STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVIVA MERRILLVILLE	7900 RHODE ISLAND STREET, MERRILLVILLE, , 46410

(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 Intakes 469092 and 469343. Intake 469092 - State deficiency related to the allegations is cited at R0349. Intake 469343 - No deficiencies related to the allegations are cited. Survey date: June 30 and July 1, 2026 Facility number: 013733 Residential Census: 58 These State Residential Findings are cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 7/7/26.	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 the regulations. The Administrator will ensure all corrective action in the following Plan of Correction has been completed.	
R 0349	Clinical Records - Noncompliance	R 0349	A. The incident report regarding resident D has since been	07/08/2026

	410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to incident charting, follow up documentation after a fall, and notification to the responsible party and physician regarding a fall and behavioral incident resulting in hospitalization for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: Resident D's record was reviewed on 6/30/26 at 11:13 a.m. Diagnoses included, but were not limited to, vascular dementia. A Progress Note, dated 3/31/26 at 7:45 p.m., indicated the resident was confused and upset while roaming around the		completed by the staff member who was on duty during the original incident. The resident's representative and physician were notified related to the behaviors, falls and ER visit. B. To determine if other residents may have been affected all 24-hour/communication logs for the last 6 months will be reviewed by the director of nursing or his/her designee. Immediate action will be taken if any item is missing an incident report and/or physician communication and/or residents' representative notification. C. The director of nursing or his/her designee will in-service all nurses and QMA's. The staff will be instructed to follow AVIVA Senior Living Policy and Procedure regarding incident reporting. D. Weekly audits of the 24-hour/communication log will be completed by the Director of nursing or his/her designee. The weekly audits will continue until a pattern of compliance is obtained. The charted audits will be reviewed at the Quality Assurance meetings to ensure continued compliance. E. All training and review will be completed by July 24, 2026	

halls looking for his wife. He was very difficult, unable to be redirected, and refused as needed (PRN) Xanax (antianxiety medication) to help him relax. The resident rolled away from the writer at the nursing station and went towards the common area. As the resident was entering the common area, he started to become verbally and physically aggressive towards residents and staff. Staff members were asked to remove and separate him from others. As staff tried to remove the resident from the common area, he began to physically fight staff members who were pushing his wheelchair. The wheelchair fell backwards, and the resident picked himself up from the floor and continued to physically attack the staff member again until he fell down to the floor. Staff were able to help him from the floor and back into the wheelchair. 911 was called and the resident was sent out to the hospital for a mental status evaluation. The resident returned from the emergency department with no new orders. The plan of care was ongoing.

A Progress Note, dated 4/1/26, indicated the resident had no complaints related to the recent fall. He was aggressively confused that morning. He had walked out of his room with his

socks on his hands and pajama pants wrapped around his waist using them as a belt. When staff tried to assist the resident he began yelling and cursing at the staff member.

The record lacked documentation that the resident's representative and physician were notified related to the behaviors, falls, and hospital stay. There was also no assessment of the resident after the fall before he was sent to the hospital.

During an interview on 7/1/26 at 2:30 p.m., the Director of Nursing indicated after a fall, the staff person was supposed to initiate an "incident report," which included which parties were notified along with documentation of an assessment. The physician and the resident's representative were both aware of the incident resulting in the resident being sent to the hospital. The staff person was focused on the resident's safety and getting him out of the facility. She then had forgot to go back in and complete the follow-up documentation for the incident.

This citation relates to Intake 469092.

instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREMeriam Hillis	TITLEExecutive Director	(X6) DATE07/13/2026