

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2026
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST, INDIANAPOLIS, , 46219			
(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 470941 and Intake 470826. Intake 470941- No state deficiencies related to the allegations. Intake 470826 - State deficiencies related to the allegations are cited at R0052, R0091, and R0217. Survey date: August 6 and 7, 2026 Facility number: 005729 Residential Census: 41 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2. Quality review completed August 12, 2026.	R 0000			
R 0052	Residents' Rights - Offense	R 0052	1.Residents B and C were	08/28/2026	

	410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be 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 protect the resident's right to be free from mental and physical abuse by another resident. This failure resulted in bruises on the resident's wrist and fear of leaving an apartment for several hours, for 2 of 3 residents reviewed for abuse (Resident B and Resident C). Findings include: 1a. The clinical record for Resident B was reviewed on 8/6/26 at 12:20 p.m. The resident's diagnosis included, but was not limited to, osteoarthritis (cartilage that lines joints broken down and bone rubs on bone). A Mini Mental Status Exam (exam used to check for cognitive impairment), dated		assessed for physical injury, emotional/psychosocial effects, and continued risk related to resident-to-resident interactions. The attending physicians were notified as indicated, and appropriate follow-up was completed. The residents' service plans were reviewed and revised as appropriate to address identified behavioral triggers, safety concerns, alcohol-related behaviors, resident-to-resident interactions, and interventions necessary to reduce the risk of recurrence. The facility also reviewed the residents' records for any additional incidents involving abuse, threats, intimidation, harassment, or physical aggression and completed any required follow-up, documentation, notification, and reporting. 2. The Executive Director or designee will conduct a review of incident reports, progress notes, behavior documentation, grievances, complaints, and other available facility records for the previous 30 days to identify any resident-to-resident incidents involving physical, verbal, mental, or emotional abuse that may not have been appropriately reported or escalated.	
--	--	--	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

3/27/26, indicated Resident B was cognitively intact. An Evaluation of Needs/ Service Plan, dated 6/5/26, indicated Resident B was alert and oriented. Resident B made sound independent decisions. 1b. The clinical record for Resident C was reviewed on 8/6/26 at 12:30 p.m. The resident's diagnosis included, but was not limited to, alcohol abuse (impaired ability to stop or control alcohol use). A Mini Mental Status Exam, dated 6/10/26, indicated Resident C had moderately impaired cognition. An Evaluation of Needs/ Service Plan, dated 6/10/26, indicated Resident C was alert and oriented. Resident B made sound, independent decisions. On 8/6/26 at 12:15 p.m., the Interim Director of Nursing (IDON) provided an Incident Report, dated 7/6/26, that indicated Resident B and Resident C were consuming alcohol together. Resident B realized all the alcohol was gone and became upset. Resident B started yelling and screaming at Resident C. Resident C began yelling and screaming at Resident B. Resident B pushed Resident C and then Resident C grabbed	Any identified incident will be reviewed for appropriate immediate intervention, resident assessment, physician notification, Administrator notification, IDOH reporting, investigation, documentation, and care/service-plan follow-up. Residents identified through this review as potentially affected will be assessed and provided appropriate interventions based upon the circumstances of the incident. 3. The facility's Resident-to-Resident Abuse Procedure will be reviewed and revised as necessary to clearly define staff responsibilities when an allegation, observation, or suspicion of physical, verbal, mental, abuse or any other incident occurs. The revised procedure will require staff to: • Immediately protect and separate residents as appropriate. • Immediately notify the nurse and Administrator/designee of any suspected or alleged abuse. • Assess each involved resident for physical injury and	
--	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Resident B's arm. A staff member got in between Resident B and Resident C and made sure both residents stayed away from each other. There were no injuries that needed medical attention. Resident B and Resident C were placed on 15-minute checks. The residents were re-educated on the policies of consuming alcohol with other residents. On 8/6/26 at 1:00 p.m., the Interim DON provided written statements from residents who witnessed the altercation and a staff member. A handwritten statement from Qualified Medication Aide (QMA) 2, dated 7/4/26 at 4:45 p.m., indicated QMA 2 had answered a call light and heard Resident C and Resident B yelling. QMA 2 went to the kitchen area and saw Resident C pointing and yelling at Resident B. QMA 2 asked Resident C to leave the kitchen area and Resident C refused to leave. Resident B left the kitchen area and, on the way, out Resident C "got in" Resident B's face. Resident B pushed Resident C out of her face and Resident C grabbed Resident B's arm. QMA 2 then stood between Resident B and Resident C to separate them. Resident B went to her room.		emotional/psychosocial effects. • Notify the attending physician and other appropriate clinicians as indicated. • Complete statements on the events that occurred. • Initiate an investigation promptly, including interviews of involved residents and witnesses. • Determine whether the incident meets applicable IDOH reporting requirements. • Submit required reports to IDOH within the applicable reporting timeframe. • Implement interventions to prevent further potential abuse while the investigation is occurring. • Review and revise the resident's care/service plan as indicated. • Continue monitoring for recurrence and document follow-up. • Implement a standardized abuse/incident notification process that identifies the required notifications and the date/time each notification was completed. The process will include Administrator,	
---	--	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	Resident C stayed in the hallway yelling. A handwritten statement from Resident E, dated 7/4/26, indicated Resident E had heard screaming and cursing from the second-floor kitchen. Resident E had opened her door and saw Resident C was yelling at Resident B. Resident C was calling Resident B a "B****" in front of other people. The staff came and told Resident C to go back to his room. Resident B was scared to go back to the kitchen. Resident C would not return to his room. Resident B went back to the kitchen to continue to cook, and another resident was in the kitchen with Resident B. Resident C came up and kicked the kitchen door. Resident B was going to hit Resident C with her cane, but the staff stopped her. The staff told Resident C to go to his room. Resident E told Resident C to go to his room. Resident C remained in the hallway, yelling at Resident B. Resident B told Resident C to leave her the "F****" alone. Resident C then grabbed Resident B by the arm and began hitting her and pulling her shirt down. The staff broke up the fight. Resident B called the police. The police came and talked with Resident C, but did not talk with Resident B. When the police left, Resident C was still in the		physician, IDOH, law enforcement, and other required entities as applicable to the circumstances. 4. All employees, including nursing staff, QMAs, direct-care staff, supervisors, and management responsible for receiving or responding to resident incidents will receive education regarding: • Resident-to-resident abuse. • Resident Rights • Physical, verbal, mental, and emotional abuse. • Examples of reportable resident-to-resident conflicts. • Immediate reporting requirements. • Administrator, Director of Nursing and Physician notification requirements. • IDOH reporting requirements and applicable timeframes. • Required investigation procedures. • Required clinical and incident documentation. • Immediate interventions to protect residents. • Care/service-plan review following an incident. • Follow-up monitoring for recurrence. • Staff responsibility to	
--	--	--	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	hallway fussing and cursing. Resident E called the police again, because the first police officer had not taken Resident B's Statement. A second police officer came and spoke with Resident B and Resident E. On 8/6/26 at 2:00 p.m., an interview was conducted with Resident B. Resident B indicated that on July 4, 2026, she had been in the kitchen cooking a meal to share with her friends. Resident C had come to the kitchen and started yelling and cursing her. Resident B had told Resident C to leave her alone. Resident B kept coming to the kitchen, screaming and yelling about Resident B using the kitchen. Resident B left the kitchen and went to Resident E's room for a while. Resident B left Resident E's room, trying to go to her own room for cooking supplies. Resident C yelled at Resident B as she was on her way back to her apartment. Resident B had threatened to hit Resident C with her cane because Resident C would not leave her alone. Resident C grabbed Resident B's arm and pushed her against a wall in the hallway. QMA 2 came and pulled Resident C off Resident B. Resident B called the police on Resident C because Resident C would not leave Resident B alone. Resident B spent several hours in Resident		report an allegation or suspicion rather than independently determining that abuse did not occur. Education will include case examples involving physical aggression, threats, intimidation, harassment, and verbal abuse so staff understand that abuse reporting is required even when an incident does not initially appear to result in a significant injury. Any staff member who has not completed the required education will receive education prior to being assigned independent resident-care duties, as applicable. 5. The Executive Director, Director of Nursing, or designee will audit 100% of abuse allegations and resident-to-resident altercations for four consecutive weeks to verify that the facility's abuse policy was implemented, then checked monthly by corporate Health Services Director for six month to ensure compliance. The audit will verify: • Immediate resident protection/intervention. • Timely Administrator notification. • Physician notification when indicated.	
--	---	--	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	E's apartment because Resident B was scared to go out to the hallway because of Resident C. Resident B continued to be intimidated and scared of Resident C after the incident. Resident B indicated she had cried about the altercation for several weeks after it happened. Resident B did not feel the July 4th incident had been investigated and did not feel that the management staff had given her a chance to tell them what had happened to her. About 3 weeks ago, Resident C came to the kitchen when Resident B was cooking. Resident C hit the door and yelled at Resident B for being in the kitchen. Resident E was in the kitchen with Resident B. Resident B had slammed the kitchen door and locked it so that Resident C could not get in. Resident C had kicked on the door and was cursing. The staff came and took Resident C back to his room. An interview was conducted with Resident E on 8/7/26 at 10:42 a.m. Resident E indicated on July 4, 2026, she had heard commotion outside her apartment door. Resident E had opened the door and saw Resident C was banging on the kitchen door and yelling. Resident B was in the kitchen. A staff member came and told Resident C to leave Resident B		• IDOH reporting when required. • Appropriate investigation. • Resident and witness interviews. • Injury and psychosocial assessments. • Clinical and incident documentation. • Care/service-plan review. • Follow-up monitoring. • Interventions to prevent recurrence. Audit results will be reviewed with the Quality Assurance/Performance Improvement Committee. Any identified variance will result in immediate corrective action, including additional staff education and review of the individual incident. The Executive Director and Director of Nursing will be responsible for ensuring continued compliance. Completion Date 8/28/2026	
--	---	--	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	alone. The staff member had told Resident C to go back to his room because Resident C was drunk. The staff member left and Resident C came out of his room again and started "fussing" at Resident B. Resident C called Resident B derogatory names. Another resident went and got staff. A staff member came up and took Resident C back to his room again. The staff member stayed around for a while to see if Resident C would come back out of his room. When the staff member left, Resident C came out again and started yelling at Resident B. Resident B came into Resident E's room and stayed for a while, then Resident B left to go back to her room to get cooking supplies. When Resident B left Resident E's room, Resident C came out of his room and started yelling at Resident B. Resident B went past Resident C in the hallway and told Resident C to leave her the "F***" alone. Resident C then grabbed Resident B's arm and was pulling on her shirt. Resident B was fighting to get away from Resident C. QMA 2 came and pulled Resident C off Resident B. Resident B was all upset and crying. Resident B came back into Resident E's apartment and called the police. The police came and talked with Resident C and left. Resident B had stayed in Resident E's			
--	---	--	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	apartment for 2 to 3 hours after the incident because Resident B was too scared to leave. The next day, Resident B had dark bruises on her arm. Resident E had been in the kitchen with Resident B a few weeks ago, when Resident C came to the kitchen door, hit the door, and started yelling and cursing at Resident B and Resident E. Resident B had slammed the kitchen door in his face and locked it. The staff had to come and get Resident C from outside the kitchen door so that Resident E and Resident B could get to Resident E's apartment. During an interview on 8/7/26 at 11:37 a.m., the Executive Director (ED) indicated the July 4,2026 incident between Resident B and Resident C started on 7/3/26. Resident B had purchased alcohol on July 3,2026 and had become upset with Resident C for drinking all the alcohol. Resident C has dementia and did not remember drinking the alcohol. Resident B was angry and started yelling at Resident C. Resident B had tried to hit Resident C with her walker and Resident C had grabbed Resident B's arm to stop her. The incident had been reported to the ED the following Monday. Resident E had claimed to witness the incident, but Resident E's door was			
--	--	--	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

always closed. The Director of Nursing at the time had examined Resident B's arm and there was an old bruise.

On 8/7/26 at 12:57 p.m., the ED provided statements from Resident B and Resident C from the incident on 7/4/26.

A typed statement from Resident C, dated 7/14/26, indicated Resident C did not know what was wrong. Everything was fine, Resident C had helped take Resident B's food up to her room. Resident C had asked Resident B for some rum. After that Resident C went to his apartment. The next day, Resident B was in the kitchen. Resident C had said hello and Resident B started yelling and screaming at Resident C and tried to hit Resident C with a walker. Resident C had grabbed Resident B's arm. Resident C denied drinking Resident B's rum and indicated he had his own stuff. Resident C indicated he did not bother anyone at the facility. Resident C tried to stay to himself and help others. Resident B was lying.

A typed statement from Resident B, dated 7/14/26, indicated Resident B had Resident C help put groceries away and Resident C had asked for some of Resident B's rum. Resident B had given Resident

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	C some rum. Resident C left Resident B's room. Resident B noticed the rum was gone and went to get Resident C's door and asked Resident C where the rum was. Resident C said that he did not have Resident B's rum. The next day Resident B was in the kitchen, and Resident C came in to talk with Resident B. Resident B told Resident C she did not want to talk because Resident B An interview was conducted with the Former Director of Nursing (FDON) on 8/7/26 at 1:29 p.m. The FDON indicated the staff had called the FDON on July 4, 2026, and informed her of an altercation between Resident B and Resident C. The FDON had examined Resident B's arm a couple of days after the incident and there were dark bruises on Resident B's arm and wrist. On 8/6/26 at 2:56 p.m., the IDON provided the Abuse Policy, last revised 2/2022, that read "...Resident Abuse: Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain			
--	--	--	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	physical, mental and psychosocial well-being... Examples of abuse are as follows, but are not inclusive... Mental Abuse...5. Saying anything to a resident which might cause him/her to worry or become alarmed...7. Harassment...Physical Abuse 1. Actually laying hands on a resident in an abrupt manner [e.g., hitting, slapping, pinching, or kicking] ...Procedure...2. Should an occurrence of abusive behavior be reported or witnessed, the Administrator shall be notified immediately...Resident- to- Resident Abuse Procedure: 1. Staff shall intervene immediately and assess the immediate needs of the resident[s] and provide any needed medical attention, if applicable. Staff must not leave if he/she be in potential danger. Rather, staff should activate the call light and/or call out for staff assistance..." This citation was related to Intake 470826.			
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	R 0091	1. Residents B and C were identified as the residents directly affected by the deficient practice. The facility completed a review of the incidents involving Residents B and C, including the July 4, 2026 physical altercation and the July	08/28/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	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 the facility Abuse Policy by not timely reporting incidents of verbal and physical abuse to the Administrator, attending physicians, and the Indiana Department of Health for 2 of 3 residents reviewed for resident-to-resident abuse (Resident B and C). Findings include: 1a. The clinical record for Resident B was reviewed on 8/6/26 at 12:20 p.m. The resident's diagnosis included, but was not limited to, osteoarthritis (cartilage that lines joints broken down and bone rubs on bone). 1b. The clinical record for Resident C was reviewed on 8/6/26 at 12:30 p.m. The resident's diagnosis included, but was not limited to, alcohol abuse (impaired ability to stop		21, 2026 verbal/behavioral incident. The residents were assessed for physical injury, emotional/psychosocial effects, and continued risk related to resident-to-resident interactions. The attending physicians were notified as indicated, and appropriate follow-up was completed. The residents' service plans were reviewed and revised as appropriate to address identified behavioral triggers, safety concerns, alcohol-related behaviors, resident-to-resident interactions, and interventions necessary to reduce the risk of recurrence. The facility also reviewed the residents' records for any additional incidents involving abuse, threats, intimidation, harassment, or physical aggression and completed any required follow-up, documentation, notification, and reporting. 2. The Executive Director or designee will conduct a review of incident reports, progress notes, behavior documentation, grievances, complaints, and other available facility records for the previous 30 days to identify any resident-to-resident incidents involving physical, verbal, mental, or emotional	
--	---	--	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

or control alcohol use). On 8/6/26 at 12:15 p.m., the Interim Director of Nursing (IDON) provided an Incident Report, dated 7/6/26. The Brief Description of Incident indicated 7/15/26 Late Report Resident B and Resident C were consuming alcohol together. Resident B realized all the alcohol was gone and became upset. Resident B started yelling and screaming at Resident C. Resident C began yelling and screaming at Resident B. Resident B pushed Resident C and then Resident C grabbed Resident B's arm. A staff member got in between Resident B and Resident C and made sure both residents stayed away from each other. There were no injuries that needed medical attention. Resident B and Resident C were placed on 15-minute checks. The Follow up- 7/15/26 indicated the residents were re-educated on the policies of consuming alcohol with other residents. A handwritten statement from Qualified Medication Aide (QMA) 2, dated 7/4/26 at 4:45 p.m., indicated QMA 2 had answered a call light and heard Resident C and Resident B yelling. QMA 2 went to the kitchen area and saw Resident C pointing and yelling at	abuse that may not have been appropriately reported or escalated. Executive Director will send Director of Operations a weekly report on all incidents that have occurred in the facility for review to ensure compliance on reporting to IDOH in a timely manner. Any identified incident will be reviewed for appropriate immediate intervention, resident assessment, physician notification, Administrator notification, IDOH reporting, investigation, documentation, and care/service-plan follow-up. Residents identified through this review as potentially affected will be assessed and provided appropriate interventions based upon the circumstances of the incident. 3. The facility's Abuse and Neglect Policy and Resident-to-Resident Abuse Procedure will be reviewed and revised as necessary to clearly define staff responsibilities when an allegation, observation, or suspicion of physical, verbal, mental, or other abuse occurs. The revised procedure will require staff to: • Immediately protect and separate residents as appropriate.	
---	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Resident B. QMA 2 asked Resident C to leave the kitchen area and Resident C refused to leave. Resident B left the kitchen area and, on the way, out Resident C "got in" Resident B's face. Resident B pushed Resident C out of her face and Resident C grabbed Resident B's arm. QMA 2 then stood between Resident B and Resident C to separate them. Resident B went to her room. Resident C stayed in the hallway yelling. The clinical record for Resident B and Resident C did not contain any information related to the incident on July 4, 2026. The clinical records did not indicate the physicians were called for either resident or that a physical exam was done on either resident. The clinical record did not contain information on what was done by staff to keep either resident safe from further abuse. During an interview on 8/7/26 at 11:37 a.m., the Executive Director (ED) indicated the July 4, 2026 incident between Resident B and Resident C started on 7/3/26. Resident B had purchased alcohol on July 3, 2026 and had become upset with Resident C for drinking all the alcohol. Resident C has dementia and did not remember drinking the alcohol. Resident B		• Immediately notify the nurse and Administrator/designee of any suspected or alleged abuse. • Assess each involved resident for physical injury and emotional/psychosocial effects. • Notify the attending physician and other appropriate clinicians as indicated. • Complete required clinical documentation and incident documentation. • Initiate an investigation promptly, including interviews of involved residents and witnesses. • Determine whether the incident meets applicable IDOH reporting requirements. • Submit required reports to IDOH within the applicable reporting timeframe. • Implement interventions to prevent further potential abuse while the investigation is occurring. • Review and revise the resident's care/service plan as indicated. • Continue monitoring for recurrence and document follow-up. Staff will be instructed that they	
---	--	---	--

was angry and started yelling at Resident C. Resident B had tried to hit Resident C with her walker and Resident C had grabbed Resident B's arm to stop her. The incident had been reported to the ED the following Monday. Resident E had claimed to witness the incident, but Resident E's door was always closed. The Director of Nursing at the time had examined Resident B's arm and there was an old bruise. An interview was conducted with the Former Director of Nursing (FDON) on 8/7/26 at 1:29 p.m. The FDON indicated the staff had called the FDON on July 4, 2026, and informed her of an altercation between Resident B and Resident C. The FDON had examined Resident B's arm a couple of days after the incident and there were dark bruises on Resident B's arm and wrist. 2. A progress note, dated 7/21/26 at 7:28 p.m., indicated Resident C had been consuming alcoholic beverages and had been agitated with Resident B because Resident B was cooking in the kitchen on the second floor. Resident C walked in slamming the door and called Resident B and Resident E "B*****". Resident C was instructed to stay away from Resident B, or the police	are not responsible for determining independently that an incident is "not abuse" before reporting it to the appropriate facility leadership. Allegations or observations of potential abuse will be immediately escalated for assessment and investigation. The facility will also implement a standardized abuse/incident notification process that identifies the required notifications and the date/time each notification was completed. The process will include Administrator, physician, IDOH, law enforcement, and other required entities as applicable to the circumstances. Facility has hired a new Director of Nursing that will be trained on how to report Abuse and Resident to Resident altercations to IDOH in a timely manner. 4. All employees, including nursing staff, QMAs, direct-care staff, supervisors, and management responsible for receiving or responding to resident incidents will receive education regarding: • The facility Abuse and Neglect Policy. • Resident-to-resident abuse. • Physical, verbal, mental,	
--	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

would be called. Resident C stood outside of Resident E's door and stated Resident B and Resident E were lying. Resident C was instructed to leave Resident B and Resident E alone. Resident C's clinical record did not contain any information that the resident's physician had been notified. Resident B's clinical record did not contain any information about the incident on 7/21/26. An interview was conducted with the ED on 8/7/26 at 2:15 p.m. The ED indicated she was not made aware of the incident on 7/21/26 when Resident C had called Resident B and Resident E "B*****" per the progress note. The ED was unsure if the incident was verbally abusive without investigating to see why Resident C had used that language and if Resident B had done or said anything to cause him to use that language. Resident B felt that the second-floor kitchen was hers. On 8/6/26 at 2:56 p.m., the IDON provided the Abuse Policy, last revised 2/2022, that read "...Resident Abuse: Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with	and emotional abuse. • Examples of reportable resident-to-resident conflicts. • Immediate reporting requirements. • Administrator notification requirements. • Physician notification requirements. • IDOH reporting requirements and applicable time frames. • Required investigation procedures. • Required clinical and incident documentation. • Immediate interventions to protect residents. • Care/service-plan review following an incident. • Follow-up monitoring for recurrence. • Staff responsibility to report an allegation or suspicion rather than independently determining that abuse did not occur. Education will include case examples involving physical aggression, threats, intimidation, harassment, and verbal abuse so staff understand that abuse reporting is required even when an incident does not initially appear to result in a significant injury. Executive Director was reeducated by the Director of	
---	---	--

resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being... Examples of abuse are as follows, but are not inclusive... Mental Abuse...5. Saying anything to a resident which might cause him/her to worry or become alarmed...7. Harassment...Physical Abuse 1. Actually laying hands on a resident in an abrupt manner [e.g., hitting, slapping, pinching, or kicking] ...Procedure...2. Should an occurrence of abusive behavior be reported or witnessed, the Administrator shall be notified immediately... 3. Appropriate documentation should be completed relative to the individual incident... 4. Should the incident be deemed an 'unusual occurrence', the State Department of Health, Adult Protective Agency, Ombudsman and Division of Aging [FSSA] shall be notified...7. The results of all investigations shall be reported to ISDH, Adult Protective Agency, Ombudsman and the Division of Aging for Medicaid Waiver residents within five [5] days of the initial reporting of the incident.... Resident- to- Resident Abuse Procedure: 1. Staff shall intervene immediately

Operations on IDOH Reporting Guidelines, Resident to Resident Abuse, and IDOH Policies and Procedures on reporting abuse.

Any staff member who has not completed the required education will receive education prior to being assigned independent resident-care duties, as applicable.

5.

The Executive Director, Director of Nursing, or designee will audit 100% of abuse allegations and resident-to-resident altercations for four consecutive weeks to verify that the facility's abuse policy was implemented.

The audit will verify:

- Immediate resident protection/intervention.
- Timely Administrator notification.
- Physician notification when indicated.
- - IDOH reporting when required.
 - Appropriate investigation.
 - Resident and witness interviews.
 - Injury and psychosocial assessments.
 - Clinical and incident

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	and assess the immediate needs of the resident[s] and provide any needed medical attention, if applicable. Staff must not leave if he/she be in potential danger. Rather, staff should activate the call light and/or call out for staff assistance...8. The attending physician and the mental health clinician, if applicable, shall be further consulted relative to the incident and any needed revisions to the current treatment regime for the involved residents. 9. The Administrator and Health Services Director shall be responsible to monitor the involved resident[s] for recurrence of abusive behavior in an effort to detect signs and symptoms of potential abusive behavior and provide early interventions to prevent recurrence..." This citation was related to Intake 470826.		documentation. • Care/service-plan review. • Follow-up monitoring. • Interventions to prevent recurrence. Audit results will be reviewed with the Quality Assurance/Performance Improvement Committee. Any identified variance will result in immediate corrective action, including additional staff education and review of the individual incident. Following the initial four-week audit period, monitoring will continue monthly for an additional two months, or until sustained compliance is demonstrated by the Corporate Health Services Director. The Executive Director and Director of Nursing will be responsible for ensuring continued compliance. Completion Date 8/28/2026	
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using	R 0217	1. Resident C's Evaluation of Needs and Service Plan were immediately reviewed by the Executive Director, Interim	08/28/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

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 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.

Director of Nursing, following identification of the deficient practice.

Resident C was reassessed for current physical, cognitive, mental, behavioral, psychosocial, and safety needs, including behaviors associated with alcohol use, agitation, aggression, verbal interactions with other residents, and the potential for recurrence of resident-to-resident conflict.

Resident C's service plan was reviewed and revised to identify the services and interventions necessary to address the resident's current needs. The revised service plan includes interventions for monitoring and responding to alcohol-related behaviors, agitation, aggression, inappropriate verbal interactions, potential triggers, redirection, separation from other residents when indicated, staff notification/escalation, and monitoring for recurrence.

The revised service plan was discussed with Resident C and/or the resident's representative as appropriate, and the service plan will be signed and dated in accordance with facility policy.

The attending physician and other appropriate healthcare professionals will be consulted as indicated regarding changes

Based on interview and record review, the facility failed to timely update a service plan for a resident who displayed agitation and aggression with another resident for 1 of 3 residents reviewed for resident-to-resident abuse (Resident C).

Findings include:

1. The clinical record for Resident C was reviewed on 8/6/26 at 12:30 p.m. The resident's diagnosis included, but was not limited to, alcohol abuse (impaired ability to stop or control alcohol use).

A Mini Mental Status Exam, dated 6/10/26, indicated Resident C had moderately impaired cognition.

An Evaluation of Needs/ Service Plan, dated 6/10/26, indicated Resident C was alert and oriented. Resident B made sound, independent decisions.

A progress note, dated 7/21/26 at 7:28 p.m., indicated Resident C had been consuming alcoholic beverages and had been agitated with Resident B because Resident B was cooking in the kitchen on the second floor. Resident C walked in slamming the door and called Resident B and Resident E

in Resident C's condition, behaviors, and service needs.

Resident B and C have been educated and provided resources to outside providers for assistance with navigating their needs with mental health and substance abuse. Resident B has chosen to see Meridian Health Services as a provider while Resident C is continuing to explore options on who to consult.

2.

The Director of Nursing or designee will review the current Evaluation of Needs and Service Plans for 100% of current residents to determine whether identified changes in condition, behavior, cognition, safety needs, or resident preferences are reflected in the resident's current service plan.

The review will specifically determine whether residents with documented behavioral changes, aggression, agitation, alcohol-related behaviors, falls, repeated incidents, changes in cognition, or other significant changes in condition have had their service plans reviewed and revised as appropriate.

Any resident identified as having a service plan that does not accurately reflect the resident's current needs will receive a

"B*****". Resident C was instructed to stay away from Resident B, or the police would be called. Resident C stood outside of Resident E's door and stated Resident B and Resident E were lying. Resident C was instructed to leave Resident B and Resident E alone.

An interview was conducted with QMA 3 on 8/7/26 at 1:45 p.m. QMA 3 indicated she had documented the progress note in Resident C's medical record on 7/21/26 at 7:28 p.m. Resident B had come to get QMA 3 because Resident C was drunk and would not let Resident B into the kitchen. QMA 3 had gone to the upstairs kitchen and found Resident C in the hallway. Resident C appeared to be drunk. QMA 3 had told Resident C to go back to his room. The staff had to tell Resident C three different times to go back to his room. QMA 3 had immediately informed the FDON of the incident. The management staff had told QMA 3 to call the police if Resident C was drunk and agitated or aggressive.

Resident C's service plan had not been updated with a service plan addressing Resident C's drinking alcohol or behaviors toward other residents.

During an interview on 8/7/26 at

reassessment and service-plan revision as appropriate.

3.

The facility will revise its Evaluation and Service Plan process to ensure that changes in a resident's condition, behavior, needs, or preferences are communicated to the appropriate staff and result in timely reassessment and service-plan review.

The facility will implement a process requiring staff to notify the nurse and/or designated management staff when a resident demonstrates a significant or recurring change in behavior or condition, including but not limited to:

- New or increased agitation or aggression.
- Verbal threats, harassment, or inappropriate interactions with other residents.
- Physical aggression or resident-to-resident conflict.
- Repeated need for staff redirection.
- Alcohol-related behaviors or apparent intoxication.
- Changes in cognition or judgment.
- Changes in psychosocial needs.
- Changes in safety risks.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2:11 p.m., the IDON indicated the service plan should have been updated.

This citation was related to Intake 470826.

- Any other change that may require a modification to the resident's services.
- Oncoming Director of Nursing will be educated and trained on timely reporting to IDOH.

The nurse and/or designated qualified staff member will review the information and determine whether a reassessment and service-plan revision is necessary.

4.

All applicable nursing staff, QMAs, direct-care staff, supervisors, and management staff responsible for resident evaluations or service plans will receive education regarding:

- 410 IAC 16.2-5-2(e).
- Recognition of changes in resident condition and needs.
- Recognition of behavioral and psychosocial changes.
- When a service-plan review is required.
- The relationship between incident reports/progress notes and service-plan revisions.
- Requirements for documenting resident-specific services and interventions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

- Communication of changes in resident needs to the nurse and management.
- Documenting behavior changes in the Behavior Binder.
- Resident participation in the service-plan review process.
- Monitoring the resident's response to interventions and revising services when interventions are ineffective.
- Examples demonstrating that repeated agitation, aggression, alcohol-related behavior, or resident-to-resident conflict may represent a change in the resident's needs requiring reassessment and possible service-plan revision.

Staff who have not completed the required education will receive education before independently performing applicable duties.

5. The Director of Nursing, Executive Director, or designee will audit 100% of residents with documented significant changes in condition, behavior, or safety needs for four consecutive weeks. After completion of the initial four-week audit, monitoring will continue monthly for an additional two months, or until sustained

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

compliance is demonstrated by the Corporate Health Services Director.

The audit will verify:

- The change was identified and communicated.
- The resident was reassessed as appropriate.
- The service plan was reviewed.
- The service plan was revised when indicated.
- Services and interventions were specific to the resident's assessed needs.
- The resident and/or representative was involved as appropriate.
- Required signatures and dates were obtained.
- Staff were informed of revised interventions.
- Follow-up was completed to determine whether interventions were effective.

Any identified variance will be corrected immediately and may result in additional staff education and/or further review of the affected resident's service plan.

Audit results will be reported to the Quality Assurance/Performance

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

			Improvement Committee for review and continued monitoring. Completion Date 8/28/2026	
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 SIGNATUREAndrea Wilson		TITLERCA		(X6) DATE08/26/2026