STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS AT SOLANA	7721 BATTERY POINTE WAY, INDIANAPOLIS, , 46240

(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 Complaints IN00462303 and IN00461031. Complaint IN00462303-State deficiencies related to the allegations are cited at R0052. Complaint IN00461031-No deficiencies related to the allegations are cited. Survey dates: July 15 and 16, 2025. Facility number: 013164 Residential Census: 86 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 24, 2025.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	What corrective action(s) will be accomplished for those residents found to have been	08/15/2025

	(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 ensure residents were free from abuse and neglect when residents with a diagnosis of dementia were allowed to consent to a consensual relationship and had a physical altercation for 2 of 2 residents reviewed for abuse. (Resident C and D) Findings include: A facility reported incident, dated 6/25/25, indicated staff entered the apartment of Resident C and found him standing by the bed, leaning over Resident D, with his hands upon her chest. Both residents sustained superficial abrasions to the face. Resident C was easily redirected, the residents were separated, and one-on-one was given to assure the safety of the residents. The residents were assessed and supervised until they were sent		affected by the deficient practice Both Residents sent out to Hospital for Psych Evaluations Residents remained separated using private duty and redirection Med review completed by outpatient psych provider for both residents Resident Turk sent to in-patient psych for evaluation and treatment Updated service plan for resident Turk and Duke Resident Duke Transferred to Secure Unit How the facility will identify other residents having the potential to be affected by the same	

	out for an evaluation in the emergency department. The physician, Power of Attorney (POA), and guardian were notified. The follow-up, dated 6/30/25, indicated the residents were in a consensual relationship and neither resident had a history of aggressive behavior. The guardian and POA were aware and consented to the relationship. Psychiatric evaluations were requested for both residents. Resident D returned from the hospital before the psychiatric evaluation was performed and was placed on one-on-one supervision until an onsite evaluation could be completed. Resident C had received an evaluation and was going to the memory care unit for day trips until a permanent transition to the memory care unit was available. 1. The clinical record for Resident C was reviewed on 7/15/25 at 11:32 a.m. The diagnoses included, but were not limited to, dementia without behavioral disorder, anxiety, and a history of cerebrovascular accident. Resident C was admitted to the facility on 6/30/23. Resident C had a Basic Interview for Mental Status (BIMS) assessment to evaluate cognitive function completed on 4/4/25. The resident had a score of 8 which indicated a moderately impaired		deficient practice and what corrective action will be taken All residents with dementia have potential to be affected by this alleged deficient practice Review all residents with dementia diagnosis, checking for residents in an intimate relationship with another resident Ensure service plans are updated as indicated Ensure notifications are present and documented What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;	

cognitive function.

A nursing progress note, dated 6/25/25 and entered as a late entry from 5/14/25, indicated the resident's POA was notified on "...this day...." the resident was having an intimate relationship with another resident. The POA was documented to not have any issues if the resident was happy.

The service plan was reviewed and did not contain documentation to indicate the resident was engaged in any intimate relationships.

The medical record was reviewed and did not contain documentation to indicate the resident was engaged in any intimate relationships or had a history of aggressive behaviors.

2. The clinical record for Resident D was reviewed on 7/15/25 at 11:44 a.m. The diagnoses included, but were not limited to, vascular dementia without behaviors, restless leg syndrome, and depression.

Resident D was admitted to the facility on 4/24/25. Resident D had a BIMS assessment to evaluate cognitive function completed on 5/16/25. The resident had a score of 7 which indicated a severely impaired cognitive function.

The service plan was reviewed

Staff educated by Ty Warner, Executive Director
or designee: Resident rights policy, Abuse policy, Notifications (ED, WD,POA,MD) when residents with dementia become engaged in an intimate relationship

MCD, Unit Coordinator, WD educated by Ty Warner, Executive Director on updating service plan when residents with dementia become
engaged in an intimate relationship

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 into place; and

ED, WD, or designee to read daily progress notes
for previous day auditing documentation for engagement in intimate
relationships to include updated service plan, and notifications are completed
and documented.

	and did not contain documentation to indicate the resident was engaged in any intimate relationships. A nursing progress note, dated 6/25/25 at 8:36 a.m., indicated a QMA had heard someone yell for help. The QMA responded, entered the room, and witnessed Resident D laying in another resident's room. Resident C was standing on the opposite side of the bed, leaning over Resident D with open hands on her chest/collar area. The QMA asked Resident C to stop what he was doing, and he did. Resident C was assessed and had an abrasion on his nose and left cheek. Resident D was assessed and was found to have slight redness and swelling to her right hand and a sore throat. The nurse asked Resident D what had happened. Resident D was noted to say the other resident was trying to get her out of his apartment and she refused to leave. When she continued to refuse, he raised his voice, and she did not like it, so she kicked and hit him. She continued to refuse to leave the apartment. Resident C then placed his open hands on her chest. Resident D was then provided one-on-one attention until emergency services arrived for transport. A nursing progress note, dated		Audits to be completed by ED/WD or designee daily for 1 week, bi weekly for 3 weeks, weekly for 4 weeks, once monthly for 4 months Audit results will be reviewed in QA Meeting Monthly	

6/25/25 at 9:28 a.m., was entered as a late entry from 5/21/25, indicated the guardian and Resident D's daughter were notified the resident was having an intimate relationship with another resident. The note indicated both the guardian and daughter consented to the relationship.

A nursing progress note, dated 6/26/25, indicated the resident was on one-on-one oversight and continued to attempt to get into the male resident's room.

A nursing progress note, dated 6/27/25, indicated the one-on-one caregiver reported Resident D did not sleep well and spent most of the night discussing intimate (sexual) encounters with Resident C and continued to attempt to leave her room and go to Resident D's room.

The resident was sent out to a neurological-psychiatric facility on 6/27/25 and returned to the facility on 7/3/25.

A nursing progress note, dated 7/6/25, indicated Resident D tried to get on the elevator to go see Resident C.

A nursing progress note, dated 7/9/25, indicated Resident D went to the memory care doors asking for Resident C.

A nursing progress note, dated

7/15/25, indicated Resident D went to the memory care door multiple times wanting to see Resident C.

A facility document, titled "Incident Report," dated 6/25/25 indicated a QMA heard someone yelling and went into Resident C's apartment. Resident C was standing on the side of the bed while the other resident was lying on the bed. He was leaning over the other resident with his open hands on her chest/collar area. The nurse asked Resident C what had happened, and he told the nurse he had asked Resident D to leave his room multiple times, but she refused. She made contact with his torso and upper legs using her legs. He then grabbed her right hand to get her to stand. Resident C said he wanted peace and did not understand how it progressed to this. The nurse assessed Resident C and found a small abrasion on the bridge of his nose, and he had complaints of bilateral knee soreness.

A facility document, titled "INTERVIEW/INVESTIGATIVE RECORD," undated, indicated Resident D was interviewed about the incident. She indicated Resident C asked her to leave his room and she refused. She told him they loved each other and had decided to be together. When Resident C

continued to request her to leave the room, she told him they had plans for the day and had to be together. She continued to discuss the relationship and about him looking at other women. She told him she was the only woman in his life, and he could not have other women. She felt he was not taking her seriously, and responded negatively by just saying "o.k." She then stated he began to yell at her, and she kicked him in the stomach and legs. He grabbed her wrist, attempting to get her to leave the room. She refused. She then indicated he began to choke her. She yelled for help; the staff responded and removed him from the room. The nurse assessed the resident and found her right wrist was slightly red and swollen, the wrist was tender to touch, and the resident had a small abrasion on the left cheek and nose. The resident did say her neck was slightly tender and requested to go to the hospital. The nurse did not see redness or a bruise. The resident was sent out to the emergency department for evaluation.

A facility document, titled "INTERVIEW/INVESTIGATIVE RECORD," dated 6/25/25, indicated Resident C was interviewed about the incident and he indicated he "...wanted peace...." and did not

understand what had happened. Resident D became upset when he asked her to leave the room. She began kicking him, making contact with his stomach and legs. He grabbed her wrist to get her up and she continued to refuse. He indicated Resident D was talking about other women and he just "...shrugged and said ok...." It got worse from that point, and he did not know why. He thought they liked each other, and he wanted peace. He felt he had to defend himself. The nurse assessed Resident C, and he was found to have an abrasion on the bridge of his nose. He did have complaints of discomfort on his knees. No other injuries were found. The resident was sent out to the emergency department for evaluation.

A facility document, titled "INTERVIEW/INVESTIGATIVE RECORD," dated 6/25/25, indicated QMA 2 walked past the room and heard concerning noises. She entered the room, and Resident D was screaming for help. She observed Resident C standing at the bedside, leaning over and pushing down onto Resident D's upper chest. The QMA asked him to stop, and he did. She moved him to the library without incident and called for assistance. Resident D was removed from the room. QMA 2 returned Resident C to his room and asked him what

had happened. He told her he asked the resident to leave his room, and she refused. QMA 2 remained with the resident until transportation arrived. The document was signed by QMA 2 on 6/25/25.

During an observation and interview, on 7/15/25 at 9:19 a.m., Resident D was observed in the common area with her walker. She indicated the incident was a misunderstanding. Resident C and her were discussing things and he grabbed her hands. He did not mean to hurt her, but he did scare her. She indicated she did have a bruise, but she bruised easily. He was not sexual with her, but they did have an intimate sexual relationship, and they were still together. They have been together for two and a half years. She indicated the relationship was consensual. Now his family would not let her talk to him. She indicated the facility had to give her a guard around the clock, because the family was making threatening comments to her after Resident C left the facility.

During an observation, on 7/15/25 at 10:30 a.m., Resident C was observed up in the dining room of the memory care unit. He was quiet and eating his meal without assistance.

During a telephone interview, on 7/15/25 at 10:28 a.m., the Power of Attorney (POA) for Resident C indicated Resident C did have a relationship with Resident D. Resident C felt it was more friendly, but Resident D felt it was more serious. Resident D had moved her things into his apartment and Resident C did not want that. The POA contacted the management and had Resident D's items moved back to her apartment. This happened three times. The facility management had to inform Resident D that Resident C did not want to share an apartment. Resident C was moved to the memory care unit and the POA did not want Resident D to know Resident C was still in the facility. The POA indicated she felt Resident D was obsessive in regard to the perceived relationship and had told people they were married. The POA did not want Resident D around her brother at all and felt he was safe on the memory care unit. Resident D could not get onto the unit. The POA had typed her phone number for her brother and posted it in his room. Resident D took the paper and had called Resident C's POA multiple times. Resident C's POA indicated she had to request the facility take the phone number away from Resident D. She indicated Resident D had to have a one-on-one person to keep her

away from her brother and his apartment until he was moved into memory care.

During an interview, on 7/15/25 at 11:02 a.m., the Regional Nurse indicated the one-on-one person was assigned to Resident D because she was the aggressor.

During an interview, on 7/15/25 at 11:03 a.m., the Executive Director indicated Resident D was sent out to a psychiatric hospital for an evaluation.

During a telephone interview, on 7/16/25 at 9:10 a.m., QMA 2 indicated she was giving another resident medication when she heard noise from Resident C's room. She entered the room, and Resident D was yelling for help. Resident C was standing over her. Resident C was pushing on Resident D's chest/neck area, and she was protecting her neck. QMA 2 separated them and had Resident C sit in the library area. The residents did have a relationship, but he wanted her out of his apartment.

During an interview, on 7/16/25 at 9:11 a.m., the Regional Nurse indicated family, and guardians could allow the residents to have a relationship, the dementia diagnosis was put in early, she did not know what stage (of dementia) either

resident was in, but residents with dementia could make their own decisions.

During an interview, on 7/16/25 at 9:15 a.m., Resident D indicated when the incident happened, they were in Resident C's room, they were arguing. He grabbed her hands, and she did what any skinny tiny woman would do and screamed for help. Staff came and called the police. She kicked him because her legs were free. He did not hit or choke her. She could not recall if he had invited her into his room. She did ask him if he wanted her to sleep with him. She indicated he gave her a ring, and it was an engagement ring. His family wanted the ring back and said she had stolen it, but it was her ring. They discussed marriage but were not married because she was catholic and he was protestant. They could marry but his family would not allow it. She had been here 2 years, and they had been together in the relationship for 2 years. She had not seen him since the incident.

During an interview, on 7/16/25 at 9:26 a.m., Resident C indicated Resident D was his friend. They were just having fun, it was consensual, they were just having fun. He indicated the relationship was intimate but not serious. Resident D hit and kicked him

but it did not hurt. Resident D was nice, and they had a lot of fun. He did not want to marry her. She wanted him to leave the facility with her.

During a telephone interview, on 7/16/25 at 9:59 a.m., the Area Vice President of Operations indicated at the beginning of the relationship both residents consented to the relationship and the facility had care plan meetings with the family and guardian about 1-2 months ago. The family and guardian consented to the relationship. There were no aggressive behaviors the facility was aware of, they had a "lover's quarrel". The facility protected both residents and sent them out for an evaluation. The facility had been talking with Resident C's POA about memory care placement for participation and activities, not for behaviors. The unit was smaller, targeted to dementia, there was less anxiety, and the staff encouraged engagement in activity. It was for quality of life. She indicated per resident rights people with dementia could consent and make decisions. The guardians and POA could make decisions which included who the residents could see and visit.

During an interview, on 7/16/25 at 10:04 a.m., the Regional Nurse indicated the residents

were seeking each other out.

During a follow-up telephone interview, on 7/16/25 at 10:54 a.m., the POA for Resident C indicated she was made aware of the relationship about one and a half months ago. The first time the Executive Director mentioned the relationship was when they were moving the female resident's items out of her brother's apartment. Her brother had told her they were best friends. She did not consent for her brother, but she did want whatever he wanted. She did ask her brother if he wanted to live with the female resident and he told her no; he wanted to be friends. The female resident did ask the POA about marriage and the POA told her it was not the right thing to do. She indicated she realized what the relationship was when she observed female items in the apartment, her underwear and other items. She asked her brother if the female spent the night and he told her she did. He referred to her as a friend, not his girlfriend. She indicated after the Executive Director and her moved the items back to the female resident's room, the resident attempted two more times to move her items back. The facility never discussed memory care placement until after the incident. She indicated she was happy with her brother's

placement on the memory care unit and felt he was safe on the unit. The female resident could not see, talk, or get to him.

During an interview, on 7/16/25 at 11:31 a.m., the Executive Director indicated he and Resident C's family member moved the female resident's items out of Resident C's room once. The female resident did attempt to move items back into the room but was redirected by facility staff. The POA did not want Resident D's items in her brother's apartment. The Executive Director indicated he did not speak to the male resident (Resident C) about the relationship.

During a telephone interview, on 7/17/25 at 11:58 a.m., the Guardian for Resident D indicated the resident was under court ordered guardianship by the State of Indiana. She was notified of the intimate relationship between the two residents on 5/14/25. She indicated she received an email from the nurse on 5/14/25. On 5/21/25, they (the guardian and facility) had a meeting. She was not sure of the appropriateness of the relationship. The facility felt it was appropriate, and she based her decision about the relationship on what the facility had said since they spent more time with the residents and if they had no concerns, she did

not as well.

A current facility policy, titled "Resident Neglect, Abuse and Misappropriation of Property," dated as revised in March of 2024 and received from the Regional Nurse on 7/16/25, indicated "...Residents will be free from...verbal, sexual, physical...abuse...."

A current facility policy, titled "Resident's Rights," dated as last reviewed in February 2022 and received from the Executive Director on 7/16/25 at 12:10 p.m., indicated "...Residents have the right to be free from...sexual abuse...physical abuse...Residents have the right to be free from verbal abuse...."

This citation relates to Complaint IN00462303.

Based on interview and record review, the facility failed to ensure residents were free from abuse and neglect when residents with a diagnosis of dementia were allowed to consent to a consensual relationship and had a physical altercation for 2 of 2 residents reviewed for abuse. (Resident C and D)

Findings include:

A facility reported incident, dated 6/25/25, indicated staff entered the apartment of Resident C and found him

standing by the bed, leaning over Resident D, with his hands upon her chest. Both residents sustained superficial abrasions to the face. Resident C was easily redirected, the residents were separated, and one-on-one was given to assure the safety of the residents. The residents were assessed and supervised until they were sent out for an evaluation in the emergency department. The physician, Power of Attorney (POA), and guardian were notified. The follow-up, dated 6/30/25, indicated the residents were in a consensual relationship and neither resident had a history of aggressive behavior. The guardian and POA were aware and consented to the relationship. Psychiatric evaluations were requested for both residents. Resident D returned from the hospital before the psychiatric evaluation was performed and was placed on one-on-one supervision until an onsite evaluation could be completed. Resident C had received an evaluation and was going to the memory care unit for day trips until a permanent transition to the memory care unit was available.

1. The clinical record for Resident C was reviewed on 7/15/25 at 11:32 a.m. The diagnoses included, but were not limited to, dementia without behavioral disorder, anxiety,

	and a history of cerebrovascular accident. Resident C was admitted to the facility on 6/30/23. Resident C had a Basic Interview for Mental Status (BIMS) assessment to evaluate cognitive function completed on 4/4/25. The resident had a score of 8 which indicated a moderately impaired cognitive function. A nursing progress note, dated 6/25/25 and entered as a late entry from 5/14/25, indicated the resident's POA was notified on "...this day...." the resident was having an intimate relationship with another resident. The POA was documented to not have any issues if the resident was happy. The service plan was reviewed and did not contain documentation to indicate the resident was engaged in any intimate relationships. The medical record was reviewed and did not contain documentation to indicate the resident was engaged in any intimate relationships or had a history of aggressive behaviors.			

2. The clinical record for Resident D was reviewed on 7/15/25 at 11:44 a.m. The diagnoses included, but were not limited to, vascular dementia without behaviors, restless leg syndrome, and depression.

Resident D was admitted to the facility on 4/24/25. Resident D had a BIMS assessment to evaluate cognitive function completed on 5/16/25. The resident had a score of 7 which indicated a severely impaired cognitive function.

The service plan was reviewed and did not contain documentation to indicate the resident was engaged in any intimate relationships.

A nursing progress note, dated 6/25/25 at 8:36 a.m., indicated a QMA had heard someone yell for help. The QMA responded, entered the room, and witnessed Resident D laying in another resident's room. Resident C was standing on the opposite side of the bed, leaning over Resident D with open hands on her chest/collar area. The QMA asked Resident C to stop what he was doing, and he did. Resident C was assessed and had an abrasion on his nose and left cheek. Resident D was assessed and was found to have slight redness and swelling to her right hand and a sore throat. The

nurse asked Resident D what had happened. Resident D was noted to say the other resident was trying to get her out of his apartment and she refused to leave. When she continued to refuse, he raised his voice, and she did not like it, so she kicked and hit him. She continued to refuse to leave the apartment. Resident C then placed his open hands on her chest. Resident D was then provided one-on-one attention until emergency services arrived for transport.

A nursing progress note, dated 6/25/25 at 9:28 a.m., was entered as a late entry from 5/21/25, indicated the guardian and Resident D's daughter were notified the resident was having an intimate relationship with another resident. The note indicated both the guardian and daughter consented to the relationship.

A nursing progress note, dated 6/26/25, indicated the resident was on one-on-one oversight and continued to attempt to get into the male resident's room.

A nursing progress note, dated 6/27/25, indicated the one-on-one caregiver reported Resident D did not sleep well and spent most of the night discussing intimate (sexual) encounters with Resident C and continued to attempt to leave

her room and go to Resident D's room.

The resident was sent out to a neurological-psychiatric facility on 6/27/25 and returned to the facility on 7/3/25.

A nursing progress note, dated 7/6/25, indicated Resident D tried to get on the elevator to go see Resident C.

A nursing progress note, dated 7/9/25, indicated Resident D went to the memory care doors asking for Resident C.

A nursing progress note, dated 7/15/25, indicated Resident D went to the memory care door multiple times wanting to see Resident C.

A facility document, titled "Incident Report," dated 6/25/25 indicated a QMA heard someone yelling and went into Resident C's apartment. Resident C was standing on the side of the bed while the other resident was lying on the bed. He was leaning over the other resident with his open hands on her chest/collar area. The nurse asked Resident C what had happened, and he told the nurse he had asked Resident D to leave his room multiple times, but she refused. She made contact with his torso and upper legs using her legs. He then grabbed her right hand to get her to stand. Resident C said he

wanted peace and did not understand how it progressed to this. The nurse assessed Resident C and found a small abrasion on the bridge of his nose, and he had complaints of bilateral knee soreness.

A facility document, titled "INTERVIEW/INVESTIGATIVE RECORD," undated, indicated Resident D was interviewed about the incident. She indicated Resident C asked her to leave his room and she refused. She told him they loved each other and had decided to be together. When Resident C continued to request her to leave the room, she told him they had plans for the day and had to be together. She continued to discuss the relationship and about him looking at other women. She told him she was the only woman in his life, and he could not have other women. She felt he was not taking her seriously, and responded negatively by just saying "o.k." She then stated he began to yell at her, and she kicked him in the stomach and legs. He grabbed her wrist, attempting to get her to leave the room. She refused. She then indicated he began to choke her. She yelled for help; the staff responded and removed him from the room. The nurse assessed the resident and found her right wrist was slightly red and

swollen, the wrist was tender to touch, and the resident had a small abrasion on the left cheek and nose. The resident did say her neck was slightly tender and requested to go to the hospital. The nurse did not see redness or a bruise. The resident was sent out to the emergency department for evaluation.

A facility document, titled "INTERVIEW/INVESTIGATIVE RECORD," dated 6/25/25, indicated Resident C was interviewed about the incident and he indicated he "...wanted peace...." and did not understand what had happened. Resident D became upset when he asked her to leave the room. She began kicking him, making contact with his stomach and legs. He grabbed her wrist to get her up and she continued to refuse. He indicated Resident D was talking about other women and he just "...shrugged and said ok...." It got worse from that point, and he did not know why. He thought they liked each other, and he wanted peace. He felt he had to defend himself. The nurse assessed Resident C, and he was found to have an abrasion on the bridge of his nose. He did have complaints of discomfort on his knees. No other injuries were found. The resident was sent out to the emergency department for evaluation.

A facility document, titled "INTERVIEW/INVESTIGATIVE RECORD," dated 6/25/25, indicated QMA 2 walked past the room and heard concerning noises. She entered the room, and Resident D was screaming for help. She observed Resident C standing at the bedside, leaning over and pushing down onto Resident D's upper chest. The QMA asked him to stop, and he did. She moved him to the library without incident and called for assistance. Resident D was removed from the room. QMA 2 returned Resident C to his room and asked him what had happened. He told her he asked the resident to leave his room, and she refused. QMA 2 remained with the resident until transportation arrived. The document was signed by QMA 2 on 6/25/25.

During an observation and interview, on 7/15/25 at 9:19 a.m., Resident D was observed in the common area with her walker. She indicated the incident was a misunderstanding. Resident C and her were discussing things and he grabbed her hands. He did not mean to hurt her, but he did scare her. She indicated she did have a bruise, but she bruised easily. He was not sexual with her, but they did have an intimate sexual relationship, and they were still together. They have been

together for two and a half years. She indicated the relationship was consensual. Now his family would not let her talk to him. She indicated the facility had to give her a guard around the clock, because the family was making threatening comments to her after Resident C left the facility.

During an observation, on 7/15/25 at 10:30 a.m., Resident C was observed up in the dining room of the memory care unit. He was quiet and eating his meal without assistance.

During a telephone interview, on 7/15/25 at 10:28 a.m., the Power of Attorney (POA) for Resident C indicated Resident C did have a relationship with Resident D. Resident C felt it was more friendly, but Resident D felt it was more serious. Resident D had moved her things into his apartment and Resident C did not want that. The POA contacted the management and had Resident D's items moved back to her apartment. This happened three times. The facility management had to inform Resident D that Resident C did not want to share an apartment. Resident C was moved to the memory care unit and the POA did not want Resident D to know Resident C was still in the facility. The POA indicated she felt Resident D was obsessive in regard to the

perceived relationship and had told people they were married. The POA did not want Resident D around her brother at all and felt he was safe on the memory care unit. Resident D could not get onto the unit. The POA had typed her phone number for her brother and posted it in his room. Resident D took the paper and had called Resident C's POA multiple times. Resident C's POA indicated she had to request the facility take the phone number away from Resident D. She indicated Resident D had to have a one-on-one person to keep her away from her brother and his apartment until he was moved into memory care.

During an interview, on 7/15/25 at 11:02 a.m., the Regional Nurse indicated the one-on-one person was assigned to Resident D because she was the aggressor.

During an interview, on 7/15/25 at 11:03 a.m., the Executive Director indicated Resident D was sent out to a psychiatric hospital for an evaluation.

During a telephone interview, on 7/16/25 at 9:10 a.m., QMA 2 indicated she was giving another resident medication when she heard noise from Resident C's room. She entered the room, and Resident D was yelling for help. Resident C was

	standing over her. Resident C was pushing on Resident D's chest/neck area, and she was protecting her neck. QMA 2 separated them and had Resident C sit in the library area. The residents did have a relationship, but he wanted her out of his apartment. During an interview, on 7/16/25 at 9:11 a.m., the Regional Nurse indicated family, and guardians could allow the residents to have a relationship, the dementia diagnosis was put in early, she did not know what stage (of dementia) either resident was in, but residents with dementia could make their own decisions. During an interview, on 7/16/25 at 9:15 a.m., Resident D indicated when the incident happened, they were in Resident C's room, they were arguing. He grabbed her hands, and she did what any skinny tiny woman would do and screamed for help. Staff came and called the police. She kicked him because her legs were free. He did not hit or choke her. She could not recall if he had invited her into his room. She did ask him if he wanted her to sleep with him. She indicated he gave her a ring, and it was an engagement ring. His family wanted the ring back and said she had stolen it, but it was her ring. They discussed marriage			

but were not married because she was catholic and he was protestant. They could marry but his family would not allow it. She had been here 2 years, and they had been together in the relationship for 2 years. She had not seen him since the incident.

During an interview, on 7/16/25 at 9:26 a.m., Resident C indicated Resident D was his friend. They were just having fun, it was consensual, they were just having fun. He indicated the relationship was intimate but not serious. Resident D hit and kicked him but it did not hurt. Resident D was nice, and they had a lot of fun. He did not want to marry her. She wanted him to leave the facility with her.

During a telephone interview, on 7/16/25 at 9:59 a.m., the Area Vice President of Operations indicated at the beginning of the relationship both residents consented to the relationship and the facility had care plan meetings with the family and guardian about 1-2 months ago. The family and guardian consented to the relationship. There were no aggressive behaviors the facility was aware of, they had a "lover's quarrel". The facility protected both residents and sent them out for an evaluation. The facility had been talking with Resident C's POA about memory care

placement for participation and activities, not for behaviors. The unit was smaller, targeted to dementia, there was less anxiety, and the staff encouraged engagement in activity. It was for quality of life. She indicated per resident rights people with dementia could consent and make decisions. The guardians and POA could make decisions which included who the residents could see and visit.

During an interview, on 7/16/25 at 10:04 a.m., the Regional Nurse indicated the residents were seeking each other out.

During a follow-up telephone interview, on 7/16/25 at 10:54 a.m., the POA for Resident C indicated she was made aware of the relationship about one and a half months ago. The first time the Executive Director mentioned the relationship was when they were moving the female resident's items out of her brother's apartment. Her brother had told her they were best friends. She did not consent for her brother, but she did want whatever he wanted. She did ask her brother if he wanted to live with the female resident and he told her no; he wanted to be friends. The female resident did ask the POA about marriage and the POA told her it was not the right thing to do. She indicated she

realized what the relationship was when she observed female items in the apartment, her underwear and other items. She asked her brother if the female spent the night and he told her she did. He referred to her as a friend, not his girlfriend. She indicated after the Executive Director and her moved the items back to the female resident's room, the resident attempted two more times to move her items back. The facility never discussed memory care placement until after the incident. She indicated she was happy with her brother's placement on the memory care unit and felt he was safe on the unit. The female resident could not see, talk, or get to him.

During an interview, on 7/16/25 at 11:31 a.m., the Executive Director indicated he and Resident C's family member moved the female resident's items out of Resident C's room once. The female resident did attempt to move items back into the room but was redirected by facility staff. The POA did not want Resident D's items in her brother's apartment. The Executive Director indicated he did not speak to the male resident (Resident C) about the relationship.

During a telephone interview, on 7/17/25 at 11:58 a.m., the Guardian for Resident D

indicated the resident was under court ordered guardianship by the State of Indiana. She was notified of the intimate relationship between the two residents on 5/14/25. She indicated she received an email from the nurse on 5/14/25. On 5/21/25, they (the guardian and facility) had a meeting. She was not sure of the appropriateness of the relationship. The facility felt it was appropriate, and she based her decision about the relationship on what the facility had said since they spent more time with the residents and if they had no concerns, she did not as well.

A current facility policy, titled "Resident Neglect, Abuse and Misappropriation of Property," dated as revised in March of 2024 and received from the Regional Nurse on 7/16/25, indicated "...Residents will be free from...verbal, sexual, physical...abuse...."

A current facility policy, titled "Resident's Rights," dated as last reviewed in February 2022 and received from the Executive Director on 7/16/25 at 12:10 p.m., indicated "...Residents have the right to be free from...sexual abuse...physical abuse...Residents have the right to be free from verbal abuse...."

	This citation relates to Complaint IN00462303.			

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