logs and change-in-condition documentation will be conducted by the Director of Nursing for 60 days and reviewed to determine if quarterly audits are necessary. The QA Committee will review outcomes at the end of QA meetings to determine if continued weekly audits are needed, and if not, the process will transition to quarterly review. The Director of Nursing is responsible for compliance.	09/30/2025

	D's recent hospitalization and overall condition. The family member had reported Resident D had complainted of discomfort including back pain and constipation over the weekend of June 21-22, 2025. The report indicated a friend of the family had visited and reported to the nursing staff Resident D's change of condition. The investigative report indicated the facility staff had been reeducated regarding timely documentation and proper reporting of resident concerns. In addition, the employee involved had been terminated from employment due to not following facility policy related to notifying the Director of Nursing of changes in Resident D's condition. A record review for Resident D was completed on 7/14/2025 at 11:02 A.M. Diagnoses included, but were not limited to: dementia, seizures and depression. A Service Plan, dated 6/9/2025 indicated Resident D needed staff assistance with making decisions based on her needs and health status. A QMA (Qualified Medication Assistant) documentation Note, on 6/23/2025 at 5:58 A.M., indicated Resident D had been sent to the emergency room for a fever of 102.3 degrees			

	Fahrenheit, a pulse of 113 beats per minute and a blood pressure of 117/59 mm/Hg (millimeters of mercury). The note indicated Resident D had been "burning up," could not sit up in bed and could not speaking clearly. The note indicated Emergency Medical Services (EMS) paramedics had assessed Resident D's temperature at 103 degrees Fahrenheit at 5:30 A.M. The Director of Nursing and Power of Attorney were notified of Resident D's condition change. However, the MD/NP nor the Director of Nursing (DON) had not been updated on Resident D's changes of condition and the changes that led to the hospitalization of Resident D. In addition, there was no documentation of Resident D's fall, any post fall assessment, complaints of constipation or back pain. A Nursing Progress Note, on 6/23/2025 at 1:21 P.M., indicated Resident D had been admitted to the hospital for sepsis, a urinary tract infection and pneumonia. Resident D's temperature had been 104 degrees Fahrenheit upon arrival to the emergency room. A Hospital Discharge Summary, dated 6/27/2025, indicated upon arrival to the emergency department, Resident D had a			

	rectal temperature of 103 degrees Fahrenheit and an oxygen saturation level in the 80's (normal 90-100%). Resident D had been admitted to the hospital for community acquired pneumonia, sepsis, hypoxia, delirium and respiratory failure. During an interview, on 7/15/2025 at 1:42 P.M., the Director of Nursing (DON) indicated she had been notified of Resident D's changes in condition from a family member, who had called and yelled at her. The DON indicated Resident D's son had come to the facility on Saturday (6/21/2025) to take the resident out for lunch, but had brought Resident D back to the facility due to resident's complaints of bad back pain. He had informed the QMA on duty of Resident D's back pain. The DON indicated a family friend had visited the resident on Sunday and the friend had informed two QMA's that Resident D had fallen and was on the floor. The DON indicated the resident's son had informed her that after reporting Resident D's fall to the QMAs, the family friend had returned to Resident D's room but no staff members ever came to the room. The family friend had helped Resident D get up off of the floor. The DON indicated during night checks on the morning of 6/23/2025, the			

	QMA had found Resident D profusely sweating and noted her cheeks were pink. The DON indicated she had not been informed of the fall, constipation complaints or the back pain prior to a text she received about Resident D's fever, on 6/23/2025 at 5:16 A.M. The DON indicated the emergency room physician indicated Resident D's temperature had been over 104 degrees Fahrenheit and the fever was "cooking her brain" due to the fever being so high for so long. The DON indicated after the fall, the QMA should have completed vital signs and an incident report, and the QMA should have reached out to report the fall and complaints of back pain and constipation to the Director of Nursing. A current policy was provided, on 7/15/2025 at 1:00 P.M., by the Executive Director. The policy titled, "Resident Change in Condition", indicated, " ...It is the policy of this community that all changes in the residents condition will be communicated to the physician, resident, family/responsible party, case manager, and other parties as directed by the resident and ensure that appropriate, timely, and effective interventions occur ...Acute Medical Change ...Any sudden or serious change in a resident's condition manifested by a marked change in physical			

	or mental health behavior will be communicated to the physician with a request for a physician visit promptly and/or acute care evaluation. The nursing staff will notify the physician ...The family, responsible party, case manager, and/or other designated parties will be notified that there has been a change in the resident's condition and what steps are being taken ...." This citation relates to complaint IN00462430. Based on record review and interview, the facility failed to notify the MD/NP of a change in condition for 1 of 4 residents reviewed for quality of care. (Resident D) Finding includes: A review of a facility reported Incident, dated 6/26/2025, reported to the Indiana Department of Health, indicated Resident D's family member had contacted the facility with concerns regarding Resident D's recent hospitalization and overall condition. The family member had reported Resident D had complainted of discomfort including back pain and constipation over the weekend of June 21-22, 2025. The report indicated a friend of the family had visited and reported to the nursing staff Resident D's			

	change of condition. The investigative report indicated the facility staff had been reeducated regarding timely documentation and proper reporting of resident concerns. In addition, the employee involved had been terminated from employment due to not following facility policy related to notifying the Director of Nursing of changes in Resident D's condition. A record review for Resident D was completed on 7/14/2025 at 11:02 A.M. Diagnoses included, but were not limited to: dementia, seizures and depression. A Service Plan, dated 6/9/2025 indicated Resident D needed staff assistance with making decisions based on her needs and health status. A QMA (Qualified Medication Assistant) documentation Note, on 6/23/2025 at 5:58 A.M., indicated Resident D had been sent to the emergency room for a fever of 102.3 degrees Fahrenheit, a pulse of 113 beats per minute and a blood pressure of 117/59 mm/Hg (millimeters of mercury). The note indicated Resident D had been "burning up," could not sit up in bed and could not speaking clearly. The note indicated Emergency Medical Services (EMS) paramedics had assessed			

	Resident D's temperature at 103 degrees Fahrenheit at 5:30 A.M. The Director of Nursing and Power of Attorney were notified of Resident D's condition change. However, the MD/NP nor the Director of Nursing (DON) had not been updated on Resident D's changes of condition and the changes that led to the hospitalization of Resident D. In addition, there was no documentation of Resident D's fall, any post fall assessment, complaints of constipation or back pain. A Nursing Progress Note, on 6/23/2025 at 1:21 P.M., indicated Resident D had been admitted to the hospital for sepsis, a urinary tract infection and pneumonia. Resident D's temperature had been 104 degrees Fahrenheit upon arrival to the emergency room. A Hospital Discharge Summary, dated 6/27/2025, indicated upon arrival to the emergency department, Resident D had a rectal temperature of 103 degrees Fahrenheit and an oxygen saturation level in the 80's (normal 90-100%). Resident D had been admitted to the hospital for community acquired pneumonia, sepsis, hypoxia, delirium and respiratory failure.			

	During an interview, on 7/15/2025 at 1:42 P.M., the Director of Nursing (DON) indicated she had been notified of Resident D's changes in condition from a family member, who had called and yelled at her. The DON indicated Resident D's son had come to the facility on Saturday (6/21/2025) to take the resident out for lunch, but had brought Resident D back to the facility due to resident's complaints of bad back pain. He had informed the QMA on duty of Resident D's back pain. The DON indicated a family friend had visited the resident on Sunday and the friend had informed two QMA's that Resident D had fallen and was on the floor. The DON indicated the resident's son had informed her that after reporting Resident D's fall to the QMAs, the family friend had returned to Resident D's room but no staff members ever came to the room. The family friend had helped Resident D get up off of the floor. The DON indicated during night checks on the morning of 6/23/2025, the QMA had found Resident D profusely sweating and noted her cheeks were pink. The DON indicated she had not been informed of the fall, constipation complaints or the back pain prior to a text she received about Resident D's fever, on 6/23/2025 at 5:16 A.M. The DON indicated the emergency			

	room physician indicated Resident D's temperature had been over 104 degrees Fahrenheit and the fever was "cooking her brain" due to the fever being so high for so long. The DON indicated after the fall, the QMA should have completed vital signs and an incident report, and the QMA should have reached out to report the fall and complaints of back pain and constipation to the Director of Nursing. A current policy was provided, on 7/15/2025 at 1:00 P.M., by the Executive Director. The policy titled, "Resident Change in Condition", indicated, " ...It is the policy of this community that all changes in the residents condition will be communicated to the physician, resident, family/responsible party, case manager, and other parties as directed by the resident and ensure that appropriate, timely, and effective interventions occur ...Acute Medical Change ...Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental health behavior will be communicated to the physician with a request for a physician visit promptly and/or acute care evaluation. The nursing staff will notify the physician ...The family, responsible party, case manager, and/or other designated parties will be notified that there has been a			

	change in the resident's condition and what steps are being taken ...." This citation relates to complaint IN00462430.			
R 0057	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(aa)(1-2) (aa) Residents have the right to privacy in written communications, including the right to: (1) send and promptly receive mail that is unopened unless the administrator has been instructed otherwise in writing by the resident; and (2) have access to stationery, postage, and writing implements at the resident ' s own expense. Based on interview and record review, the facility failed to ensure mail was received on Saturdays. This deficient practice had the potential to affect 29 of 29 residents who resided in the facility. Finding includes: During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she did not receive mail on Saturdays. She indicated the mailman gave the mail to the front desk person, and that person was to hand it out to the residents. Resident B	R 0057	Residents of the Community have the potential to be affected by the alleged deficiency. Mail delivery procedures were updated, and a secured mailbox system was implemented by the Executive Director. Weekend mail oversight was assigned to weekend shift. Residents were informed of the mailbox system, and mail delivery practices were reviewed to determine additional residents affected. Staff training was completed on July 31, 2025 by the Executive Director on timely delivery of mail and mailbox procedures. Mailboxes usage for all residents has been reimplemented. Mail logs will be reviewed weekly for 60 days and the QA Committee will review outcomes at the end of QA meetings to determine if continued weekly audits are needed, and if not, the process will transition to quarterly review. The Executive Director and Administrative Assistant are responsible for compliance.	09/30/2025

	indicated, "the front desk staff are not here on the weekends, so the mail just lays up at the front desk for other residents to get into." She indicated they used to have keys for their mailboxes, but had not had keys since Covid, 3 years ago. During an interview, on 7/15/2025 at 1:35 P.M., the Administrator indicated the residents had not had keys for the mail boxes since 2023, and "it would be a big mess to get the boxes changed and new keys." The Administrator indicated the mail came in to the facility and was given to the front desk staff and she was to deliver the mail to the residents. On weekends, the mail should have been delivered to the residents by the nursing staff. On 7/15/2025 at 1:50 P.M., the Administrator provided the policy titled, "Clerical Services", dated 10/1/2021, and indicated the policy is the one currently used by the facility. The policy indicated " ... 2. Mail delivery will be provided to the apartment on a temporary basis in cases of illness or injury. 3. Mail delivery to the apartment can be provided routinely if going to the mailbox area is an undue hardship for the resident and it is part of the assistance/service plan...." On 7/15/2025 at 1:50 P.M., the			

Administrator provided the policy titled," Resident Rights", dated 10/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated "... (I) Every resident shall have the right to receive or to send personal mails or any other correspondence without interception or interference by the operator or any person affiliated with the operator...."

This state finding relates to Complaint IN00460167.

Based on interview and record review, the facility failed to ensure mail was received on Saturdays. This deficient practice had the potential to affect 29 of 29 residents who resided in the facility.

Finding includes:

During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she did not receive mail on Saturdays. She indicated the mailman gave the mail to the front desk person, and that person was to hand it out to the residents. Resident B indicated, "the front desk staff are not here on the weekends, so the mail just lays up at the front desk for other residents to get into." She indicated they used to have keys for their mailboxes, but had not had keys since Covid, 3 years ago.

During an interview, on

	7/15/2025 at 1:35 P.M., the Administrator indicated the residents had not had keys for the mail boxes since 2023, and "it would be a big mess to get the boxes changed and new keys." The Administrator indicated the mail came in to the facility and was given to the front desk staff and she was to deliver the mail to the residents. On weekends, the mail should have been delivered to the residents by the nursing staff. On 7/15/2025 at 1:50 P.M., the Administrator provided the policy titled, "Clerical Services", dated 10/1/2021, and indicated the policy is the one currently used by the facility. The policy indicated " ... 2. Mail delivery will be provided to the apartment on a temporary basis in cases of illness or injury. 3. Mail delivery to the apartment can be provided routinely if going to the mailbox area is an undue hardship for the resident and it is part of the assistance/service plan...." On 7/15/2025 at 1:50 P.M., the Administrator provided the policy titled," Resident Rights", dated 10/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated "... (I) Every resident shall have the right to receive or to send personal mails or any other correspondence without interception or interference by			

	the operator or any person affiliated with the operator...." This state finding relates to Complaint IN00460167.			
R 0121	Personnel - Noncompliance 410 IAC 16.2-5-1.4(f)(1-4) (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.	R 0121	Residents of the Community have the potential to be affected by the alleged deficiency. Missing TB test documentation was completed and filed immediately by the Director of Nursing and Administrative Assistant. A full audit of resident records was completed on 7/18/2025 to ensure proper TB documentation for each file. A process was reinforced for staff to receive TB testing upon hire, with the second step scheduled and documented. Training for the DON on documentation of TB test records was completed on July 31, 2025, by the Executive Director. New admissions and new hires will be reviewed during weekly move-in/onboarding meetings for 60 days. The QA Committee will review outcomes at the end of QA meetings to determine if continued weekly audits are needed, and if not, the process will transition to quarterly review. The Administrative Assistant and Director Of Nursing are responsible for compliance.	09/30/2025

	(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure staff members received second step Tuberculosis (TB) screening for 3 of 5 employee records reviewed. (DON, Housekeeper 3 & QMA 6) Finding includes: A review of employee records was completed on 7/15/2025 at 10:03 A.M. for Housekeeper 3, QMA 6 and the DON. The review indicated Housekeeper 3 was hired on 4/7/2025, QMA 6 was hired on 11/4/2024 and the DON was hired on 2/27/2025. Employee records lacked documentation that Housekeeper 3, QMA 6 and the			

DON received their second step TB screening.

During an interview, on 7/15/2025 at 11:14 A.M., the Administrator indicated QMA 6, Housekeeper 3 and the DON should have received their second step TB screenings.

On 7/15/2025 at 11:17 A.M. the Administrator provided the policy titled, "Mantoux Testing Policy", dated 11/1/2021, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Statement: All new employees will have a two-step Mantoux test for tuberculosis...."

Based on record review and interview, the facility failed to ensure staff members received second step Tuberculosis (TB) screening for 3 of 5 employee records reviewed. (DON, Housekeeper 3 & QMA 6)

Finding includes:

A review of employee records was completed on 7/15/2025 at 10:03 A.M. for Housekeeper 3, QMA 6 and the DON.

The review indicated Housekeeper 3 was hired on 4/7/2025, QMA 6 was hired on 11/4/2024 and the DON was hired on 2/27/2025.

Employee records lacked documentation that

	Housekeeper 3, QMA 6 and the DON received their second step TB screening. During an interview, on 7/15/2025 at 11:14 A.M., the Administrator indicated QMA 6, Housekeeper 3 and the DON should have received their second step TB screenings. On 7/15/2025 at 11:17 A.M. the Administrator provided the policy titled, "Mantoux Testing Policy", dated 11/1/2021, and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Statement: All new employees will have a two-step Mantoux test for tuberculosis...."			
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;	R 0217	Residents of the Community have the potential to be affected by the alleged deficiency. Service plans were immediately reviewed and signed as required. Resident files were audited to determine who may have been affected by incomplete service plans, but there were not any findings. Director of Nursing was educated by the Executive Director on July 28, 2025, regarding timely completion and signature tracking for service plans. Service plan audits will be conducted weekly for 60 days and the QA Committee will review outcomes at the end of QA meetings to determine if continued weekly audits are needed, and if not, the process will transition to quarterly review. Director of Nursing is responsible for	09/30/2025

	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 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. 2. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and she had not signed any service plans. The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and		compliance.	

insomnia.

A current Service Plan, dated 5/7/2025, lacked the residents' signature.

3. The record for Resident C was reviewed on 7/14/2025 mat 11:57 A.M. Diagnoses included, but were not limited to bipolar, severe depression, obesity and diabetes.

A current Service Plan, dated 6/9/2025, lacked the residents' signature.

During an interview, on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated the service plans were not signed by the residents and should have been.

4. A record review for Resident E was completed on 7/14/2025 at 11:25 A.M. Diagnoses included, but were not limited to: atrial fibrillation, dementia, anxiety and respiratory failure.

A Service Plan for Resident E, dated 7/22/2024, indicated Resident E required the facility staff to provide medication and laundry assistance. The service plan was signed by the resident's representative.

However a Service Plan, dated 12/8/2024, indicated Resident E now required assistance from the facility nursing staff to provide medication, laundry,

	mobility, toileting, grooming, bathing, dressing, transfer, nighttime surveillance, memory prompting and decision-making assistance. The service plan had not been signed by the representative of the resident. During an interview, on 7/15/2025 at 11:13 A.M., the Director of Nursing (DON) indicated Resident E's needs had increased in his level of care. The DON indicated the service plan changes had not been signed by the resident or the resident's representative. A current policy was provided by the Executive Director, on 7/15/2025 at 1:00 P.M. The policy titled, "Coordination-Individualization of Service Plan", indicated, " ...Policy: The community uses an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the resident's needs based on their preferences and priorities. The Service Plan is a communication tool that provides associates with education related to each resident's needs and preferences and assists associates in providing quality, person-centered service ...5. The service plan is reviewed and revised at least every 6 months or after a change in condition and shall be signed			

	and dated by the resident ...." Based on record review and interview, the facility failed to ensure residents and/or their reresentative signed their Service Plans for 4 of 7 residents reviewed for Service Plans. (Residents 6, B, C & E) Findings include: 1. A record review for Resident 6 was completed on 7/15/2025 at 10:01 A.M.and indicated the record lacked a Service Plan signed by the resident. 2. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and she had not signed any service plans. The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia. A current Service Plan, dated 5/7/2025, lacked the residents' signature.			

	3. The record for Resident C was reviewed on 7/14/2025 mat 11:57 A.M. Diagnoses included, but were not limited to bipolar, severe depression, obesity and diabetes. A current Service Plan, dated 6/9/2025, lacked the residents' signature. During an interview, on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated the service plans were not signed by the residents and should have been. 4. A record review for Resident E was completed on 7/14/2025 at 11:25 A.M. Diagnoses included, but were not limited to: atrial fibrillation, dementia, anxiety and respiratory failure. A Service Plan for Resident E, dated 7/22/2024, indicated Resident E required the facility staff to provide medication and laundry assistance. The service plan was signed by the resident's representative. However a Service Plan, dated 12/8/2024, indicated Resident E now required assistance from the facility nursing staff to provide medication, laundry, mobility, toileting, grooming, bathing, dressing, transfer, nighttime surveillance, memory prompting and decision-making assistance. The service plan had not been signed by the			

representative of the resident.

During an interview, on 7/15/2025 at 11:13 A.M., the Director of Nursing (DON) indicated Resident E's needs had increased in his level of care. The DON indicated the service plan changes had not been signed by the resident or the resident's representative.

A current policy was provided by the Executive Director, on 7/15/2025 at 1:00 P.M. The policy titled, "Coordination-Individualization of Service Plan", indicated, " ...Policy: The community uses an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the resident's needs based on their preferences and priorities. The Service Plan is a communication tool that provides associates with education related to each resident's needs and preferences and assists associates in providing quality, person-centered service ...5. The service plan is reviewed and revised at least every 6 months or after a change in condition and shall be signed and dated by the resident ...."

Based on record review and interview, the facility failed to ensure residents and/or their reresentative signed their

	Service Plans for 4 of 7 residents reviewed for Service Plans. (Residents 6, B, C & E) Findings include: 1. A record review for Resident 6 was completed on 7/15/2025 at 10:01 A.M.and indicated the record lacked a Service Plan signed by the resident. 2. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and she had not signed any service plans. The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia. A current Service Plan, dated 5/7/2025, lacked the residents' signature. 3. The record for Resident C was reviewed on 7/14/2025 mat 11:57 A.M. Diagnoses included, but were not limited to bipolar, severe depression, obesity and diabetes. A current Service Plan, dated 6/9/2025, lacked the residents' signature. During an interview, on			

	7/15/2025 at 2:00 P.M., the Director of Nursing indicated the service plans were not signed by the residents and should have been. 4. A record review for Resident E was completed on 7/14/2025 at 11:25 A.M. Diagnoses included, but were not limited to: atrial fibrillation, dementia, anxiety and respiratory failure. A Service Plan for Resident E, dated 7/22/2024, indicated Resident E required the facility staff to provide medication and laundry assistance. The service plan was signed by the resident's representative. However a Service Plan, dated 12/8/2024, indicated Resident E now required assistance from the facility nursing staff to provide medication, laundry, mobility, toileting, grooming, bathing, dressing, transfer, nighttime surveillance, memory prompting and decision-making assistance. The service plan had not been signed by the representative of the resident. During an interview, on 7/15/2025 at 11:13 A.M., the Director of Nursing (DON) indicated Resident E's needs had increased in his level of care. The DON indicated the service plan changes had not been signed by the resident or the resident's representative.			

	A current policy was provided by the Executive Director, on 7/15/2025 at 1:00 P.M. The policy titled, "Coordination-Individualization of Service Plan", indicated, " ...Policy: The community uses an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the resident's needs based on their preferences and priorities. The Service Plan is a communication tool that provides associates with education related to each resident's needs and preferences and assists associates in providing quality, person-centered service ...5. The service plan is reviewed and revised at least every 6 months or after a change in condition and shall be signed and dated by the resident ...." Based on record review and interview, the facility failed to ensure residents and/or their reresentative signed their Service Plans for 4 of 7 residents reviewed for Service Plans. (Residents 6, B, C & E) Findings include: 1. A record review for Resident 6 was completed on 7/15/2025 at 10:01 A.M.and indicated the record lacked a Service Plan signed by the resident.			

	2. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and she had not signed any service plans. The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia. A current Service Plan, dated 5/7/2025, lacked the residents' signature. 3. The record for Resident C was reviewed on 7/14/2025 mat 11:57 A.M. Diagnoses included, but were not limited to bipolar, severe depression, obesity and diabetes. A current Service Plan, dated 6/9/2025, lacked the residents' signature. During an interview, on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated the service plans were not signed by the residents and should have been.			

	4. A record review for Resident E was completed on 7/14/2025 at 11:25 A.M. Diagnoses included, but were not limited to: atrial fibrillation, dementia, anxiety and respiratory failure. A Service Plan for Resident E, dated 7/22/2024, indicated Resident E required the facility staff to provide medication and laundry assistance. The service plan was signed by the resident's representative. However a Service Plan, dated 12/8/2024, indicated Resident E now required assistance from the facility nursing staff to provide medication, laundry, mobility, toileting, grooming, bathing, dressing, transfer, nighttime surveillance, memory prompting and decision-making assistance. The service plan had not been signed by the representative of the resident. During an interview, on 7/15/2025 at 11:13 A.M., the Director of Nursing (DON) indicated Resident E's needs had increased in his level of care. The DON indicated the service plan changes had not been signed by the resident or the resident's representative. A current policy was provided by the Executive Director, on 7/15/2025 at 1:00 P.M. The policy titled, "Coordination-Individualization			

	of Service Plan", indicated, " ...Policy: The community uses an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the resident's needs based on their preferences and priorities. The Service Plan is a communication tool that provides associates with education related to each resident's needs and preferences and assists associates in providing quality, person-centered service ...5. The service plan is reviewed and revised at least every 6 months or after a change in condition and shall be signed and dated by the resident ...." Based on record review and interview, the facility failed to ensure residents and/or their reresentative signed their Service Plans for 4 of 7 residents reviewed for Service Plans. (Residents 6, B, C & E) Findings include: 1. A record review for Resident 6 was completed on 7/15/2025 at 10:01 A.M.and indicated the record lacked a Service Plan signed by the resident. 2. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service			

plan and she had not signed any service plans.

The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia.

A current Service Plan, dated 5/7/2025, lacked the residents' signature.

3. The record for Resident C was reviewed on 7/14/2025 mat 11:57 A.M. Diagnoses included, but were not limited to bipolar, severe depression, obesity and diabetes.

A current Service Plan, dated 6/9/2025, lacked the residents' signature.

During an interview, on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated the service plans were not signed by the residents and should have been.

4. A record review for Resident E was completed on 7/14/2025 at 11:25 A.M. Diagnoses included, but were not limited to: atrial fibrillation, dementia, anxiety and respiratory failure.

A Service Plan for Resident E, dated 7/22/2024, indicated Resident E required the facility staff to provide medication and

	laundry assistance. The service plan was signed by the resident's representative. However a Service Plan, dated 12/8/2024, indicated Resident E now required assistance from the facility nursing staff to provide medication, laundry, mobility, toileting, grooming, bathing, dressing, transfer, nighttime surveillance, memory prompting and decision-making assistance. The service plan had not been signed by the representative of the resident. During an interview, on 7/15/2025 at 11:13 A.M., the Director of Nursing (DON) indicated Resident E's needs had increased in his level of care. The DON indicated the service plan changes had not been signed by the resident or the resident's representative. A current policy was provided by the Executive Director, on 7/15/2025 at 1:00 P.M. The policy titled, "Coordination-Individualization of Service Plan", indicated, " ...Policy: The community uses an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the resident's needs based on their preferences and priorities. The Service Plan is a communication tool that provides associates with			

education related to each resident's needs and preferences and assists associates in providing quality, person-centered service ...5. The service plan is reviewed and revised at least every 6 months or after a change in condition and shall be signed and dated by the resident ...."

Based on record review and interview, the facility failed to ensure residents and/or their reresentative signed their Service Plans for 4 of 7 residents reviewed for Service Plans. (Residents 6, B, C & E)

Findings include:

1. A record review for Resident 6 was completed on 7/15/2025 at 10:01 A.M.and indicated the record lacked a Service Plan signed by the resident.

2. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and she had not signed any service plans.

The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia.

A current Service Plan, dated

	5/7/2025, lacked the residents' signature. 3. The record for Resident C was reviewed on 7/14/2025 mat 11:57 A.M. Diagnoses included, but were not limited to bipolar, severe depression, obesity and diabetes. A current Service Plan, dated 6/9/2025, lacked the residents' signature. During an interview, on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated the service plans were not signed by the residents and should have been. 4. A record review for Resident E was completed on 7/14/2025 at 11:25 A.M. Diagnoses included, but were not limited to: atrial fibrillation, dementia, anxiety and respiratory failure. A Service Plan for Resident E, dated 7/22/2024, indicated Resident E required the facility staff to provide medication and laundry assistance. The service plan was signed by the resident's representative. However a Service Plan, dated 12/8/2024, indicated Resident E now required assistance from the facility nursing staff to provide medication, laundry, mobility, toileting, grooming, bathing, dressing, transfer, nighttime surveillance, memory			

	prompting and decision-making assistance. The service plan had not been signed by the representative of the resident. During an interview, on 7/15/2025 at 11:13 A.M., the Director of Nursing (DON) indicated Resident E's needs had increased in his level of care. The DON indicated the service plan changes had not been signed by the resident or the resident's representative. A current policy was provided by the Executive Director, on 7/15/2025 at 1:00 P.M. The policy titled, "Coordination-Individualization of Service Plan", indicated, " ...Policy: The community uses an individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the resident's needs based on their preferences and priorities. The Service Plan is a communication tool that provides associates with education related to each resident's needs and preferences and assists associates in providing quality, person-centered service ...5. The service plan is reviewed and revised at least every 6 months or after a change in condition and shall be signed and dated by the resident ...." Based on record review and			

	interview, the facility failed to ensure residents and/or their reresentative signed their Service Plans for 4 of 7 residents reviewed for Service Plans. (Residents 6, B, C & E) Findings include: 1. A record review for Resident 6 was completed on 7/15/2025 at 10:01 A.M.and indicated the record lacked a Service Plan signed by the resident.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to document changes in condition in the medical record for 1 of 4 residents reviewed for quality of care. (Resident D) Finding includes:	R 0349	Residents of the Community have the potential to be affected by the alleged deficiency. The resident's documentation was immediately updated upon discovery. Resident clinical notes were audited to ensure no other documentation was missing for other residents. Nursing staff and QMAs were in-serviced on July 31, 2025, by the Executive Director and Director of Nursing on documentation standards, timeliness, and accuracy. Weekly audits of documentation will be completed by the Director of Nursing for 60 days and the QA Committee will review outcomes at the end of QA meeting to determine if continued weekly audits are needed, and if not, the process will transition to quarterly review. The Director of Nursing is responsible for compliance.	09/30/2025

	A review of a facility reported Incident, dated 6/26/2025, reported to the Indiana Department of Health indicated Resident D's family member had contacted the facility with concerns of Resident D's recent hospitalization and overall condition. The family member had reported Resident D had complainted of discomfort including back pain and constipation over the weekend of June 21-22, 2025. The report indicated a friend of the family had visited and reported to the nursing staff Resident D's change of condition. The investigative report indicated the facility staff had been reeducated regarding timely documentation and proper reporting of resident concerns. In addition, the employee involved had been terminated from employment due to not following facility policy related to notifying the Director of Nursing of changes in Resident D's condition. A record review for Resident D was completed on 7/14/2025 at 11:02 A.M. Diagnoses included, but were not limited to: dementia, seizures and depression.			

	A Service Plan, dated 6/9/2025 indicated Resident D needed staff assistance with making decisions based on her needs and health status. During an interview, on 7/15/2025 at 1:42 P.M., the Director of Nursing (DON) indicated she had been notified of Resident D's changes in condition from a family member, who had called and yelled at her. The DON indicated Resident D's son had come to the facility on Saturday (6/21/2025) to take the resident out for lunch, but had brought Resident D back to the facility due to resident's complaints of bad back pain. He had informed the QMA on duty of Resident D's back pain. The DON indicated a family friend had visited the resident on Sunday and the friend had informed two QMA's that Resident D had fallen and was on the floor. The DON indicated the resident's son had informed her that after reporting Resident D's fall to the QMAs, the family friend had returned to Resident D's room but no staff members ever came to the room. The family friend had helped Resident D get up off of the floor. The DON indicated after the fall, the QMA should have completed vital signs and an incident report, and the QMA should have reached out to report the fall and complaints of back pain and			

	constipation to the Director of Nursing. A current policy was provided, on 7/15/2025 at 1:00 P.M., by the Executive Director. The policy titled, "Resident Change in Condition", indicated, " ...It is the policy of this community that all changes in the resident condition will be communicated to the physician, resident, family/responsible party, case manager, and other parties as directed by the resident and ensure that appropriate, timely, and effective interventions occur ...Acute Medical Change ...All nursing actions, physician contacts, and resident assessment information will be documented in the nursing progress notes ...Document resident change of condition and response on the Condition of Change form and continue in the nursing progress notes if necessary. Documentation notes will include time and physician response ...The licensed nurse responsible for the resident will continue assessment and documentation in the nurses notes every shift or until the resident's condition has stabilized ...." This citation relates to complaint IN00462430. Based on record review and interview, the facility failed to document changes in condition			

	in the medical record for 1 of 4 residents reviewed for quality of care. (Resident D) Finding includes: A review of a facility reported Incident, dated 6/26/2025, reported to the Indiana Department of Health indicated Resident D's family member had contacted the facility with concerns of Resident D's recent hospitalization and overall condition. The family member had reported Resident D had complainted of discomfort including back pain and constipation over the weekend of June 21-22, 2025. The report indicated a friend of the family had visited and reported to the nursing staff Resident D's change of condition. The investigative report indicated the facility staff had been reeducated regarding timely documentation and proper reporting of resident concerns. In addition, the employee involved had been terminated from employment due to not following facility policy related to notifying the Director of Nursing of changes in Resident D's condition.			

	A record review for Resident D was completed on 7/14/2025 at 11:02 A.M. Diagnoses included, but were not limited to: dementia, seizures and depression. A Service Plan, dated 6/9/2025 indicated Resident D needed staff assistance with making decisions based on her needs and health status. During an interview, on 7/15/2025 at 1:42 P.M., the Director of Nursing (DON) indicated she had been notified of Resident D's changes in condition from a family member, who had called and yelled at her. The DON indicated Resident D's son had come to the facility on Saturday (6/21/2025) to take the resident out for lunch, but had brought Resident D back to the facility due to resident's complaints of bad back pain. He had informed the QMA on duty of Resident D's back pain. The DON indicated a family friend had visited the resident on Sunday and the friend had informed two QMA's that Resident D had fallen and was on the floor. The DON indicated the resident's son had informed her that after reporting Resident D's fall to the QMAs, the family friend had returned to Resident D's room but no staff members ever came to the room. The family friend had helped Resident D get up			

	off of the floor. The DON indicated after the fall, the QMA should have completed vital signs and an incident report, and the QMA should have reached out to report the fall and complaints of back pain and constipation to the Director of Nursing.			

	A current policy was provided, on 7/15/2025 at 1:00 P.M., by the Executive Director. The policy titled, "Resident Change in Condition", indicated, " ...It is the policy of this community that all changes in the resident condition will be communicated to the physician, resident, family/responsible party, case manager, and other parties as directed by the resident and ensure that appropriate, timely, and effective interventions occur ...Acute Medical Change ...All nursing actions, physician contacts, and resident assessment information will be documented in the nursing progress notes ...Document resident change of condition and response on the Condition of Change form and continue in the nursing progress notes if necessary. Documentation notes will include time and physician response ...The licensed nurse responsible for the resident will continue assessment and documentation in the nurses notes every shift or until the resident's condition has stabilized ...." This citation relates to complaint IN00462430.			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information	R 0356	Residents of the Community have the potential to be affected by the alleged deficiency. Hospital Preferences were updated on July 14, 2025, and all resident records	09/30/2025

	file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 23 of 29 residents. Finding includes: The emergency binder was		were reviewed to ensure preferences are known and documented. The admission process was updated to ensure preferences are obtained and recorded within the first day of admission. If a resident voices different preferences, records will be immediately updated, and staff notified. Training for the DON on documentation of hospital preferences was completed on July 31, 2025, by the Executive Director. Hospital preference documentation will be reviewed weekly for 60 days. The QA Committee will review outcomes at the end of QA meetings to determine if continued weekly audits are needed, and if not, the process will transition to quarterly review. The Executive Director and Director of Nursing are responsible for compliance.	

reviewed on 7/14/2025 at 3:36 P.M. The hospital preference was missing on 23 of the face sheets.

During an interview, on 7/14/2025 at 4:06 P.M., the Administrator indicated the emergency binder should have had the hospital preference listed on the face sheets.

On 7/15/2025 at 8:30 A.M., the Administrator provided the policy titled, "Resident Information Sheet", dated 10/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated " ... 1. A resident information sheet is completed at the time of move-in and includes detailed information that is necessary for the event of an emergency. It should included, but not limited to: a. Name of emergency contact and contact phone numbers. b. Hospital preference...."

Based on record review, observation and interview, the facility failed to ensure an emergency information binder was accurate and complete with all required resident information for 23 of 29 residents.

Finding includes:

The emergency binder was reviewed on 7/14/2025 at 3:36 P.M. The hospital preference was missing on 23 of the face

	sheets. During an interview, on 7/14/2025 at 4:06 P.M., the Administrator indicated the emergency binder should have had the hospital preference listed on the face sheets. On 7/15/2025 at 8:30 A.M., the Administrator provided the policy titled, "Resident Information Sheet", dated 10/1/2021, and indicated the policy was the one currently used by the facility. The policy indicated " ... 1. A resident information sheet is completed at the time of move-in and includes detailed information that is necessary for the event of an emergency. It should included, but not limited to: a. Name of emergency contact and contact phone numbers. b. Hospital preference...."			
R 0382	Mental Health Screening - Noncompliance 410 IAC 16.2-5-11.1(f) (f) Each resident with a major mental illness must have a comprehensive care plan that is developed within thirty (30) days after admission to the residential care facility. Based on record review and interview, the facility failed to complete a comprehensive plan of care for 2 of 3 residents	R 0382	Residents of the Community have the potential to be affected by the alleged deficiency. Residents without documented mental health care plans were identified, and plans were addressed in collaboration with appropriate providers. Active residents were assessed for behavioral health diagnoses that require additional oversight and corresponding care plan needs. Training was conducted for Director of Nursing on July 28, 2025 on behavioral and mental health care planning by the Executive Director. Care plans for	09/30/2025

	reviewed for mental illness. (Resident B & 2) Findings include: 1. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and had not signed any service plans. The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia. Resident B admitted to the facility on 1/28/2025. "A Level of Service Assessment, "dated 5/7/2025, indicated Resident B was oriented to person, place and time or sufficiently oriented to function independently if within his familiar surroundings. Resident B needed reassurance only at times of a major decisions and her attitudes, disturbance, and emotional states create less than daily difficulties, which are modifiable to tolerable levels given training and patience on the part of the caregiver. May be actively abusing substances. Under Notes: Occasional behaviors regarding pain medication and times. Caregiver administration		mental health will be monitored monthly for 60 days, and the QA Committee will review outcomes at the end of QA meetings/minutes to determine if continued weekly audits are needed, and if not, the process will transition to quarterly review. The Director of Nursing is responsible for compliance.	

	and /or observation of medications requiring judgement for necessity, dosage and/or effect." A comprehensive care plan related to mental health was not available. During an interview. on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated there was no comprehensive care plan addressing the resident's major depressive disorder. 2. A record review for Resident 2 was completed on 7/14/2025 at 10:10 A.M. Diagnoses included, but were not limited to: schizoaffective disorder bipolar type, anxiety disorder and narcolepsy. Resident 2 was admitted to the facility on 11/19/2024. A Level of Service Assessment, dated 4/15/2025, indicated Resident 2 was sufficiently oriented to function independently if within his familiar surroundings and needed reassurance only at times of a major decision. A Nursing Practitioner Note, on 6/12/2025 at 5:14 P.M., indicated Resident 2 had a visit related to an acute follow-up for worsening symptoms of anxiety, psychotropic medication review and management, and			

	evaluation of moods and behaviors related to his schizoaffective disorder, bipolar type and primary narcolepsy. The note indicated Resident 2 showed no distress, but his mood was mostly anxious, and his affect (observable expression of emotion) was congruent to his mood. Resident 2 reported worsening symptoms of anxiety, "I can hardly take it. I am very nervous about my health. I can't seem to relax at all." The nursing staff had indicated Resident 2 had been obsessed about his stomach issues that had caused worsening anxiety symptoms. During an interview, on 7/15/2025 at 11:01 A.M., the Director of Nursing (DON) indicated that a psychiatric nurse practitioner followed Resident 2. She indicated Resident 2 did not have a comprehensive care plan for his schizoaffective disorder, and he should have had a comprehensive care plan for his schizoaffective disorder. A policy for a mental health comprehensive care plan was requested on 7/15/2025 at 11:36 A.M.			

	The Executive Director indicated, on 7/15/2025 at 2:15 P.M., the facility did not have a policy for a comprehensive mental health care plan. Based on record review and interview, the facility failed to complete a comprehensive plan of care for 2 of 3 residents reviewed for mental illness. (Resident B & 2) Findings include: 1. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and had not signed any service plans. The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia. Resident B admitted to the facility on 1/28/2025. "A Level of Service Assessment, "dated 5/7/2025, indicated Resident B was oriented to person, place and time or sufficiently oriented to function independently if within his familiar surroundings. Resident B needed reassurance only at times of a major decisions and her attitudes,			

	disturbance, and emotional states create less than daily difficulties, which are modifiable to tolerable levels given training and patience on the part of the caregiver. May be actively abusing substances. Under Notes: Occasional behaviors regarding pain medication and times. Caregiver administration and /or observation of medications requiring judgement for necessity, dosage and/or effect." A comprehensive care plan related to mental health was not available. During an interview. on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated there was no comprehensive care plan addressing the resident's major depressive disorder. 2. A record review for Resident 2 was completed on 7/14/2025 at 10:10 A.M. Diagnoses included, but were not limited to: schizoaffective disorder bipolar type, anxiety disorder and narcolepsy. Resident 2 was admitted to the facility on 11/19/2024. A Level of Service Assessment, dated 4/15/2025, indicated Resident 2 was sufficiently oriented to function independently if within his familiar surroundings and			

needed reassurance only at times of a major decision.

A Nursing Practitioner Note, on 6/12/2025 at 5:14 P.M., indicated Resident 2 had a visit related to an acute follow-up for worsening symptoms of anxiety, psychotropic medication review and management, and evaluation of moods and behaviors related to his schizoaffective disorder, bipolar type and primary narcolepsy. The note indicated Resident 2 showed no distress, but his mood was mostly anxious, and his affect (observable expression of emotion) was congruent to his mood. Resident 2 reported worsening symptoms of anxiety, "I can hardly take it. I am very nervous about my health. I can't seem to relax at all." The nursing staff had indicated Resident 2 had been obsessed about his stomach issues that had caused worsening anxiety symptoms.

During an interview, on 7/15/2025 at 11:01 A.M., the Director of Nursing (DON) indicated that a psychiatric nurse practitioner followed Resident 2. She indicated Resident 2 did not have a comprehensive care plan for his schizoaffective disorder, and he should have had a comprehensive care plan for his schizoaffective disorder.

	A policy for a mental health comprehensive care plan was requested on 7/15/2025 at 11:36 A.M. The Executive Director indicated, on 7/15/2025 at 2:15 P.M., the facility did not have a policy for a comprehensive mental health care plan. Based on record review and interview, the facility failed to complete a comprehensive plan of care for 2 of 3 residents reviewed for mental illness. (Resident B & 2) Findings include: 1. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and had not signed any service plans. The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia. Resident B admitted to the facility on 1/28/2025. "A Level of Service Assessment, "dated 5/7/2025, indicated Resident B was oriented to person, place and time or sufficiently oriented to			

function independently if within his familiar surroundings. Resident B needed reassurance only at times of a major decisions and her attitudes, disturbance, and emotional states create less than daily difficulties, which are modifiable to tolerable levels given training and patience on the part of the caregiver. May be actively abusing substances. Under Notes: Occasional behaviors regarding pain medication and times. Caregiver administration and /or observation of medications requiring judgement for necessity, dosage and/or effect."

A comprehensive care plan related to mental health was not available.

During an interview. on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated there was no comprehensive care plan addressing the resident's major depressive disorder.

2. A record review for Resident 2 was completed on 7/14/2025 at 10:10 A.M. Diagnoses included, but were not limited to: schizoaffective disorder bipolar type, anxiety disorder and narcolepsy.

Resident 2 was admitted to the facility on 11/19/2024.

A Level of Service Assessment,

	dated 4/15/2025, indicated Resident 2 was sufficiently oriented to function independently if within his familiar surroundings and needed reassurance only at times of a major decision. A Nursing Practitioner Note, on 6/12/2025 at 5:14 P.M., indicated Resident 2 had a visit related to an acute follow-up for worsening symptoms of anxiety, psychotropic medication review and management, and evaluation of moods and behaviors related to his schizoaffective disorder, bipolar type and primary narcolepsy. The note indicated Resident 2 showed no distress, but his mood was mostly anxious, and his affect (observable expression of emotion) was congruent to his mood. Resident 2 reported worsening symptoms of anxiety, "I can hardly take it. I am very nervous about my health. I can't seem to relax at all." The nursing staff had indicated Resident 2 had been obsessed about his stomach issues that had caused worsening anxiety symptoms. During an interview, on 7/15/2025 at 11:01 A.M., the Director of Nursing (DON) indicated that a psychiatric nurse practitioner followed Resident 2. She indicated Resident 2 did not have a comprehensive care plan for his			

schizoaffective disorder, and he should have had a comprehensive care plan for his schizoaffective disorder.

A policy for a mental health comprehensive care plan was requested on 7/15/2025 at 11:36 A.M.

The Executive Director indicated, on 7/15/2025 at 2:15 P.M., the facility did not have a policy for a comprehensive mental health care plan.

Based on record review and interview, the facility failed to complete a comprehensive plan of care for 2 of 3 residents reviewed for mental illness. (Resident B & 2)

Findings include:

1. During an interview, on 7/14/2025 at 10:08 A.M., Resident B indicated she had moved in January 2025 and had not participated in her service plan and had not signed any service plans.

The record for Resident B was reviewed on 7/15/2025 at 10:38 A.M. Diagnoses included, but were not limited to heart disease, anxiety, major depressive disease and insomnia.

Resident B admitted to the facility on 1/28/2025.

	"A Level of Service Assessment, "dated 5/7/2025, indicated Resident B was oriented to person, place and time or sufficiently oriented to function independently if within his familiar surroundings. Resident B needed reassurance only at times of a major decisions and her attitudes, disturbance, and emotional states create less than daily difficulties, which are modifiable to tolerable levels given training and patience on the part of the caregiver. May be actively abusing substances. Under Notes: Occasional behaviors regarding pain medication and times. Caregiver administration and /or observation of medications requiring judgement for necessity, dosage and/or effect." A comprehensive care plan related to mental health was not available. During an interview. on 7/15/2025 at 2:00 P.M., the Director of Nursing indicated there was no comprehensive care plan addressing the resident's major depressive disorder. 2. A record review for Resident 2 was completed on 7/14/2025 at 10:10 A.M. Diagnoses included, but were not limited to: schizoaffective disorder bipolar type, anxiety disorder and			

	narcolepsy. Resident 2 was admitted to the facility on 11/19/2024. A Level of Service Assessment, dated 4/15/2025, indicated Resident 2 was sufficiently oriented to function independently if within his familiar surroundings and needed reassurance only at times of a major decision. A Nursing Practitioner Note, on 6/12/2025 at 5:14 P.M., indicated Resident 2 had a visit related to an acute follow-up for worsening symptoms of anxiety, psychotropic medication review and management, and evaluation of moods and behaviors related to his schizoaffective disorder, bipolar type and primary narcolepsy. The note indicated Resident 2 showed no distress, but his mood was mostly anxious, and his affect (observable expression of emotion) was congruent to his mood. Resident 2 reported worsening symptoms of anxiety, "I can hardly take it. I am very nervous about my health. I can't seem to relax at all." The nursing staff had indicated Resident 2 had been obsessed about his stomach issues that had caused worsening anxiety symptoms. During an interview, on 7/15/2025 at 11:01 A.M., the			

	Director of Nursing (DON) indicated that a psychiatric nurse practitioner followed Resident 2. She indicated Resident 2 did not have a comprehensive care plan for his schizoaffective disorder, and he should have had a comprehensive care plan for his schizoaffective disorder. A policy for a mental health comprehensive care plan was requested on 7/15/2025 at 11:36 A.M. The Executive Director indicated, on 7/15/2025 at 2:15 P.M., the facility did not have a policy for a comprehensive mental health care plan.			
R 0383	Mental Health Screening - Deficiency 410 IAC 16.2-5-11.1(g)(1-2) (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities.	R 0383	Residents of the Community have the potential to be affected by the alleged deficiency. Residents without documented mental health care plans were identified, and plans were addressed in collaboration with appropriate providers. Active residents were assessed for behavioral health diagnoses that require additional oversight and corresponding care plan needs. Training was conducted for Director of Nursing on July 28, 2025 on behavioral and mental health care planning by the Executive Director. Care plans for mental health will be monitored monthly for 60 days and the QA Committee will review outcomes at the end of QA meetings to determine if continued weekly audits are needed, and if not, the	09/30/2025

	(B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on record review and interview, the facility failed to provide a comprehensive mental health care plan in conjunction with a mental health provider for 1 of 4 residents reviewed for major mental illnesses. (Resident 2) Finding includes: A record review for Resident 2 was completed on 7/14/2025 at 10:10 A.M. Diagnoses included, but were not limited to: schizoaffective disorder bipolar type, anxiety disorder and narcolepsy. Resident 2 admitted to the facility on 11/19/2024. A Level of Service Assessment, dated 4/15/2025, indicated Resident 2 was oriented to function independently if within his familiar surroundings and needed reassurance only at times of a major decision. A Nursing Practitioner Note, on 6/12/2025 at 5:14 P.M., indicated Resident 2 had a visit related to an acute follow-up for worsening symptoms of anxiety,		process will transition to quarterly review. The Director of Nursing is responsible for compliance.	

psychotropic medication review and management, and evaluation of moods and behaviors related to his schizoaffective disorder, bipolar type and primary narcolepsy. The note indicated Resident 2 showed no distress, but his mood was mostly anxious, and his affect (observable expression of emotion) was congruent to his mood. Resident 2 reported worsening symptoms of anxiety, "I can hardly take it. I am very nervous about my health. I can't seem to relax at all." The nursing staff had indicated Resident 2 had been obsessed about his stomach issues that had caused worsening anxiety symptoms.

During an interview, on 7/15/2025 at 11:01 A.M., the Director of Nursing (DON) indicated that a psychiatric nurse practitioner followed Resident 2. She indicated Resident 2 did not have a comprehensive care plan for his schizoaffective disorder, and he should have had a comprehensive care plan in conjunction with a mental health provider for his schizoaffective disorder.

A policy for a mental health comprehensive care plan in conjunction with a mental health provider was requested on 7/15/2025 at 11:36 A.M.

The Executive Director indicated, on 7/15/2025 at 2:15 P.M., the facility did not have a policy for a comprehensive mental health care plan in conjunction with a mental health provider.

Based on record review and interview, the facility failed to provide a comprehensive mental health care plan in conjunction with a mental health provider for 1 of 4 residents reviewed for major mental illnesses. (Resident 2)

Finding includes:

A record review for Resident 2 was completed on 7/14/2025 at 10:10 A.M. Diagnoses included, but were not limited to: schizoaffective disorder bipolar type, anxiety disorder and narcolepsy.

Resident 2 admitted to the facility on 11/19/2024.

A Level of Service Assessment, dated 4/15/2025, indicated Resident 2 was oriented to function independently if within his familiar surroundings and needed reassurance only at times of a major decision.

A Nursing Practitioner Note, on 6/12/2025 at 5:14 P.M., indicated Resident 2 had a visit related to an acute follow-up for worsening symptoms of anxiety, psychotropic medication review

and management, and evaluation of moods and behaviors related to his schizoaffective disorder, bipolar type and primary narcolepsy. The note indicated Resident 2 showed no distress, but his mood was mostly anxious, and his affect (observable expression of emotion) was congruent to his mood. Resident 2 reported worsening symptoms of anxiety, "I can hardly take it. I am very nervous about my health. I can't seem to relax at all." The nursing staff had indicated Resident 2 had been obsessed about his stomach issues that had caused worsening anxiety symptoms.

During an interview, on 7/15/2025 at 11:01 A.M., the Director of Nursing (DON) indicated that a psychiatric nurse practitioner followed Resident 2. She indicated Resident 2 did not have a comprehensive care plan for his schizoaffective disorder, and he should have had a comprehensive care plan in conjunction with a mental health provider for his schizoaffective disorder.

A policy for a mental health comprehensive care plan in conjunction with a mental health provider was requested on 7/15/2025 at 11:36 A.M.

The Executive Director

	indicated, on 7/15/2025 at 2:15 P.M., the facility did not have a policy for a comprehensive mental health care plan in conjunction with a mental health provider.			

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 SIGNATURETerri	TITLEMcLemore	(X6) DATE09/19/2025