STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ON OLD MERIDIAN	12130 OLD MERIDIAN ST, CARMEL, , 46032

(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 469344. Intake 469344-State deficiencies related to the allegations are cited at R29. Survey date: May 15, 2026 Facility number: 012141 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on May 21, 2026.	R 0000		
R 0029	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(d) (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.	R 0029	1. ***Immediate Solution: With respect to the specific resident/situation cited***. Team Member CNA 2 was terminated from her	06/12/2026

Based on interview and record review, the facility failed to ensure a staff member treated a resident with respect and dignity for 1 of 3 residents reviewed for dignity. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 5/15/26 at 8:48 a.m. The diagnoses included, but were not limited to, essential hypertension and major depressive disorder.

A facility statement, dated 4/21/26, indicated when the Assisted Living Coordinator interviewed Resident C, the resident indicated CNA 2 talked abruptly and irritably, was rude, and she (Resident C) should be treated with respect. The CNA should not be able to treat old people this way.

A facility statement, dated 4/22/26, indicated CNA 2 entered Resident C's room during her nightly rounds, on 4/19/26, to wake and help Resident C. The resident told CNA 2 to get out. Then, on 4/21, she went to check on the resident, and the resident asked if she was the same girl from last week and told her to leave. CNA 2 then had Qualified Medication Aide (QMA) 3 come and help.

A facility statement, dated

position at Sunrise. Completed on 04/24/26. Resident C remains at Sunrise, is pleased with current caregivers and continues to do well.

B. Expand Scope: With respect to how the facility will identify residents/situations for the identified concerns Assisted Living Coordinator and Resident Care Director interviewed other current residents that were provided care by Team Member CNA 2 to confirm that no further residents had been affected. Completed 04/23/26.

C. Systemic Change: With respect to what systemic measures have been put into place to address the stated concern. The Executive Director and Leadership Team reviewed the grievance and resident rights policy.
Re-training our team members on approaching residents when providing care, actively engaging with the residents in a positive and dignified manner.
The Executive Director/Leadership Team/designee will be reviewing the resident rights policy with current team members. Completed by 06/12/26.

D. Monitoring: With respect to how the plan of correction will

	4/22/26, indicated when the Assisted Living Coordinator interviewed Resident C, the resident indicated CNA 2 entered her room again, on 4/21/26, and she told the CNA to leave. She was rude, talked abruptly, and she should not have been treated this way. An email, dated 4/22/26 at 9:25 a.m., indicated QMA 3 reported Resident C was crying and stated CNA 2 was always rude, treated her like filth, and came in with an attitude which made her feel like she had done something wrong when she had not done anything wrong. A facility counseling document, dated 4/24/26, indicated CNA 2 was counseled due to a rude tone, aggressiveness, and disrespect. Resident C had requested CNA 2 not return to her room. The counselling document related to the time frame for improvement was selected "other" and indicated "Termination". The document was signed by the Executive Director (ED) and Assisted Living Coordinator and was completed over the phone with CNA 2. During an interview, on 5/15/26 at 10:35 a.m., Resident C indicated CNA 2 was "full of disrespect and shook her to her core". She did not want to stay in the facility because of the		***be monitored*** ED/Department Coordinators/designees are responsible for compliance with the plan of correction by conducting random weekly check-ins with residents to ensure that our team members are meeting their care needs in a positive and dignified manner. We will conduct these check-ins for the next 180 days. The results of weekly audits will be sent to the QAPI committee for review. The Executive Director will report on compliance with the plan of correction during the Quality Assurance and Performance Improvement meeting and is responsible for implementing retraining or corrective action as needed to ensure ongoing compliance	

treatment. It looked like CNA 2 was "full of hate towards her".

During an interview, on 5/15/26 at 10:41 a.m., QMA 3 indicated CNA 2 had come to him and reported Resident C was upset and tearful. He reported the incident to the Assisted Living Coordinator.

During an interview, on 5/15/26 at 10:54 a.m., the Assisted Living Coordinator indicated she had received a call from CNA 2. CNA 2 indicated Resident C told her to leave her room during the night shift. The Assisted Living Coordinator indicated there were other residents who requested CNA 2 not to take care of them anymore. CNA 2 was terminated due to multiple customer service concerns and other residents requesting she be removed from their assignments. It was a pattern and they did terminate her.

A current facility policy, titled "Resident Rights", dated 2019 and received from the ED on 5/15/26 at 12:56 p.m., indicated "...Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality...."

This citation relates to Intake 469344.

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 SIGNATURETerona Long	TITLEExecutive Director	(X6) DATE05/30/2026