STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT GRANGER	6330 N FIR RD, GRANGER, , 46530

(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 Complaint IN00463528. Complaint IN00463528 - State deficiencies related to the allegations are cited at R0052. Unrelated deficiencies are also cited at R0052. Survey date: July 30 & 31, 2025 Facility number: 012229 Residential Census: 134 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	8/15/25 To whom it may concern: on July 30st and July 31st, 2025, a complaint survey was completed at Storypoint Granger. Attached is the plan of correction for tag R052. The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violations of regulations. The community respectfully requests a desk review in lieu of a post – survey revisit. Thank you for your time and consideration, Tiffany Fultz	

			Wellness Director Storypoint Granger	
R 0052	Residents' Rights - Offense 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. A. Based on observation, interviews, and record review, the facility failed to protect a resident's right to be free from physical abuse and failed to ensure a resident's dignity was maintained for 1 of 3 resident's reviewed for resident rights. (Resident B). B. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect, when a staff member escorted a cognitively impaired resident, outside of a secure area, to an activity, allowed the resident to leave the activity, without	R 0052	R052 – Residents' Right – Offense It is the practice of this provider to ensure residents have the right to be free from sexual abuse, physical abuse, mental abuse, corporal punishment, neglect, and involuntary seclusion. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** The wellness staff were re-educated by the DNS/Designee regarding the protocol (Appendix A) for reporting a fall during and after normal business hours. All staffing departments were re-educated by the DNS/Designee regarding the protocol (Appendix B) for Abuse, Neglect, or Exploitation, as well as (Appendix C) Resident Rights and (Appendix D) Elopement.	08/13/2025

	detection and proceed to the nearest exit and leave the facility's property. (Resident C) Findings include: A. Review of a facility reported the incident, # 322, dated 7/20/25 at 10:10 A.M. indicated Resident B had been observed laying in his bed, when CNA 3 and CNA 4 entered his apartment to provide morning care. The door to the resident's room was not closed but left wide open. Resident B had been incontinent of urine. CNA 3 was observed pulling on the resident's arms to undress him of his urine soaked clothing while he was sitting on the bed. The resident then became resistant to care. The CNAs then stood the resident up and continued to undress him. Resident B was observed standing naked in the room within the view of the open door. CNA 3 continued the care and attempted to redress the resident, again pulling on his arm to move him forward, away from the bed, when the resident attempted to swing his right arm at CNA 3. CNA 3 moved out of the line of impact from Resident B's swinging arm and he was observed to fall into a dresser, hitting his head on the dresser and the wall, before he fell to the floor. The resident was observed rubbing his head. CNA 3 and CNA 4 pushed the		Resident C did not experience any negative outcomes related to the deficient concern. Resident B sustained a dime sized skin tear to left forearm; redness was noted to the right side of his face. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected. The wellness staff were re-educated by the DNS/Designee regarding the protocol (Appendix A) for reporting a fall immediately during and after normal business hours. All staffing departments were re-educated by the DNS/Designee regarding the protocol (Appendix B) for Abuse, Neglect, or Exploitation, as well as (Appendix C) Resident Rights and (Appendix D) Elopement. ***What measures will be put in***	

	resident forward to a seated position, pulling on his head and neck area, and continued to attempt to dress the resident. The staff then pulled him up from the floor by his arms. The resident was observed to be unsteady on his feet and fell again to the floor. CNA 3 and 4 continued to dress the resident and attempted to stand him again, but the resident was resistive to standing and remained on the floor. The staff then left the room and Resident B was observed on the floor in his room from the hall. The incident report indicated Resident B had obtained a skin tear to his left arm and a reddened area to his head. The incident report indicated the "Immediate action" taken by the facility included assessing the resident for injuries and notifying the Director of Nursing, Assistant Director of Nursing, primary care physician, responsible party, and Hospice services. The Hospice nurse had also assessed the resident on 7/21/25 and the resident's physician had requested an Emergency Room evaluation, but the resident's responsible party had refused to have the resident sent to the Emergency Room. The "Preventive Measures" taken by the facility on 7/21/25 were that CNA 3 and CNA 4		***place or what systemic changes will be made to ensure that the deficient practice does not recur:*** The policy on “Abuse, Neglect or Exploitation was reviewed with staff regarding the immediate reporting of any occurrence and allegations of abuse that directly threaten the welfare, safety, or health of any resident, per policy. (Appendix B), staff were re-educated by the DNS/Designee regarding the need to report any unusual occurrence or allegations of abuse that directly threaten the welfare, safety or health of a resident, “immediately” to the ED/DNS. Any staff who are not reporting any unusual occurrence or allegations of abuse that directly threatens the welfare, safety, or health of any resident will be reprimanded according to and including termination. If concerns are noted, the ED/DNS will be notified immediately for corrective action.	

	were suspended pending an investigation. The incident report follow up indicated on 7/24/25, the investigation had been completed and CNA 3 and CNA 4 were terminated upon completion of the investigation Review of an Internal Incident Report Form dated 7/21/25 at 3:30 P.M., indicated on 7/20/21 at 10:30 A.M., CNAs had assisted a combative resident with incontinence care, the resident fell two times and hit his head. The CNAs had not reported the incident immediately. The employees had been suspended pending an investigation, the resident was assessed for injuries and had complained of pain to the right side of his head. The skin was noted to have been discolored on his head and right shoulder Review of a facility video, dated 7/20/2025 from approximately 10:02 A.M. to approximately 10:25 A.M., provided on 7/30/25 at 11:50 A.M. by he Director of Nursing showed CNA 3 and CNA 4 providing morning care to Resident B. The video was viewed in the conference room with the Director of Nursing and the Assistant Wellness Director. CNA 3 and CNA 4 were observed to enter Resident B's room where CNA 3 approached		The policy on Falls was reviewed with staff regarding the immediate reporting of any falls witnessed or unwitnessed per policy, (Appendix A). Staff were re-educated by the DNS/Designee regarding the need to report any falls immediately. Any staff who are not reporting any falls witnessed or unwitnessed will be reprimanded according to the policy up to and including termination. The policy on Elopement was reviewed with staff regarding the protocol per policy, (Appendix D). The staff were re-educated by the DNS/Designee regarding the procedure in the event of a person missing or an elopement. In the event of a cognitively impaired resident participating in an activity on assisted living, the Life Enrichment assistant will verbally give report to the memory care clinical staff and utilize the sign in and out sheet. (Appendix E). The Life Enrichment staff will be present during the activity while another staff member monitors the entrances to ensure residents safety.	

	Resident B, who was sleeping in his bed under the covers. CNA 3 took the covers off of he resident and grabbed the resident by his lower legs, dragged his legs around to the side of the bed and then placed them off of the bed. Resident B's upper body was still in a laying position on the bed when CNA 3 grabbed the resident's right arm and pulled him to a seated position. CNA 3 then pulled the resident by his arms to a standing position and removed his shirt, pulled down his pants and removed his incontinence underwear. The resident was observed standing with pants down around his ankles and wearing no other clothing. Resident B shuffled away from CNA 3 with his pants around his ankles, while the door remained open and the resident was in clear view of the facility hallway. CNA 3 then pulled the resident's arm to get him to walk closer to her and the resident was observed to lose his balance and fall forward. As the resident began to fall, he struck out at CNA 3 who moved out of the way of the strike. Resident B was observed to fall and strike his head on the dresser. Resident B was observed to rub his head after the fall, while laying unclothed on the ground. CNA 3 and CNA 4 attempted to get the resident to a seated position by pushing his head forward. CNA 3 and		Any staff who fail to participate and or follow the Elopement procedure per policy will be reprimanded per policy up to and including termination. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** The policy on “Abuse, Neglect or Exploitation was reviewed with staff regarding the immediate reporting of any occurrence and allegations of abuse that directly threaten the welfare, safety, or health of any resident, per policy. (Appendix B), staff were re-educated by the DNS/Designee regarding the need to report any unusual occurrence or allegations of abuse that directly threaten the welfare, safety or health of a resident, “immediately” to the ED/DNS. To ensure staff is aware of the correct procedure of reporting any unusual occurrence and allegations of abuse that directly	

	CNA 4 continued to attempt to dress Resident B while he was on the floor. The CNAs continued their attempts to get the resident to stand, resulting in another fall, at which time, the CNAs ended their attempts to dress and stand the resident. CNA 3 and CNA 4 were then observed to leave the residents room and stand in the hallway, leaving the resident on the floor. Qualified Medication Aide (QMA) 8 arrived to the room at 10:13 A.M., and Licensed Practical Nurse (LPN) 2, arrived at Resident B's room at 10:16 A.M., LPN 2 was observed to close the Resident's door, assisted the resident to a chair, and conducted an assessment. During an interview with the Assistant Wellness Director on 7/30/25 at 11:50 A.M., while viewing the video, she indicated CNA 3 had been very rough with Resident B by yanking on him when getting him up from the bed and in her attempts to get him up from the floor. The Assistant Wellness Director indicated CNA 3 had yanked the resident's arm while he was standing at the bedside, which caused him to fall and hit his head on the dresser. She indicated the resident had not struck out at the CNA before he fell, but had struck out during the fall. The Assistant Wellness Director indicated CNA 3 and CNA 4 had made multiple		threaten the welfare, safety or health of a resident, the DNS/Designee will question staff daily for 2 weeks, weekly for 2 weeks and monthly for 2 months. (Appendix F). The DNS/Designee will complete care observations daily for 2 weeks, weekly for 2 weeks and monthly for 2 months, (Appendix G). Any staff not aware of the policy will be identified, retrained and or reprimanded, according to policy up to and including termination. All new employees will be trained upon hire. If threshold of 100% is not met, an action plan for the employee will be implemented. Starting with retraining and proceeding to corrective action per policy up to and including termination. **By what date the systemic changes will be completed: Completed date 8-11-25** The policy on Falls was reviewed with staff regarding the immediate reporting of any falls witnessed or unwitnessed per policy, (Appendix A). Staff were re-educated by the DNS/Designee regarding	

attempts to get the resident to his feet by pulling on him in a rough manner and that the residents room door was inappropriately left open the entire time.

On 7/30/25 at 11:50 A.M., during an interview with the Director of Nursing, while viewing the video, she indicated she and the Assistant Wellness Director had been notified of the incident on 7/20/25 when LPN 2 contacted them to reported CNA 3 and CNA 4 had been rough with Resident B's care and that he had fallen. The Director of Nursing indicated LPN 2 reported the resident had fallen during care and hit his head. The Director of Nursing indicated Resident B's family, the Hospice provider, and physician were notified and they were directed to send the resident to the Emergency Room for an evaluation, but his family had refused. The Director of Nursing indicated CNA 3 and CNA 4 reported that Resident B had been combative with care and he had attempted to hit CNA 3, causing him to lose his balance and he had fallen. The Director of Nursing indicated that LPN 2 had viewed the video, later in the day, on 7/20/25, and had noted that the report she had received from CNA 3 and CNA 4 was not accurate, so she had then reported the incident to the

the need to report any falls immediately.

To ensure staff is aware of the correct procedure of reporting any falls immediately the DNS/Designee will question staff daily for 2 weeks, weekly for 2 weeks and monthly for 2 months, (Appendix H). Any staff not aware of the policy will be identified, retrained and or reprimanded, according to policy up to and including termination. All new employees will be trained upon hire.

If threshold of 100% is not met, an action plan for the employee will be implemented. Starting with retraining and proceeding to corrective action per policy up to and including termination.

By what date the systemic changes will be completed: Completed date 8-11-25

The policy on Elopement was reviewed with staff regarding the protocol per policy, (Appendix D). The staff were re-educated by the DNS/Designee regarding the procedure in the event of a person missing or an

	Director of Nursing. On 7/30/25 at 2:00 P.M., Resident B's clinical record was reviewed. Diagnoses included but were not limited to, Alzheimer's Disease, anxiety, depression, heart failure, and bladder cancer. Resident B's service plan included but were not limited to; Escort/Mobility, dated 4/03/24, indicate Resident B could be resistive to care at times and required care in pairs and multiple approaches. Transfers, dated 4/03/24, indicated Resident B would be able to transfer safely and required reminders for ability to get in and out of bed, chair, car, etc. Dressing, 4/03/24, indicated Resident B would be supported with behavior expression during dressing, and the resident required assistance with upper and lower body dressing, and that Staff remain present for duration of activity, and that the resident could be resistive to care at times requiring care in pairs and multiple approaches Resident B's progress note dated 7/20/25 at 4:29 P.M.,		elopement. To ensure staff is aware of the correct protocol and procedure of a missing person or elopement the DNS/Designee will complete Elopement/Missing person drills weekly for 4 weeks then drills will be on-going monthly. (Appendix I). Any staff not aware of the policy or fail to participate in the drills will be identified, retrained and or reprimanded, according to policy up to and including termination. All new employees will be trained upon hire. If threshold of 100% is not met, an action plan for the employee will be implemented. Starting with retraining and proceeding to corrective action per policy up to and including termination. **By what date the systemic changes will be completed: Completed date 8-13-25**	

indicated Resident B had a witnessed fall in his apartment, CNA 3 indicated the resident had been lowered to the floor. LPN 2 indicated when she had viewed the video recording she noticed CNA 3 and CNA 4 had been struggling to get the resident dressed for lunch and the resident appeared agitated and had attempted to hit CNA 3, who stepped out of the way, causing the resident to fall forward and hit his head on a desk. LPN 2 indicated she had observed the resident sitting on the floor in the middle of his room. LPN 2 indicated thr resident had a dime sized skin tear to his left forearm and redness to the right side of the face. There were no other injuries noted on the assessment.

On 7/30/25 at 12:30 P.M., the Director of Nursing provided a policy titled, "Abuse, Neglect, or Exploitation dated 6/07/23, and indicated it was the current facility policy. The policy indicated,"...Abuse...of any resident will not be tolerated..."

B. A facility self-reported incident #316, dated 6/9/25 at 2:10 P.M., indicated Resident C had been taken off the memory care unit to attend an activity/performance and had wandered off. He was last observed in the area at 2:00 P.M., however it was discovered

he was not in the room at 2:10 P.M. The staff started a search and the resident was observed exiting out of the facility parking lot door and was found walking in the parking lot. He was redirected back into the community and back to the memory care unit, where he resided.

A hand written form, dated 6/6/25, by QMA 6 indicated the Activity Assistant had come to memory care unit to get residents for a musical in the main activity room around 1:15 P.M. QMA 6 had noted that Resident C needed to be toileted before going to the activity, so she had taken the resident from the group and toileted him. When QMA 6 arrived back to main activity room with Resident C, off the memory secure unit, QMA 6 seated the resident and informed a staff member where he was seated and she had acknowledged QMA 6 with a nod of her head and had looked in Resident C's direction. QMA 6 then returned to the memory care unit.

An Email statement by CNA 7, dated 6/6/25 at 4:22 P.M., indicated she had been collecting laundry when she heard "Raggedy Ann" (elopement announcement-someone missing).on the overhead

intercom. CNA 7 indicated she was not sure what the resident looked like so she had checked the elopement book. She then heard someone say Resident C was in the parking lot, so she went to the parking lot and observed QMA 9 driving her car in the parking lot. QMA 9 had pointed over to the church parking lot and informed CNA 7 that Resident C might be walking with a lady. Several other staff members arrived and had escorted the resident back inside the building.

A hand written form titled, "Statement for Code Silver", undated, indicated Hospice Nurse 5 had thought it was a family member when she had observed someone exit the building, around 2:20 P.M. Hospice Nurse 5 indicated Resident C had then walked past her car and walked toward the church . Hospice nurse 5 indicated she had not been aware that a "silver code" had been called.

During an interview, on 7/30/25 at 12:12 P.M. the Director of Nursing (DON) indicated a lady in the church parking lot, located next to the facility, had found the resident. The staff had then gone to the parking lot and found him with a lady from the church and had brought him back into the facility.

During an interview, on 7/30/25 at 12:19 P.M. CNA 7 indicated she had gone out to the parking lot to search for the resident, when someone who no longer worked at the facility pointed her towards the church parking lot. When she had arrived to the church parking lot, Resident C was walking with a lady from the church, towards the facility.

On 7/30/25 at 12:20 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: Alzheimer's Disease and anxiety.

An Elopement Risk Evaluation, dated 3/18/25, indicated the resident was at risk for an elopement. The evaluation indicated "...Resident is placed on a wander management system or routine assurance check protocol by the community. The resident's whereabouts should be verified routinely throughout the day and night. Ensure the resident is maintained in sight during programs/activities...."

A Nursing Progress Note dated 6/6/25 at 9:31 P.M., indicated the resident was attending an activity on the Assisted Living side of the building and " ...Resident was observed enjoying the activity at 2 pm. At 2:10 pm resident was noticed

missing from activity room on AL [Assist Living], Nursing staff immediately started to search for resident. Resident was observed leaving out the facility back door, approximately 2 mins [minutes] later CNA was able to obtain resident...."

On 7/30/25 at 1:18 P.M. an observation of the exit doorway, which was approximately 25-30 feet from the activity area was observed with the DON. The resident had to pass through 2 doorways to exit the facility. After exiting the facility, the resident had traveled down a driveway with a building on the one side and grass on the other. The resident had gone through a grassy area to get to the church parking lot, which was approximately 100-125 feet from the exit door. The DON indicated the resident had not had any previous exit seeking behavior and had no plan of care for exit seeking behaviors.

On 7/30/25 at 1:44 P.M., Resident C was observed walking in the hallway, on the secure unit. He walked up to three other residents, who were with an Activity Aide. Those three residents were preparing to go out for a walk, outside the facility. Resident C was redirected by another staff member towards the community restroom, where he entered and was provided privacy. He exited

and a staff member directed him to the memory care/dining area. Resident C was pleasant and followed commands without difficulty.

On 7/30/25 at 12:30 PM the DON provided a policy titled, " Abuse, Neglect, or Exploitation", dated 6/7/23 and indicated the policy was the current one used by the facility. The policy indicated " ...3. Definitions ...Neglect - inability or failure to provide adequate food, shelter, clothing, medical care, etc ...Abuse, neglect , or exploitation of any resident will not be tolerated ...3. Supervision a. Community will address situations in which abuse, neglect, or exploitation are more likely to occur ...Care planning of residents with special needs and/or behavior expressions that might lead to conflict, or neglect. Examples of special needs and/or behavior expressions may include refusal or resistance to care, entering other residents' rooms uninvited, exit seeking, self-injury, and residents with communication difficulties ...."

This citation relates to Complaint IN00463528.

A. Based on observation, interviews, and record review, the facility failed to protect a resident's right to be free from physical abuse and failed to

ensure a resident's dignity was maintained for 1 of 3 resident's reviewed for resident rights. (Resident B).

B. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect, when a staff member escorted a cognitively impaired resident, outside of a secure area, to an activity, allowed the resident to leave the activity, without detection and proceed to the nearest exit and leave the facility's property. (Resident C)

Findings include:

A. Review of a facility reported the incident, # 322, dated 7/20/25 at 10:10 A.M. indicated Resident B had been observed laying in his bed, when CNA 3 and CNA 4 entered his apartment to provide morning care. The door to the resident's room was not closed but left wide open. Resident B had been incontinent of urine. CNA 3 was observed pulling on the resident's arms to undress him of his urine soaked clothing while he was sitting on the bed. The resident then became resistant to care. The CNAs then stood the resident up and continued to undress him. Resident B was observed standing naked in the room within the view of the open door. CNA 3 continued the care and

attempted to redress the resident, again pulling on his arm to move him forward, away from the bed, when the resident attempted to swing his right arm at CNA 3. CNA 3 moved out of the line of impact from Resident B's swinging arm and he was observed to fall into a dresser, hitting his head on the dresser and the wall, before he fell to the floor. The resident was observed rubbing his head. CNA 3 and CNA 4 pushed the resident forward to a seated position, pulling on his head and neck area, and continued to attempt to dress the resident. The staff then pulled him up from the floor by his arms. The resident was observed to be unsteady on his feet and fell again to the floor. CNA 3 and 4 continued to dress the resident and attempted to stand him again, but the resident was resistive to standing and remained on the floor. The staff then left the room and Resident B was observed on the floor in his room from the hall. The incident report indicated Resident B had obtained a skin tear to his left arm and a reddened area to his head.

The incident report indicated the "Immediate action" taken by the facility included assessing the resident for injuries and notifying the Director of Nursing, Assistant Director of Nursing, primary care physician,

responsible party, and Hospice services. The Hospice nurse had also assessed the resident on 7/21/25 and the resident's physician had requested an Emergency Room evaluation, but the resident's responsible party had refused to have the resident sent to the Emergency Room.

The "Preventive Measures" taken by the facility on 7/21/25 were that CNA 3 and CNA 4 were suspended pending an investigation.

The incident report follow up indicated on 7/24/25, the investigation had been completed and CNA 3 and CNA 4 were terminated upon completion of the investigation

Review of an Internal Incident Report Form dated 7/21/25 at 3:30 P.M., indicated on 7/20/21 at 10:30 A.M., CNAs had assisted a combative resident with incontinence care, the resident fell two times and hit his head. The CNAs had not reported the incident immediately. The employees had been suspended pending an investigation, the resident was assessed for injuries and had complained of pain to the right side of his head. The skin was noted to have been discolored on his head and right shoulder

Review of a facility video, dated 7/20/2025 from approximately 10:02 A.M. to approximately 10:25 A.M., provided on 7/30/25 at 11:50 A.M. by he Director of Nursing showed CNA 3 and CNA 4 providing morning care to Resident B. The video was viewed in the conference room with the Director of Nursing and the Assistant Wellness Director. CNA 3 and CNA 4 were observed to enter Resident B's room where CNA 3 approached Resident B, who was sleeping in his bed under the covers. CNA 3 took the covers off of he resident and grabbed the resident by his lower legs, dragged his legs around to the side of the bed and then placed them off of the bed. Resident B's upper body was still in a laying position on the bed when CNA 3 grabbed the resident's right arm and pulled him to a seated position. CNA 3 then pulled the resident by his arms to a standing position and removed his shirt, pulled down his pants and removed his incontinence underwear. The resident was observed standing with pants down around his ankles and wearing no other clothing. Resident B shuffled away from CNA 3 with his pants around his ankles, while the door remained open and the resident was in clear view of the facility hallway. CNA 3 then pulled the resident's arm to get him to walk closer to her and the

resident was observed to lose his balance and fall forward. As the resident began to fall, he struck out at CNA 3 who moved out of the way of the strike. Resident B was observed to fall and strike his head on the dresser. Resident B was observed to rub his head after the fall, while laying unclothed on the ground. CNA 3 and CNA 4 attempted to get the resident to a seated position by pushing his head forward. CNA 3 and CNA 4 continued to attempt to dress Resident B while he was on the floor. The CNAs continued their attempts to get the resident to stand, resulting in another fall, at which time, the CNAs ended their attempts to dress and stand the resident. CNA 3 and CNA 4 were then observed to leave the residents room and stand in the hallway, leaving the resident on the floor. Qualified Medication Aide (QMA) 8 arrived to the room at 10:13 A.M., and Licensed Practical Nurse (LPN) 2, arrived at Resident B's room at 10:16 A.M., LPN 2 was observed to close the Resident's door, assisted the resident to a chair, and conducted an assessment.

During an interview with the Assistant Wellness Director on 7/30/25 at 11:50 A.M., while viewing the video, she indicated CNA 3 had been very rough with Resident B by yanking on him when getting him up from

the bed and in her attempts to get him up from the floor. The Assistant Wellness Director indicated CNA 3 had yanked the resident's arm while he was standing at the bedside, which caused him to fall and hit his head on the dresser. She indicated the resident had not struck out at the CNA before he fell, but had struck out during the fall. The Assistant Wellness Director indicated CNA 3 and CNA 4 had made multiple attempts to get the resident to his feet by pulling on him in a rough manner and that the residents room door was inappropriately left open the entire time.

On 7/30/25 at 11:50 A.M., during an interview with the Director of Nursing, while viewing the video, she indicated she and the Assistant Wellness Director had been notified of the incident on 7/20/25 when LPN 2 contacted them to reported CNA 3 and CNA 4 had been rough with Resident B's care and that he had fallen. The Director of Nursing indicated LPN 2 reported the resident had fallen during care and hit his head. The Director of Nursing indicated Resident B's family, the Hospice provider, and physician were notified and they were directed to send the resident to the Emergency Room for an evaluation, but his family had refused. The Director

of Nursing indicated CNA 3 and CNA 4 reported that Resident B had been combative with care and he had attempted to hit CNA 3, causing him to lose his balance and he had fallen. The Director of Nursing indicated that LPN 2 had viewed the video, later in the day, on 7/20/25, and had noted that the report she had received from CNA 3 and CNA 4 was not accurate, so she had then reported the incident to the Director of Nursing.

On 7/30/25 at 2:00 P.M., Resident B's clinical record was reviewed. Diagnoses included but were not limited to, Alzheimer's Disease, anxiety, depression, heart failure, and bladder cancer.

Resident B's service plan included but were not limited to;

Escort/Mobility, dated 4/03/24, indicate Resident B could be resistive to care at times and required

care in pairs and multiple approaches.

Transfers, dated 4/03/24, indicated Resident B would be able to transfer safely and required reminders for ability to get in and out of bed, chair, car, etc.

Dressing, 4/03/24, indicated Resident B would be supported

with behavior expression during dressing, and the resident required assistance with upper and lower body dressing, and that Staff remain present for duration of activity, and that the resident could be resistive to care at

times requiring care in pairs and multiple approaches

Resident B's progress note dated 7/20/25 at 4:29 P.M., indicated Resident B had a witnessed fall in his apartment, CNA 3 indicated the resident had been lowered to the floor. LPN 2 indicated when she had viewed the video recording she noticed CNA 3 and CNA 4 had been struggling to get the resident dressed for lunch and the resident appeared agitated and had attempted to hit CNA 3, who stepped out of the way, causing the resident to fall forward and hit his head on a desk. LPN 2 indicated she had observed the resident sitting on the floor in the middle of his room. LPN 2 indicated thr resident had a dime sized skin tear to his left forearm and redness to the right side of the face. There were no other injuries noted on the assessment.

On 7/30/25 at 12:30 P.M., the Director of Nursing provided a policy titled, "Abuse, Neglect, or Exploitation dated 6/07/23, and

indicated it was the current facility policy. The policy indicated,"...Abuse...of any resident will not be tolerated..."

B. A facility self-reported incident #316, dated 6/9/25 at 2:10 P.M., indicated Resident C had been taken off the memory care unit to attend an activity/performance and had wandered off. He was last observed in the area at 2:00 P.M., however it was discovered he was not in the room at 2:10 P.M. The staff started a search and the resident was observed exiting out of the facility parking lot door and was found walking in the parking lot. He was redirected back into the community and back to the memory care unit, where he resided.

A hand written form, dated 6/6/25, by QMA 6 indicated the Activity Assistant had come to memory care unit to get residents for a musical in the main activity room around 1:15 P.M. QMA 6 had noted that Resident C needed to be toileted before going to the activity, so she had taken the resident from the group and toileted him. When QMA 6 arrived back to main activity room with Resident C, off the memory secure unit, QMA 6 seated the resident and informed a staff member where he was seated and she had

acknowledged QMA 6 with a nod of her head and had looked in Resident C's direction. QMA 6 then returned to the memory care unit.

An Email statement by CNA 7, dated 6/6/25 at 4:22 P.M., indicated she had been collecting laundry when she heard "Raggedy Ann" (elopement announcement-someone missing).on the overhead intercom. CNA 7 indicated she was not sure what the resident looked like so she had checked the elopement book. She then heard someone say Resident C was in the parking lot, so she went to the parking lot and observed QMA 9 driving her car in the parking lot. QMA 9 had pointed over to the church parking lot and informed CNA 7 that Resident C might be walking with a lady. Several other staff members arrived and had escorted the resident back inside the building.

A hand written form titled, "Statement for Code Silver", undated, indicated Hospice Nurse 5 had thought it was a family member when she had observed someone exit the building, around 2:20 P.M. Hospice Nurse 5 indicated Resident C had then walked past her car and walked toward the church . Hospice nurse 5 indicated she had not been

aware that a "silver code" had been called.

During an interview, on 7/30/25 at 12:12 P.M. the Director of Nursing (DON) indicated a lady in the church parking lot, located next to the facility, had found the resident. The staff had then gone to the parking lot and found him with a lady from the church and had brought him back into the facility.

During an interview, on 7/30/25 at 12:19 P.M. CNA 7 indicated she had gone out to the parking lot to search for the resident, when someone who no longer worked at the facility pointed her towards the church parking lot. When she had arrived to the church parking lot, Resident C was walking with a lady from the church, towards the facility.

On 7/30/25 at 12:20 P.M., a review of the clinical record for Resident C was conducted. The resident's diagnoses included, but were not limited to: Alzheimer's Disease and anxiety.

An Elopement Risk Evaluation, dated 3/18/25, indicated the resident was at risk for an elopement. The evaluation indicated "...Resident is placed on a wander management system or routine assurance check protocol by the community. The resident's

	whereabouts should be verified routinely throughout the day and night. Ensure the resident is maintained in sight during programs/activities...." A Nursing Progress Note dated 6/6/25 at 9:31 P.M., indicated the resident was attending an activity on the Assisted Living side of the building and " ...Resident was observed enjoying the activity at 2 pm. At 2:10 pm resident was noticed missing from activity room on AL [Assist Living], Nursing staff immediately started to search for resident. Resident was observed leaving out the facility back door, approximately 2 mins [minutes] later CNA was able to obtain resident...."			

On 7/30/25 at 1:18 P.M. an observation of the exit doorway, which was approximately 25-30 feet from the activity area was observed with the DON. The resident had to pass through 2 doorways to exit the facility. After exiting the facility, the resident had traveled down a driveway with a building on the one side and grass on the other. The resident had gone through a grassy area to get to the church parking lot, which was approximately 100-125 feet from the exit door. The DON indicated the resident had not had any previous exit seeking behavior and had no plan of care for exit seeking behaviors.

On 7/30/25 at 1:44 P.M., Resident C was observed walking in the hallway, on the secure unit. He walked up to three other residents, who were with an Activity Aide. Those three residents were preparing to go out for a walk, outside the facility. Resident C was redirected by another staff member towards the community restroom, where he entered and was provided privacy. He exited and a staff member directed him to the memory care/dining area. Resident C was pleasant and followed commands without difficulty.

On 7/30/25 at 12:30 PM the DON provided a policy titled, " Abuse, Neglect, or Exploitation",

	dated 6/7/23 and indicated the policy was the current one used by the facility. The policy indicated " ...3. Definitions ...Neglect - inability or failure to provide adequate food, shelter, clothing, medical care, etc ...Abuse, neglect , or exploitation of any resident will not be tolerated ...3. Supervision a. Community will address situations in which abuse, neglect, or exploitation are more likely to occur ...Care planning of residents with special needs and/or behavior expressions that might lead to conflict, or neglect. Examples of special needs and/or behavior expressions may include refusal or resistance to care, entering other residents' rooms uninvited, exit seeking, self-injury, and residents with communication difficulties ...." This citation relates to Complaint IN00463528.			

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 SIGNATURE	TITLE	(X6) DATE