STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELEBRATION VILLA OF RICHMOND	3700 SOUTH A STREET, RICHMOND, , 47374

(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 467113 and 467931. Intake 467113 - No deficiencies related to the allegations are cited. Intake 467931 - State deficiency related to the allegation are cited at R0091. Survey dates: February 24 and 25, 2026. Facility number: 010888 Residential census: 42 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on March 2, 2026.	R 0000	This plan of correction is not to be construed as an admission of, or agreement with the findings and conclusions in the statement of deficiencies. This Plan of Correction is being submitted as required by regulation.	
R 0091	Administration and Management - Noncompliance	R 0091	All residents have the potential to be affected by this deficient	03/06/2026

	410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview and record review the facility failed to ensure an allegation of abuse was investigated and reported to the Indiana Department Of Health for 1 of 6 residents reviewed for abuse (Resident C). Finding include: During an interview with the Executive Director (ED) on 2/24/26 at 12:25 p.m., the ED indicated the State Ombudsman reported to her on 2/12/26, that Resident B's private beautician and Resident B were making fun of Resident C. The ED had not reported the allegation to the State or complete an investigation. The ED had talked with Resident B and she denied		practice. The allegation of abuse identified during the survey was immediately reviewed by the Executive Director and Director of Nursing. The investigation was completed and the allegation was reported to the IDOH in accordance with state requirements. The resident was assessed to ensure safety and well-being. The Executive Director, Director of Nursing, and all staff were re-educated on the facility's abuse policy, including the requirement that all allegations of abuse must be immediately investigated and reported to the IDOH. A review of incident reports and grievance logs for the previous 30 days was conducted to ensure no other allegations of abuse were not investigated or reported. No additional concerns were identified, and no other residents were affected.The Executive Director or designee will review all incident reports daily to ensure any allegation of abuse is immediately investigated and reported per facility policy and state regulations. Findings will be reviewed during monthly QA meetings for the next three months, and additional monitoring will continue as needed to ensure ongoing compliance.	

that it happened. The ED had not talked with Resident B's beautician. The ED did not think it was allegation of abuse.

During an interview with the State Ombudsman, on 2/24/26 at 2:04 p.m., she indicated on 2/12/26 she went to the facility and reported to the ED that there was an allegation of possible verbal abuse from Resident B and Resident B's private beautician. Resident B and the beautician were cussing and making fun of Resident C. This occurred in the facilities beauty shop. The ED had reported the beautician had been rude to her and the staff before.

Review of the clinical record of Resident C on 2/25/26 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance and depression.

The level of care for Resident C, dated 1/12/26, indicated the resident was independent with mobility and transfers. The resident needed cognitive/behavioral support and often needed redirection when she was anxious and confused.

The level of care for Resident B, dated 10/28/25, indicated the resident was oriented to person,

	place and time. The resident had behaviors of agitation and irritability. The abuse policy provided by the ED, on 2/24/28 at 12:58 p.m., indicated the facility prohibited abuse of residents. The ED would report all allegations of abuse to IDOH within 24 hours. The community would thoroughly investigate all allegations of abuse. The community would take appropriate action to prevent further incidents of abuse. The resident had the right to be free of abuse by anyone, including but not limited to, other residents, friends or other individuals. The residents had the right to be free of verbal abuse. The definition of verbal abuse was the use of oral, written or gestured language that willfully included disparaging, and derogatory terms to residents, or within hearing distance regardless of their age, ability to comprehend, or disability. This Citation relates to Intake 467931.			

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 SIGNATURESusan Wiley	TITLERCS	(X6) DATE03/13/2026